State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 599

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The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight

A bill for an act

relating to human services; requiring commissioner of human services to modify the reimbursement methodology for federally qualified health centers and rural health clinics and implement related initiatives; requiring reports; amending Minnesota Statutes 2008, section 256B.0625, subdivision 30.

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

Section 1. Minnesota Statutes 2008, 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, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. 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)~~ (b) Effective January 1, 2001, 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.~~

(c) The commissioner shall provide supplemental payments to federally qualified health centers and rural health clinics, in compliance with United States Code, title 42, section 1396a(bb)(5), no less frequently than every four months. In providing supplemental payments under this paragraph, the commissioner shall base payments on claims encounter data provided by federally qualified health centers and rural health clinics.

(d) Quarterly supplemental payments made under paragraph (c) shall include sufficient claims detail so as to allow federally qualified health centers and rural health clinics to reconcile the payments with the encounter data submitted.

(e) If the center or clinic disagrees with the claims detail used to support the payment amounts, it shall have 30 days to notify the commissioner in writing, and the commissioner shall have 30 days after the receipt of this notice to consider the center or clinic's submission and issue a final revised payment or response. The center or clinic may challenge this final action under section 256B.0643, and the commissioner shall then initiate an administrative hearing under section 14.57.

(f) Absent a challenge under paragraph (e), the commissioner has six months after the payment of funds under paragraph (c) to reconcile the claims data submitted with other appropriate data. After this six-month period, the payment for the claims shall be considered settled.

(g) The commissioner shall submit an annual report, beginning January 1, 2010, and each January 1 thereafter, on implementation of the reconciliation process for federally qualified health centers and rural health clinics. The annual report must specify, for each federally qualified health center and rural health clinic, the calendar years for which the commissioner has finalized medical assistance payments and the calendar years that are still outstanding.

(h) The commissioner, by January 1, 2010, shall modify the reimbursement methodology for federally qualified health centers and rural health clinics, in order to classify the adoption and implementation of electronic health record systems as a change in scope of services, and thereby eligible for a positive prospective payment system rate adjustment to reflect the costs of the adoption and implementation. With respect to this change in scope of services, the commissioner's review is limited to consideration of the adoption and implementation of the electronic health record system and related costs.

(i) Effective for services provided on or after July 1, 2009, the commissioner shall allow federally qualified health centers and rural health clinics to bill under the fee-for-service system for face-to-face encounters between medical assistance patients and:

(1) community health workers, until care coordination payments for health care homes are implemented in Minnesota;

(2) dental hygienists, subject to the collaborative agreement required under section 150A.10, subdivision 1a;

(3) licensed pharmacists providing medication therapy management; and

(4) oral health practitioners, in the event that oral health practitioners begin practice in Minnesota.

EFFECTIVE DATE. The amendments to paragraphs (c) to (f) are effective July 1, 2009.

Sec. 2. **PROCEDURES MANUAL FOR CLINIC REIMBURSEMENT.**

The commissioner of human services, by January 1, 2010, shall develop a written manual specifying agency procedures and policies related to medical assistance reimbursement of federally qualified health centers and rural health clinics. The manual must include, but is not limited to, information on: policies and procedures related to changes in the scope of services; new rate development; requirements for data submittal by federally qualified health centers, rural health clinics, and health plan companies; and changes in methodology related to implementation of Minnesota Statutes, section 256B.0625, subdivision 30, paragraph (h). The commissioner shall regularly update the manual, and shall make the information in the manual available to federally qualified health centers, rural health clinics, and other interested parties.

EFFECTIVE DATE. This section is effective July 1, 2009.