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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: 19-0012

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
Services 601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

August 28, 2020

Matt Anderson, Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Mr. Anderson:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #19-0012 -- Reduces provider tax, reduces limits in Medicare fee schedule, and increases the payment rates for Doula services.

--Effective Date: July 1, 2019

--Approval Date: August 25, 2020

If you have any additional questions, please have a member of your staff contact Sandra Porter at (312) 353-8310 or via e-mail at Sandra.Porter@cms.hhs.gov.

Sincerely,

Digitally signed by James G. Scott -S
Date: 2020.08.28 10:47:15 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Ann Berg, DHS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

August 28, 2020

Matt Anderson, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Mr. Anderson:

This letter is being sent as a companion letter to the Centers for Medicare and Medicaid Services (CMS) approval of Minnesota state plan amendment (SPA) #19-0012 submitted on September 30, 2019. This SPA revises payment rates for certain services to reflect the reduction in Minnesota's provider tax; limits payment for certain supplies and equipment to the Medicare fee schedule amount; increases payment rates for services provided by doulas; and makes some technical corrections effective July 1, 2019.

CMS approves SPA 19-0012 with the following concerns that the state must adhere to going forward for ALL applicable SPA submissions:

1. **Non-Compliant Tribal Consultation:** The state failed to issue a sufficient tribal consultation notice 30 days prior to submitting SPA 19-0012 to CMS as required per the State's approved tribal consultation SPA 13-034. Rather, the state issued its tribal consultation notice to the Tribes, Indian Health Programs and Urban Indian Organizations on the same date (September 30, 2019) the SPA was submitted to CMS.

   CMS strongly encourages the state to perform tribal consultation according to Minnesota's approved State Plan. Solicitation of advice from Indian Health Programs and Urban Indian Organizations is evaluated based on the state's adherence to the approved State Plan pages in Section 1.4, pages 9-9.2. The legal citation for the tribal consultation requirement can be found in the Social Security Act (Act) at §1902(a)(73) as follows:

   > "*in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this subchapter that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that — A. shall include solicitation of advice* ***prior to submission*** *of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a* ***direct effect*** *on Indians, Indian Health Programs, or Urban Indian Organizations; …*"

   It is important to remember that the Act requires consultation when there is a direct effect on Indians, Indian Health Programs and Urban Indian Organizations. Minnesota's approved tribal consultation SPA defines direct effect as follows:

   > ***Changes that are likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations are those that would impact eligibility determinations, reduce payment rates, change payment methodologies, reduce covered services, or change provider qualification requirements****."*

The state plan also specifies that the notice will "include a brief description of the proposal, its likely impact on Indian people or Indian health care providers, and a process and timeline for comment." CMS strongly encourages the state to provide a description of the proposal and its likely impact on Indians, Indian Health Programs and Urban Indian Organizations with any future tribal consultation notices that are issued**.**

Please be aware that failure to conduct tribal consultation prior to submission of SPAs having a direct effect on Indians, Indian Health Programs and Urban Indian Organizations, could result in a disapproval or a situation where the state would have to withdraw a SPA. The State would then need to consult and solicit advice and resubmit the SPA or waiver request, thereby delaying the effective date of the change.

2. **Public Notice Requirements:** CMS accepted the public notice published in the state register, along with a tax notice sent to providers for the change in the MinnesotaCare Tax, as sufficient notice for the reduction of the MinnesotaCare Tax Adjustment in SPA 19-0012. However, the notice lacked clear and pertinent language concerning the Minnesota provider tax and its relationship to the various rate reductions proposed in the SPA. Going forward, please ensure that the state's public notice is sufficient as described herein. Public notice is necessary to inform providers and other stakeholders of any changes states intend to make to their Medicaid payment methodologies. These notices ensure that providers and others are aware of changes in payment and do not rely on prior payment methodologies. Longstanding Federal regulations at 42 CFR 447.205 require states to issue public notice for any significant proposed changes in its methods and standards for setting Medicaid payment rates for services. In addition to the details on the required timing of public notice, the regulation also lays out the appropriate platforms in which public notice can be issued (websites, newspapers, and state registers) as well as required content of the notice.

   In addition to the requirements laid out in 42 CFR 447.205, there was a CMCS Informational Bulletin released June 24, 2016 as well as State Medicaid Director Letter (SMDL) 17-0004, that provides further detailed guidance regarding the timing and contents of a public notice. The Informational Bulletin and the SMDL (enclosed) indicate that with respect to the regulations, CMS expects states will issue public notices that:

   1) Explicitly identify the Medicaid service(s) being affected by the proposed payment change;
   2) Identify the dollar amount of any rate change(s) or the percent increase or decrease in the rate(s);
   3) Explain the expected increase or decrease in annual aggregate expenditures by the benefit category or service being affected;
   4) In instances where the changes in methods and standards are applied across benefit categories, such as across the board percentage rate increases or decreases, provide a comprehensive list of the services that will be affected by the change; and
   5) Provide all relevant information required by the regulation within the text of the public notice without reliance on websites or documents external to the public notice.

   Please be aware that failure to issue proper public notice can result in states being required to re-issue notice, possibly delaying the effective date of the SPA implementing the proposed change. It can also result in disapproval of the SPA.

If you have any questions concerning this SPA, please contact Sandra Porter of my staff at (312) 353-8310.

Sincerely,

James G. Scott
Director, Division of Program Operations

cc: Ann Berg, DHS

Enclosures (2): CMCS Informational Bulletin 06-24-16, SMDL #17-0004

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: June 24, 2016

FROM: Vikki Wachino, Director
Center for Medicaid and CHIP Services

SUBJECT: Federal public notice and public process requirements for changes to Medicaid payment rates

The purpose of this CMCS Informational Bulletin is to summarize procedures states must follow when making changes to provider payments under the Medicaid state plan and to emphasize the importance of public notice content and timing requirements. Specific to payment changes, there are three types of procedures:

- public notice policies that pertain to all proposed changes to provider payment rates or methodologies
- public input process policies, which apply when states reduce rates or restructure payments, and are designed to obtain input related access to care
- public input process policies that are specific to changes to institutional provider payment rates

Some of these requirements are longstanding; others were codified in CMS' November 2, 2015 final rule: "Medicaid Program: Methods for Assuring Access to Covered Medicaid Services" (80 FR 67576). This rule updated public notice requirements and provided guidance on public process procedures to identify and analyze access to care concerns, among other policies. The final rule established a new transparent, data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act (the Act). The final rule applies to services covered under the Medicaid state plan and paid on a fee-for-service basis. Where relevant, these new requirements are noted below.

Public Notice for All Proposed Changes to Payment Rates or Methodologies

Longstanding federal regulations at 42 CFR 447.205 require states to issue public notice of proposed changes in statewide methods and standards for setting Medicaid payment rates. Public notice is necessary to inform providers and other stakeholders of any changes states intend to make to their Medicaid payment methodologies, so that providers and others do not rely on prior payment methodologies. The notice must be issued at least one day prior to the effective date of the state's proposed change. CMS' November 2015 final rule modified these requirements slightly to authorize states to issue public notice on state websites or, as was previously allowable, in newspapers and state registers.

Importantly, the final rule issued in November 2015 did not modify the requirements regarding the content states must include in the public notice, which have been in place for many years. Failure to issue proper public notice can result in states being required to re-issue notice and a delay in the effective date of the state plan amendment (SPA) implementing the proposed change. It can also result in disapproval of the SPA.

Public Input Processes Related to Access to Care

The final rule also described new requirements for provider and public input processes to inform determinations about access to care when states propose to reduce rates or restructure Medicaid payments. These new requirements, effective January 4, 2016, were established in the November 2015 final rule and are described in regulations at 42 CFR 447.204. Prior to submitting SPAs to CMS, states are required to make information available so that beneficiaries, providers and other stakeholders may provide input on beneficiary access to the affected services and the impact that the proposed payment change will have, if any, on continued service access. States are expected to obtain input from beneficiaries, providers and other stakeholders, and analyze the input to identify and address access to care concerns. States must obtain this information prior to submitting a SPA to CMS and maintain a record of the public input and how the agency responded to the input. When a state submits the SPA to CMS, the regulation requires the state to also submit a specific analysis of the information and concerns expressed in input from affected stakeholders. CMS will rely on this and other documentation submitted by the state to inform our SPA approval decisions. Failure to conduct the public processes and analyze input from beneficiaries, providers and stakeholders on the impact payment changes will have, if any, on access to care can also result in a delay of the SPA approval or disapproval of the SPA.

Public Input Processes Specific to Changes to Institutional Provider Rates

Specific public input processes pertain when states propose to change institutional provider payment methodologies. These are described in statute at section 1903(a)(13)(A) of the Act and predate the November 2015 rulemaking.[1] These public input processes are designed to give providers and other affected stakeholders an opportunity to review and comment on changes to institutional provider payment rates.

The attachment to this informational bulletin, Summary of Public Notice and Public Process Requirements, provides a summary of the three above requirements.

Public Notice Content Requirements:

To meet CMS public notice requirements, states must include all of the information required by 42 CFR 447.205 in their public notice of rate changes. The public notice must identify the

[1] Section 1902(a)(13)(A) of the Act requires a public process for institutional payment rate or methodology changes. For more information see State Medicaid Director's letter dated 12/10/97: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD121097.pdf .

specific services and/or benefits that are affected by changes in state plan methods and standards for setting payment rates. In addition, states should not rely on information referenced external to the public notice, such as state legislative websites or provider bulletins, to meet the content requirements in the regulation. The actual published notice must include all of the required content.

The public notice content requirements are described in Federal regulations:

42 CFR 447.205(c) Content of notice. The notice must –

(1) Describe the proposed change in methods and standards;

(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

(3) Explain why the agency is changing its methods and standards;

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; and

(6) If there are public hearing, give the location, date and time for hearing or tell how this information may be obtained.

With respect to the above regulations, CMS expects states will issue public notices that:

1) Explicitly identify the Medicaid service(s) being affected by the proposed payment change.
2) Identify the dollar amount of any rate change(s) or the percent increase or decrease in the rate(s).
3) Explain the expected increase or decrease in annual aggregate expenditures by the benefit category or service being affected.
4) In instances where the changes in methods and standards are applied across benefit categories, such as across the board percentage rate increases or decreases, provide a comprehensive list of the services that will be affected by the change.
5) Provide all relevant information required by the regulation within the text of the public notice without reliance on websites or documents external to the public notice.

Efficiencies for Operationalizing Notices and Processes:

States may find it efficient to coordinate the implementation of these public notice and public input process requirements. States may use a single mechanism to meet all three requirements as long as:

- all of the statutory and regulatory requirements for each process are met;

- the public is notified of changes in state plan methods and standards for setting payment rates prior to the effective date of the change;
- parties interested in institutional rates have a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications; and
- beneficiaries, providers and stakeholders are able to provide input to the Medicaid agency on the impact payment changes will have on access to care before the state submits the SPA to CMS for review. These processes could include input received through: face-to-face meetings, written letters, emails, online forms, or other effective mechanisms a state uses to solicit public input.

For example, a state proposing to decrease inpatient hospital payment rates could use the state Medicaid agency's website as the source of public notice and the processes for institutional rate-setting and informing access to care. Prior to submitting the SPA to CMS, the state could issue a public notice that includes all of the information required for the notice, the proposed inpatient hospital rates, methodologies and justifications, and a state agency email box address available for stakeholders to submit comments and concerns about the rates or the effects the changes may have on beneficiary access to care. The state would need to analyze and consider the public input and republish the rates once they are finalized. The state would also need to submit its analysis of the public comments on access to care to CMS with the SPA submission. Such a process would fulfill the three requirements for notice and public process.

If states have further questions, they may contact their CMS Regional Office.

Requirement	Authority	Timing	Purpose
Public Process for Determining Institutional Rates	1903(a)(13)(A)	The state agency must allow time to publish the proposed rates, allow for review and comments, and publish the final rates.	Gives interested parties a reasonable opportu and comment on the proposed rates, method justifications. In the case of hospitals, such rates must take situation of hospitals which serve a dispropo of low-income patients with special needs. States must publish proposed and final rates methodologies underlying the rates, and just rates.
Public Process to Inform Access to Care	1902(a)(30)(A) 42 CFR 447.204	Before the state submits the SPA to CMS for consideration.	Ensures beneficiaries, providers and other a stakeholders an opportunity to provide input that proposed payment changes will have, if continued service access. The state should maintain a record of the pu how it responded to such input. States must specific analysis of the information and con in input from affected stakeholders.
Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates	1902(a)(4) 1902(a)(30) 42 CFR 447.205	At least one day before the effective date of the methodology change. Prior to CMS SPA approval.	Ensures providers are aware of changes in p and standards and are not relying on prior pa methodologies. See informational bulletin for content of not

Attachment: Summary of Public Notice and Public Process Requirements

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 17-004

RE: Medicaid Access to Care Implementation Guidance

November 16, 2017

Dear State Medicaid Director:

The purpose of this letter is to provide clarification and additional policy direction to states on compliance with the Social Security Act (the Act) and federal regulations issued by the Centers for Medicare & Medicaid Services (CMS). Specifically, this letter describes guidance on implementation approaches for the Medicaid access to care fee for service (FFS) requirements found at 42 CFR 447.203(b).

CMS is committed to working with states on targeted approaches to ensure Medicaid FFS rates meet federal requirements while minimizing state administrative burden. We are conducting a wholesale review of the regulatory access to care requirements and using the experience we have gained through reviews of states' access monitoring efforts to identify opportunities through new rulemaking to alleviate burden for states. Such opportunities could include exploring a regulatory exception for high managed care states, further codifying the thresholds described in this letter and providing additional policy clarifications based on our implementation experience thus far. In the interim, we are issuing this letter to offer the flexibilities available to us prior to finalizing new regulations.

Background:

Section 1902(a)(30)(A) of the Act requires states to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Federal regulations at 42 CFR 447.203(b) and 447.204 provide for a transparent process for states to document whether Medicaid FFS payments are sufficient to enlist providers consistent with the Act.

42 CFR 447.203(b) requires states to develop and submit to CMS an Access Monitoring Review Plan (AMRP) for a core set of services (primary care, physician specialist, behavioral health care, pre-and post-natal obstetric, and home health) that is updated at least every three years. In addition, the AMRP must cover additional types of services for which the state or CMS has received a significantly higher than usual volume of complaints from beneficiaries, providers, or other stakeholders. The AMRP must identify a data-driven process to review access to care and address: the extent to which beneficiary needs are fully met; the availability of care through enrolled providers; changes in beneficiary service utilization; the characteristics of the beneficiary population; and actual or estimated levels of provider payment available from other payers.

Additionally, §447.203(b)(6) requires a state to: (1) add services to its AMRP when reducing or restructuring FFS rates for other Medicaid services *in circumstances when the changes could result in diminished access* (emphasis added) and (2) develop a plan to monitor the effects of the rate reductions for at least three years. In such circumstances, §447.204(b) requires a state to submit to CMS with its state plan amendment (SPA) submission: the most recent AMRP (revised to include additional services to be monitored), an analysis of the effect the change in payment rates will have on access, and a specific analysis of the information and concerns expressed in input from affected stakeholders. As discussed in the Center for Medicaid & CHIP Services Informational Bulletin issued on June 24, 2016, stakeholder concerns may be submitted through the public notice process described at 42 CFR 447.205 or a separate process used to solicit feedback on the effect of rate changes on access to care as long as the public notice requirements are also met.

In addition to the requirements set forth in those regulations, CMS may request that states provide information that would allow CMS to compare the Medicaid population's access to care with that of the general population in the same geographic area.[1]

Policy Guidance:

States have requested clarification regarding the circumstances in which provider payment reductions would likely not result in diminished access to care, including: states that pay at or above the Medicare rate under FFS, are proposing relatively minor reductions to provider payment rates, or have high managed care penetration rates. In considering these situations, CMS is offering additional guidance to clarify circumstances that would likely not result in diminished access and, as such, would not require the analysis and monitoring procedures described in the regulations.

Nominal Reductions and Compliance with Federal Requirements:

There are circumstances, including certain types of provider rate reductions, which are unlikely to result in diminished access, and therefore, where states would not be required to conduct the analysis and monitoring procedures specified in the regulation. For example, circumstances where a state's Medicaid FFS payment rates remain at least as high as the Medicare rates (including the applicable cost-sharing) for the same specific service after the reduction is implemented would be unlikely to result in diminished access. In the absence of information to the contrary (such as a high volume of access complaints which would trigger the regulatory requirements) CMS has determined the following circumstances are unlikely to diminish access, and as such, would not invoke the requirements of §447.203(b)(6):

- Reductions necessary to implement CMS federal Medicaid payment requirements (e.g., federal upper payment limits and financial participation limits), but only in circumstances under which the state is not exercising discretion as to how the requirement is implemented in rates. For example, if the federal statute or regulation imposes an aggregate upper payment limit that requires the state to reduce provider payments, the state should consider the impact of the payment reduction on access.

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[1] A recent 9th Circuit decision has interpreted section 1902(a)(30)(A) of the Act as requiring the Secretary, when reviewing a proposed SPA, to consider the state's Medicaid population's access to care "relative to that of the general public." *Hoag Mem'l Hosp. Presbyterian v. Price,* No. 15-56547, slip op. at 17 (9th Cir. Aug. 7, 2017).

- Reductions that will be implemented as a decrease to all codes within a service category or targeted to certain codes, but for services where the payment rates continue to be at or above Medicare and/or average commercial rates.
- Reductions that result from changes implemented through the Medicare program, where a state's service payment methodology adheres to the Medicare methodology (e.g. modifications to diagnostic related groups and the resource based relative value scale, adoption of new Medicare payment systems, consistency with value-based purchasing initiatives, etc.).

Anticipating Diminished Access:

For some nominal payment adjustments it may be difficult for states to determine whether proposed SPA changes may result in diminished access. In those instances, states should follow the public process described in §447.204(a) and consider the information received through that process to determine whether the proposed change is likely to diminish access. Examples of payment changes that may fall under this process include, but are not limited to:

- Reductions where the state has actively worked with provider groups to address concerns over a proposed rate change or modified the proposed rate change to address the concerns (e.g. as part of a delivery system re-design a state reduces volume-based supplemental payments and proposes to pay-for-performance based on quality measures, reducing the overall Medicaid revenue to providers. However, the provider industry works with the state legislature on the re-design effort).
- Reductions that are targeted to a small number of distinct codes or payments within a service category, where the overall change in net payments within that service category is nominal (e.g., less than 4% of overall spending for the service category – such as physician services, reductions to targeted supplemental payments affecting few providers, etc.).
- Nominal single-year rate freezes or inflationary changes that result in providers receiving less of an increase than anticipated for a given payment year.
- Nominally restructured payments or rate changes that are intended to address matters of program and financial integrity or to provide more efficient care (e.g., changes in standards of practice, documented over-utilization, up-coding, cost rebasing).
- Reductions where the affected services are primarily delivered through managed care and the individuals enrolled in FFS do not utilize the services or only utilize services before transitioning to managed care (e.g., during periods of retroactive eligibility or presumptive eligibility).

When contemplating nominal payment changes such as those described above, a state should document that it followed the public process as described in §447.204. If no probable access concerns are identified through that process or the state adequately addresses such concerns, the state would not need to include the access analysis or formal monitoring plan with its SPA submission because it is unlikely the changes would result in diminished access to care. Similarly, states that have engaged the provider community in the rate-setting process (including through the legislative process), and reached general agreement on the proposed changes would also not be required to submit the access analysis or formal monitoring plan as part of its SPA submission. In these situations, CMS strongly encourages states to use the ongoing beneficiary and provider feedback mechanisms to quickly identify any access issues that

may arise, even though the state is not required to include the affected services in its formal AMRP.

Clarification for States with High Managed Care Penetration:

States with high managed care penetration rates have raised concerns that the requirements of the regulations present unnecessary burden with little benefit. While CMS purposefully did not apply a percentage threshold to exempt states from the AMRP process described in the regulations, CMS did not intend for states to analyze and monitor FFS access in instances when the FFS system does not consistently provide services. The requirements of §447.203(b)(6) are intended to apply only to services that are carved out of the managed care delivery system and paid through FFS and for the populations that remain covered through FFS and utilize the affected services. States with high managed care penetration rates should scale the AMRP analysis and monitoring efforts to consider: only the services that are carved out of managed care and paid FFS, and the individuals who are enrolled in the FFS system beyond transition periods.

Some states have brought forward program specific data and information demonstrating that, prior to enrolling with a managed care plan, beneficiaries only receive FFS services for short transition periods based on presumptive or retrospective eligibility processes, or that the FFS service system includes only individuals in certain eligibility categories that rarely or never utilize services subject to the AMRP process. CMS urges states to present this information at the time of SPA submissions and to provide reasonable support that changes in rates are unlikely to affect access for populations eligible for FFS services and are consistent with section 1902(a)(30)(A) of the Act.

Expediting SPA Submission Process:

CMS is also committed to reviewing all SPAs in a timely manner. A primary purpose of the access to care requirements is to provide CMS with the information necessary to make timely approval decisions for SPAs that reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access. The regulations require states to provide the access analysis and monitoring procedures with SPA submissions so that, absent any additional concerns, CMS can make approval decisions on the first 90 day clock. To the extent states meet the submission requirements, CMS should be able to process rate reduction SPAs without requesting additional information on access to care. In addition, for rate changes that reduce provider payments but fall under the policies described in this letter, states should provide a description of applicable policy consideration as part of the SPA submission. This information will ensure that CMS has sufficient documentation that proposed SPA changes will not diminish access to care and will greatly expedite our review and approval.

If you have additional question, please contact Kristin Fan, 410-786-4581.

Sincerely,

/s/

Brian Neale
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health

National Association of State Alcohol and Drug Abuse Directors

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19-12

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTER FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN   AMENDMENT TO BE CONSIDERED AS NEW PLAN   X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
§ 1902(bb) of the SSA
42 C.F.R. §§ 440.70(b)(3), 440.120(c)
42 C.F.R, Subpart B

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY 2020 $ -2,547
b. FFY 2021 $ -1,957

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-B, pp 4 to 4e, 5 to 5e, 27 to 27b, 37d, 63, Supplement 2 to Att. 4.19-B, p 2, 3, 15

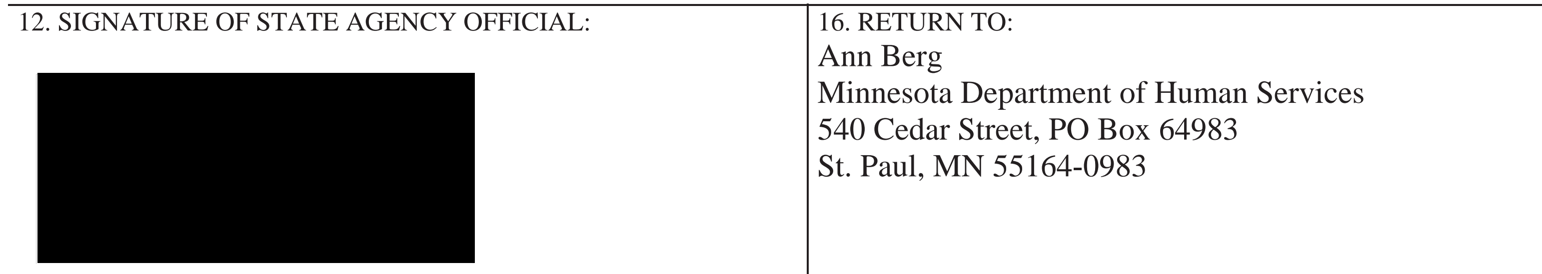
9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-B, pp 4 to 4e, 5 to 5e, 27 to 27a, 37d, 63, Supplement 2 to Att. 4.19-B, same

10. SUBJECT OF AMENDMENT:

Miscellaneous changes in payment rates.

11. GOVERNOR'S REVIEW *(Check One)*:
x GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



16. RETURN TO:
Ann Berg
Minnesota Department of Human Services
540 Cedar Street, PO Box 64983
St. Paul, MN 55164-0983

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
9/30/2019

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 30, 2019

18. DATE APPROVED: August 25, 2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

FORM CMS-179 (07-92)

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.

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

Alternative Payment Methodology I

For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is 100% of cost as determined using Medicare cost principles, plus: 1)an additional annual payment described below, for state fiscal year 2011 and thereafter which includes a Department medical education payment for each state fiscal year and distributed to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled teaching clinics; 2) qualifying payments for meeting the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item C; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

The Department will pay for clinic services as follows:

A. A clinic will be paid for the reasonable cost of clinic services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 C.F.R. Part 413. The Department will pay for medical services, less the costs of providing dental services, at a single rate per visit based on the cost of all services furnished by the clinic.

B. A clinic will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the clinic.

C. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:
   - Blood pressure less than 140/90; and
   - Lipids less than 100; and
   - Patient is taking aspirin daily if over age 40; and
   - Patient is not using tobacco; and
   - For diabetic only, Hemoglobin A1c levels at less than 8.

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

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. Clinics must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after January 1, 2020 ~~July 1, 2009~~, the rate adjustment is $250 ~~plus 2%~~ every six months when all of the above criteria are met.

D. Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
   - Submitted charge; or
   - $10.14~~, plus 2 percent~~.

   Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
   - Submitted charge; or
   - $20.27~~, plus 2 percent~~.

   Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:
   - Submitted charge; or
   - $40.54~~, plus 2 percent~~.

   Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:
   - Submitted charge; or
   - $60.81~~, plus 2 percent~~.

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

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient’s first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

Alternative Payment Methodology II

For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the clinic’s PPS rate plus 4 percent through State Fiscal Year 2005.

Effective for services provided on or after January 1, ~~2006,~~2020, the methodology is the clinic’s PPS rate plus~~: 1) 2 percent plus; ~~1~~2)~~an additional annual payment described below~~, for state fiscal year 2011 and thereafter~~, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching clinics; ~~3~~2) ~~effective for services provided on or after July 1, 2007,~~ qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; ~~4~~3) ~~effective for services provided on or after July 1, 2010,~~ qualifying payments for health care home services as described in item B; ~~5~~4) ~~effective for services provided on or after July 1, 2016,~~ qualifying payments for behavioral health home services as described in item C.

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

A. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, the clinic must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after ~~July 1, 2009~~January 1, 2020, the rate adjustment is $250 ~~plus 2%~~ every six months when all of the above criteria are met.

B. Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:

- Submitted charge; or
- $10.14~~, plus 2 percent~~.

Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:

- Submitted charge; or
- $20.27~~, plus 2 percent~~.

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

Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- $40.54~~, plus 2 percent~~.

Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81~~, plus 2 percent~~.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

C. Effective for services provided on or after ~~July 1, 2016~~January 1, 2020, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

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

A FQHC 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 FQHC's payments back to January 1, 2001 when the FQHC's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM II, and APM III) rates for FQHCs will include a rate for dental services, if provided, and a rate for all other FQHC services of the provider or provider group. Hereinafter, "all other FQHC services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a FQHC's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(3) 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 FQHC 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 FQHC'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 FQHC'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 FQHC professionals, including all encounters provided by FQHC staff outside of the FQHC to FQHC patients.

In order to comply with §1902(bb)(4) of the Act, for a FQHC that first qualifies as a FQHC providers beginning on or after fiscal year 2000, the Department will compare the new FQHC to other FQHCs in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a FQHC-specific rate based upon the FQHC'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)

Alternative Payment Methodology I

For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, an interim rate is established, subject to reconciliation at the end of the cost reporting period. The alternative payment methodology is 100% of cost as determined using Medicare cost principles, plus: 1)an additional annual payment described below, for state fiscal year 2011 and thereafter, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching FQHCs; 2) qualifying payments for meeting the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item C; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

The Department will pay for FQHC services as follows:

A. A FQHC will be paid for the reasonable cost of FQHC services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 CFR Part 413. The Department will pay for medical services, less the cost of providing dental services, at a single rate per visit based on the cost of all services furnished by the FQHC.

B. A FQHC will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the FQHC.

C. Effective July 1, 2007, through June 30, 2009, eligible FQHCs are paid an additional $125 plus 2% every six months for each recipient for whom the FQHC demonstrates optimal diabetic and/or cardiovascular care which includes:
   - Blood pressure less than 140/90; and
   - Lipids less than 100; and
   - Patient is taking aspirin daily if over age 40; and
   - Patient is not using tobacco; and
   - For diabetic only, Hemoglobin A1c levels at less than 8.

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

Each recipient must have had at least two prior office visits with the claiming FQHC within the six months before the submission of the claim for the additional payment. Eligible FQHCs must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, the FQHC must submit documentation of the provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after ~~July 1, 2009~~January 1, 2020, the rate adjustment is $250 ~~plus 2%~~ every six months when all of the above criteria are met.

D. Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
- Submitted charge; or
- $10.14~~, plus 2 percent~~.

Effective for services provided on or after ~~July 1,~~ 2010January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
- Submitted charge; or
- $20.27~~, plus 2 percent~~.

Effective for services provided on or after ~~July 1,~~ 2010January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:
- Submitted charge; or
- $40.54~~, plus 2 percent~~.

Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:
- Submitted charge; or
- $60.81~~, plus 2 percent~~.

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 each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for FQHCs certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

Alternative Payment Methodology II

For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the FQHC's PPS rate plus 4 percent through State Fiscal Year 2005.

Effective for services provided on or after January 1, ~~2006~~2020, the methodology is the FQHC's PPS rate plus~~: 1) 2 percent plus 2)for state fiscal year 2011 and thereafter, which includes~~ 1) a ~~Department~~ medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled teaching FQHCs~~,~~; ~~3~~2) ~~effective for services provided on or after July 1, 2007,~~ qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; ~~and 4~~3) ~~effective for services provided on or after July 1, 2010,~~ qualifying payments for health care home services as described in item B; and ~~5~~4) ~~effective for services provided on or after July 1, 2016,~~ qualifying payments for behavioral health home services as described in item C.

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

A. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after ~~July 1, 2009~~January 1, 2020, the rate adjustment is $250 ~~plus 2%~~ every six months when all of the above criteria are met.

B. Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:

- Submitted charge; or
- $10.14~~, plus 2 percent~~.

Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services is the lower of:

- Submitted charge; or
- $20.27~~, plus 2 percent~~.

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

Effective for services provided on or after ~~July 1,~~ 2010January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- $40.54~~, plus 2 percent~~.

Effective for services provided on or after ~~July 1, 2010~~January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81~~, plus 2 percent~~.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

C. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

Notwithstanding the other payment methodologies outlined in this section 7.c., effective for services provided on or after July 1, 2019, medical supplies and equipment, and orthotics that are subject to the upper payment limit in accordance with section 1903 (i)(27) of the Social Security Act, are paid the lower of:

1. The submitted charge; or
2. The Medicare fee schedule amount without regard to any other allowable increases, including the MinnesotaCare tax.

Augmentative and alternative communication devices and pressure support ventilators are excluded from the above provision.

Hearing aids, eyeglasses and oxygen are purchased on a volume basis through competitive bidding in accordance with section 1915(a)(1)(B) of the Act and regulations at 42 C.F.R. § 431.54(d).

Medical supplies and equipment that are not purchased on a volume basis are paid the lower of:

1. submitted charge;
2. Medicare fee schedule amount for medical supplies and equipment; or
3. if Medicare has not established a payment amount for the medical supply or equipment, an amount determined using one of the following methodologies:
   (a) 50th percentile of the usual and customary charges submitted for the previous two calendar years minus 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment;
   (b) if no information about usual and customary charges exists, payment is based upon the manufacturer's suggested retail price minus 20 percent; or
   (c) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

Effective for services provided on or after July 1, 2010, medical supplies and equipment manufactured for pediatric patients, medical supplies and equipment manufactured for bariatric patients, and HCPCS codes A7520, A7521, B4088, and E0202, are paid the lower of:

1. submitted charge; or
2. a payment amount determined by using one of the following methodologies:
   (a) 50th percentile of the usual and customary charges submitted for the previous two calendar years minus 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment;
   (b) if no information about usual and customary charges exists, payment is based upon the manufacturer's suggested retail price minus 20 percent; or
   (c) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

Effective for services provided on or after July 1, 2017, pressure support ventilators are paid at the lower of:

1. The submitted charge, or
2. The Medicare fee schedule rate plus 47 percent.

Effective for service on or after January 1, 2014, blood glucose meters and diabetic testing strips are paid at the lower of

1. submitted charge, and
2. ~~wholesale acquisition cost plus 2%~~ the methodology described in Item 12.a.

In addition, the state agency will receive a rebate for preferred blood glucose meters and test strips in accordance with the manufacturer's contract with the state.

Effective September 1, 2011, augmentative and alternative communication device manufacturers and vendors must be paid the lower of the:

(1) submitted charge; or
(2) (a)manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or
(b)manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

Enteral products are paid the lower of:

(1) submitted charge; or
(2) the 50th percentile of the usual and customary charges submitted for the previous two calendar years minus 20 percent, plus current calendar year Medicare inflation factors; or
(3) if a payment rate cannot be calculated using submitted charges, an amount determined using one of the following methodologies:
a) the manufacturer's suggested retail price minus 20 percent; or
b) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

Pediatric enteral products may be paid at the average wholesale price.

Parenteral products are paid using the methodology in items 12.a., Prescribed drugs, for drugs dispensed by a pharmacy.

Effective for services provided on or after October 1, 2011, home infusion therapy services provided by home infusion pharmacies are paid the lower of:

(1) the submitted charge; or
(2) a per diem amount for home infusion therapy services as defined in home infusion HCPCS codes. The per diem rate is equal to the combined payment rates for the component services which include, but are not limited to, medical supplies and equipment, professional pharmacy services, care coordination, delivery and shipping and products used in a standard total parental nutrition formula.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

No dispensing fee is paid for home infusion therapies when dispensed by home infusion pharmacies.

The base rates as described above in this item, are adjusted by the following clauses of Supplement 2 of this Attachment:

- U. Facility services rate decrease 2009.
- aa. Miscellaneous services and materials rate decrease 2011.
- ee. Rate decrease effective July 1, 2014.
- gg. Miscellaneous services and materials rate increase effective September 1, 2014.
- hh. Rate increase effective July 1, 2015.
- jj. Rate increase for miscellaneous services, effective July 1, 2015.

12a. Prescribed Drugs (continued):

With the following exceptions, the professional dispensing fee is $10.48 per prescription, for prescriptions filled using drugs that meet the definition of “covered outpatient drugs” according to 42 U.S.C. § 1396r-8(k)(2).

1) The professional dispensing fee for intravenous drugs that require mixing by the pharmacist is $10.48 per bag.

2) The professional dispensing fee for over-the-counter drugs is $10.48 for “outpatient prescription drugs” when dispensed in quantities equal to or greater than the manufacturer’s package size. The dispensing fee is prorated based on the percent of the package dispensed when the pharmacy dispenses a quantity less than the manufacturer’s package size.

3) The professional dispensing fee for prescribed over-the-counter drugs that are not “covered outpatient drugs” shall be $3.65. The dispensing fee is prorated based on the percent of the package dispensed when the pharmacy dispenses a quantity less than the manufacturer’s package size.

In addition, the State agency will receive a rebate for prescribed drugs in accordance with the manufacturer’s contract with the Centers for Medicare & Medicaid Services.

The base rates as described in this item are adjusted by the following paragraph(s) of Supplement 2:

cc. Supplemental payment for medical education
d. MinnesotaCare Tax Adjustment ~~The~~ (ingredient cost only) ~~is adjusted to account for the Minnesota Wholesale Drug Tax.~~

20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

Payment was derived from the additional costs of delivering these services above and beyond the global prenatal care package.

Procedure Code(s)	**Component**	**Base Rate: 1/1/02**
H1001	At Risk Antepartum Management	$64.89
H1002	Care Coordination	$25.95
H1003	Prenatal Education	$38.92
H1004	At Risk Post-Partum Follow-Up Home Visit	$52.79

Effective for services on or after July 1, ~~2014~~2019, antepartum and postpartum doula services are paid at the lower of:
1. The submitted charge, or
2. $~~25.71~~ 47.00 per session

Effective for services on or after July 1, ~~2014~~2019, doula services provided during labor and delivery are paid at the lower of:
1. The submitted charge, or
2. $~~257.10~~ 488.00 per session

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:
- A. IHS/638 Facilities
- B. Critical Access Hospitals
- C. TPL
- D. MinnesotaCare Tax Rate Adjustment
- E. Modifiers
- G. Community and Public Health Clinics increase
- I. Exceptions to payment methodology and reconstructing a rate
- R. Professional Services Rate Decrease July 2009
- S. Professional Services Rate Decrease July 2010

Payment for services for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:

a. the patient liability according to the provider/third party payer (insurer) agreement;
b. covered charges minus the third party payment amount; or
c. the Medical Assistance rate minus the third party payment amount.

D. MinnesotaCare Tax Rate Adjustment

Total payment for services provided on or after ~~January 1, 2004~~January 1, 2020, is increased by ~~two~~ 1.8 percent for the following Minnesota providers and services. This is an increase to the rate methodology described elsewhere in this Attachment for the following Minnesota providers and services. This rate increase is applied after all other payment rate increases or decreases described below.

- outpatient hospital services (Item 2.a)
- x-ray services (Item 3)
- EPSDT services, excluding rehabilitative services and services provided to a recipient with severe emotional disturbance residing in a children's residential treatment facility (Item 4.b)
- physicians' services (Item 5.a)
- medical and surgical services furnished by a dentist (Item 5.b)
- podiatrists' services (Item 6.a)
- optometrists' services (Item 6.b)
- chiropractors' services (Item 6.c)
- other practitioners' services: mental health, public health nursing, ambulatory surgical center, certified registered nurse anesthetist, nurse practitioner, case management services provided as a component of receiving clozapine, and clinical nurse specialist services (Item 6.d)
- clinic services (Item 9)
- dental services (Item 10)
- physical therapy services (Item 11.a)
- occupational therapy services (item 11.b)
- speech, language, and hearing therapy services (Item 11.c)
- dentures (Item 12.b)
- eyeglasses (Item 12.d)
- diagnostic, screening, and preventive services (Items 13.a, 13.b, and 13.c)
- rehabilitative services: day treatment for mental illness, rehabilitative restorative

and specialized maintenance physical therapy, occupational therapy, and speech, language and hearing therapy services, and respiratory therapy services (Item 13.d)

- services for individuals age 65 or older in institutions for mental diseases (Item 14)
- inpatient psychiatric facility services for individuals under 22 years of age (Item 16)
- nurse midwife services (Item 17)
- pregnancy-related and postpartum services for 60 days after the pregnancy ends (Item 20.a)
- services for any other medical condition that may complicate pregnancy (Item 20.b)
- certified pediatric or family nurse practitioner services (Item 23)
- licensed ambulance services, excluding volunteer ambulance services (Item 24.a)
- emergency hospital services (Item 24.e)
- the drug ingredient component of pharmacy services (item 12.a, effective July 1, 2019, at 1.8 percent.
- Services of rural health clinics (item 2.b.), for health care home services, behavioral health home services, and alternative payment methodologies II and III.
- Services of federally qualified health centers (FQHCs)(item 2.c), for health care home services, behavioral health home services, and alternative payment methodologies II and III.

E. Modifiers

22 modifier: unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered. (Item 5.a)

99 modifier: multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99. (Item 5.a)

F. Family Planning

Effective for services provided on or after July 1, 2007, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 25% over the rate in effect on June 30, 2007. (Item 5.a.)

Effective for services provided on or after July 1, 2013, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 20% over the rate in effect on June 30, 2013. (Item 5.a.)

G. Community and Public Health Clinic

Effective July 1, 1989, rates for services provided by **community and public health** clinics are increased by 20%, except for laboratory services.

gg. Miscellaneous services and materials rate increase effective September 1, 2014
Effective for services provided on or after September 1, 2014, the following service payment rates are increased by 3 percent:

Ambulatory surgery center facility fees (Item 9)
Hospice services (Item 18)
Renal dialysis services (Item 2.a)
Outpatient hospital facility fees (2.a)
Laboratory services (Item 3)
Public health nursing services (Item 6.d.B)
Eyeglasses not subject to a volume purchase contract (Item 12.d)
Hearing aids not subject to a volume purchase contract (Item 7.c)

gg.1 Noted exceptions to clause gg:
1. For hospice services, exclude revenue code 0658.
   For outpatient hospital exclude [mental health] procedure codes 90800-90899, 96101-96103, 96118-96120, 97535 HE.

hh. Rate increase effective July 1, 2015
Effective for services provided on or after July 1, 2015, the following sequence of payment rate changes apply:

1. Payment is increased by 9.5 percent for medical supplies, durable medical equipment, prosthetics, and orthotics that were subject to Medicare's competitive bid process on January 1, 2009.
2. Payment is increased by 2.94 percent for medical supplies, durable medical equipment, prosthetics, and orthotics paid under the Medical Assistance fee schedule. This increase does not apply to durable medical equipment and supplies subject to a volume-purchase contract, certain diabetic testing supplies, items paid by report, and items provided to dually eligible individuals where Medicare is the primary payer.
3. Payment is increased by 3 percent for medical supplies and durable medical equipment, prosthetics, and orthotics. This increase does not apply to durable medical equipment and supplies subject to a volume-purchase contract, certain diabetic testing supplies, and items provided to dually eligible individuals where Medicare is the primary payer.

Effective for services provided on or after July 1, 2019, total reimbursement for items and services subject to the Medicare DME upper payment limit may not exceed the Medicare fee schedule rate. This limit does not apply to pressure support ventilators.