State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 4519

03/04/2024 Authored by Bierman
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to human services; requiring individual pricing of phototherapy lights; modifying payment methodologies for certain enteral nutrition equipment and supplies; modifying processes for establishing payment rates for certain medical equipment and supplies; making technical changes; amending Minnesota Statutes 2022, section 256B.767; Minnesota Statutes 2023 Supplement, section 256B.766.

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

Section 1. Minnesota Statutes 2023 Supplement, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

Subdivision 1. **Payment reductions for basic care services effective July 1, 2009.** ~~(a)~~ Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation.

Subd. 2. **Classification of therapies as basic care services.** ~~Effective July 1, 2010,~~ The commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in ~~this paragraph~~ subdivision 1 shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services ~~provided on or after July 1, 2010~~.

Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~ Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1

effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

Subd. 4. **Temporary payment reductions effective September 1, 2011.** ~~(c)~~ (a) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

~~(d)~~ (b) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

Subd. 5. **Payment increases effective September 1, 2014.** ~~(e)~~ (a) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent.

(b) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this ~~paragraph~~ subdivision.

Subd. 6. **Temporary payment reductions effective July 1, 2014.** ~~(f)~~ Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent.

Subd. 7. **Payment increases effective July 1, 2015.** (a) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates for durable medical equipment, prosthetics, orthotics, or supplies as determined under ~~paragraphs (i) and (j)~~ subdivisions 9 and 10.

~~(g)~~ (b) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified

in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under ~~this~~ paragraph (b).

Subd. 8. **Exempt services.** ~~(h)~~ This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

Subd. 9. **Individually priced items.** ~~(i)~~ (a) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: customized and other specialized tracheostomy tubes and supplies, electric patient lifts, phototherapy lights, and durable medical equipment repair and service.

(b) This ~~paragraph~~ subdivision does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item.

(c) The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

Subd. 10. **Rate increases effective July 1, 2015.** ~~(j)~~ (a) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

~~This~~ (b) Paragraph (a) does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in ~~paragraph (i)~~ subdivision 9.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in ~~this~~ paragraph (a).

Subd. 11. **Rates for ventilators.** ~~(k)~~ (a) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the provider's submitted charge or the Medicare fee schedule rate.

(b) Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the provider's submitted charge or 47 percent above the Medicare fee schedule rate.

(c) For payments made in accordance with this ~~paragraph~~ subdivision, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this ~~paragraph~~ subdivision.

Subd. 12. **Rates subject to the upper payment limit.** ~~(l)~~ Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this ~~paragraph~~ subdivision.

Subd. 13. **Temporary rates for enteral nutrition and supplies.** ~~(m)~~ (a) For dates of service on or after July 1, 2023, through June 30, 2024, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate must be the payment rate in effect on June 30, 2023.

(b) This subdivision expires June 30, 2024.

Subd. 14. **Rates for enteral nutrition and supplies.** ~~(n)~~ For dates of service on or after July 1, 2024, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision and updated annually each January 1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner for the previous calendar year, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment must be the manufacturer's suggested retail price of that product or supply ~~minus 20~~ plus ... percent. If the manufacturer's suggested retail price is not available, payment must be the ~~actual acquisition cost of that product or supply plus 20 percent~~ provider's submitted charge minus 50 percent.

Subd. 15. **Payments based on manufacturer's suggested retail price.** For medical supplies and equipment payments based on the manufacturer's suggested retail price methodology set forth in Minnesota Rules, part 9505.0445, item S, the commissioner shall establish the payment amount on an annual basis for each product code with an annual volume of at least 100 paid claim lines.

Sec. 2. Minnesota Statutes 2022, section 256B.767, is amended to read:

256B.767 MEDICARE PAYMENT LIMIT.

Subdivision 1. **Services subject to a payment limit based on Medicare rates.** ~~(a)~~ Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service, as adjusted for any changes in Medicare payment rates after July 1, 2010. The commissioner shall ~~implement this section after any other rate adjustment that is effective July 1, 2010, and shall~~ reduce rates under this section by first reducing or eliminating provider rate add-ons.

Subd. 2. **Services exempt from the payment limit.** ~~(b)~~ (a) This section does not apply to services provided by advanced practice certified nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D. Notwithstanding this exemption,

medical assistance fee-for-service payment rates for advanced practice certified nurse midwives and licensed traditional midwives shall equal and shall not exceed the medical assistance payment rate to physicians for the applicable service.

~~(c)~~ (b) This section does not apply to mental health services or physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

~~(d) Effective July 1, 2015,~~ (c) This section shall not apply to durable medical equipment, prosthetics, orthotics, or supplies.

~~(e)~~ (d) This section does not apply to physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).