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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE NO. 2112

March 14, 2007
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The bill was read for the first time and referred to the Committee on Health and Human Services

1.1 A bill for an act
1.2 relating to human services; increasing the medical assistance payment rates for
1.3 dental services provided to children; requiring a report on provider taxes paid
1.4 by dental providers and payments made to dental providers from the health care
1.5 access fund; amending Minnesota Statutes 2006, section 256B.76.

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

1.7 Section 1. Minnesota Statutes 2006, section 256B.76, is amended to read:

1.8 **256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.**

1.9 (a) Effective for services rendered on or after October 1, 1992, the commissioner
1.10 shall make payments for physician services as follows:

1.11 (1) payment for level one Centers for Medicare and Medicaid Services' common
1.12 procedural coding system codes titled "office and other outpatient services," "preventive
1.13 medicine new and established patient," "delivery, antepartum, and postpartum care,"
1.14 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
1.15 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
1.16 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
1.17 30, 1992. If the rate on any procedure code within these categories is different than the
1.18 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
1.19 then the larger rate shall be paid;

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

1.22 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
1.23 percentile of 1989, less the percent in aggregate necessary to equal the above increases

2.1 except that payment rates for home health agency services shall be the rates in effect
2.2 on September 30, 1992;
2.3 (4) effective for services rendered on or after January 1, 2000, payment rates for
2.4 physician and professional services shall be increased by three percent over the rates in
2.5 effect on December 31, 1999, except for home health agency and family planning agency
2.6 services; and
2.7 (5) the increases in clause (4) shall be implemented January 1, 2000, for managed
2.8 care.
2.9 (b) Effective for services rendered on or after October 1, 1992, the commissioner
2.10 shall make payments for dental services as follows:
2.11 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
2.12 percent above the rate in effect on June 30, 1992;
2.13 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
2.14 percentile of 1989, less the percent in aggregate necessary to equal the above increases;
2.15 (3) effective for services rendered on or after January 1, ~~2000, payment rates for~~
2.16 ~~dental services shall be increased by three percent over the rates in effect on December~~
2.17 ~~31, 1999~~ 2008, payment rates for dental services shall be 90 percent of 2006 submitted
2.18 charges;
2.19 (4) the commissioner shall award grants to community clinics or other nonprofit
2.20 community organizations, political subdivisions, professional associations, or other
2.21 organizations that demonstrate the ability to provide dental services effectively to public
2.22 program recipients. Grants may be used to fund the costs related to coordinating access for
2.23 recipients, developing and implementing patient care criteria, upgrading or establishing
2.24 new facilities, acquiring furnishings or equipment, recruiting new providers, or other
2.25 development costs that will improve access to dental care in a region. In awarding grants,
2.26 the commissioner shall give priority to applicants that plan to serve areas of the state in
2.27 which the number of dental providers is not currently sufficient to meet the needs of
2.28 recipients of public programs or uninsured individuals. The commissioner shall consider
2.29 the following in awarding the grants:
2.30 (i) potential to successfully increase access to an underserved population;
2.31 (ii) the ability to raise matching funds;
2.32 (iii) the long-term viability of the project to improve access beyond the period
2.33 of initial funding;
2.34 (iv) the efficiency in the use of the funding; and
2.35 (v) the experience of the proposers in providing services to the target population.

3.1 The commissioner shall monitor the grants and may terminate a grant if the grantee
3.2 does not increase dental access for public program recipients. The commissioner shall
3.3 consider grants for the following:

3.4 (i) implementation of new programs or continued expansion of current access
3.5 programs that have demonstrated success in providing dental services in underserved
3.6 areas;

3.7 (ii) a pilot program for utilizing hygienists outside of a traditional dental office to
3.8 provide dental hygiene services; and

3.9 (iii) a program that organizes a network of volunteer dentists, establishes a system to
3.10 refer eligible individuals to volunteer dentists, and through that network provides donated
3.11 dental care services to public program recipients or uninsured individuals;

3.12 (5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
3.13 shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

3.14 (6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000,
3.15 for managed care; and

3.16 (7) effective for services provided on or after January 1, 2002, payment for
3.17 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
3.18 lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

3.19 (c) Effective for dental services rendered on or after January 1, 2002, the
3.20 commissioner may, within the limits of available appropriation, increase reimbursements
3.21 to dentists and dental clinics deemed by the commissioner to be critical access dental
3.22 providers. Reimbursement to a critical access dental provider may be increased by not
3.23 more than 50 percent above the reimbursement rate that would otherwise be paid to
3.24 the provider. Payments to health plan companies shall be adjusted to reflect increased
3.25 reimbursements to critical access dental providers as approved by the commissioner.
3.26 In determining which dentists and dental clinics shall be deemed critical access dental
3.27 providers, the commissioner shall review:

3.28 (1) the utilization rate in the service area in which the dentist or dental clinic operates
3.29 for dental services to patients covered by medical assistance, general assistance medical
3.30 care, or MinnesotaCare as their primary source of coverage;

3.31 (2) the level of services provided by the dentist or dental clinic to patients covered
3.32 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
3.33 source of coverage; and

3.34 (3) whether the level of services provided by the dentist or dental clinic is critical to
3.35 maintaining adequate levels of patient access within the service area.

4.1 In the absence of a critical access dental provider in a service area, the commissioner may
4.2 designate a dentist or dental clinic as a critical access dental provider if the dentist or
4.3 dental clinic is willing to provide care to patients covered by medical assistance, general
4.4 assistance medical care, or MinnesotaCare at a level which significantly increases access
4.5 to dental care in the service area.

4.6 The commissioner shall annually establish a reimbursement schedule for critical
4.7 access dental providers and provider-specific limits on total reimbursement received
4.8 under the reimbursement schedule, and shall notify each critical access dental provider
4.9 of the schedule and limit.

4.10 (d) An entity that operates both a Medicare certified comprehensive outpatient
4.11 rehabilitation facility and a facility which was certified prior to January 1, 1993, that is
4.12 licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33
4.13 percent of the clients receiving rehabilitation services in the most recent calendar year are
4.14 medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation
4.15 services at rates that are 38 percent greater than the maximum reimbursement rate
4.16 allowed under paragraph (a), clause (2), when those services are (1) provided within the
4.17 comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing
4.18 facilities owned by the entity.

4.19 (e) Effective for services rendered on or after January 1, 2007, the commissioner
4.20 shall make payments for physician and professional services based on the Medicare
4.21 relative value units (RVU's). This change shall be budget neutral and the cost of
4.22 implementing RVU's will be incorporated in the established conversion factor.

4.23 Sec. 2. **REPORT ON REVENUE PAID BY DENTAL PROVIDERS INTO THE**
4.24 **HEALTH CARE ACCESS FUND.**

4.25 The commissioner of human services, in conjunction with the commissioner of
4.26 revenue, shall determine the amount of revenue deposited into the health care access
4.27 fund for calendar years 2004, 2005, and 2006, that was derived from taxes imposed on
4.28 dental providers under Minnesota Statutes, sections 295.50 to 295.57. The commissioner
4.29 of human services shall also identify the total amount paid to dentists and critical access
4.30 dental providers from the health care access fund for the corresponding time period either
4.31 by the Department of Human Services directly or through the prepaid medical assistance
4.32 program. The commissioner shall report to the chairs of the senate and house finance
4.33 committees on these amounts by January 15, 2008.