P.O. Box 64975

St. Paul, MN 55164-0975

# **Essential Community Provider2025 Annual Report**

Essential Community Providers (ECP) are required to file an annual report. Complete and return this form with any attachments to the address above or to health.mcs@state.mn.us . **Reports must be received by April 15, 2025.** If you have questions, you may contact us at health.mcs@state.mn.us.

|  |
| --- |
| **Name of ECP** |
| **Address of Primary Location (Do not use PO Box address)** |
| **Contact Person Name** | **Contact Phone Number** |
| **Contact Email Address** | **Facility Phone Number** |
| **Organization’s Web Site Address** |

## Verification of Tax Exempt, Non-Profit Status

*Check “Does not apply” if your organization DID NOT qualify for ECP designation as a non-profit, tax-exempt entity.*

1. Minnesota Statutes Chapter 317A non-profit status since application for ECP designation.

[ ]  Changed

[ ]  Unchanged

[ ]  Does Not Apply

1. Internal Revenue Code, section 501(c)(3) tax-exempt status since application for ECP designation.

[ ]  Changed

[ ]  Unchanged

[ ]  Does Not Apply

## Sliding Fee Scale

*Complete this section ONLY IF your organization qualified for ECP designation as a non-profit, tax-exempt entity.*

Has the sliding fee included with your most recent ECP application or annual report hanged? **If the sliding fee scale has changed, attach any new sliding fee scale to this report.**

[ ]  Changed [ ]  Unchanged [ ]  Does Not Apply

## CPT Codes

Have health services provided by your organization changed since your most recent ECP application or annual report? **If services have changed, submit a new CPT list.**

[ ]  Changed

[ ]  Unchanged

## High-Risk, Special Needs, and Underserved; Insurance Status

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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Total Number of Clients, 2024** |  |  | **Projected Number of Clients, 2025** |  |

“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

• 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

* Live in an area with a shortage of primary care health services

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

|  |  |  |
| --- | --- | --- |
| **High-risk and/or Special Needs Clients** | **Underserved Clients** | **Total High-risk, Special Needs, Underserved Clients\*** |
| **Income, culture, ethnicity, race, etc.** | **Geographical Location** |
|  |  |  |  |

Pick any point in the past calendar year. Estimate the number of clients who had:

|  |  |
| --- | --- |
| **Public Insurance** |  |
| **No Insurance** |  |

If you assist clients in applying for insurance (either public or commercial), respond to the following question. You may estimate.

|  |  |
| --- | --- |
| **In the past year, how many clients obtained insurance with your assistance**? |  |

**Complete the client column OR the encounter column. Use data from the preceding calendar year:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of :** | **Clients** | **OR** | **Encounters** |
| **Utilizing sliding fee scale\*** |  |  |  |
| **Receiving any other type of financial assistance\*\*** |  |  |  |

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

\*\*Count any assistance other than sliding fee scales and payment plans under which the client will pay the full amount they were billed; for example, write-offs, charity care**.**

## Supportive and Stabilizing Services

Have supportive or stabilizing services changed since your most recent ECP application or annual report changed? If information has changed, attach a sheet explaining how and why.

**Transportation services**
**Child care services**
**Linguistic services**
**Culturally sensitive and competent services**[ ]  Changed
[ ]  Changed
[ ]  Changed
[ ]  Changed [ ]  Unchanged
[ ]  Unchanged
[ ]  Unchanged
[ ]  Unchanged

## Health Plan Company Affiliation (New in 2025)

**By law, a health plan company must offer a provider contract to all designated ECP clinics located in the area served by the health plan company.**

**Do you contract with health plans?
Yes** [ ]  **No** [ ]

**Have you been denied a contract with any health plans in your area?
No** [ ]  **Yes** [ ]  **Name(s) of plans that denied a contract:**

## List of Locations

Please complete “[Appendix A ECP Location List 2025 (Excel) (https://www.health.state.mn.us/facilities/insurance/managedcare/ecp/docs/appenda.xlsx)](file:///C%3A%5CUsers%5Cfostem1%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CPOC2Z8G2%5CAppendix%20A%20ECP%20Location%20List%202025%20%28Excel%29%20%28https%3A%5Cwww.health.state.mn.us%5Cfacilities%5Cinsurance%5Cmanagedcare%5Cecp%5Cdocs%5Cappenda.xlsx%29)” and return with your report.