

# NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

December 20, 2024

James G. Scott, Director  
Centers for Medicare & Medicaid Services  
Kansas City Regional Operations Group  
Division of Medicaid Field Operations-North  
601 East 12<sup>th</sup> Street, Suite 355  
Kansas City, Missouri 64106-2898

RE: Nebraska State Plan Amendment NE 24-0013

Dear Mr. Scott:

Enclosed please find the above referenced amendment to the Nebraska State Plan to clarify agency policies and provider requirements for federally qualified health centers (FQHCs).

The Division of Medicaid and Long-Term Care sent notice on September 5, 2024 (attached) to the federally recognized Native American Tribes and Indian Health Programs within the State of Nebraska to discuss the impact the proposed state plan amendment might have, if any, on the Tribes. No comments were received.

If you have content questions, please feel free to contact Jeremy Brunssen at [Jeremy.Brunssen@nebraska.gov](mailto:Jeremy.Brunssen@nebraska.gov) or 402-540-0380. For submittal questions, please contact Dawn Kastens at [Dawn.Kastens@nebraska.gov](mailto:Dawn.Kastens@nebraska.gov) or 531-893-3779.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew Ahern".

Matthew Ahern, Deputy Director  
Division of Medicaid and Long-Term Care  
Department of Health and Human Services

cc: Tyson Christensen

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr> <td style="width: 20px;">2</td> <td style="width: 20px;">4</td> <td style="width: 20px;">—</td> <td style="width: 20px;">0</td> <td style="width: 20px;">0</td> <td style="width: 20px;">1</td> <td style="width: 20px;">3</td> </tr> </table>	2	4	—	0	0	1	3	2. STATE <table border="1" style="display: inline-table; text-align: center; width: 60px;"> <tr> <td style="width: 20px;">N</td> <td style="width: 20px;">E</td> </tr> </table>	N	E
	2	4	—	0	0	1	3				
N	E										
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="checkbox"/> XIX <input type="checkbox"/> XXI											

TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2024
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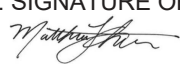
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR Part 405 Subpart X	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)  a. FFY <u>2025</u> \$ <u>0</u> b. FFY <u>2026</u> \$ <u>0</u>
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7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Att. 4.19-B, Item 2c, Pgs 1, 1a, 1b, 1c, 2, 3, and 4	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Att. 4.19-B, Item 2c, Pgs 1, 1a, 1b, 1c, 1.1 2, 3, and 4
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9. SUBJECT OF AMENDMENT  
Federally Qualified Health Centers

10. GOVERNOR'S REVIEW (Check One)

<input type="radio"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="radio"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="radio"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	<input checked="" type="radio"/> OTHER, AS SPECIFIED: Governor has waived review
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11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO Dawn Kastens Division of Medicaid & Long-Term Care Nebraska Department of Health and Human Services 301 Centennial Mall South Lincoln, NE 68509
12. TYPED NAME Matthew Ahern	
13. TITLE Deputy Director, Division of Medicaid & Long-Term Care	
14. DATE SUBMITTED December 20, 2024	

<b>FOR CMS USE ONLY</b>	
16. DATE RECEIVED	17. DATE APPROVED

<b>PLAN APPROVED - ONE COPY ATTACHED</b>	
18. EFFECTIVE DATE OF APPROVED MATERIAL	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL	21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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

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X The payment methodology for FQHCs will conform to Section 702 of the BIPA 2000 legislation. (All States should check this one.)

       The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for FQHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology will:

1. be agreed to by the State and the center or clinic; and
2. will result in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

FEDERALLY-QUALIFIED HEALTH CENTERS

FQHCs will be reimbursed under one of two methodologies as described below:

a) PROSPECTIVE PAYMENT SYSTEM (PPS)

Effective January 1, 2001, the Prospective Payment System (PPS) base rate will be computed as follows:

1. Combine reasonable costs from the FQHC center/clinic fiscal year 1999 and 2000 cost reports.
2. Divide the costs by the combined Total Adjusted Visits from the two fiscal year cost reports (Form HCFA - 222-92 Worksheet C, Part 1, Line 6; or Form HCFA - 2552-96 Worksheet M-3, Line 6).

This PPS base rate will be the center's final rate for January 1, 2001 through September 30, 2001. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Federally Qualified Health Center Market Basket.

The PPS base rate may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the FQHC. An adjustment to the base rate upon a change in the scope of services will be prospective and will become effective when the change is approved by the State. A change in the scope of FQHC services shall occur if:

- The center/clinic has added or has dropped any service that meets the definition of FQHC services as provided in Section 1905(a)(2)(B) and (C); and
- The service is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary.

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TN #. NE 24-0013

Supersedes

Approval Date \_\_\_\_\_

Effective Date \_\_\_\_\_

TN #. NE 16-0001

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

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b) ALTERNATIVE PAYMENT METHODOLOGY (APM)

Effective January 1, 2016, the Alternative Payment Methodology (APM) base rate will be computed as follows:

1. Total FQHC Allowable Costs (Line 10 of Part II Determination of Total Allowable Cost) Applicable to RHC/FQHC Services
2. Total FQHC Non-Allowable Costs (Line 11 of Part II Determination of Total Allowable Cost Applicable to RHC/FQHC Services)
3. Total Overhead (Line 14 of Part II Determination of Total Allowable Cost Applicable to RHC/FQHC Services)
4. Total FQHC Visits (Line 8 of Part I Visits and Productivity)
5. Total Physician Visits Under Agreement (Line 9 of Part I Visits and Productivity)
6. Calculate allowable cost percentage by applying the ratio of allowable to total cost
7. Apply allowable cost percentage to total overhead
8. Compute the total allowable cost including overhead
9. Compute the total visits
10. Calculate the cost per visit
11. Trend the cost per visit for each base year to the YE2014 time period using the Medicare Economic Index (MEI).
12. Calculate a blended average cost per visit across the three years of base data for each FQHC. In general, the average weight used for the YE2012/2013/2014 time periods is 10%/25%/65% although this percentage should be determined to give apparent outliers lower weighting.
13. The YE2014 blended rate is then projected to the CY2016 using a three-year average MEI trend of 0.8% per year.

The rate paid to the center or clinic under this methodology will result in payment of an amount which is at least equal to the PPS payment rate. The APM base rate will be updated annually based on the Federally Qualified Health Center Market Basket. The State will periodically rebase the FQHC encounter rates using the FQHC most recent available cost reports and other relevant data. Rebasing will be done only for clinics that are reimbursed under the APM.

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TN #. NE 24-0013

Supersedes

TN #. NE 16-0001

Approval Date \_\_\_\_\_

Effective Date \_\_\_\_\_

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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c) DENTAL ALTERNATIVE PAYMENT METHODOLOGY (APM)

Effective July 1, 2020, the Dental Alternative Payment Methodology (APM) base rate will be computed as follows:

1. Determine dental-related expenditures and visits for the FQHCs using the 2016 and 2017 Uniform Data System (UDS) submissions for each Nebraska FQHC that will operate under the APM reimbursement methodology for FQHC Dental visits.
2. Determine the base costs which reflect direct dental expenditures and the allowable portion of overhead costs. An allocation of overhead costs to dental expenditures was provided within the submitted UDS data. These allocated costs were included as part of the APM development, with a cap such that no more than a 20% increase to the direct dental expenditures (a maximum of 1.2 x direct dental expenditures) is allocated to either the 2016 or 2017 expenditures underlying the base cost per visit.
  1. Dental costs have been based on 2016 and 2017 UDS data, "T8a\_L5\_Ca". This is table 8A, row L5.
2. Determine the number of visits. The visits used in the calculation of the cost per visit for each base year are based on the same 2016 and 2017 UDS data for each Nebraska FQHC.
3. Trend the CY2016 data for one year at the 1.8% market basket for 2017, and then at an average annual market basket rate of 1.9% for two years to 2019, and for one year at the CY2020 market basket rate of 2.2% to 2020.
4. Trend the CY2017 data at an average annual market basket rate of 1.9% for two years to 2019 and at the market basket rate of 2.2% to 2020.
5. Calculate a blended average cost per visit by combining the two years of base data for each FQHC. The weight used for 2016 and 2017 is 25% and 75%, respectively.
6. Compare the 2020 APM rate calculated in Steps 1 through 6 to the CY2020 PPS rate. The dental APM payment will be equal to the greater of the calculated dental APM or the PPS rate.

The APM rate must be agreed to by the center or clinic and result in payment of an amount which is at least equal to the PPS payment rate. The APM base rate will be updated annually based on the Federally Qualified Health Center Market Basket.

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TN #. NE 24-0013

Supersedes

TN #. NE 20-0008

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Effective Date \_\_\_\_\_

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

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CHANGE IN SCOPE OF SERVICES

A change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of service, addition or reduction of staff members to or from an existing service, or an increase or decrease in the number of encounters are not considered in and of themselves a change in the scope of services. It is the responsibility of the FQHC to notify the Division of Medicaid of any changes in the scope of services and to provide the proper documentation to support the rate change. Adjustments to the base rate for the increase or decrease in scope of services will be reflected in the FQHC's respective rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

FQHC MANAGED CARE PPS PAYMENT

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will be reimbursed at the PPS rate, unless an FQHC otherwise elects with the state to receive reimbursement at the APM rate.

FQHC MANAGED CARE APM PAYMENT

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) and elect with the state to have their rate computed under the Alternative Payment Methodology will be reimbursed at the APM rate.

FQHC DENTAL MANAGED CARE PAYMENT

FQHCs that have elected the dental APM and provide dental services under a contract with a Medicaid Managed Care Entity (MCE) will be reimbursed at the Dental APM rate for those dental services.

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TN #. NE 24-0013

Supersedes

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Effective Date \_\_\_\_\_

TN #. NE 20-0008

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

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PAYMENT ASSURANCES

Effective January 1, 2016 and for date of service on or after January 1, 2016, centers/clinics may choose to have their rate computed under the Alternative Payment Methodology. To choose this method, the FQHC center/clinic must make this selection on the written memorandum form provided by the Department.

Nebraska Medicaid makes payment for services provided by federally qualified health centers (FQHCs) as defined in section 1905(a)(2)(C) of the Social Security Act on the basis of 100 percent of reasonable costs attributed to the care of Medicaid-eligible clients, as established by the Nebraska Department of Health and Human Services Finance and Support.

Reasonable costs are determined by the Department on the basis of the FQHCs cost report, submitted as the Medicare cost report (Form HCFA-222). Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

An FQHC paid under this APM in accordance with Section 1902(bb)(6) of the act will receive 100% of their rate in effect as of this date, as determined and described in section (b). For those non-FQHC services for which no charge has been established by Medicare, FQHCs are reimbursed according to Nebraska Medicaid practitioner fee schedule.

All payments made by Nebraska Medicaid and its Managed Care Entities (MCEs) will be made in accordance with Section 1902(bb) of the Social Security Act and will result in a payment amount which is at least equal to the amount that would otherwise be paid under the prospective payment system (PPS).

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TN #. NE 24-0013

Supersedes

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Effective Date \_\_\_\_\_

TN #. NE 16-0001

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

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RATES FOR NEW FQHC CENTERS/CLINICS

Effective January 1, 2001, initial interim rates for new FQHCs entering the program after 1999, will be the average PPS rate of all FQHC clinic/centers in Nebraska, unless the FQHC chooses an interim rate which is the average APM rate of all relevant FQHC clinic/centers in Nebraska. These average PPS or APM rates will be updated annually based on the Federally Qualified Health Center Market Basket until the FQHC receives its individual PPS or APM rate. The State will periodically rebase the FQHC APM rates using the most recent available cost reports and other relevant data. New FQHCs will receive their own individual PPS or APM rate when the State rebases the FQHC APM rates for the first time after the FQHC's enrollment with Nebraska Medicaid. Once the PPS/APM base rate has been established, it will be updated annually based on the Federally Qualified Health Center Market Basket.

The rate for any additional or satellite FQHC clinic/location will be the same rate as the FQHC's existing clinic/location(s).

RATES FOR OUT-OF-STATE FQHCs

The Department pays out-of-state federally qualified health centers (FQHCs) participating in Medicaid at a rate which is the average PPS rate of all FQHC clinic/centers in Nebraska, unless the FQHC chooses an interim rate which is the average APM rate of all FQHC clinic/centers in Nebraska. Once the out-of-state FQHC's rate has been established, it will be updated annually based on the Federally Qualified Health Center Market Basket.

The Department pays for covered dental services appropriately provided by out-of-state federally qualified health centers (FQHCs) participating in Medicaid in accordance with the Nebraska Medicaid Dental Fee Schedule. Out-of-state federally qualified health centers (FQHCs) participating in Medicaid will have their encounter rate for dental visits determined by the Dental Alternative Payment Methodology (DAPM) for appropriately delivered covered dental services if they also have at least one federally qualified health center (FQHC) location in Nebraska which has elected to have its encounter rate for dental visits determined by the Dental Alternative Payment Methodology (DAPM).

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Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_

TN #. NE 16-0001



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
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Payment for Telehealth Services: Payment for the professional service performed by the distant site practitioner (i.e., where the practitioner is physically located at time of telehealth encounter) will be equal to what would have been paid without the use of telehealth. If a FQHC service is appropriately provided via telehealth and the center/clinic is the distant site, the FQHC will be reimbursed at their applicable encounter rate. Non-FQHC services provided via telehealth are not eligible for reimbursement at the encounter rate. Non-FQHC services appropriately provided via telehealth will be paid according to the applicable service-specific Nebraska Medicaid fee schedule (i.e., Physician and Mental Health and Substance Use Fee Schedule). For services appropriately provided via telehealth where the FQHC is the originating site, the FQHC will be reimbursed at the Nebraska Medicaid originating site fee as set forth in state regulations, as amended.

The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Telehealth services. Telehealth transmission cost and originating site fee are found on the Physician and Mental Health and Substance Use Fee Schedules, as authorized elsewhere in the plan.

The agency's fee schedule rate was set as of July 1, 2024 and is effective for telehealth and originating site services provided on or after that date. All rates are published and updated annually on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 24-0013

Supersedes

TN # NE 24-0010

Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_