

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A clinic receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a clinic's payments back to January 1, 2001 when the clinic's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM IV ~~APM II, and APM III~~) rates for clinics will include a rate for dental services, if provided, and a rate for all other rural health clinic services of the provider or provider group. Hereinafter, "all other rural health clinic services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a clinic's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(6) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the clinic must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the clinic's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a clinic's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by clinic professionals, including all encounters provided by clinic staff outside of the clinic to clinic patients.

In order to comply with §1902(bb)(4) of the Act, for a clinic that first qualifies as a clinic provider beginning on or after fiscal year 2000, the Department will compare the new clinic to other clinics in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a clinic-specific rate based upon the clinic's budget or historical costs adjusted for changes in the scope of services.

STATE: MINNESOTA
Effective: July 1, 2021
TN: 21-13
Approved:
Supersedes: 19-12 (16-11,13-26,09-10,07-12,07-09,05-16,05-07,05-02)

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2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued).

Alternative Payment Methodology I

This alternative payment methodology is not available for dates of service on and after January 1, 2021.

For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is 100% of cost as determined using Medicare cost principles, plus: 1) an additional annual payment described below, for state fiscal year 2011 and thereafter which includes a Department medical education payment for each state fiscal year and distributed to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled teaching clinics; 2) qualifying payments for meeting the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item C; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

The Department will pay for clinic services as follows:

- A. A clinic will be paid for the reasonable cost of clinic services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 C.F.R. Part 413. The Department will pay for medical services, less the costs of providing dental services, at a single rate per visit based on the cost of all services furnished by the clinic.
- B. A clinic will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the clinic.
- C. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional \$125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:
 - Blood pressure less than 140/90; and
 - Lipids less than 100; and
 - Patient is taking aspirin daily if over age 40; and
 - Patient is not using tobacco; and
 - For diabetic only, Hemoglobin A1c levels at less than 8.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.
(continued)

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. Clinics must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after January 1, 2020, the rate adjustment is \$250 every six months when all of the above criteria are met.

D. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:

- Submitted charge; or
- \$10.14.

Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:

- Submitted charge; or
- \$20.27.

Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- \$40.54.

Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- \$60.81.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is \$245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of \$350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

Alternative Payment Methodology II (reserved)

~~For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the clinic's PPS rate plus 4 percent through State Fiscal Year 2005.~~

~~Effective for services provided on or after January 1, 2020, the methodology is the clinic's PPS rate plus an additional annual payment described below, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching clinics; 2) qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; 3) qualifying payments for health care home services as described in item B; 4) qualifying payments for behavioral health home services as described in item C.~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

~~A. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional \$125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:~~

- ~~• Blood pressure less than 140/90; and~~
- ~~• Lipids less than 100; and~~
- ~~• Patient is taking aspirin daily if over age 40; and~~
- ~~• Patient is not using tobacco; and~~
- ~~• For diabetic only, Hemoglobin A1c levels at less than 8.~~

~~Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, the clinic must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after July 1, 2009 January 1, 2020, the rate adjustment is \$250 plus 2% every six months when all of the above criteria are met.~~

~~B. Effective for services provided on or after July 1, 2010 January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$10.14, plus 2 percent.~~

~~Effective for services provided on or after July 1, 2010 January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$20.27, plus 2 percent.~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.
(continued)

~~Effective for services provided on or after July 1, 2010 January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$40.54, plus 2 percent.~~

~~Effective for services provided on or after July 1, 2010 January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$60.81, plus 2 percent.~~

~~For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:~~

- ~~• The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or~~
- ~~• The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.~~

~~C. Effective for services provided on or after July 1, 2016 January 1, 2020, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is \$245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of \$350.00 per member, per month.~~

~~The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.
(continued)

~~Alternative Payment Methodology III~~

~~For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology reimburses the clinic for a single medical visit at either the clinic's PPS rate, APM I rate, or APM II rate as agreed to by the clinic. When the clinic provides services to a patient through both a somatic medical and mental health encounter on the same day, the rate for the visit will be 200% of what would otherwise be paid under the PPS, APM I, or APM II methodologies.~~

~~Payment~~

~~A clinic providing services under a contract with a Medicaid managed care entity (MCE) will receive monthly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the PPS or chosen alternative payment methodology (APM I, APM II, or APM III).~~

~~At the end of the clinic's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the clinic's contract with the MCE would have yielded under the clinic's chosen Medicaid fee-for-service alternative payment methodology (PPS, APM I, APM II, or APM III). The clinic will be paid the difference between the amount calculated using the Medicaid fee-for-service alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service alternative amount exceeds the total amount of supplemental and MCE payments. The clinic will refund the difference between the Medicaid fee-for-service alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service alternative amount is less than the total amount of supplemental and MCE payments.~~

STATE: MINNESOTA
Effective: January 1, 2021
TN: 21-13
Approved:
Supersedes: 13-26 (12-25,09-10,07-12,07-09,05-16,05-07,05-02,04-15a)

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2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.
(continued)

~~For rural health clinic payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.~~

~~The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:~~

- ~~A. Medicaid coverage of services that differs from Medicare coverage;~~
- ~~B. the applicable visits; and~~
- ~~C. the establishment of a separate dental payment rate, if dental services are provided.~~

~~The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.~~

~~For purposes of this item, "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c).~~

~~The base rates as described in this item are adjusted by the following paragraph(s) of Supplement 2:~~

~~cc. Supplemental payment for medical education~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

Alternative Payment Methodology IV

A rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, shall be reimbursed a single encounter rate for each medical or dental service. If a medical service and a dental service are provided to the same patient on the same day, the clinic will be reimbursed both the medical and the dental encounter rate.

For rural health clinic payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

- A. Medicaid coverage of services that differs from Medicare coverage;
- B. the applicable visits; and
- C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

For purposes of this item, "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c).

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

Payment

The medical encounter rate shall be computed based on the clinic's allowable base year(s) medical costs divided by the number of qualifying medical encounters in the base year(s). The dental encounter rate shall be computed based on the clinic's allowable base year(s) dental costs divided by the number of qualifying dental encounters in the base year(s). Allowable costs are determined in accordance with current applicable Medicare cost principles including direct patient care costs and patient-related support services costs. Qualifying encounters are encounters in which the patient is seen by a practitioner eligible to independently bill for the services provided.

Payment rates for services delivered on or after January 1, 2021 will use the clinic's allowable costs as reported on the Medicare cost report and encounters for the clinic fiscal years ending 2017 and 2018. The base year rate shall be trended to the payment year using the CMS FQHC Market Basket inflation factor less the productivity adjustment.

Clinic encounter rates calculated under this APM shall be inflated annually using the FQHC Market Basket, less the productivity adjustment, until the next rebasing.

Every two years these rates will be rebased using the allowable costs, as reported on the Medicare cost report, and encounters from the clinic fiscal years that are three and four years prior to the rebasing year.

Treatment of Health Care Education Program Costs

A clinic's costs related to participation in health care education programs shall be considered allowable costs. The total allowable costs will be reduced by any Medical Education and Research (MERC) grants received to compensate training facilities for a portion of the clinical training costs.

Change in Scope Adjustments

Payment adjustments due to changes in scope will not be implemented unless the change in scope results in a payment increase or decrease of 2.5 percent or higher. The effective date of the payment adjustment will be the later of:

- a. The date the Health Resources and Services Administration (HRSA) approves the change in scope or

STATE: MINNESOTA
Effective: July 1, 2021
TN: 21-13
Approved:
Supersedes: NEW

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- b. The effective start date of the services included in the change in scope.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

If HRSA approval of the change in scope is not required. A clinic may submit a change in scope request directly to the Department of Human Services. The payment adjustment effective date for change in scope requests submitted directly to the Department will be the later of:

- a. The date the Department received the clinic's change in scope request or
- b. The effective start date of the services included in the change in scope.

Initial change in scope adjustments may be computed using estimated costs and encounters. Payment adjustments based on estimated costs or encounters will be reviewed no later than 45 days following the date that is one year after the effective date of the payment adjustment. If the rate determined using the estimated costs or encounters differs from the rate calculated using actual cost and encounters by more than 2.5 percent, the rate based on estimated costs or encounters shall be adjusted to the rate based on actual costs and encounters retroactive to the effective date of the scope change payment adjustment.

In addition to the cost based encounter rate, qualifying clinics will receive the following health care home or behavioral health home payments:

- A. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
 - Submitted charge; or
 - \$10.14.
- B. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
 - Submitted charge; or
 - \$20.27.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.
(continued)

- C. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:
- Submitted charge; or
 - \$40.54.
- D. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:
- Submitted charge; or
 - \$60.81.

For each of the Groups A through D above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
 - The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.
- E. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is \$245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of \$350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC.

A FQHC receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a FQHC's payments back to January 1, 2001 when the FQHC's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM IV ~~APM II, and APM III~~) rates for FQHCs will include a rate for dental services, if provided, and a rate for all other FQHC services of the provider or provider group. Hereinafter, "all other FQHC services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a FQHC's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(3) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the FQHC must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the FQHC's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a FQHC's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by FQHC professionals, including all encounters provided by FQHC staff outside of the FQHC to FQHC patients.

In order to comply with §1902(bb)(4) of the Act, for a FQHC that first qualifies as a FQHC providers beginning on or after fiscal year 2000, the Department will compare the new FQHC to other FQHCs in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a FQHC-specific rate based upon the FQHC's budget or historical costs adjusted for changes in the scope of services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC.(Continued)

Alternative Payment Methodology I

This alternative payment methodology is not available for services delivered on and after January 1, 2021.

For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, an interim rate is established, subject to reconciliation at the end of the cost reporting period. The alternative payment methodology is 100% of cost as determined using Medicare cost principles, plus: 1) an additional annual payment described below, for state fiscal year 2011 and thereafter, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching FQHCs; 2) qualifying payments for meeting the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item C; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

The Department will pay for FQHC services as follows:

- A. A FQHC will be paid for the reasonable cost of FQHC services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 CFR Part 413. The Department will pay for medical services, less the cost of providing dental services, at a single rate per visit based on the cost of all services furnished by the FQHC.
- B. A FQHC will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the FQHC.
- C. Effective July 1, 2007, through June 30, 2009, eligible FQHCs are paid an additional \$125 plus 2% every six months for each recipient for whom the FQHC demonstrates optimal diabetic and/or cardiovascular care which includes:
 - Blood pressure less than 140/90; and
 - Lipids less than 100; and
 - Patient is taking aspirin daily if over age 40; and
 - Patient is not using tobacco; and
 - For diabetic only, Hemoglobin A1c levels at less than 8.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Each recipient must have had at least two prior office visits with the claiming FQHC within the six months before the submission of the claim for the additional payment. Eligible FQHCs must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, the FQHC must submit documentation of the provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after January 1, 2020, the rate adjustment is \$250 every six months when all of the above criteria are met.

A. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:

- Submitted charge; or
- \$10.14.

Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:

- Submitted charge; or
- \$20.27.

Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- \$40.54.

Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- \$60.81.

STATE: MINNESOTA
Effective: July 1, 2021
TN: 21-13
Approved:
Supersedes: 19-12 (16-11,13-26,09-10,07-12,07-09,05-16,05-07,05-02)

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2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for FQHCs certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is \$245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of \$350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

Alternative Payment Methodology II (reserved)

~~For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the FQHC's PPS rate plus 4 percent through State Fiscal Year 2005.~~

~~Effective for services provided on or after January 1, 2020, the methodology is the FQHC's PPS rate plus: 1) a medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled teaching FQHCs; 2) qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; 3) qualifying payments for health care home services as described in item B; and 4) qualifying payments for behavioral health home services as described in item C.~~

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

~~A. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional \$125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:~~

- ~~• Blood pressure less than 140/90; and~~
- ~~• Lipids less than 100; and~~
- ~~• Patient is taking aspirin daily if over age 40; and~~
- ~~• Patient is not using tobacco; and~~
- ~~• For diabetic only, Hemoglobin A1c levels at less than 8.~~

~~Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after January 1, 2020, the rate adjustment is \$250 every six months when all of the above criteria are met.~~

~~B. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$10.14.~~

~~Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$20.27.~~

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

~~Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$40.54.~~

~~Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:~~

- ~~• Submitted charge; or~~
- ~~• \$60.81.~~

~~For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:~~

~~The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or~~

- ~~• The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.~~

~~C. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is \$245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of \$350.00 per member, per month.~~

~~The base rates as described in this item are adjusted by paragraph ee. of Supplement 2 entitled, Supplemental Payment for Medical Education.~~

STATE: MINNESOTA
Effective: July 1, 2021
TN: 21-13
Approved:
Supersedes: 13-26 (10-06,09-10,07-12,07-09,05-16,05-07,05-02,04-15a)

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2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Alternative Payment Methodology III (reserved)

~~For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology reimburses the FQHC for a single medical visit at either the FQHC's PPS rate, APM I rate, or APM II rate as agreed to by the FQHC. When the FQHC provides services to a patient through both a somatic medical and mental health encounter on the same day, the rate for the visit will be 200% of what would otherwise be paid under the PPS, APM I, or APM II methodologies.~~

Payment

~~A FQHC providing services under a contract with a Medicaid managed care entity (MCE) will receive monthly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received in accordance with the PPS or chosen alternative payment methodology (APM I, APM II, or APM III).~~

~~At the end of the FQHC's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with the MCE would have yielded under the FQHC's chosen Medicaid fee-for-service alternative payment methodology (PPS, APM I, APM II, or APM III). The FQHC will be paid the difference between the amount calculated using the Medicaid fee-for-service alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the Medicaid fee-for-service alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service alternative amount is less than the total amount of supplemental and MCE payments.~~

STATE: MINNESOTA
Effective: July 1, 2021
TN: 21-13
Approved:
Supersedes: NEW

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2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

~~For FQHC payments, "visit" means a face-to-face encounter between a FQHC patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.~~

~~The State uses the FQHC's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:~~

- ~~A. Medicaid coverage of services that differs from Medicare coverage;~~
- ~~B. the applicable visits; and~~
- ~~C. the establishment of a separate dental payment rate, if dental services are provided.~~

~~The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.~~

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Alternative Payment Methodology IV

A FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, shall be reimbursed a single encounter rate for each medical or dental service. If a medical service and a dental service are provided to the same patient on the same day, the clinic will be reimbursed both the medical and the dental encounter rate.

For federally qualified health center payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

- A. Medicaid coverage of services that differs from Medicare coverage;
- B. the applicable visits; and
- C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

For purposes of this item, "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c)

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Payment

The encounter rate shall be computed based on the clinic's allowable base year(s) costs divided by the number of qualifying encounters in the base year(s). Allowable costs are determined in accordance with current applicable Medicare cost principles including direct patient care costs and patient-related support services costs. Qualifying encounters are encounters in which the patient is seen by a practitioner eligible to independently bill for the services provided.

Payment rates for services delivered on or after January 1, 2021 will use the clinic's allowable costs as reported on the Medicare cost report and encounters for the clinic fiscal years ending 2017 and 2018. The base year rate shall be trended to the payment year using the CMS FQHC Market Basket inflation factor less the productivity adjustment.

Clinic encounter rates shall be inflated annually using the FQHC Market Basket, less the productivity adjustment, until the next rebasing.

Clinic encounter rates shall be rebased every two years using the allowable costs, as reported on the Medicare cost report, and encounters from the clinic fiscal years that are three and four years prior to the rebasing year.

Treatment of Health Care Education Program Costs

A clinic's costs related to participation in health care education programs shall be considered allowable costs. The total allowable costs will be reduced by any Medical Education and Research (MERC) grants received to compensate training facilities for a portion of the clinical training costs.

Change in Scope Adjustments

Payment adjustments due to changes in scope will not be implemented unless the change in scope results in a payment increase or decrease of 2.5 percent or higher. The effective date of the payment adjustment will be the later of:

- a. The date the Health Resources and Services Administration (HRSA) approves the change in scope or
- b. The effective start date of the services included in the change in scope.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

If HRSA approval of the change in scope is not required. A clinic may submit a change in scope request directly to the Department of Human Services. The payment adjustment effective date for change in scope requests submitted directly to the Department will be the later of:

- a. The date the Department received the clinic's change in scope request or
- b. The effective start date of the services included in the change in scope.

Initial change in scope adjustments may be computed using estimated costs and encounters. Payment adjustments based on estimated costs or encounters will be reviewed no later than 45 days following the date that is one year after the effective date of the payment adjustment. If the rate determined using the estimated costs or encounters differs from the rate calculated using actual cost and encounters by more than 2.5 percent, the rate based on estimated costs or encounters shall be adjusted to the rate based on actual costs and encounters retroactive to the effective date of the scope change payment adjustment.

In addition to the cost based encounter rate, qualifying clinics will receive the following health care home or behavioral health home payments:

- A. Effective for services provided on or after January 1, 2021, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
 - Submitted charge; or
 - \$10.14.
- B. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
 - Submitted charge; or
 - \$20.27.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

- C. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:
- Submitted charge; or
 - \$40.54.
- D. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:
- Submitted charge; or
 - \$60.81.

For each of the Groups A through D above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
 - The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.
- E. Effective for services provided on or after July 1, 2016, for FQHCs certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is \$245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of \$350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

Approved:

Supersedes: 17-11 (14-01,11-02,10-21,09-25,09-20,08-17,07-12,07-08,07-09,07-06, 06-19, 05-21)

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Effective for services provided on or after January 14, 2014, payment for physician services is the lowest of:

- 1) submitted charges; or
- 2) a) The Resource Based Relative Value Scale calculated values (as published by the Centers for Medicare & Medicaid Services in November of the previous calendar year); or
- b) State agency established rate; or
- C) For delivery services, including cesarean delivery services that are not complicated:
59400, 59510, 59610: \$1387.89
59409, 59514, 59612: \$540.00
59410, 59515, 59614: \$696.73

Effective July 1, 2013, **vaccines** are paid the lower of:

- (1) the submitted charge;
- (2) Medicare allowable; or
- (3) if Medicare has not established a payment amount:
 - a. the wholesale acquisition cost; or
 - b. the average wholesale price minus 5%.

An additional payment for administration of the vaccine will be made at a rate equal to the lesser of the submitted charge, or the RBRVS rate.

Payment for vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act is limited to vaccine administration. The state pays for administration of the vaccine at a rate equal to the lower of the submitted charge, or the RBRVS rate. Payment shall not exceed the regional maximum established by the DHHS Secretary.

Payment for administration of COVID-19 vaccinations is made at the rates established by Medicare in effect at the time the service is provided. COVID-19 vaccine administration will be paid at 100% of the geographically adjusted (GCPI) Medicare equivalent rates. This rate is limited to cases where vaccine administration is separately reimbursable at the fee schedule rate and does not apply to bundled or encounter rates.