

STATE: MINNESOTA  
Effective: January 1, 2019  
TN: 19-12

ATTACHMENT 4.19-B  
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Approved:

Supersedes: 16-11 (13-26, 09-10, 07-12, 07-09, 05-16/05-07/05-02)

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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.

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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.

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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 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, 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, 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, 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, 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.~~

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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, the methodology is the clinic's PPS rate plus: ~~1) 2 percent plus;~~ 12) 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; ~~32)~~ 32) 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; ~~43)~~ 43) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item B; ~~54)~~ 54) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item C.

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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, 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, 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, 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.~~

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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, 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, 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, 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.

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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.

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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.

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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, 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, 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, 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, 2010, 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, 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.~~

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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, the methodology is the FQHC's PPS rate plus: 1) ~~2 percent plus 2~~ 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, 32) 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 43) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item B; 54) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item C.

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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, 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, 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, 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.~~

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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, 2010, 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, 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.

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Supersedes: 17-19 (14-03, (11-19, 11-02, 10-21, 10-02, 09-25, 04-05, 02-02)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.

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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.

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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.

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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

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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, 2019, 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

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- 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.

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**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.