STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

For EPSDT services provided on or after April 1, 1990, the following applies.

For services reimbursed under the Nebraska Medicaid Practitioner Fee Schedule, Nebraska Medicaid pays for EPSDT services (except for clinical diagnostic laboratory services) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance abuse services. The agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

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Medicaid reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance abuse treatment services will be paid according to the methodology in Attachment 4.19-A.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rates for the comparable in-person service.

Payment for Telehealth Transmission costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

Medicaid reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission shall be in compliance with the quality standards for real time, two-way interactive audiovisual transmission as set forth in state regulations as amended.

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Other Licensed Practitioners: Licensed Alcohol and Drug Counselor (LADC)
Rehabilitation Services - 42 CFR 440.130(d): Day Treatment/Intensive Outpatient Service by Direct Care Staff; Community Treatment Aide; Professional Resource Family Care; Therapeutic Group Home; Multisystemic Therapy; Functional Family Therapy; and Peer Support.

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance abuse services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at
http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

The Nebraska Medicaid fee schedule outlined above will be established using the following methodologies:

- If a Medicare fee exists for a defined covered procedure code, then Nebraska will set the Nebraska Medicaid fee schedule for LADC at 95 percent of the licensed Master's level rate paid under Attachment 3.1A, Item 6d for any codes permitted under their scope of practice per Nebraska state law.
- Where Medicare fees do not exist for a covered code, the fee schedule will be set using a market-based pricing methodology as described below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

  The market-based pricing methodology will be composed of provider cost modeling for four key components: direct care salary expenses, employee related expenses, program indirect expenses and administrative expenses. The analysis includes national compensation studies for Nebraska to determine the appropriate wage or salary expense for the direct care worker providing each service based on the staffing requirements and roles and responsibilities of the worker, published information related to employee related expenses and other notable cost components and cost data and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development:

  (1) Staffing Assumptions and Staff Wages
  (2) Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
  (3) Program-Related Expenses (e.g., supplies)
  (4) Provider Overhead Expenses
  (5) Program Billable Units

  The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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A. Reimbursement Methodology for Special Education School-Based Services
School-based services, known as Medicaid in Public Schools (MIPS), are delivered by the Nebraska Public School Districts (K-12 educational institutions and Educational Service Units (ESUs); and include the following services pursuant to Nebraska Revised Statute 68-911(4):
1. Medical Transportation Services
2. Mental Health and substance Use Disorder Services
3. Nursing Services
4. Physical Therapy Services
5. Occupational Therapy Services
6. Personal Care Services
7. Services for Speech, Hearing, and Language Disorders
8. Visual Care Services

B. Direct Medical Services Payment Methodology:
Beginning with cost reporting period September 1, 2017, effective for services on or after September 1, 2017, the State of Nebraska Medicaid Agency will begin settling Medicaid reimbursement for direct medical services.

Changes to the payment methodology are presented to accommodate the state moving to a cost based reporting methodology for its MIPS direct service program. ESU, school or school district employees perform direct service activities in support of the Medicaid program. Under the new payment methodology, a random moment time study (RMTS) is used for identifying and categorizing Medicaid direct service activities performed by employees.

The time-study results serves as the basis for developing each school district's quarterly interim payments for the direct service activities utilizing a quarterly cost report methodology. The same time study results are used in the calculation of annual MIPS Cost Settlements. The annual MIPS Cost Settlement compares each school district's quarterly interim payments for the same period to the annual Cost Settlement calculation. Each school district's quarterly interim payments are compared to their Annual Cost Settlement to determine if they have been over or under paid.

If interim payments exceed the amount calculated on the annual Cost Settlement, the school district is obligated to return the overpayment to the State of Nebraska. If interim payments are less than the amount calculated on the annual Cost Settlement, the State of Nebraska will pay these additional monies to the school district.

C. Data Capture for the Cost of Providing Health-Related Services
Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, are captured utilizing the following data:
   a. MIPS cost reports received from school districts and ESUs;
   b. Nebraska Department of Education (NDE) Unrestricted Indirect Cost Rate (IDCR);
   c. Random Moment Time Study (RMTS) Activity Code 4b (Direct Medical Services), and Activity Code 10 (General Administration): and
   d. School District/ESUs specific IEP Ratios.

D. Data Sources and Cost Finding Steps
The following provides a description of the data sources and steps to complete the cost reporting and reconciliation:
1. Allowable Costs:
   Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in State Plan Attachment 3.1-A, Item b, pages 36-43 section of the covered Medicaid services delivered by school districts and ESUs. These direct costs are calculated on a district-specific level and are reduced by any federal payments for these costs, resulting in adjusted direct costs.

   Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the quarterly MIPS Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that are approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data becomes audited Chart of Account records kept at the school district and ESUs level. The Chart of Accounts is uniform throughout the state of Nebraska.

a. Direct Medical Services
   Non-federal cost pool for allowable providers consists of:
   i. Salaries;
   ii. Benefits;
   iii. Medically-related purchased services; and
   iv. Medically-related supplies and materials

2. Indirect Costs:
   Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its adjusted direct costs. Nebraska public school districts and ESUs use predetermined fixed rates for indirect costs. Nebraska Department of Education has, in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by school districts and ESUs in Nebraska. Pursuant to the authorization in 34 CFR §75.561(b), NDE approves unrestricted indirect cost rates for school districts for the ED, which is the cognizant agency for school districts. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

   Indirect Cost Rate
   a. Apply the Nebraska Department of Education Cognizant Agency Unrestricted Indirect Cost Rate applicable for the dates of service in the rate year.
   b. The NDE IDCR is the unrestricted indirect cost rate calculated by the Nebraska Department of Education.

3. Time Study Percentages:
   A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The appropriate time study results are applied to the direct medical services and targeted case management services cost pools. The direct medical services costs and targeted case management services costs and their respective time study results are aligned to ensure proper cost allocation. The CMS approval letter for the time study are maintained by the State of Nebraska and CMS.
4. IEP Ratio Determination:
   A district-specific IEP Ratio is established for each participating school district or ESU on an annual basis. This annual IEP Ratio is applied to each quarterly cost report for the determination of interim payments, and is used in the calculation of the annual Cost Settlement. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students. The names and birthdates of students with a health related IEP identified from the December 1 Report and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The students with a health related IEP are identified and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The numerator of the rate are the students with an IEP that are eligible for Medicaid and the denominator is the total number of students with an IEP.
5. Total Medicaid Reimbursable Cost:
   The result of the previous steps is a total Medicaid reimbursable cost for each school district or ESU for Direct Medical Services. Reported expenditures must be reasonable, allowable, and allocable, and must be adjusted, if necessary, to comport with the guidelines specified in the CMS-approved time study.

E. Specialized Transportation Services Payment Methodology
   The effective date of specialized transportation services begins on September 1, 2017. Providers are reimbursed on an annual basis for trips originating and terminating from the school building for students with a plan of care, IEP or IFSP, to receive a Medicaid approved school health service. The calculation of specialized transportation reimbursement is completed annually through the annual Cost Settlement process. Specialized transportation services are defined as transportation services that require a specially equipped vehicle, or the use of specialized equipment.

Transportation costs included on the cost report worksheet only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Contract Use Cost
8. Depreciation

The source of these costs are audited Chart of Accounts data kept at the school district and ESU level. The Chart of Accounts is uniform throughout the State of Nebraska. Special education transportation costs include those adapted for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities.

When school districts or ESUs are not able to discretely identify the special education transportation cost from the general education transportation costs, a special education transportation cost discounting methodology is applied. A rate is established and applied to the total transportation cost of the school district or ESU.

This rate is based on the Total IEP SPED Students in District Receiving Specialized Transportation divided by the Total Students in District Receiving Transportation. The result of this rate (%) multiplied by the Total School District or ESU Transportation Cost for each of the categories listed above are included on the cost report. It is important to note that this cost will be further discounted by the ratio of Medicaid Eligible SPED IEP One Way Trips divided by the total number of SPED IEP One Way Trips. This data will be provided from bus logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are reimbursed.

Transportation is claimed as a Medicaid service when the following conditions are met:
1. Special transportation is specifically listed in the IEP as a required service;
2. The child required transportation in a vehicle adapted to serve the needs of an individual with a disability;
3. A Medicaid covered service is provided on the day of specialized transportation;
4. When claiming these costs, each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided; and
5. The driver has a valid driver's license.

F. Certification of Costs Process:
On a quarterly and annual basis, each provider certifies through its cost report, its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

G. Quarterly Interim Payment Process
For Medicaid services provided in schools during the state fiscal year, each school district and ESU completes a quarterly cost report to calculate their allowable interim payments. The primary purposes of the cost report process are to: document the provider's total CMS-approved, Medicaid allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.

H. Annual Cost Report Process
Each provider completes an annual cost report for all school health services delivered during the previous state fiscal year covering September 1 through August 31. The cost report is due on or before September 1 of the year following the reporting period. The primary purposes of the cost report are to:
1. Document the provider’s total CMS-approved, Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its quarterly interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures. The annual MIPS Cost Report includes a certification of funds statement to be completed, certifying the provider’s actual, incurred costs/expenditures. All filed annual MIPS Cost Reports are subject to a desk review by DHHS or its designee.

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I. The Cost Reconciliation Process
The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual MIPS Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments during the reporting period, resulting in a cost reconciliation. For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

J. The Cost Settlement Process
For services delivered for a period covering September 1st, through August 31st, the annual MIPS Cost Report is due on or before September 1st of the preceding year (4 months after the fiscal year end), with the cost reconciliation and settlement processes completed no later than May 1st (9 months after the fiscal year end).

If a provider's interim payments exceed the actual, certified costs of the provider for school health services to Medicaid clients, the provider returns an amount equal to the overpayment. If the actual, certified costs of a provider for school health services exceed the interim Medicaid payments, DHHS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider. DHHS shall issue a notice of settlement that denotes the amount due to or from the provider.