MANAGED CARE SYSTEMS SECTION
Essential Community Providers Designation
P.O. Box 64975, St. Paul, Minnesota 55164-0975
Telephone: (651) 201-5100
Email: health.mcs@state.mn.us

Essential Community Provider Application for Designation

Pursuant to Minnesota Statutes, Section 62Q.19 and Minnesota Rules, Chapter 4688

General Information

Minnesota Statutes §62Q.19 authorizes the commissioner of health to designate providers as essential community providers. An applicant must be a non-profit, tax-exempt entity; a local government unit; certain hospital districts; an Indian tribal government, health service, or service unit; community health board; or a qualified sole community hospital. All applicants must have demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons, high-risk and special needs populations, and underserved and other special needs populations. In addition, they must have a plan to identify the need for supportive and stabilizing services and to enable clients to access these services.

Application Instructions

1. Provide all requested information. Be as complete as possible. If a section does not apply to you, mark it "Not Applicable" and explain why. If you need additional space to answer a question, use a separate page(s) and clearly indicate to which section it applies.
2. You are responsible for identifying current requirements of law or rules relating to essential community providers that may not be indicated in this application form; this information can be found online for Minnesota Statutes §62Q.19 (https://www.revisor.mn.gov/statutes/cite/62Q.19) and Minnesota Rules Chapter 4688 (https://www.revisor.mn.gov/rules/4688/).
3. **You must include a non-refundable application fee of $60, payable to: "Treasurer, State of Minnesota" with this application.**
4. Submit the completed application to:

   Minnesota Department of Health
   Managed Care Systems Section
   P.O. Box 64975
   Saint Paul, MN 55164-0975

   If you have questions about how to complete this application, email health.mcs@state.mn.us or call us at (651) 201-5100.

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Essential Community Provider Application for Designation

PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK

SECTION 1 – Applicant and Contact Information

☐ New Application ☐ Re-designation

Name of Organization		
Street Address (no P.O. box address)	Mailing Address (if different than Street Address)	
City	State	Zip
County	Organization Website	Organization Telephone
Contact Person/Title	Contact Email Address	Contact Telephone
I have included the $60 application fee: ☐ Yes ☐ No	Date Application Submitted	

SECTION 2 – Qualifying Status and Evidence

(See Minnesota Statutes, Section 62Q.19, subd. 1(a))

Are you applying as a(n):

☐Local government unit ☐Indian tribal government ☐Indian health service unit

☐Tax-exempt non-profit entity ☐Community Health Board ☐Former state hospital

☐Rural sole community hospital ☐Licensed Birth Center ☐District Hospital

☐Hospital and affiliated clinics predominately serving patients under the age of 21

☐Psychiatric residential treatment facility

☐Federally Qualified Health Center (FQHC)

If you are applying as a tax-exempt non-profit entity, attach the following supporting documentation:

1. Evidence of Minnesota Statutes Chapter 317A non-profit status; and
2. Evidence of Internal Revenue Code § 501 (c)(3) tax-exempt status; and
3. A copy of your current sliding fee schedule (Minnesota Rules, 4688.0020, B(2); 4688.0040, subp. 5); and
4. A statement that you do not restrict access or services because of a client's financial limitations.

If you are applying as a hospital and affiliated specialty clinics predominately serving patients under the age of 21, attach evidence of:

1. Providing intensive specialty pediatric services that are routinely provided in fewer than five hospitals in Minnesota; and
2. Serving children from at least half of the counties in Minnesota; and
3. Primarily serving patients under the age of 21.

If you are applying as a (rural) sole community hospital, attach evidence of:

1. Eligibility to be classified as a sole community hospital according to the Code of Federal regulations, title 42 § 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services; and
2. A net operating income loss in two of the previous three most consecutive hospital fiscal years for which audited financial information is available; and
3. Consisting of 40 or fewer licensed beds.

SECTION 3 – Overview of Organization

1. Provide an overview of your organization. Include a copy of your organizational chart, if available.
2. Complete Appendix A ECP Location List (Excel). Please be sure to identify each location to be included under the ECP designation. Each clinic included in the ECP designation must meet all ECP requirements. For each location, list name, NPI, address, telephone number, and county, and identify the category(s) of care and or service(s) provided, and whether services are restricted to students.

Appendix A ECP Location List (Excel):
(https://www.health.state.mn.us/facilities/insurance/managedcare/ecp/docs/appenda.xlsx)

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SECTION 4 – Services and CPT codes

(See Minnesota Statutes, Section 62Q.19, subd. 1 ©; Minnesota Rules, 4688.0020, C)

1. List the Current Procedural Terminology (CPT) code and its descriptor for all services offered.

SECTION 5 – Staffing, Facilities, and Scheduling

(See Minnesota Rules, 4688.0020, D; 4688.0040, subp. 2)

Attach the following information to this application:

1. Evidence you have sufficient personnel and facilities to provide timely medical care to your clients, consistent with the community norms. Include a list of the types of health care professionals and the number of each type you have who provide services to your clients.
2. A copy of your appointment scheduling policy and procedures. Provide data on how long a caller must wait between their call and an appointment. Average waiting times must fall within community norms.
3. An explanation how you monitor appointment scheduling and waiting times, and how you take corrective actions when needed.

SECTION 6 – Uninsured, High-Risk, and Underserved Persons

(See Minnesota Rules, 4688.0020, item E; and definitions on page 1 of this application)

Numbers requested in this section allow us to evaluate whether the ECP program is effective in reaching uninsured, underserved, high-risk, and special needs populations Use calendar years in responding.

Number of clients in the preceding calendar year	
Number of clients projected in the current calendar year	

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Complete the table below for the preceding calendar year:

"High-risk/special needs" includes, but is not limited to, people with chronic health or medical conditions; people with persistent serious mental health issues; people who are chemically dependent; people with high-cost preexisting conditions; adolescents and elderly; and/or people at high risk of requiring treatment.

"Underserved" means individuals who face barriers to health care due to income, culture, ethnicity, language, or race' or who live in an area with a shortage of primary care health services.

High risk and/or special needs clients	Underserved Clients	Total High risk, Special Needs, Underserved Clients

A client may be both high-risk/special needs and underserved, so the last column may be less than the sum of the first two.

Complete the following tables using data from the preceding calendar year:

Insurance Type	Number of Clients
Commercial Insurance	
Public Insurance	
Other Insurances	
No Insurance	

Patient Financial Assistance & Billing Outcomes	Number of Clients
Utilized sliding fee scale *	
Received "write-offs"	
Received "charity care" **	
Sent to collections	

* Only entities qualifying as tax-exempt, non-profits must offer a sliding fee scale. Others may enter "0."

** Provide this information only if you differentiate "charity care" from a sliding fee scale or a write-off.

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SECTION 7 – Supportive and Stabilizing Services

(See Minnesota Statutes, Section 62Q.19, subd. 1 (d); Minnesota Rules, 4688.0020, F; 4688.0040, subp. 3)

1. An ECP **must** provide or coordinate **transportation, child care, interpretation, and culturally sensitive and competent services,** as appropriate to the population and geographic area served.
    a. Complete the table below by checking "Provided" and/or "Coordinated," or "Not Applicable," and estimate the number or percent of clients who used these services in the past year.
    b. If you indicate that a service does not apply to your organization, explain why that service is not appropriate for the area or population served.
    c. Explain the following:
        i. How you assess the need for these services; and
        ii. How the clients access these services.
2. Describe pre-service and in-service training requirements for professional support staff on cultural awareness and health affecting high-risk and special needs clients. Attach a training curriculum for a recent training or describe focus of that training.
    a. Alternatively, show that for each site you have professional staff familiar with the cultural background of your clients.
3. On a separate piece of paper, describe other supportive and stabilizing services you offer clients.

Service	Provided	Coordinated	Not Applicable	# of Client who used these services in the past year
Transportation Services				
Child care services				
Linguistic Services				

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SECTION 8 – Client Feedback

1. Provide any recent client satisfaction surveys, and a summary of the results.
2. How many complaints or grievances did you receive in the last year? What was the nature of the complaints or grievances received? How many were substantiated?

I hereby swear that information submitted with this application is true to the best of my knowledge.

_____

Signature of officer Date

_____

Name and Title of Signer (typed or printed) Name of Facility