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

__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 Medicare Economic Index (MEI).
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.

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

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 Medicare Economic Index (MEI). 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.

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

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.
   a. Dental costs have been based on 2016 and 2017 UDS data, “T8a_L5_Ca”. This is table 8A, row L5.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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 Medicare Economic Index (MEI).

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

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 APM rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

FQHC DENTAL MANAGED CARE WRAP PAYMENT

FQHCs that have elected the dental APM and provide dental services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly supplemental payments from the state equivalent to the difference between the payment the FQHC received from the MCE(s) and the payments the FQHC would have received under the alternative methodology. At the end of each FQHC fiscal year, the total amount of supplemental and MCE payments received by the FQHC will be reviewed against the calculated amount that the actual number of visits provided under the FQHCs contract with MCE(s) would have yielded under the alternative methodology. If the total amount of supplemental and MCE payments exceeds the amount calculated using alternative methodology amount and the actual number of visits, the FQHC will refund the difference. If the alternative methodology amount exceeds the total amount of supplemental and MCE payments, the FQHC will be paid the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC.

For Medicaid clients enrolled with a managed care entity (MCE), the State anticipates that the MCE will pay each center/clinic, an encounter rate that is at least equal to the PPS base rate specific to each center. To ensure that the appropriate amounts are being paid to each center, the State will perform an analysis of the MCE's data at least quarterly and verify that the payments made by the MCE in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to centers/clinics reimbursed under the PPS and APM rate methodology.

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

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 scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not constitute a change in the scope of services. Also, a change in the cost of service is not considered in and itself a change in the scope of services.
It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of services and provided 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 PPS 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 receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received under the PPS. At the end of each FQHC's fiscal year, the total amount of the supplemental and the MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with one or more MCEs would have yielded under the PPS. The FQHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount is less than the supplemental MCE payments.

For Medicaid clients enrolled with a managed care entity (MCE), the State anticipates that the MCE will pay each center/clinic, an encounter rate that is at least equal to the PPS base rate specific to each center. To ensure that the appropriate amounts are being paid to each center, the State will perform an analysis of the MCE's data at least quarterly and verify that the payments made by the MCE in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to centers/clinics reimbursed under the PPS and APM rate methodology.

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

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.

The Nebraska Medical Assistance Program (NMAP) 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, NMAP makes payment according to Nebraska Medicaid practitioner fee schedule.

FQHC MANAGED CARE APM PAYMENT

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payment the FQHC receives from MCE(s) and the payments the FQHC would have received under the alternative methodology. At the end of each FQHC fiscal year, the total amount of supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHCs contract with MCE(s) would have yielded under the alternative methodology. The FQHC will be paid the difference between the amount calculated using the alternative methodology and the actual number of visits, and the total amount of the supplemental and MCE payments received by the FQHC, if the alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC if the alternative method is less than the total amount of the supplemental and MCE payments.

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

Effective January 1, 2017, for Medicaid clients enrolled with a managed care entity (MCE), the State anticipates that the MCE will pay each center/clinic, an encounter rate that is at least equal to the PPS base rate specific to each center. To ensure that the appropriate amounts are being paid to each center, the State will perform an analysis of the MCE's data at least quarterly and verify that the payments made by the MCE in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to centers/clinics reimbursed under the PPS and APM rate methodology.

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. The FQHC's individual PPS or APM base rate will be computed later, using its initial cost report. Once the PPS/APM base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI). The interim rate will be retroactively settled based on the FQHC center/clinic initial cost report. The State will periodically rebase the FQHC APM rates using the FQHC most recent available cost reports and other relevant data

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

Payment for Telehealth Services: Payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or 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 core service is provided via telehealth and the center/clinic is the distant site, the FQHC will be reimbursed at the PPS or the APM encounter rate (whichever was chosen at the time of the service). Non FQHC services provided via telehealth would not be eligible for PPS/APM payment. Non-FQHC services will be paid according to the Nebraska Medicaid Physician and Mental Health and Substance Use Fee Schedule, as authorized elsewhere in the plan.

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

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. 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 transmission cost and originating site services provided on or after that date. All rates are published 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.