

1.1 moves to amend H.F. No. 2760 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 30, is
1.4 amended to read:

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

1.11 (b) A federally qualified health center (FQHC) that is beginning initial operation shall
1.12 submit an estimate of budgeted costs and visits for the initial reporting period in the form
1.13 and detail required by the commissioner. An FQHC that is already in operation shall submit
1.14 an initial report using actual costs and visits for the initial reporting period. Within 90 days
1.15 of the end of its reporting period, an FQHC shall submit, in the form and detail required by
1.16 the commissioner, a report of its operations, including allowable costs actually incurred for
1.17 the period and the actual number of visits for services furnished during the period, and other
1.18 information required by the commissioner. FQHCs that file Medicare cost reports shall
1.19 provide the commissioner with a copy of the most recent Medicare cost report filed with
1.20 the Medicare program intermediary for the reporting year which support the costs claimed
1.21 on their cost report to the state.

1.22 (c) In order to continue cost-based payment under the medical assistance program
1.23 according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation
1.24 as an essential community provider within six months of final adoption of rules by the
1.25 Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and

2.1 rural health clinics that have applied for essential community provider status within the
2.2 six-month time prescribed, medical assistance payments will continue to be made according
2.3 to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural
2.4 health clinics that either do not apply within the time specified above or who have had
2.5 essential community provider status for three years, medical assistance payments for health
2.6 services provided by these entities shall be according to the same rates and conditions
2.7 applicable to the same service provided by health care providers that are not FQHCs or rural
2.8 health clinics.

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

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

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

2.21 (g) Effective for services provided on or after January 1, 2021, all claims for payment
2.22 of clinic services provided by FQHCs and rural health clinics shall be paid by the
2.23 commissioner, according to an annual election by the FQHC or rural health clinic, under
2.24 the current prospective payment system described in paragraph (f) or the alternative payment
2.25 methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also
2.26 urban Indian organizations under Title V of the federal Indian Health Improvement Act, as
2.27 provided under paragraph (k).

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

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

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

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

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

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

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

3.7 (i) Effective for services provided on or after January 1, 2015, all claims for payment
3.8 of clinic services provided by FQHCs and rural health clinics shall be paid by the
3.9 commissioner. the commissioner shall determine the most feasible method for paying claims
3.10 from the following options:

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

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

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

3.28 (k) The commissioner shall establish an encounter payment rate that is equivalent to the
3.29 all inclusive rate (AIR) payment established by the Indian Health Service and published in
3.30 the Federal Register. The encounter rate must be updated annually and must reflect the
3.31 changes in the AIR established by the Indian Health Service each calendar year. FQHCs
3.32 that are also urban Indian organizations under Title V of the federal Indian Health
3.33 Improvement Act may elect to be paid: (1) at the encounter rate established under this
3.34 paragraph; (2) under the alternative payment methodology described in paragraph (l); or

4.1 (3) under the federally required prospective payment system described in paragraph (f).
4.2 FQHCs that elect to be paid at the encounter rate established under this paragraph must
4.3 continue to meet all state and federal requirements related to FQHCs and urban Indian
4.4 organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

4.5 (1) All claims for payment of clinic services provided by FQHCs and rural health clinics,
4.6 that have elected to be paid under this paragraph, shall be paid by the commissioner according
4.7 to the following requirements:

4.8 (1) the commissioner shall establish a single medical and single dental organization
4.9 encounter rate for each FQHC and rural health clinic when applicable;

4.10 (2) each FQHC and rural health clinic is eligible for same day reimbursement of one
4.11 medical and one dental organization encounter rate if eligible medical and dental visits are
4.12 provided on the same day;

4.13 (3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance
4.14 with current applicable Medicare cost principles, their allowable costs, including direct
4.15 patient care costs and patient-related support services. Nonallowable costs include, but are
4.16 not limited to:

4.17 (i) general social services and administrative costs;

4.18 (ii) retail pharmacy;

4.19 (iii) patient incentives, food, housing assistance, and utility assistance;

4.20 (iv) external lab and x-ray;

4.21 (v) navigation services;

4.22 (vi) health care taxes;

4.23 (vii) advertising, public relations, and marketing;

4.24 (viii) office entertainment costs, food, alcohol, and gifts;

4.25 (ix) contributions and donations;

4.26 (x) bad debts or losses on awards or contracts;

4.27 (xi) fines, penalties, damages, or other settlements;

4.28 (xii) fundraising, investment management, and associated administrative costs;

4.29 (xiii) research and associated administrative costs;

4.30 (xiv) nonpaid workers;

5.1 (xv) lobbying;

5.2 (xvi) scholarships and student aid; and

5.3 (xvii) nonmedical assistance covered services;

5.4 (4) the commissioner shall review the list of nonallowable costs in the years between
5.5 the rebasing process established in clause (5), in consultation with the Minnesota Association
5.6 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
5.7 publish the list and any updates in the Minnesota health care programs provider manual;

5.8 (5) the initial applicable base year organization encounter rates for FQHCs and rural
5.9 health clinics shall be computed for services delivered on or after January 1, 2021, and:

5.10 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
5.11 from 2017 and 2018;

5.12 (ii) must be according to current applicable Medicare cost principles as applicable to
5.13 FQHCs and rural health clinics without the application of productivity screens and upper
5.14 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
5.15 payment limit;

5.16 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
5.17 reports that are ~~three~~ one and ~~four~~ two years prior to the rebasing year. Years in which
5.18 organizational cost or claims volume is reduced or altered due to a pandemic, disease, or
5.19 other public health emergency shall not be used as part of a base year when the base year
5.20 includes more than one year. The commissioner may use the Medicare cost reports of a year
5.21 unaffected by a pandemic, disease, or other public health emergency, or previous two
5.22 consecutive years, inflated to the base year as established under item (iv);

5.23 (iv) must be inflated to the base year using the inflation factor described in clause (6);
5.24 and

5.25 (v) the commissioner must provide for a 60-day appeals process under section 14.57;

5.26 (6) the commissioner shall annually inflate the applicable organization encounter rates
5.27 for FQHCs and rural health clinics from the base year payment rate to the effective date by
5.28 using the CMS FQHC Market Basket inflator established under United States Code, title
5.29 42, section 1395m(o), less productivity;

5.30 (7) FQHCs and rural health clinics that have elected the alternative payment methodology
5.31 under this paragraph shall submit all necessary documentation required by the commissioner
5.32 to compute the rebased organization encounter rates no later than six months following the

6.1 date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid
6.2 Services;

6.3 (8) the commissioner shall reimburse FQHCs and rural health clinics an additional
6.4 amount relative to their medical and dental organization encounter rates that is attributable
6.5 to the tax required to be paid according to section 295.52, if applicable;

6.6 (9) FQHCs and rural health clinics may submit change of scope requests to the
6.7 commissioner to take into account any increase or decrease in the scope of services furnished
6.8 by the center or clinic during that fiscal year, including but not limited to:

6.9 (i) if the change of scope would result in an increase or decrease of 2.5 percent or higher
6.10 in the medical or dental organization encounter rate currently received by the FQHC or
6.11 rural health clinic; or

6.12 (ii) if the cost to the FQHC of providing covered health care services to eligible clients
6.13 has increased or decreased due to one or more of the following events:

6.14 (A) a change in the type of health care services the FQHC provides;

6.15 (B) a change in the intensity, meaning the total quantity of labor and materials consumed
6.16 by an individual client during an average encounter, of health care services the FQHC
6.17 provides;

6.18 (C) a change in the duration, meaning the length of an average encounter, of health care
6.19 services the FQHC provides; or

6.20 (D) a change in the amount of health care services the FQHC provides in an average
6.21 encounter;

6.22 (10) for FQHCs and rural health clinics seeking a change in scope with the commissioner
6.23 under clause (9) that requires the approval of the scope change by the federal Health
6.24 Resources Services Administration:

6.25 (i) FQHCs and rural health clinics shall submit the change of scope request, including
6.26 the start date of services, to the commissioner within seven business days of submission of
6.27 the scope change to the federal Health Resources Services Administration;

6.28 (ii) the commissioner shall establish the effective date of the payment change as the
6.29 federal Health Resources Services Administration date of approval of the FQHC's or rural
6.30 health clinic's scope change request, or the effective start date of services, whichever is
6.31 later; and

7.1 (iii) within 45 days of one year after the effective date established in item (ii), the
7.2 commissioner shall conduct a retroactive review to determine if the actual costs established
7.3 under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in
7.4 the medical or dental organization encounter rate, and if this is the case, the commissioner
7.5 shall revise the rate accordingly and shall adjust payments retrospectively to the effective
7.6 date established in item (ii);

7.7 (11) for change of scope requests that do not require federal Health Resources Services
7.8 Administration approval, the FQHC and rural health clinic shall submit the request to the
7.9 commissioner before implementing the change, and the effective date of the change is the
7.10 date the commissioner received the FQHC's or rural health clinic's request, or the effective
7.11 start date of the service, whichever is later. The commissioner shall provide a response to
7.12 the FQHC's or rural health clinic's request within 45 days of submission and provide a final
7.13 approval within 120 days of submission. This timeline may be waived at the mutual
7.14 agreement of the commissioner and the FQHC or rural health clinic if more information is
7.15 needed to evaluate the request;

7.16 (12) the commissioner, when establishing organization encounter rates for new FQHCs
7.17 and rural health clinics, shall consider the patient caseload of existing FQHCs and rural
7.18 health clinics in a 60-mile radius for organizations established outside of the seven-county
7.19 metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan
7.20 area. If this information is not available, the commissioner may use Medicare cost reports
7.21 or audited financial statements to establish base rates;

7.22 (13) the commissioner, when establishing organization encounter rates under this section
7.23 for FQHCs and rural health clinics resulting from a merger of existing clinics or the
7.24 acquisition of an existing clinic by another existing clinic, must use the combined costs and
7.25 caseloads from the clinics participating in the merger or acquisition to set the encounter rate
7.26 for the new clinic organization resulting from the merger or acquisition. The scope of services
7.27 for the newly formed clinic must be inclusive of the scope of services of the clinics
7.28 participating in the merger or acquisition;

7.29 (14) the commissioner shall establish a quality measures workgroup that includes
7.30 representatives from the Minnesota Association of Community Health Centers, FQHCs,
7.31 and rural health clinics, to evaluate clinical and nonclinical measures; and

7.32 (15) the commissioner shall not disallow or reduce costs that are related to an FQHC's
7.33 or rural health clinic's participation in health care educational programs to the extent that

8.1 the costs are not accounted for in the alternative payment methodology encounter rate
8.2 established in this paragraph.

8.3 (m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health
8.4 center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC.
8.5 Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to
8.6 a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to
8.7 comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish
8.8 an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses
8.9 the same method and rates applicable to a Tribal facility or health center that does not enroll
8.10 as a Tribal FQHC.

8.11 (n) FQHC reimbursement for mental health targeted case management services is limited
8.12 to:

8.13 (1) only those services described under subdivision 20 and provided in accordance with
8.14 contracts executed with counties authorized to subcontract for mental health targeted case
8.15 management services; and

8.16 (2) an FQHC's actual incurred costs as separately reported on the cost report submitted
8.17 to the Centers for Medicare and Medicaid Services and further identified in reports submitted
8.18 to the commissioner.

8.19 (o) Counties contracting with FQHCs for mental health targeted case management remain
8.20 responsible for the nonfederal share of the cost of the provided mental health targeted case
8.21 management services. The commissioner must bill each county for the nonfederal share of
8.22 the mental health targeted case management costs as reported by the FQHC."

8.23 Amend the title accordingly