Medical assistance covers medically necessary services and consultations delivered via ~~telemedicine~~ telehealth when performed by:

- a licensed or state registered health care provider;
- a mental health practitioner working under the supervision of a mental health professional;
- a certified community health worker;
- an alcohol and drug counselor;
- recovery peers;
- substance abuse disorder treatment coordinators
- mental health certified peer specialists and certified family peer specialists;
- rehabilitation workers in ARMHS;
- mental health behavioral aides operating in a CTSS program;
- federally qualified health centers and rural health centers including Indian Health providers; and
- providers qualified in accordance with par. 13(d) of Attachment 3.1-A to provide a comprehensive assessment for substance use disorder services, in the same manner as if the service or consultation was delivered in person.

Telehealth means the delivery of health care services or consultations through the use of real time two-way interactive video and visual or audio-only communication to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~Telemedicine~~ Telehealth includes the application of secure video conferencing, store and forward technology, and synchronous interactions between a ~~is the delivery of health care services while the~~ patient ~~is~~ at an originating site and ~~the~~ a health care provider ~~is~~ at a distant site. A communication between health care providers, or a health care provider and a patient that consists solely of mail, e-mail, or facsimile does not constitute ~~telemedicine~~ telehealth ~~services~~. ~~Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing, or store and forward technology, or via telephone when social distancing or quarantine is necessary either for the provider or the patient and video communication is not feasible.~~ Providers utilizing ~~telemedicine~~ telehealth must comply with criteria established by the Minnesota Department of Human Services in order to demonstrate that a quality assurance process and established protocols for patient safety have been addressed before, during, and after a particular service is delivered via telehealth~~telemedicine~~.

26. Personal care services, continued

a. The Personal Care Assistance Choice provider agency must ensure arms-length transactions without undue influence or coercion with the recipient and personal care assistant.

3. Under Personal Care Assistance Choice, qualified professionals must visit the recipient in the recipient's home at least once every 180 days. ~~These visits may be conducted remotely using telephonic or other electronic means.~~ Qualified professionals report to the appropriate authorities any suspected abuse, neglect, or financial exploitation of the recipient.

4. Authorization to use the Personal Care Assistance Choice option will be denied, revoked, or suspended if:

a. the public health nurse or qualified professional, as defined below in F.1., determines that use of this option jeopardizes the recipient's health and safety;

b. the parties do not comply with the written agreement; or

c. the use of the option results in abusive or fraudulent billing.

E. **Qualified Professionals**

1. "Qualified professional" means the following professionals as defined in Minnesota Statute § 256b.0625, subdivision 19c' employed by a personal care provider agency: a registered nurse, mental health professional, licensed social worker, or qualified developmental disability specialist.

2. A qualified professional performs the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care services. The qualified professional develops a care plan based on the service plan developed by the assessor.

3. Recipients or responsible parties utilizing either Personal Care Assistance Choice or personal care provider organizations must have qualified professional supervision of personal care assistants.

G. **Personal Care Assistants**

1. Must be at least 18 years of age, except that a 16 or 17 year old may be a personal care assistant if they meet all of the requirements for the position, have supervision every 60 days, and are employed by only one personal care provider agency;

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A. IHS/638 Facilities

Except for child welfare-targeted case management services and relocation service coordination services, services provided by facilities of the Indian Health Service (which include, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act., P.L. 106-260, operating as 638 facilities) are paid at the rates negotiated between the Indian Health Service and the Centers for Medicare & Medicaid Services and published by the Indian Health Service in the Federal Register, Child-welfare targeted case management services are paid in accordance with the methodology in item 19.b., child welfare-targeted case management services. Relocation service coordination services are paid in accordance with the methodology in item 19.c, relocation service coordination services.

An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.

Telehealth visits provided through real-time interactive audio and video communication may be used to satisfy the face-to-face requirement.

B. Critical Access Hospitals

Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Centers for Medicare & Medicaid Services) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.

C. Third Party Liability

In accordance with Minnesota Statutes, §2568.37, subdivision 5a: No Medical Assistance payment will be made when covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A clinic receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a clinic's payments back to January 1, 2001 when the clinic's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM II, and APM III) rates for clinics will include a rate for dental services, if provided, and a rate for all other rural health clinic services of the provider or provider group. Hereinafter, "all other rural health clinic services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a clinic's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(6) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the clinic must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the clinic's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a clinic's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by clinic professionals, including all encounters provided by clinic staff outside of the clinic to clinic patients. Telehealth visits provided through real-time interactive audio and video communication may be used to satisfy the face-to-face requirement.

In order to comply with §1902(bb)(4) of the Act, for a clinic that first qualifies as a clinic provider beginning on or after fiscal year 2000, the Department will compare the new clinic to other clinics in the same or adjacent areas with similar caseloads. If no comparable provider exists, the Department will compute a clinic-specific rate based upon the clinic's budget or historical costs adjusted for changes in the scope of services.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

For FQHC payments, "visit" means a face-to-face encounter between a FQHC patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Telehealth visits provided through real-time interactive audio and video communication may be used to satisfy the face-to-face requirement.

The State uses the FQHC's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

A. Medicaid coverage of services that differs from Medicare coverage;

B. the applicable visits; and

C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.