29-000 FEDERALLY-QUALIFIED HEALTH CENTERS (FQHC'S)

29-001 Standards for Participation: To be considered a ~~f~~Federally-~~q~~Qualified ~~h~~Health ~~c~~Center (FQHC) for the Nebraska Medical Assistance Program, as allowed by section 6404 of P.L. 101-239, a health center must furnish proof that the United States Public Health Service has determined that it is qualified under Sections 329, 330, or 340 of the Public Health Service Act, or that it qualifies by meeting other requirements established by the Secretary of the Federal Health and Human Services.

29-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

29-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;
2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and
3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed by the HMO, regardless of whether the service is provided by a PCP enrolled with the HMO or a family planning provider outside the HMO.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

29-002.02 Primary Care Case Management (PCCM) Plans: All NMAP regulations apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider ~~shall~~ must obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As define under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and
2. Abortions: As currently defined, abortions require prior authorization by NMAP.

29-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP ~~shall~~ must authorize the services to be provided by the approved provider as needed with the following exceptions:

1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers ~~shall~~ must contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.
2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 ~~shall~~ must bill that service on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837), using HCPCS/CPT procedure codes. These services require referral/ authorization from the client's PCP. The provider ~~shall~~ must contact the PCP before providing these services. If a client requires hospitalization for dental treatment or for medical and surgical services billed on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837), the provider ~~shall~~ must contact the PCP for referral/authorization.
3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

29-002.03 Mental Health and Substance Abuse Services Mental health and substance abuse services (MH/SA) are provided by the MH/SA managed care plan for all NHC clients. This plan includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized by the Plan.

29-003 Payment for Services Provided by FQHCs: ~~Effective April 1, 1990, 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 reasonable costs allocated to the care of Medicaid-eligible clients.~~ NMAP will pay for services provided by FQHCs under a prospective payment system (PPS) that is in compliance with Section 1902(bb) of the Social Security Act. The Department assures that payment to an FQHC will result in payment to the center of an amount which is at least equal to the Prospective Payment System rate.

29-003.01 Definitions: The following definitions apply in this chapter.

Encounter means~~: A~~ a face-to-face visit between a Medicaid-eligible patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

Encounter Rate means~~: The all-inclusive rate that the Department reimburses the FQHC for an encounter. The encounter rate shall be determined by dividing the total reasonable costs allocated to Medicaid-eligible patients from the FQHC's latest cost report by the total number of encounters by Medicaid-eligible patients during that same time period.~~ the all-inclusive PPS rate that the Department reimburses the FQHC for an encounter.

Encounter Payments means~~:~~ PPS rate paid to the FQHC by the Department multiplied by the number of encounters billed ~~and paid at the encounter rate. The total dollars paid to the FQHC by the Department based on the number of encounters billed and paid at the encounter rate.~~

Medicare Cost Report means the report filed by each provider with its Medicare intermediary as required in the Medicare Rural Health Clinic and Federal Qualified Health Center Manual.

Prospective Payment System (PPS) means the payment system where in the reimbursement rate is paid for services provided.

~~Interim Payments: Payments made by the Department to an FQHC which are subject to the cost reconciliation process. The payments may be encounter payments and/or payments made based on the Nebraska Medicaid Practitioners Fee Schedule.~~

~~Reasonable Costs: Determined by the Department on the basis of the FQHC's cost report, submitted as the Medicare cost report (Form HCFA-2552) or any other cost reporting form approved by the Department for this use. Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.~~

~~Providers participating in the NMAP as FQHCs must submit a plan for allocating costs to the NMAP program. This plan must also indicate the annual cost reporting period by which the FQHC plans to report its annual costs to the Department.~~

29-004 Prospective Payment System

29-004.01 Prospective Payment System Base Rates: The Prospective Payment System base rate will be computed as follows:

1. Combine reasonable costs from the FQHC fiscal year 1999 and 2000 cost reports; and
2. Divide the costs by the 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).

Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

29-004.02 Rates for New Providers: The Department will establish rates for a new FQHC entering the program after 1999 as follows:

1. For the initial year, the interim rate will be the average PPS rate of all FQHCs in Nebraska. The interim rate will be retroactively settled based on the FQHC's initial cost report.
2. The FQHC's individual PPS base rate will be computed later, using its initial cost report.
3. The PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

~~29-003.02 Cost Reconciliation Process: Interim payments will be subject to reconciliation at the end of the cost reporting period. Following the receipt of the FQHC's Medicare cost report (or other acceptable cost reporting form), the Department will compute a retroactive adjustment to the allowable Medicaid costs for the cost reporting period.~~

~~The Department will make additional payment to the FQHC when the allowable reported Medicaid costs exceed the interim payments made to the FQHC. Payments will be made within 90 days of receipt of the cost report by the Department.~~

~~The FQHC must reimburse the Department when its allowable reported Medicaid costs for the cost reporting period are less than the interim payments. Payments owed to the Department must be made within 90 days following notice by the Department to the FQHC of the amount due.~~

~~29-004 Billing for FQHC Services: FQHCs shall bill for their services on Form CMS-1450 (see 471-000-51) or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837). FQHCs shall use the appropriate HCPCS/CPT procedure codes and revenue codes when billing for services.~~

~~FQHCs shall bill for HEALTH CHECKS (Early and Periodic Screening, Diagnosis, and Treatment-EPSDT-Exams) on Form CMS-1500 (see 471-000-58) or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837).~~

29-004.03 FQHC Managed Care Payments: 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 the MCE(s) and the payments the FQHC would have received under the PPS methodology.

29-004.03A At the end of each FQHC fiscal year, the Department will compare:

1. The total amount of supplemental and MCE payments received by the FQHC; to
2. The amount that the actual number of visits provided under the FQHC's contract with the MCE(s) would have yielded under the PPS methodology.

The Department will pay the FQHC the difference between item 1 and item 2 if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC must refund the difference between item 1 and item 2 if the PPS payment is less than the total amount of the supplemental and MCE payments.

29-004.04 Non-FQHC Services: For non-FQHC services, NMAP will pay according to the Nebraska Medicaid Practitioners Fee Schedule.

29-004.05 Payment for Telehealth Services: Payment for telehealth services will be the Medicaid rate for the comparable in-person service. FQHC core services provided via telehealth technologies are not covered under the encounter rate.

29-004.05A Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs related to non-core services will be the lower of:

1. The provider's submitted charge; or
2. The maximum allowable amount.

The Department will pay for 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 transmissions (see 471 NAC 1-006).

29-005 Cost Reports: Providers participating in the NMAP as FQHCs must submit an annual cost report to the Department.

The Medicare cost report form CMS-222-92 can be found in the Provider Reimbursement Manual-Part-2 (Pub. 15-2), Chapter 29 located at http://www.cms.hhs.gov/manuals/PBM/list.asp on the CMS website.

Each FQHC must report and supply the Department with necessary documentation, cost reports, and any other documentation when requested.

29-006 Billing for FQHC Services: FQHCs must bill for their services on Form CMS-1450 (see 471-000-51) or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837). FQHCs must use the appropriate HCPCS/CPT procedure codes and revenue codes when billing for services.

FQHCs must bill for HEALTH CHECKS (Early and Periodic Screening, Diagnosis, and Treatment-EPSDT-Exams) on Form CMS-1500 (see 471-000-58) or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837).

FQHCs must bill all laboratory/radiology services and other non-FQHC services on the form CMS-1500 (see 471-000-58) or electronically using the standard health care claim; Professional transaction (ASC X12N 837) using the non-FQHC number.