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A bill for an act

relating to health care; establishing an alternative payment system for federally qualified health centers and rural health clinics; amending Minnesota Statutes 2018, section 256B.0625, subdivision 30.

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

Section 1. Minnesota Statutes 2018, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare

program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective January 1, 2021, each federally qualified health center and rural health clinic shall elect to be paid under the prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

~~(g)~~ (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be paid by the commissioner. The commissioner shall determine the most feasible method for paying claims from the following options:

(1) federally qualified health centers and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) federally qualified health centers and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

~~(i)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

~~(j)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal

matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by a federally qualified health center and a rural health clinic shall be paid by the commissioner according to the following requirements:

(1) each federally qualified health center and rural health clinic must receive a single medical and a single dental organization rate;

(2) the commissioner shall reimburse a federally qualified health center and a rural health clinic for allowable costs, including direct patient care costs and patient-related support services. These costs include but are not limited to:

(i) acquiring, implementing, and maintaining electronic health records and patient management systems;

(ii) community health workers who need acute and chronic care management;

(iii) care coordinations;

(iv) the new federally qualified health center or rural health clinic service that is not incorporated in the baseline prospective payment system rate, or a deletion of a federally qualified health center or a rural health clinic service that is incorporated in the baseline rate;

(v) a change in service due to amended regulatory requirements or rules;

(vi) a change in service resulting from relocating or remodeling a federally qualified health center or a rural health clinic;

(vii) a change in types of services due to a change in applicable technology and medical practice used by the center or clinic;

(viii) an increase in service intensity attributable to changes in the types of patients served, including but not limited to populations with HIV or AIDS, mental health or chemical dependency conditions, or other chronic diseases; or homeless, elderly, migrant, or other special populations;

(ix) a change in the services described in United States Code, title 42, section 1396d(a)(2)(B) and (C), or in the provider mix of a federally qualified health center or a rural health clinic or one of the federally qualified health center's or rural health clinic's sites;

(x) a change in operating costs attributable to capital expenditures associated with a modification of the scope of the services described in United States Code, title 42, section 1396d(a)(2)(B) and (C), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic;

(xi) indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; and

(xii) a change in the scope of a project approved by the federal Health Resources and Services Administration (HRSA);

(3) the base year payment rates for a federally qualified health center and a rural health clinic must:

(i) be determined using each federally qualified health center's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) be according to current Medicare cost principles as applicable to a federally qualified health center and a rural health clinic without the application of productivity screens and upper payment limits or the Medicare prospective payment system federally qualified health center aggregate mean upper payment limit; and

(iii) provide for a 60-day appeals process under section 14.57;

(4) the commissioner shall annually inflate the payment rate for a federally qualified health center and a rural health clinic from the base year payment rate to the effective date by using the Bureau of Economic Analysis' personal consumption expenditures medical care inflator;

(5) a federally qualified health center's and a rural health clinic's payment rates shall be rebased by the commissioner every two years and adjusted biannually by the CMS Federally Qualified Health Center Market Basket;

(6) the commissioner shall seek approval from the Centers for Medicare and Medicaid Services to modify payments to federally qualified health centers and rural health clinics according to subdivision 63;

(7) the commissioner shall reimburse a federally qualified health center and a rural health clinic an additional two percent of a federally qualified health center's or a rural health clinic's medical and dental rates established under this subdivision only if payment of the two percent provider tax is required to be paid according to section 295.52;

(8) for a federally qualified health center and a rural health clinic seeking a change of scope of services:

(i) the federally qualified health center and the rural health clinic shall submit requests with the commissioner if the change of scope would result in a 2.5 percent increase or decrease in the medical or dental rate currently received by the federally qualified health center or rural health clinic;

(ii) the federally qualified health center and the rural health clinic shall submit the request to the commissioner within seven business days of submitting the scope change to the federal HRSA;

(iii) the effective date of the payment change is the date the HRSA approved the federally qualified health center's or rural health clinic's change of scope request;

(iv) for change of scope requests that do not require HRSA approval, the federally qualified health center and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the federally qualified health center's or rural health clinic's request; and

(v) the commissioner shall respond to the federally qualified health center's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived by the mutual agreement of the commissioner and the federally qualified health center or rural health clinic if more information is needed to evaluate the request; and

(9) the commissioner shall establish a rate-setting process for new federally qualified health centers and rural health clinics considering a comparison of patient caseload of a federally qualified health center and a rural health clinic in a 30-mile radius for organizations established outside the seven-county metropolitan area and in a five-mile radius for organizations in the seven-county metropolitan area. If a comparison is not feasible, the commissioner may use Medicare cost reports or audited financial statements to establish base rate.