

This Document can be made available in alternative formats upon request

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 4981

03/18/2024 Authored by Her
The bill was read for the first time and referred to the Committee on Human Services Policy
03/21/2024 Adoption of Report: Re-referred to the Committee on Health Finance and Policy

1.1 A bill for an act
1.2 relating to health insurance; establishing Medical Assistance rate adjustments for
1.3 physician and professional services; increasing rates for certain residential services;
1.4 requiring a statewide reimbursement rate for behavioral health home services;
1.5 appropriating money; amending Minnesota Statutes 2022, sections 256B.0757,
1.6 subdivision 5, by adding a subdivision; 256B.76, subdivision 6; Minnesota Statutes
1.7 2023 Supplement, sections 254B.05, subdivision 5; 256.969, subdivision 2b;
1.8 256B.76, subdivision 1; 256B.761; repealing Minnesota Statutes 2022, section
1.9 256B.0625, subdivision 38.

1.10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.11 Section 1. Minnesota Statutes 2023 Supplement, section 254B.05, subdivision 5, is amended
1.12 to read:

1.13 Subd. 5. Rate requirements. (a) The commissioner shall establish rates consistent with
1.14 the requirements of section 254B.12 for substance use disorder services and service
1.15 enhancements funded under this chapter.

1.16 (b) Effective for residential substance use disorder services listed in this subdivision and
1.17 rendered on or after January 1, 2025, the commissioner shall increase rates by ... percent.
1.18 The commissioner shall adjust rates for such services annually, by January 1 of each year,
1.19 according to the change from the midpoint of the previous rate year to the midpoint of the
1.20 rate year for which the rate is being determined using the Centers for Medicare and Medicaid
1.21 Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year
1.22 before the rate year. This paragraph does not apply to federally qualified health centers,
1.23 rural health centers, Indian health services, certified community behavioral health clinics,
1.24 cost-based rates, and rates that are negotiated with the county.

2.1 (c) For payments made under paragraph (b), if and to the extent that the commissioner
2.2 identifies that the state has received federal financial participation for residential substance
2.3 use disorder services in excess of the amount allowed under Code of Federal Regulations,
2.4 title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare
2.5 and Medicaid Services with state money and maintain the full payment rate under paragraph
2.6 (b).

2.7 (d) Effective for services rendered on or after January 1, 2025, the commissioner shall
2.8 increase capitation payments made to managed care plans and county-based purchasing
2.9 plans to reflect the rate increase for residential substance use disorder services. Managed
2.10 care plans and county-based purchasing plans must use the capitation rate increase provided
2.11 under this paragraph to increase payment rates to residential substance use disorder services
2.12 providers. The commissioner must monitor the effect of this rate increase on enrollee access
2.13 to residential substance use disorder services. If for any contract year federal approval is
2.14 not received for this paragraph, the commissioner must adjust the capitation rates paid to
2.15 managed care plans and county-based purchasing plans for that contract year to reflect the
2.16 removal of this provision. Contracts between managed care plans and county-based
2.17 purchasing plans and providers to whom this paragraph applies must allow recovery of
2.18 payments from those providers if capitation rates are adjusted in accordance with this
2.19 paragraph. Payment recoveries must not exceed the amount equal to any increase in rates
2.20 that results from this provision.

2.21 ~~(b)~~ (e) Eligible substance use disorder treatment services include:

2.22 (1) those licensed, as applicable, according to chapter 245G or applicable Tribal license
2.23 and provided according to the following ASAM levels of care:

2.24 (i) ASAM level 0.5 early intervention services provided according to section 254B.19,
2.25 subdivision 1, clause (1);

2.26 (ii) ASAM level 1.0 outpatient services provided according to section 254B.19,
2.27 subdivision 1, clause (2);

2.28 (iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19,
2.29 subdivision 1, clause (3);

2.30 (iv) ASAM level 2.5 partial hospitalization services provided according to section
2.31 254B.19, subdivision 1, clause (4);

2.32 (v) ASAM level 3.1 clinically managed low-intensity residential services provided
2.33 according to section 254B.19, subdivision 1, clause (5);

3.1 (vi) ASAM level 3.3 clinically managed population-specific high-intensity residential
3.2 services provided according to section 254B.19, subdivision 1, clause (6); and

3.3 (vii) ASAM level 3.5 clinically managed high-intensity residential services provided
3.4 according to section 254B.19, subdivision 1, clause (7);

3.5 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
3.6 and 245G.05;

3.7 (3) treatment coordination services provided according to section 245G.07, subdivision
3.8 1, paragraph (a), clause (5);

3.9 (4) peer recovery support services provided according to section 245G.07, subdivision
3.10 2, clause (8);

3.11 (5) withdrawal management services provided according to chapter 245F;

3.12 (6) hospital-based treatment services that are licensed according to sections 245G.01 to
3.13 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
3.14 144.56;

3.15 (7) adolescent treatment programs that are licensed as outpatient treatment programs
3.16 according to sections 245G.01 to 245G.18 or as residential treatment programs according
3.17 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
3.18 applicable tribal license;

3.19 (8) ASAM 3.5 clinically managed high-intensity residential services that are licensed
3.20 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which
3.21 provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7),
3.22 and are provided by a state-operated vendor or to clients who have been civilly committed
3.23 to the commissioner, present the most complex and difficult care needs, and are a potential
3.24 threat to the community; and

3.25 (9) room and board facilities that meet the requirements of subdivision 1a.

3.26 ~~(e)~~ (f) The commissioner shall establish higher rates for programs that meet the
3.27 requirements of paragraph ~~(b)~~ (e) and one of the following additional requirements:

3.28 (1) programs that serve parents with their children if the program:

3.29 (i) provides on-site child care during the hours of treatment activity that:

3.30 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
3.31 9503; or

- 4.1 (B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or
- 4.2 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
- 4.3 licensed under chapter 245A as:
- 4.4 (A) a child care center under Minnesota Rules, chapter 9503; or
- 4.5 (B) a family child care home under Minnesota Rules, chapter 9502;
- 4.6 (2) culturally specific or culturally responsive programs as defined in section 254B.01,
- 4.7 subdivision 4a;
- 4.8 (3) disability responsive programs as defined in section 254B.01, subdivision 4b;
- 4.9 (4) programs that offer medical services delivered by appropriately credentialed health
- 4.10 care staff in an amount equal to two hours per client per week if the medical needs of the
- 4.11 client and the nature and provision of any medical services provided are documented in the
- 4.12 client file; or
- 4.13 (5) programs that offer services to individuals with co-occurring mental health and
- 4.14 substance use disorder problems if:
- 4.15 (i) the program meets the co-occurring requirements in section 245G.20;
- 4.16 (ii) 25 percent of the counseling staff are licensed mental health professionals under
- 4.17 section 245I.04, subdivision 2, or are students or licensing candidates under the supervision
- 4.18 of a licensed alcohol and drug counselor supervisor and mental health professional under
- 4.19 section 245I.04, subdivision 2, except that no more than 50 percent of the mental health
- 4.20 staff may be students or licensing candidates with time documented to be directly related
- 4.21 to provisions of co-occurring services;
- 4.22 (iii) clients scoring positive on a standardized mental health screen receive a mental
- 4.23 health diagnostic assessment within ten days of admission;
- 4.24 (iv) the program has standards for multidisciplinary case review that include a monthly
- 4.25 review for each client that, at a minimum, includes a licensed mental health professional
- 4.26 and licensed alcohol and drug counselor, and their involvement in the review is documented;
- 4.27 (v) family education is offered that addresses mental health and substance use disorder
- 4.28 and the interaction between the two; and
- 4.29 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
- 4.30 training annually.

5.1 ~~(d)~~ (g) In order to be eligible for a higher rate under paragraph ~~(e)~~ (f), clause (1), a
5.2 program that provides arrangements for off-site child care must maintain current
5.3 documentation at the substance use disorder facility of the child care provider's current
5.4 licensure to provide child care services.

5.5 ~~(e)~~ (h) Adolescent residential programs that meet the requirements of Minnesota Rules,
5.6 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
5.7 in paragraph ~~(e)~~ (f), clause ~~(4)~~ (5), items (i) to (iv).

5.8 ~~(f)~~ (i) Subject to federal approval, substance use disorder services that are otherwise
5.9 covered as direct face-to-face services may be provided via telehealth as defined in section
5.10 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically
5.11 appropriate to the condition and needs of the person being served. Reimbursement shall be
5.12 at the same rates and under the same conditions that would otherwise apply to direct
5.13 face-to-face services.

5.14 ~~(g)~~ (j) For the purpose of reimbursement under this section, substance use disorder
5.15 treatment services provided in a group setting without a group participant maximum or
5.16 maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of
5.17 48 to one. At least one of the attending staff must meet the qualifications as established
5.18 under this chapter for the type of treatment service provided. A recovery peer may not be
5.19 included as part of the staff ratio.

5.20 ~~(h)~~ (k) Payment for outpatient substance use disorder services that are licensed according
5.21 to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless
5.22 prior authorization of a greater number of hours is obtained from the commissioner.

5.23 ~~(i)~~ (l) Payment for substance use disorder services under this section must start from the
5.24 day of service initiation, when the comprehensive assessment is completed within the
5.25 required timelines.

5.26 Sec. 2. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended
5.27 to read:

5.28 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
5.29 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
5.30 to the following:

5.31 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
5.32 methodology;

6.1 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
6.2 under subdivision 25;

6.3 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
6.4 distinct parts as defined by Medicare shall be paid according to the methodology under
6.5 subdivision 12; and

6.6 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

6.7 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
6.8 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
6.9 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
6.10 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
6.11 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
6.12 years are updated, a Minnesota long-term hospital's base year shall remain within the same
6.13 period as other hospitals.

6.14 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
6.15 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
6.16 area, except for the hospitals paid under the methodologies described in paragraph (a),
6.17 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
6.18 manner similar to Medicare. The base year or years for the rates effective November 1,
6.19 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
6.20 ensuring that the total aggregate payments under the rebased system are equal to the total
6.21 aggregate payments that were made for the same number and types of services in the base
6.22 year. Separate budget neutrality calculations shall be determined for payments made to
6.23 critical access hospitals and payments made to hospitals paid under the DRG system. Only
6.24 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
6.25 rebased during the entire base period shall be incorporated into the budget neutrality
6.26 calculation.

6.27 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
6.28 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
6.29 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
6.30 a five percent increase or decrease from the base year payments for any hospital. Any
6.31 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
6.32 shall maintain budget neutrality as described in paragraph (c).

6.33 (e) For discharges occurring on or after November 1, 2014, the commissioner may make
6.34 additional adjustments to the rebased rates, and when evaluating whether additional

7.1 adjustments should be made, the commissioner shall consider the impact of the rates on the
7.2 following:

7.3 (1) pediatric services;

7.4 (2) behavioral health services;

7.5 (3) trauma services as defined by the National Uniform Billing Committee;

7.6 (4) transplant services;

7.7 (5) obstetric services, newborn services, and behavioral health services provided by
7.8 hospitals outside the seven-county metropolitan area;

7.9 (6) outlier admissions;

7.10 (7) low-volume providers; and

7.11 (8) services provided by small rural hospitals that are not critical access hospitals.

7.12 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

7.13 (1) for hospitals paid under the DRG methodology, the base year payment rate per
7.14 admission is standardized by the applicable Medicare wage index and adjusted by the
7.15 hospital's disproportionate population adjustment;

7.16 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
7.17 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
7.18 October 31, 2014;

7.19 (3) the cost and charge data used to establish hospital payment rates must only reflect
7.20 inpatient services covered by medical assistance; and

7.21 (4) in determining hospital payment rates for discharges occurring on or after the rate
7.22 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
7.23 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
7.24 program in effect during the base year or years. In determining hospital payment rates for
7.25 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
7.26 methods and allowable costs of the Medicare program in effect during the base year or
7.27 years.

7.28 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
7.29 the rates established under paragraph (c), and any adjustments made to the rates under
7.30 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

8.1 total aggregate payments for the same number and types of services under the rebased rates
8.2 are equal to the total aggregate payments made during calendar year 2013.

8.3 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
8.4 thereafter, payment rates under this section shall be rebased to reflect only those changes
8.5 in hospital costs between the existing base year or years and the next base year or years. In
8.6 any year that inpatient claims volume falls below the threshold required to ensure a
8.7 statistically valid sample of claims, the commissioner may combine claims data from two
8.8 consecutive years to serve as the base year. Years in which inpatient claims volume is
8.9 reduced or altered due to a pandemic or other public health emergency shall not be used as
8.10 a base year or part of a base year if the base year includes more than one year. Changes in
8.11 costs between base years shall be measured using the lower of the hospital cost index defined
8.12 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
8.13 claim. The commissioner shall establish the base year for each rebasing period considering
8.14 the most recent year or years for which filed Medicare cost reports are available, except
8.15 that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019.
8.16 The estimated change in the average payment per hospital discharge resulting from a
8.17 scheduled rebasing must be calculated and made available to the legislature by January 15
8.18 of each year in which rebasing is scheduled to occur, and must include by hospital the
8.19 differential in payment rates compared to the individual hospital's costs.

8.20 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
8.21 for critical access hospitals located in Minnesota or the local trade area shall be determined
8.22 using a new cost-based methodology. The commissioner shall establish within the
8.23 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
8.24 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
8.25 the total cost for critical access hospitals as reflected in base year cost reports. Until the
8.26 next rebasing that occurs, the new methodology shall result in no greater than a five percent
8.27 decrease from the base year payments for any hospital, except a hospital that had payments
8.28 that were greater than 100 percent of the hospital's costs in the base year shall have their
8.29 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
8.30 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
8.31 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
8.32 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
8.33 following criteria:

8.34 (1) hospitals that had payments at or below 80 percent of their costs in the base year
8.35 shall have a rate set that equals 85 percent of their base year costs;

9.1 (2) hospitals that had payments that were above 80 percent, up to and including 90
9.2 percent of their costs in the base year shall have a rate set that equals 95 percent of their
9.3 base year costs; and

9.4 (3) hospitals that had payments that were above 90 percent of their costs in the base year
9.5 shall have a rate set that equals 100 percent of their base year costs.

9.6 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
9.7 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
9.8 methodology may include, but are not limited to:

9.9 (1) the ratio between the hospital's costs for treating medical assistance patients and the
9.10 hospital's charges to the medical assistance program;

9.11 (2) the ratio between the hospital's costs for treating medical assistance patients and the
9.12 hospital's payments received from the medical assistance program for the care of medical
9.13 assistance patients;

9.14 (3) the ratio between the hospital's charges to the medical assistance program and the
9.15 hospital's payments received from the medical assistance program for the care of medical
9.16 assistance patients;

9.17 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

9.18 (5) the proportion of that hospital's costs that are administrative and trends in
9.19 administrative costs; and

9.20 (6) geographic location.

9.21 (k) Effective for discharges occurring on or after January 1, 2024, the rates paid to
9.22 hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific
9.23 to each hospital that qualifies for a medical education and research cost distribution under
9.24 section 62J.692, subdivision 4, paragraph (a).

9.25 (l) Effective for discharges occurring on or after January 1, 2025, the commissioner shall
9.26 increase payments for inpatient behavioral health services provided by hospitals paid under
9.27 the DRG methodology by increasing the adjustment for behavioral health services under
9.28 paragraph (e).

9.29 (m) Effective for discharges occurring on or after January 1, 2025, the commissioner
9.30 shall increase capitation payments made to managed care plans and county-based purchasing
9.31 plans to reflect the rate increase provided under paragraph (l). Managed care plans and
9.32 county-based purchasing plans must use the capitation rate increase provided under this

10.1 paragraph to increase payment rates for inpatient behavioral health services provided by
10.2 hospitals paid under the DRG methodology. The commissioner must monitor the effect of
10.3 this rate increase on enrollee access to inpatient behavioral health services. If for any contract
10.4 year federal approval is not received for this paragraph, the commissioner must adjust the
10.5 capitation rates paid to managed care plans and county-based purchasing plans for that
10.6 contract year to reflect the removal of this provision. Contracts between managed care plans
10.7 and county-based purchasing plans and providers to whom this paragraph applies must
10.8 allow recovery of payments from those providers if capitation rates are adjusted in accordance
10.9 with this paragraph. Payment recoveries must not exceed the amount equal to any increase
10.10 in rates that results from this provision.

10.11 Sec. 3. Minnesota Statutes 2022, section 256B.0757, subdivision 5, is amended to read:

10.12 Subd. 5. **Payments for health home services.** The commissioner shall make payments
10.13 to each designated provider for the provision of health home services described in subdivision
10.14 3, except for behavioral health home services, to each eligible individual under subdivision
10.15 2 that selects the health home as a provider.

10.16 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
10.17 whichever is later. The commissioner of human services shall notify the revisor of statutes
10.18 when federal approval is obtained.

10.19 Sec. 4. Minnesota Statutes 2022, section 256B.0757, is amended by adding a subdivision
10.20 to read:

10.21 Subd. 5a. **Payments for behavioral health home services.** (a) Notwithstanding
10.22 subdivision 5, the commissioner shall determine and implement a single statewide
10.23 reimbursement rate for behavioral health home services under this section. The rate must
10.24 be no less than \$408 per member per month. The commissioner must adjust the statewide
10.25 reimbursement rate annually according to the change from the midpoint of the previous rate
10.26 year to the midpoint of the rate year for which the rate is being determined using the Centers
10.27 for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth
10.28 quarter of the calendar year before the rate year.

10.29 (b) The commissioner must review and update the behavioral health home services rate
10.30 under paragraph (a) at least every four years. The updated rate must account for the average
10.31 hours required for behavioral health home team members spent providing services and the
10.32 Department of Labor prevailing wage for required behavioral health home team members.
10.33 The updated rate must ensure that behavioral health home services rates are sufficient to

11.1 allow providers to meet required certifications, training, and practice transformation
 11.2 standards, staff qualification requirements, and service delivery standards.

11.3 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
 11.4 whichever is later. The commissioner of human services shall notify the revisor of statutes
 11.5 when federal approval is obtained.

11.6 Sec. 5. Minnesota Statutes 2023 Supplement, section 256B.76, subdivision 1, is amended
 11.7 to read:

11.8 Subdivision 1. **Physician and professional services reimbursement.** ~~(a) Effective for~~
 11.9 ~~services rendered on or after October 1, 1992, the commissioner shall make payments for~~
 11.10 ~~physician services as follows:~~

11.11 ~~(1) payment for level one Centers for Medicare and Medicaid Services' common~~
 11.12 ~~procedural coding system codes titled "office and other outpatient services," "preventive~~
 11.13 ~~medicine new and established patient," "delivery, antepartum, and postpartum care," "critical~~
 11.14 ~~care," cesarean delivery and pharmacologic management provided to psychiatric patients,~~
 11.15 ~~and level three codes for enhanced services for prenatal high risk, shall be paid at the lower~~
 11.16 ~~of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;~~

11.17 ~~(2) payments for all other services shall be paid at the lower of (i) submitted charges,~~
 11.18 ~~or (ii) 15.4 percent above the rate in effect on June 30, 1992; and~~

11.19 ~~(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th~~
 11.20 ~~percentile of 1989, less the percent in aggregate necessary to equal the above increases~~
 11.21 ~~except that payment rates for home health agency services shall be the rates in effect on~~
 11.22 ~~September 30, 1992.~~

11.23 ~~(b)~~ (a) Effective for services rendered on or after January 1, 2000, through December
 11.24 31, 2024, payment rates for physician and professional services shall be increased by three
 11.25 percent over the rates in effect on December 31, 1999, except for home health agency and
 11.26 family planning agency services. The increases in this paragraph shall be implemented
 11.27 January 1, 2000, for managed care.

11.28 ~~(e)~~ (b) Effective for services rendered on or after July 1, 2009, through December 31,
 11.29 2024, payment rates for physician and professional services shall be reduced by five percent,
 11.30 except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced
 11.31 by 6.5 percent for the medical assistance and general assistance medical care programs,
 11.32 over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph ~~(d)~~
 11.33 (c) do not apply to office or other outpatient visits, preventive medicine visits and family

12.1 planning visits billed by physicians, advanced practice registered nurses, or physician
12.2 assistants in a family planning agency or in one of the following primary care practices:
12.3 general practice, general internal medicine, general pediatrics, general geriatrics, and family
12.4 medicine. This reduction and the reductions in paragraph ~~(d)~~ (c) do not apply to federally
12.5 qualified health centers, rural health centers, and Indian health services. Effective October
12.6 1, 2009, payments made to managed care plans and county-based purchasing plans under
12.7 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in
12.8 this paragraph.

12.9 ~~(d)~~ (c) Effective for services rendered on or after July 1, 2010, through December 31,
12.10 2024, payment rates for physician and professional services shall be reduced an additional
12.11 seven percent over the five percent reduction in rates described in paragraph ~~(e)~~ (b). This
12.12 additional reduction does not apply to physical therapy services, occupational therapy
12.13 services, and speech pathology and related services provided on or after July 1, 2010. This
12.14 additional reduction does not apply to physician services billed by a psychiatrist or an
12.15 advanced practice registered nurse with a specialty in mental health. Effective October 1,
12.16 2010, payments made to managed care plans and county-based purchasing plans under
12.17 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in
12.18 this paragraph.

12.19 ~~(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,~~
12.20 ~~payment rates for physician and professional services shall be reduced three percent from~~
12.21 ~~the rates in effect on August 31, 2011. This reduction does not apply to physical therapy~~
12.22 ~~services, occupational therapy services, and speech pathology and related services.~~

12.23 ~~(f)~~ (d) Effective for services rendered on or after September 1, 2014, through December
12.24 31, 2024, payment rates for physician and professional services, including physical therapy,
12.25 occupational therapy, speech pathology, and mental health services shall be increased by
12.26 five percent from the rates in effect on August 31, 2014. In calculating this rate increase,
12.27 the commissioner shall not include in the base rate for August 31, 2014, the rate increase
12.28 provided under section 256B.76, subdivision 7. This increase does not apply to federally
12.29 qualified health centers, rural health centers, and Indian health services. Payments made to
12.30 managed care plans and county-based purchasing plans shall not be adjusted to reflect
12.31 payments under this paragraph.

12.32 ~~(g)~~ (e) Effective for services rendered on or after July 1, 2015, payment rates for physical
12.33 therapy, occupational therapy, and speech pathology and related services provided by a
12.34 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
12.35 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments

13.1 made to managed care plans and county-based purchasing plans shall not be adjusted to
13.2 reflect payments under this paragraph.

13.3 ~~(h)~~ (f) Any ratables effective before July 1, 2015, do not apply to early intensive
13.4 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

13.5 ~~(i)~~ (g) The commissioner may reimburse physicians and other licensed professionals for
13.6 costs incurred to pay the fee for testing newborns who are medical assistance enrollees for
13.7 heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when
13.8 the sample is collected outside of an inpatient hospital or freestanding birth center and the
13.9 cost is not recognized by another payment source.

13.10 Sec. 6. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

13.11 Subd. 6. **Medicare relative value units.** ~~Effective for services rendered on or after~~
13.12 ~~January 1, 2007, the commissioner shall make payments for physician and professional~~
13.13 ~~services based on the Medicare relative value units (RVU's). This change shall be budget~~
13.14 ~~neutral and the cost of implementing RVU's will be incorporated in the established conversion~~
13.15 ~~factor~~ (a) Effective for physician and professional services included in the Medicare Physician
13.16 Fee Schedule, the commissioner shall make payments at rates at least equal to 100 percent
13.17 of the corresponding rates in the Medicare Physician Fee Schedule. Payment rates set under
13.18 this paragraph must use Medicare relative value units (RVUs) and conversion factors at
13.19 least equal to those in the Medicare Physician Fee Schedule to implement the resource-based
13.20 relative value scale.

13.21 (b) The commissioner shall revise fee-for-service payment methodologies under this
13.22 section upon the issuance of a Medicare Physician Fee Schedule final rule by the Centers
13.23 for Medicare and Medicaid Services to ensure the payment rates under this subdivision are
13.24 at least equal to the corresponding rates in such final rule.

13.25 (c) Before or at the same time the commissioner revises and implements payment rates
13.26 for other services under paragraph (a), the commissioner must revise and implement payment
13.27 rates for mental health services based on RVUs and rendered on or after January 1, 2025,
13.28 such that the payment rates are at least equal to 100 percent of the Medicare Physician Fee
13.29 Schedule in accordance with paragraph (a).

13.30 (d) All mental health services and substance use disorder services performed in a primary
13.31 care or mental health care health professional shortage area, medically underserved area,
13.32 or medically underserved population, as maintained and updated by the United States
13.33 Department of Health and Human Services, are eligible for a ten percent bonus payment.

14.1 Such services are eligible for a bonus based upon the performance of the service in a health
 14.2 professional shortage area if the provider maintains an office in a health professional shortage
 14.3 area.

14.4 (e) Effective for services rendered on or after January 1, 2025, the commissioner shall
 14.5 increase capitation payments made to managed care plans and county-based purchasing
 14.6 plans to reflect the rate increases provided under this subdivision. Managed care plans and
 14.7 county-based purchasing plans must use the capitation rate increase provided under this
 14.8 paragraph to increase payment rates to the providers corresponding to the rate increases.
 14.9 The commissioner must monitor the effect of this rate increase on enrollee access to services
 14.10 under this subdivision. If for any contract year federal approval is not received for this
 14.11 paragraph, the commissioner must adjust the capitation rates paid to managed care plans
 14.12 and county-based purchasing plans for that contract year to reflect the removal of this
 14.13 provision. Contracts between managed care plans and county-based purchasing plans and
 14.14 providers to whom this paragraph applies must allow recovery of payments from those
 14.15 providers if capitation rates are adjusted in accordance with this paragraph. Payment
 14.16 recoveries must not exceed the amount equal to any increase in rates that results from this
 14.17 provision.

14.18 Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.761, is amended to read:

14.19 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

14.20 (a) Effective for services rendered on or after July 1, 2001, payment for medication
 14.21 management provided to psychiatric patients, outpatient mental health services, day treatment
 14.22 services, home-based mental health services, and family community support services shall
 14.23 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
 14.24 1999 charges.

14.25 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
 14.26 services provided by an entity that operates: (1) a Medicare-certified comprehensive
 14.27 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,
 14.28 with at least 33 percent of the clients receiving rehabilitation services in the most recent
 14.29 calendar year who are medical assistance recipients, will be increased by 38 percent, when
 14.30 those services are provided within the comprehensive outpatient rehabilitation facility and
 14.31 provided to residents of nursing facilities owned by the entity.

14.32 (c) In addition to rate increases otherwise provided, the commissioner may restructure
 14.33 coverage policy and rates to improve access to adult rehabilitative mental health services
 14.34 under section 256B.0623 and related mental health support services under section 256B.021,

15.1 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected
15.2 state share of increased costs due to this paragraph is transferred from adult mental health
15.3 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent
15.4 base adjustment for subsequent fiscal years. Payments made to managed care plans and
15.5 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
15.6 the rate changes described in this paragraph.

15.7 (d) Any ratables effective before July 1, 2015, do not apply to early intensive
15.8 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

15.9 (e) Effective for services rendered on or after January 1, 2024, payment rates for
15.10 behavioral health services included in the rate analysis required by Laws 2021, First Special
15.11 Session chapter 7, article 17, section 18, except for adult day treatment services under section
15.12 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services
15.13 under section 256B.0949; and substance use disorder services under chapter 254B, must be
15.14 increased by three percent from the rates in effect on December 31, 2023. Effective for
15.15 services rendered on or after January 1, 2025, payment rates for behavioral health services
15.16 included in the rate analysis required by Laws 2021, First Special Session chapter 7, article
15.17 17, section 18, except for adult day treatment services under section 256B.0671, subdivision
15.18 3; early intensive developmental behavioral intervention services under section 256B.0949;
15.19 and substance use disorder services under chapter 254B, must be annually adjusted according
15.20 to the change from the midpoint of the previous rate year to the midpoint of the rate year
15.21 for which the rate is being determined using the Centers for Medicare and Medicaid Services
15.22 Medicare Economic Index as forecasted in the fourth quarter of the calendar year before
15.23 the rate year. For payments made in accordance with this paragraph, if and to the extent
15.24 that the commissioner identifies that the state has received federal financial participation
15.25 for behavioral health services in excess of the amount allowed under United States Code,
15.26 title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare
15.27 and Medicaid Services with state money and maintain the full payment rate under this
15.28 paragraph. This paragraph does not apply to federally qualified health centers, rural health
15.29 centers, Indian health services, certified community behavioral health clinics, cost-based
15.30 rates, and rates that are negotiated with the county. This paragraph expires upon legislative
15.31 implementation of the new rate methodology resulting from the rate analysis required by
15.32 Laws 2021, First Special Session chapter 7, article 17, section 18.

15.33 (f) Effective January 1, 2024, the commissioner shall increase capitation payments made
15.34 to managed care plans and county-based purchasing plans to reflect the behavioral health
15.35 service rate increase provided in paragraph (e). Managed care and county-based purchasing

16.1 plans must use the capitation rate increase provided under this paragraph to increase payment
16.2 rates to behavioral health services providers. The commissioner must monitor the effect of
16.3 this rate increase on enrollee access to behavioral health services. If for any contract year
16.4 federal approval is not received for this paragraph, the commissioner must adjust the
16.5 capitation rates paid to managed care plans and county-based purchasing plans for that
16.6 contract year to reflect the removal of this provision. Contracts between managed care plans
16.7 and county-based purchasing plans and providers to whom this paragraph applies must
16.8 allow recovery of payments from those providers if capitation rates are adjusted in accordance
16.9 with this paragraph. Payment recoveries must not exceed the amount equal to any increase
16.10 in rates that results from this provision.

16.11 (g) Effective for services under this section billed and coded under Healthcare Common
16.12 Procedure Coding System H, S, and T codes, the commissioner shall increase the payment
16.13 rates as necessary to align with the Medicare Physician Fee Schedule.

16.14 Sec. 8. **APPROPRIATION.**

16.15 \$8,785,000 in fiscal year 2025 is appropriated from the general fund to the commissioner
16.16 of human services for the payment increases under Minnesota Statutes, section 256.969,
16.17 subdivision 2b, paragraphs (l) and (m). The aggregate amount of the increased payments
16.18 under Minnesota Statutes, section 256.969, subdivision 2b, paragraphs (l) and (m), must at
16.19 least equal the amount of this appropriation.

16.20 Sec. 9. **REPEALER.**

16.21 Minnesota Statutes 2022, section 256B.0625, subdivision 38, is repealed.

256B.0625 COVERED SERVICES.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.