

## **Payment Methodology – Non-Hospital**

**Revised:** [January 22, 2025](#)

This section outlines the Minnesota Health Care Programs (MHCP) payment methodologies for non-hospital services, including rate variations and legislative changes:

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### **Rate Variations and Legislative Changes**

#### **HCPSC Modifiers**

MHCP may increase or decrease payment when certain HCPSC and CPT modifiers are used.

#### **Legislative Changes Related to Rates**

In the following situations, MHCP may estimate the 50<sup>th</sup> percentile of the prevailing charge for 1989, less the percent reduction:

- There were less than five billings in the calendar year specified in legislation governing maximum payment rates
- The service was not available in the calendar year specified in legislation governing maximum payment rates
- The payment amount is the result of a provider appeal
- The procedure code description has changed since the calendar year specified in legislation governing maximum payment rates and, therefore, the prevailing charge information reflects the same code but a different procedure description
- The 50<sup>th</sup> percentile, less the percent reduction, reflects a payment which is grossly inequitable when compared with payment rates for procedure or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category
- The procedure code is for an unlisted service

When one of the above situations occurs, MHCP will use the following methodology to reconstruct a rate comparable to the 50<sup>th</sup> percentile of the prevailing rate, less the percent reduction:

- Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates
- Refer to surrounding or comparable procedure codes
- Refer to the 50<sup>th</sup> percentile, less the percent reduction of years subsequent to the calendar year specified in legislation governing maximum payment rates and back down the amount by applying an appropriate Consumer Price Index (CPI) formula
- Refer to relative value indexes
- Refer to payment information from other third parties, such as Medicare
- Refer to a previous rate and add the aggregate increase to the previous rate
- Refer to the submitted charge and "back down" the charge by a CPI formula

The legislature has increased rates for certain services as follows:

- 7.5 percent for diagnostic and routine dental services (July 1989) Ended
- 5 percent for all other dental services (July 1989) Ended
- 20 percent for public health clinic and community health clinic services (July 1989) Ended for Dental Services Dec. 31, 2021
- 5 percent for physical therapy, speech-language therapy, occupational therapy, respiratory therapy (July 1997)
- 5 percent for Medical Assistance (MA) and General Assistance Medical Care (GAMC) dental (July 1997) Ended
- 15 percent for MinnesotaCare dental (July 1997) Ended Dec. 31, 2021
- 3 percent for MA and GAMC and MinnesotaCare dental (July 1998) Ended
- 3 percent for physical therapy, speech-language therapy, occupational therapy, respiratory therapy (July 1998)
- 3 percent for physician and professional services except home health (January 2000)
- 3 percent for dental (January 2000) Ended
- 2 percent for services subject to the hospital, surgical and health care provider taxes (January 2004)
- 2.2553 percent for physical therapy, occupational therapy, speech-language therapy (October 2005)
- 2.2553 percent for physical therapy, occupational therapy, speech-language therapy (October 2006)
- 23.7 percent for specified critical access mental health services provided by psychiatrists and advanced practice registered nurses with a psychiatric specialty, community mental health centers or mental health clinics and centers certified under Minnesota Statutes, 245I.20 and Essential Community Providers (July 2007) Ended Dec. 31, 2024
- 2 percent for physical therapy, occupational therapy, speech-language therapy (October 2007)
- 2 percent for physical therapy, occupational therapy, speech-language therapy (October 2008)
- 5 percent dental services on or after Jan. 1, 2014, (excluding state-operated dental clinics, federally qualified health centers (FQHC), rural health clinics (RHC) and Indian Health Service (IHS)) Ended Dec. 31, 2021
- 3 percent for basic care services, which include ambulatory surgery, eyeglasses and contact lenses, hospice, hearing aids, laboratory, renal dialysis and public health nursing (September 2014)
- 5 percent for physician and other professional services, which includes physician, mental health, physical therapy, speech therapy, occupational therapy, podiatry, chiropractic, audiology, vision, radiology, nurse midwife and nurse practitioner services (September 2014)
- 3 percent for durable medical equipment and supplies, prosthetics and orthotics (July 2015)

- 9.65 percent to dental treating providers outside the seven-county metro area (July 2015) Ended Dec. 31, 2021
- 90 percent for physical therapy, occupational therapy and speech pathology services provided by an essential community provider that was a state hospital specializing in the treatment of cerebral palsy, spina bifida, epilepsy, closed-head injuries, specialized orthopedic problems and other disabling conditions (July 2015)
- 9.5 percent Medicare rate increase for medical supplies, durable medical equipment, prosthetics and orthotics that were subject to Medicare's competitive bidding process on Jan. 1, 2009 (July 2015)
- 2.94 percent increase for all medical supplies, durable medical equipment, prosthetics and orthotics paid under the Medical Assistance (MA) 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 people where Medicare is the primary payer (July 2015)
- 5 percent for ambulance services outside the cities of Duluth, Mankato, Moorhead, St. Cloud or Rochester and within a municipality with a population less than 1,000 (January 2016)
- 23.8 percent for dental services for MA members under age 21 (July 2017) Ended Dec. 31, 2021
- The 23.7 percent for critical access mental health services is extended to include mental health clinics and centers certified under Minnesota Statutes, 245I.20 but are not Essential Community Providers (July 2017) Ended Dec. 31, 2024
- 54 percent for dental services for MinnesotaCare members (January 2018) Ended Dec. 31, 2021
- 98 percent for dental services MA and MinnesotaCare members (January 2022)
- 20 percent increase for family planning and abortion services. (January 2024)
- 3 percent increase for behavioral health services, except for adult day treatment services, early intensive developmental and behavioral intervention services, and substance use disorder services (January 2024).
- 50 percent over the reimbursement rate in effect as of June 30, 2023, for adult day treatment (January 2024).

The legislature decreased rates for certain services as follows:

- 6 percent for individual and group psychotherapy services (July 1990)
- 35 percent for therapy services provided by physical or occupational therapist assistant
- 5 percent for services provided to GAMC recipients (July 2003)
- 3 percent for basic care services, which include medical supplies and durable medical equipment (DME), ambulatory surgery, eyeglasses and contact lenses, prosthetics and orthotics, hearing aids, laboratory, renal dialysis and public health nursing (July 2009)
- This reduction does not apply to physician and professional services, inpatient hospital services, family planning services, dental services, prescription drugs, mental health, medical transportation, FQHC, RHC, IHS, tribal health services and Medicare cost-sharing
- An additional 1.5 percent for MA and GAMC for service dates July 1, 2009, through June 30, 2011 (July 2009)
- The 3 percent and 1.5 percent reductions apply to physical therapy, speech therapy and occupational therapy services beginning with dates of service on and after July 1, 2010 (July 2010)
- 5 percent for physician and other professional services, which includes physician, physical therapy (through June 30, 2010), speech therapy (through June 30, 2010), occupational therapy (through June 30, 2010), podiatry, chiropractic, audiology, vision, radiology, nurse midwife, and nurse practitioner services

- This reduction does not apply to office or other outpatient visits, preventative medicine visits or family planning visits when billed by physicians, advanced practice nurses or physician assistants in a family planning agency, general practice, general internal medicine practice, general pediatric practice, general geriatric practice or family medicine practice.
- An additional 1.5 percent for MA or GAMC for service dates July 1, 2009, through June 30, 2010 (July 2009)
- An additional 7 percent for all major programs for dates of service on and after July 1, 2010. This 7 percent reduction does not apply to the exclusions listed under 5 percent (above) or to physician services provided by psychiatrists or advanced practice nurses with a specialty in mental health (July 2010)
- 3 percent dental services, professional services, miscellaneous services and materials for service dates Sept. 1, 2011, through June 30, 2013
- 4.5 percent ambulance services for service dates on or after Sept. 1, 2011
- 4.5 percent special transportation services (STS) for service dates on or after Sept. 1, 2011
- 4.5 percent access transportation services (ATS) for taxi and other commercial carriers for service dates on or after Sept. 1, 2011
- 5 percent outpatient hospital facility fees for service dates Sept. 1, 2011, through June 30, 2013
- 0.33 percent medical supplies and durable medical equipment, prosthetics and orthotics for service dates on or after July 1, 2014, through June 30, 2015
- The 23.7 percent increase for specified critical access mental health services provided by psychiatrists and advanced practice registered nurses with a psychiatric specialty, community mental health centers or mental health clinics and centers certified under Minnesota Statutes, 245I.20 and Essential Community Providers and those that are not Essential Community Providers (July 2007) Ended Dec. 31, 2024, and will be phased out according to the following schedule:
  - Decrease to 11.85 percent for specified critical access mental health services provided by psychiatrists and advanced practice registered nurses with a psychiatric specialty, community mental health centers or mental health clinics and centers certified under Minnesota Statutes, 245I.20 and Essential Community Providers and those that are not Essential Community Providers (January 2025)
  - Decrease to 5.92 percent for specified critical access mental health services provided by psychiatrists and advanced practice registered nurses with a psychiatric specialty, community mental health centers or mental health clinics and centers certified under Minnesota Statutes, 245I.20 and Essential Community Providers and those that are not Essential Community Providers (January 2026)
  - Decrease to zero percent for specified critical access mental health services provided by psychiatrists and advanced practice registered nurses with a psychiatric specialty, community mental health centers or mental health clinics and centers certified under Minnesota Statutes, 245I.20 and Essential Community Providers and those that are not Essential Community Providers (January 2027)

### **Ambulatory Surgical Center Facility Fees**

Services for which there is a federal maximum allowable payment will be paid at the lower of the following:

- Provider's submitted charge
- Payment rate listed in the Federal Register Notice

Ambulatory surgical center facility fees for services rendered on or after Oct. 1, 1992, are usually paid the lower of:

- Provider's submitted charge

- 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable.

### **Anesthesiology**

Anesthesia services rendered by physicians or certified registered nurse anesthetists (CRNAs) are paid according to the formula used by Medicare. For physicians, a conversion factor "at percentile of calendar year set by legislature" is used. Review the table in the [Anesthesia Services](#) section of the MHCP Provider Manual for the [payment formulas](#).

### **Child & Teen Checkups (C&TC) (Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program) Services**

C&TC services are paid at the lower of:

- Provider's submitted charge
- 75<sup>th</sup> percentile of the usual and customary fee based on billings submitted by all providers of service during the previous 12-month period of July 1, 2009, through June 30, 2010, and effective Oct. 1, 2010

### **Dental**

Dental services rendered on or after Oct. 1, 1992, are paid at the lower of:

- Provider's submitted charge
- 25 percent above the rate in effect on June 30, 1992

All dental rates will be converted from the 50<sup>th</sup> percentile of 1982 to the 50<sup>th</sup> percentile of 1989, less the percent in aggregate necessary to equal the above increases.

Tooth sealants and fluoride treatments provided on or after Oct. 1, 1999, are paid at the lower of:

- Provider's submitted charge
- 80 percent of the 1997 median charge

Diagnostic examinations and dental x-rays provided to children under age 21 on or after Jan. 1, 2002, are paid at the lower of:

- Provider's submitted charge
- 85 percent of the 1999 median charge

### **Equipment and Supplies**

Medical supplies and equipment not subject to volume purchase are paid at the lower of:

- Provider's submitted charge
- Medicare fee schedule amount

If Medicare has not established a fee schedule amount for the medical supply or equipment, MHCP will determine an amount using one of the following methodologies:

- 50<sup>th</sup> percentile of the usual and customary charges submitted for the code for the previous two calendar years minus 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment
- If no information about usual and customary charges exists, payment is based upon the manufacturer's suggested retail price minus 20 percent
- If no information exists about manufacturer's suggested retail price, payment is based on wholesale cost plus 20 percent

Medical supplies and equipment for pediatric patients, bariatric patients and HCPCS codes A7520, A7521, B4088 and E0202 are paid the lower of:

- Provider's submitted charge
- Payment amount determined using one of the following methodologies:
- 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
- If no information about usual and customary charges exists, payment is based on the manufacturer's suggested retail price minus 20 percent
- If no information exists about manufacturer's suggested retail price payment is based on wholesale cost plus 20 percent

Medical supplies and equipment for dually eligible members when Medicare is primary payer on Medicare paid lines are subject to the competitive bidding single payment amount (SPA) under the CMS DMEPOS competitive bidding program.

### **Prosthetics and orthotics**

Prosthetics and orthotics are paid at the lower of:

- Provider's submitted charge
- Medicare fee schedule amount. If Medicare has not established a fee schedule amount for the medical supply or equipment, MHCP will determine an amount using one of the following methodologies:
- 50<sup>th</sup> percentile of the usual and customary charges submitted for the code for the previous calendar years minus 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment
- If no information about usual and customary charges exists for the previous calendar year, payment is based upon the manufacturer's suggested retail price minus 20 percent
- If no information exists about manufacturer's suggested retail price, payment is based on wholesale cost plus 20 percent

### **Augmentative and alternative communication device**

Augmentative and alternative communication device manufacturers and vendors must be paid the lower of:

- Provider's submitted charge
- Manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems
- Manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems

### **Enteral products**

Enteral products are paid the lower of:

- Provider's submitted charge
- Medicare fee schedule amount
- 50<sup>th</sup> percentile of the usual and customary charges submitted for the previous calendar years minus 20 percent, plus current calendar year Medicare inflation factors

If a payment rate cannot be calculated using submitted charges, MHCP claims determines an amount using one of the following methodologies:

- The manufacturer's suggested retail price minus 20 percent
- If no information exists about manufacturer's suggested retail price, payment is based on wholesale cost plus 20 percent

Pediatric enteral products may be paid at the AWP.

Parenteral products are paid using the prescribed drugs for drugs dispensed by a pharmacy methodology. Drugs dispensed by a pharmacy are paid the lower of:

- The estimated actual acquisition costs of the drugs, or the maximum allowable cost set by the State agency, plus a fixed dispensing fee
- Provider's usual and customary charge

### **Home infusion therapy**

Home Infusion therapy services provided by home infusion pharmacies are paid the lower of:

- Provider's submitted charge
- A per diem amount as defined in-home infusion HCPCS codes

If Medicare has not established a payment amount, MHCP will determine an amount using the criteria for supplies and equipment.

### **Volume Purchase**

**Hearing aids** are paid at the lower of:

- Provider's submitted charge
- Negotiated fee as agreed to in the contract

If the hearing aid is a non-contract aid, the payment is at the single-unit cost.

Dispensing fees for hearing aids are billed and paid separately.

**Oxygen** is paid at the lower of:

- Provider's submitted charge
- Negotiated contract rate

### **Family Planning**

Effective July 1, 2007, a 25 percent increase above the rates in place on June 30, 2007, was implemented for family planning services. Effective July 1, 2013, an additional 20 percent increase above the rates in place on June 30, 2013, was implemented for family planning services. Refer to [Family Planning Codes with Increased Rates](#) for the list of codes that receive the legislative rate increases for family planning services.

### **Home Health Agency**

Home Health Agency services are paid at the lower of:

- Provider's submitted charge
- Medicare cost per visit limits based on Medicare cost reports and submitted by freestanding home health agencies in the Minneapolis and St. Paul area in the calendar year specified in legislation governing maximum payment rates

### **Hospice**

Hospice services are paid at the lowest of:

- Provider's submitted charge
- Medicare maximum allowable
- State agency established rate

### **Tribal and Indian Health Service Facility**

Tribal and Indian Health Service facility payments are based on the methodology in Sections 321(a) and 322(b) of the Public Health Service Act.

## Laboratory Services

Laboratory services are paid at the lower of:

- Provider's submitted charge
- Medicare fee schedule amount

If Medicare has not established a fee schedule amount, an amount will be determined using one of the following methodologies:

- 50<sup>th</sup> percentile of the charges submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates, less 25 percent
- 50<sup>th</sup> percentile of the charges submitted by all provider of the service in years subsequent to the calendar year specified in legislation governing maximum payment rates backed down by the appropriate CPI formula, less 25 percent
- An average of the number of independent laboratory providers' charges, less 25 percent

## Mental Health Services

Effective for services provided on or after Jan. 1, 2011, payment for mental health services is the lower of the following:

- Provider's submitted charge
- The Resource Based Relative Value Scale calculated values
- State agency established rate

Services provided by a **master's prepared mental health professional** (Licensed Practitioner (LP), Clinical Nurse Specialist-Mental Health (CNS-MH), Licensed Independent Clinical Social Worker (LICSW)) are paid at the lower of the following:

- Provider's submitted charge
- 80 percent of the allowable rate
- 100 percent of the allowable rate if provided in a Community Mental Health Center (CMHC)

## Targeted Case Management for Serious and Persistent Mental Illness Services (Rule 79)

Targeted case management for serious and persistent mental illness services (Rule 79) payment rate is established in [Minnesota Rules, 9505.0491](#).

## Nursing Services

### Private Duty Nursing Services

Private duty nursing services are paid the lower of:

- Provider's submitted charge
- Maximum rate established by the legislature effective July 1, 2001

### Public Health Nursing

Public health nursing services are paid the lower of:

- Provider's submitted charge
- State agency established rate

### Nursing Facility and ICF/DD

Minnesota statutes and rules establish per diem rates that are paid on behalf of the member in a nursing facility or Intermediate Care Facility for the Developmentally Disabled (ICF/DD). Private room rates are paid up to 115 percent of the member's current case mix, but only if the facility chooses to assign costs and MHCP has authorized a private room.

The 2003 legislative session made the following changes to nursing facility rates:

- Nursing facilities reimbursed under Minnesota Statutes, section 256B.431: The operating payment rate in effect before June 30 is the operating rate in effect on July 1
- The number of days for which a rate enhancement will be paid for nursing facility admissions on or after July 1, 2003, are reduced from 90 paid days to 30 calendar days. Rate enhancement for admissions prior to July 1, 2003, will cease on July 30, 2003
- Nursing facility bed-hold day rates are reduced from 79 percent to 60 percent of the usual rate, when the facility meets occupancy standards
- The amount paid for MHCP for Medicare coinsurance will be the lesser of the actual coinsurance amount, or the amount by which the MA case mix payment rate exceeds the Medicare payment rate less the coinsurance amount
- The automatic inflation increase to the operating portion of the rate is eliminated for state fiscal years 2004-2005, for nursing facilities under contract through the Alternative Payment System (APS). The inflation factor is only applied to the property portion of the rate
- For Rule 50 facilities, until otherwise specified in legislation, the operating portion of the rate will carry forward from one year to the next. The property portion of the rate will be recalculated based on the law, rule and the cost report
- For both APS and Rule 50 NFs, other non-operating portions of the rate will be recalculated as well
- Requirements for advance notice of rate increases to nursing facility residents are clarified. Even in situations where the 30-day advance notice is not required, timely notice must be given before a rate increase can take effect

### **Skilled Nursing Facility**

Before July 1, 2003, MHCP paid the Medicare Part A room and board coinsurance for MA eligible nursing facility residents. Legislation now limits the amount of the Medicare Part A coinsurance that MA may pay.

For services rendered on or after July 1, 2003, MCHP will pay the lesser of:

- The actual coinsurance amount
- The amount by which the MA RUGS III case mix payment rate exceeds the Medicare rate less the coinsurance amount. For coinsurance days occurring during a 30-day enhanced rate period for new admits, the enhanced MA rate is used

This legislative change may result in the amount of a member's resources exceeding the obligation to the facility. To refund the excess payment made by the resident, send a check to DHS or request a deduction from a future warrant. Refer to the section titled Refund of Payment for instructions.

Nursing facilities may not apply unpaid coinsurance amounts to a member's resources. The MA allowed amount for the coinsurance must be considered payment in full, even if it is a zero payment. Nursing facilities may consider coinsurance amounts that are not paid in full by MA to be a bad debt for Medicare purposes. Use the DHS RA for information to claim the bad debt from the Medicare Intermediary.

Requirements of the rate equalization law do not limit the amount of the Medicare copay that a nursing facility may collect from a private pay resident.

### **ICF/DD Services**

- Payment rates for an ICF/DD are reduced by decreasing their total operating payment rate by one percent. The adjustment is applied by multiplying the total payment rate in effect on the preceding June 30, excluding the property-related payment rate, by one percent.
- Facilities with receivership or closure agreements are excluded.

- ICF/DD facility rates increased \$3.00 per day effective on June 1, 2003.
- MHCP is authorized to designate up to 25 beds for the purpose of facilitating short-term admissions to an ICF/DD to meet short-term behavioral care needs or specialized medical care needs by providing occupancy adjustments of up to 15 days per month.
- ICF/DD residents have increased flexibility and choice in how they have their active treatment needs met during the day. Effective July 1, 2003, the facility is obligated to pay 1/12 of the \$1,040 total per licensed bed each month. This amounts to \$86.67 per licensed bed per month. ICF/DD facilities will receive an invoice from MHCP about the amount the facility needs to remit to meet the requirements of this legislation. These must be paid monthly on the 15<sup>th</sup> of each month, beginning July 15, 2003.

### **Swing Bed Services**

Law sets the daily MHCP payment rate for swing bed services as the statewide average payment rate for all MA nursing facilities' per diem. The swing bed payment rate is computed annually, following the state's fiscal year, July 1 through June 30 and is effective October 1. MHCP notifies eligible facilities by mail of the new rate each year.

### **Personal Care Assistance**

Personal care assistance services are paid the lower of:

- Provider's submitted charge
- Maximum rate established by the legislature, effective July 1, 2001

### **Physician**

Physician and clinic services include the following provider types:

- Audiologist
- Chiropractor
- Community health clinic
- Dentists providing medical services
- Family planning clinic
- Individual education plan
- Mental health clinic
- Occupational therapist
- Optician
- Optometrist
- Physical therapist
- Physician
- Physician clinic
- Podiatrist
- Psychologist
- Public health clinic
- Rehabilitation agency
- Speech-language pathologist

Effective for services provided on or after Jan. 1, 2011, payment for mental health services is the lower of the following:

- Provider's submitted charge
- Resource-based relative value scale (RBRVS) rate
- State agency established rate
- "Pharmacological Management" provided to psychiatric patients, and HCPCS level III codes for enhanced services for prenatal at risk, will be paid at the lower of the:

- Provider's submitted charge
- 25 percent above the rate in effect on June 30, 1992
- Services provided by a **physician assistant (PA)** are paid to the supervising enrolled provider at the lower of the following:
  - Provider's submitted charge
  - 90 percent of the allowable
- Services provided by an **enrolled advanced practice registered nurse (APRN)** are paid at the lower of the following:
  - Provider's submitted charge
  - 90 percent of the allowable
- Services provided by an enrolled **clinical nurse specialist (CNS)** are paid at the lower of the following:
  - Provider's submitted charge
  - 90 percent of the allowable
- Services provided by **non-psychiatric physician extenders** are paid to the supervising enrolled provider at the lower of the following:
  - Provider's submitted charge
  - 65 percent of the reference file allowable

### **Renal Dialysis Services**

The dialysis composite rate is the rate established by CMS for Medicare. MHCP will pay the lower of:

- Provider's submitted charge
- Composite rate

### **Rural Health Clinic and Federally Qualified Health Center Services**

Rural Health Clinic services and Federally Qualified Health Center services, including other ambulatory services covered under the State Plan, are covered at the clinic or center's prospective payment system (PPS) rate prescribed by the Benefits Improvement and Protection Act (BIPA) of 2000, Section 702. Dental services are paid at a separate clinic or center-specific PPS rate. Certain providers may qualify for a payment rate under an alternative payment method, provided for by BIPA, and described in the State Plan.

### **Transportation Services**

**Ground ambulance transportation** is paid the lower of:

- Provider's submitted charge
- Medicare unadjusted base payment rate; except on procedure codes A0427 and A0429 which are paid at the lower of the provider's submitted charge and the state agency established rate

**State administered non-emergency medical transportation (NEMT)** is paid the lower of:

- Provider's submitted charge
- MA allowable charge

**Local county and tribal administered NEMT and related ancillary services** are paid to the county or tribe at the lower of:

- Provider's (county or tribe) submitted charge
- MA allowable charge

Payment for ancillary services to a member during life support transportation or to obtain other medically necessary covered services must be based on the type of ancillary service and is not subject to proration.

### **Air Ambulance Transportation**

Air ambulance transportation is paid at a rate consistent with the level of medically necessary service provided during the member's transport. Payment is the lower of:

- Provider's submitted charge
- Medicare unadjusted base payment

Payment for air ambulance transportation of a member not having a life-threatening condition requiring air ambulance transport will be at the level of medically necessary services that otherwise would have been appropriate for the member at the rates specified above.

### **Vaccines**

For coverage and billing policy for children and adults, refer to the [Immunizations and Vaccinations](#) section of the MHCP Provider Manual.

### **Minnesota Adult Vaccine Program**

Vaccine administration is paid the lower of:

- Provider's submitted charge
- Resource-based relative value scale (RBRVS) rate

Vaccines are paid the lower of:

- Provider's submitted charge
- Medicare allowable
- Medicare payment amount:
- Wholesale acquisition cost
- Average wholesale price (AWP) minus 5 percent

### **Minnesota Vaccines for Children Program**

Vaccines available through the MNVFC program are paid only an administration fee equal to the lesser of the:

- Provider's submitted charge
- Minnesota's regional maximum administration fee for vaccines under the MNVFC program

### **Waivered Services**

If a service provided under a waiver is comparable in type, amount, duration and scope to an MA service, the reimbursable amount must be the same as if it were provided under the MA program. Payment for specific waived services, or MA-covered services that are different in amount, duration or scope, are determined according to the rule established for the particular waived program.

Effective July 1, 2003, provider payment rates are reduced by 1 percent for the following providers or programs:

- Home and community-based services for the elderly, except extended home care services
- Alternative Care home and community-based services, except home health, personal care assistant and private duty nursing services
- Day training and habilitation services for adults with developmental disabilities (DD)

Allocations to county agencies for home and community-based waived services will be reduced 1 percent for the following. This reduction does not include home care, extended home care or extended transportation services.

- Services provided to members with DD. The allowable budget will be reduced to assure savings for the biennium. Counties must make rate adjustments or changes in spending to

achieve the total reduction required by the legislature. This reduction does not apply to home care or extended home care services

- Brain Injury (BI) waived services
- Community Alternative Care (CAC) waived services
- Community Access for Disability Inclusion (CADI) waived services

DD diversion allocations were available during FY04 and FY05. Conversion allocations for members in ICF/DDs that downsize or close continue to be available.

Allocations for CADI are limited to an average monthly growth of 95 members.

BI spending must be managed to the equivalent of limiting allocations to 150 per year.

### **Miscellaneous Rates**

For health services not listed above, MHCP may use competitive bidding, negotiate a rate or establish a payment rate by other means consistent with statutes, federal regulations and state rules.

### **Legal References**

[Minnesota Statutes, 245I.20](#) (Mental Health Clinic)

[Minnesota Statutes, 256B.76](#) (Physician and Dental Reimbursement)

[Minnesota Rules, 9549.0010 to 9549.0080](#) (Nursing Facility Payment Rates)

[Minnesota Statutes, 256B.431](#) (Rate Determination—resident care costs)

[Minnesota Statutes, 256B.434](#) (Alternate rates for nursing facility)

[Minnesota Statutes, 256B.0625](#), subdivision 13e (Payment rates—drugs and vaccines)

[Minnesota Statutes, 256B.0625](#), subdivision 17a (Transportation costs—nonemergency medical transportation service)

[Minnesota Statutes, 256B.0625](#), subdivision 31 (Medical supplies and equipment)

[Minnesota Rules, 9505.0445](#) (Payment Rates—covered health services)