..... moves to amend H.F. No. 1269, the first engrossment, as follows:

Page 1, delete section 1

Page 5, line 19, delete "July 1, 2017" and insert "January 1, 2019"

Page 6, delete lines 9 to 31

Page 7, delete lines 1 to 32

Page 8, delete lines 1 to 22 and insert:

"(l) Effective for services provided on or after January 1, 2019, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be paid by the commissioner according to the current prospective payment system described in paragraph (f), or an alternative payment methodology with 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 federally qualified health centers and rural health clinics for allowable costs, including direct patient care costs and patient-related support services, based upon Medicare cost principles that apply at the time the alternative payment methodology is calculated;

(3) the 2019 payment rates for federally qualified health centers and rural health clinics:

(i) must be determined using each federally qualified health center's and rural health clinic's Medicare cost reports from 2015 and 2016. A provider must submit the required cost reports to the commissioner within six months of the second base year calendar or fiscal year end. Cost reports must be submitted six months before the quarter in which the base rate will take effect;

(ii) must be according to current Medicare cost principles applicable to federally qualified health centers and rural health clinics at the time of the alternative payment rate calculation

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) must provide for a 60-day appeals process;

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

(5) the commissioner shall establish a statewide trend inflator using 2015-2020 costs replacing the use of the personal consumption expenditures medical care inflator with the 2023 rate calculation forward;

(6) federally qualified health center and rural health clinic payment rates shall be rebased by the commissioner every two years using the methodology described in paragraph (k), clause (3), using the provider's Medicare cost reports from the previous third and fourth years. In nonrebasing years, the commissioner shall adjust using the Medicare economic index until 2023 when the statewide trend inflator is available;

(7) the commissioner shall increase payments by two percent according to Laws of Minnesota 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6. This is an add-on to the rate and must not be included in the base rate calculation;

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

(i) the commissioner shall require federally qualified health centers and rural health clinics to submit requests to the commissioner, if the change of scope would result in the medical or dental payment rate currently received by the federally qualified health center or rural health clinic increasing or decreasing by at least 2-1/2 percent;

(ii) federally qualified health centers and rural health clinics shall submit the request to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(iii) the effective date of the payment change is the date the Health Resources Services Administration approves 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 Health Resources Services Administration approval, federally qualified health centers and rural health clinics shall submit the request to the commissioner before implementing the change, and the effective

date of the change is the date the commissioner receives the request from the federally qualified health center or rural health clinic; and

(v) the commissioner shall provide a response to the federally qualified health center's or rural health clinic's change of scope request within 45 days of submission and provide a final decision regarding approval or disapproval within 120 days of submission. If more information is needed to evaluate the request, this timeline may be waived by mutual agreement of the commissioner and the federally qualified health center or rural health clinic; and

(9) the commissioner shall establish a payment rate for new federally qualified health center and rural health clinic organizations, considering the following factors:

(i) a comparison of patient caseload of federally qualified health centers and rural health clinics within a 60-mile radius for organizations established outside of the seven-county metropolitan area and within a 30-mile radius for organizations within the seven-county metropolitan area; and

(ii) if a comparison is not feasible under item (i), the commissioner may use Medicare cost reports or audited financial statements to establish the base rate. "

Page 8, line 24, delete "By January 1, 2018,"

Page 8, line 26, after "a" insert "report on the feasibility of a"

Page 8, line 28, delete everything after "program" and insert "and ensure that duplicate discounts for drugs do not occur."

Page 8, delete lines 29 to 32

Page 9, line 1, delete "notify" and insert "present the report to"

Page 9, line 3, delete everything after "assistance" and insert a period

Page 9, delete line 4

Renumber the sections in sequence and correct the internal references

Amend the title accordingly