NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

December 1, 2025

The Honorable Jim Pillen
Governor of Nebraska
P.O. Box 94848
Lincoln, NE 68509

Mr. Brandon Metzler
Clerk of the Legislature
P.O. Box 94604
Lincoln, NE 68509

Subject: Nebraska Medicaid Annual Report

Dear Governor Pillen and Mr. Metzler:

In accordance with the Nebraska Revised Statute § 68-908(4), please find the attached report on the state fiscal year Medicaid Annual Report.

We are grateful for our partners, communities across the state, and the thousands of Medicaid providers across Nebraska who share the Department of Health and Human Services' mission to "Help People Live Better Lives." The Division of Medicaid & Long-Term Care looks forward to doing its part to improve the lives of the state's Medicaid beneficiaries.

Sincerely,

Drew Gonshorowski
Director, Division of Medicaid and Long-Term Care

Attachment

Department of Health and Human Services
Report

NEBRASKA
Good Life. Great Mission.

Division of Medicaid and Long-Term Care

Nebraska Medicaid Annual Report

December 2025

Neb. Rev. Stat. § 68-908

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Executive Summary

The Division of Medicaid & Long-Term Care (MLTC), a division of the Nebraska Department of Health and Human Services (DHHS), administers Nebraska's Medicaid program. Each state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within guidelines set by the federal government.

Medicaid is a significant payer of health services in Nebraska. The program currently represents a roughly $4 billion investment into the health of our communities – particularly for the more than 400,000 Nebraskans who were Medicaid beneficiaries during at least one month in the state fiscal year 2025 (SFY25). The program serves low-income children and adults, the aged, and individuals with disabilities. Additionally, approximately 70,000 providers are under contract with Nebraska Medicaid.

Nebraska Medicaid has proactively expanded community outreach and engagement this year. Ensuring that Nebraskans have access to crucial information and points of contact continues to be a priority for the program. MLTC's outreach has primarily focused on Medicaid beneficiaries, providers, Tribes, community partners, and advocates. These external relationships enable the program to identify opportunities for improvement and address challenges quickly.

MLTC acts as a steward for stakeholders and taxpayers by facilitating access to high quality and cost-efficient health care. This requires MLTC to continually evaluate and improve:

- Information technology systems and business process models;
- The health services array and delivery models;
- Provider policies and payment methodologies; and
- Beneficiary program eligibility and processes.

Looking forward, MLTC continues plotting its strategic plan for the next several years. The division thanks its many stakeholders and is eager to continue providing the community with comprehensive healthcare and exceptional customer service for years to come.

MLTC Organizational Structure

MLTC includes Medicaid and the Children's Health Insurance Program (CHIP). Medicaid serves low-income children and adults, the aged, and individuals with disabilities, covering 16.86%[1] of Nebraskans.

MLTC has almost 200 full-time employees and collaborates with the Office of Economic Assistance (OEA) for Eligibility Operations.

OEA and MLTC merged their Eligibility Operations (EO) staff into a single, unified team within OEA. This change is designed to enhance our service delivery and operational efficiency. The long-term goals for the unified team are to:

- Reduce redundancies;
- Create a seamless customer experience;
- Reduce administrative burden; and
- Improve access.

The decision to merge reflects a commitment to providing the best possible service to Nebraskans and ensuring the most efficient use of resources.

[1] Calculated using the SFY25 total Medicaid enrollment found in Appendix 3 and US Census population projections.

Division Structure

Policy, Plan Management, and Communications

Policy and Plan Management is responsible for overseeing the Heritage Health managed care program, regulatory compliance, and ensuring compliance with the state and federal authorities under which the Medicaid program operates. This includes proposing updates to the Medicaid state plan, monitoring legislation, and managing health plan contracts.

Communications staff help beneficiaries, stakeholders, and the public understand Nebraska Medicaid and the services it provides to Nebraskans. This section is primarily responsible for aligning policies, procedures, guidance documents, and other internal and public-facing information to ensure that the Nebraska Medicaid program complies with relevant state and federal law.

Eligibility Operations

Eligibility Operations is responsible for determining eligibility for Medicaid programs. Eligibility Operations is managed within OEA as of September 2024.

Finance and Program Integrity

Finance and Program Integrity is responsible for the financial operations of the division including analysis, planning, budgeting, and reporting. Additionally, the unit is responsible for provider screening and enrollment, rates and reimbursement policies, as well as fee-for-service (FFS) claims processing. This section is also responsible for monitoring Medicaid provider fraud, waste, and abuse.

Project and Performance Management

Project and Performance Management drives the implementation of Medicaid's strategic initiatives through the management of MLTC's data and analytics capabilities, IT initiatives, and planning activities.

Medical Services, Behavioral Health, and Pharmacy

Medical Services helps determine the services covered under Nebraska Medicaid and ensures that Medicaid-covered services adhere to evidence-based standards of care.

Population Health

Population Health is responsible for assessing health outcomes across the Medicaid population. Population Health includes medical, behavioral health, pharmacy, dental, long-term care, and home and community-based services.

Eligibility and Populations Served

Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a public health program that provides coverage for low-income individuals. Nebraska Medicaid, in general, provided coverage for individuals in the following eligibility categories in SFY25:

- Children;
- Aged, blind, and disabled (ABD);
- Pregnant women;
- Parent/caretaker relatives; and

- Adults ages 19-64.

Eligibility factors, such as income and resource guidelines, vary by group. Medicaid enrollment and costs are closely related to economic factors (see Table 1 below and Appendix 1). Average enrollment increased in SFY2020 due to the COVID-19 public health emergency (PHE) when Medicaid cases remained open and due to the launch of Medicaid expansion. The resumption of eligibility determination beginning in March 2023 has seen the average monthly enrollment decrease steadily. In SFY24 Medicaid enrollment was 364,256 and in SFY25 enrollment was 338,130; a decrease of 7.17 percent (see Appendix 2).

Most Nebraska Medicaid beneficiaries (including CHIP children, pregnant women, and parents/caretaker relatives) are subject to modified adjusted gross income (MAGI) budgeting methodology as required by the Affordable Care Act (ACA). It uses federal income tax rules and tax filing status to determine an individual's Medicaid eligibility. This methodology simplifies eligibility groups and aligns them with eligibility for state or federal insurance marketplaces. Other Medicaid eligibility groups in the state, such as those who qualify based on age or disability, are subject to different criteria. Tables 1, 2, and 3 explain several Nebraska Medicaid programs and their eligibility requirements.

Table 1. 2025 Federal Poverty Level (FPL) Annual Income Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$ 7,825.00	$ 15,650.00	$ 21,597.00	$ 31,300.00
2	$ 10,575.00	$ 21,150.00	$ 29,187.00	$ 42,300.00
3	$ 13,325.00	$ 26,650.00	$ 36,777.00	$ 53,300.00
4	$ 16,075.00	$ 32,150.00	$ 44,367.00	$ 64,300.00
5	$ 18,825.00	$ 37,650.00	$ 51,957.00	$ 75,300.00
6	$ 21,575.00	$ 43,150.00	$ 59,547.00	$ 86,300.00
7	$ 24,325.00	$ 48,650.00	$ 67,137.00	$ 97,300.00

Table 2. Nebraska Medicaid MAGI Coverage Groups and Income Eligibility Requirements

Program	Description	Income Limit*
Subsidized Adoption and Guardianship Assistance (SAGA)	Individuals ages 19-21, if subsidized guardianship or adoption agreement was entered into after age 16.	Twenty-three percent (23%) of the federal poverty level (FPL)
Institution for Mental Diseases (IMD)	Individuals in an institution for mental disease ages 19-21.	Fifty-one percent (51%) of the FPL.
Parent/Caretaker Relatives	Parents or caretaker-relatives of a dependent child under the age of 19.	Fifty-eight percent (58%) of the FPL
Pregnant Women	Pregnant women Medicaid eligible through pregnancy and 12 months postpartum.	194% of the FPL
Newborn to Age One	Children from birth to age one. There is continuous eligibility for 12 full months following the date of birth for infants born to a Medicaid-eligible parent.	162% of the FPL

Program	Description	Income Limit*
Children Ages One to Five	Children ages one to five.	145% of the FPL
Children Ages Six to Eighteen	Children ages six to 18.	133% of the FPL
Children's Health Insurance Program (CHIP)	CHIP was created in 1997 under Title XXI of the Social Security Act. In Nebraska, CHIP uses the same delivery system, benefits package, and regulations as Medicaid. Eligible children must be otherwise uninsured.	213% of the FPL
599 CHIP	This CHIP program covers prenatal and delivery services for the unborn, not yet Medicaid eligible.	197% of the FPL
Heritage Health Adult (Medicaid Expansion)	Adults between ages 19 and 64 who are ineligible for another Medicaid category.	133% of the FPL

*An additional 5% disregard may apply to certain programs' income limits.

Table 3. Nebraska Medicaid Non-MAGI Coverage Groups and Income Eligibility Requirements

Program	Description	Income Limit
Former Foster Care	An individual under 26, was in foster care and receiving Medicaid at age 18 or 19, and ineligible for Medicaid under another program.	No income or resource guidelines; must meet general eligibility requirements (citizenship, residency, etc.)
Transitional Medical Assistance (TMA)	12 months of transitional coverage for parent/caretaker relatives no longer Medicaid eligible due to earned income. In the second six months, if income is above 100% FPL, family may pay a premium and become Medicaid eligible.	The first six months are without regard to income. The second six months, 185% of the FPL.
Aged, Blind, and Disabled	Individuals who are determined blind or disabled by SSA.	100% of the FPL with certain resource limits
Medicare Buy-In	Specified low-income Medicare beneficiaries (SLMB) and qualified individuals for whom the state pays a Medicare Part B Premium.	SLMB = 120% QI = 135% Of the FPL with certain resource limits
Medically Needy	Individuals with medical needs and exceed income requirements for other Medicaid categories. This category allows individuals to obligate their income above the standard on their medical bills and establish Medicaid eligibility.	Income level is based on a standard of need. For a household size of 2, the income guideline is $392/month.

Program	Description	Income Limit
Medicaid Insurance for Workers with Disabilities	These are individuals with disabilities who are eligible for Medicaid but for their earnings. They are disabled and working but need their Medicaid coverage to enable them to work.	200% of the FPL Between 200% FPL and 250%, they must pay a premium.
Katie Beckett	Are aged 18 or younger with severe disabilities who live with their parent(s), but who would otherwise require hospitalization or institutionalization due to their high level of healthcare needs.	The parent's income is waived under the Tax Equity and Fiscal Responsibility Act (TEFRA).
Breast and Cervical Cancer	Women who were screened for breast or cervical cancer by the Every Women Matters Program and found in need of care.	Women are below 225% FPL using EWM criteria.
Emergency Medical Services for Aliens	Individuals are ineligible due to citizenship or immigration status and have a condition requiring emergency medical care (including emergency labor and delivery).	Income and resources vary depending on the category of eligibility.
Subsidized Adoption	Children under 18 with an adoption assistance agreement in effect or with foster care maintenance payments made under Title IV-E of the Act. A medical review is required for non-IV-E.	No income or resource guidelines.
Subsidized Guardianship	Children under 18 for whom kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	No income or resource guidelines.

The adult category continues to show the most significant change year over year in total number of eligible individuals, decreasing by 9.31 percent from SFY24 to SFY25. The Aged, Blind, and Disabled categories saw a decrease: a 1.13 percent increase for Aged and a 2.75 percent decrease for Blind & Disabled. Children's enrollment decreased by 5.32 percent. Overall, enrollment decreased by 7.17 percent.

Appendices 4 and 5 compare the cost of different eligibility categories. While the Aged and the Blind & Disabled categories represent 16.46 percent of beneficiaries, they account for 41.38 percent of expenditures. In contrast, children account for 50.24 percent of beneficiaries but only 22.75 percent of expenditure. Further cost-per-enrollee details are included in Appendix 4.

Appendix 5 does not account for all Medicaid and CHIP expenditures, partly because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not included are drug rebate payments made outside the Medicaid Management Information System (MMIS)[2], and

premium payments paid on behalf of persons eligible for Medicare. Beneficiary demographic data is not available for these expenditures. This means some expenditures, particularly in the Aged and the Blind & Disabled categories, are understated.

[2] These payments include Aged and Disabled Waiver Providers (paid in N-FOCUS), sub-award agencies (On-Base), and assistive technology partnership contractors (Nebraska Information System).

Nebraska Annual Summary

Here is the Nebraska Medicaid annual summary data for State Fiscal Year 2025.

Nebraska Medicaid received a total of 177,663 initial applications for eligibility, with 94,738 approved applications and 82,925 denied applications.

Nebraska Medicaid completed 349,242 eligibility determinations, also known as Medicaid renewals, with 249,049 beneficiaries retaining eligibility and 100,193 beneficiaries losing eligibility (case closures). Please note the total eligibility determinations include beneficiaries who had multiple eligibility determinations in SFY25. Please reference Appendix 6 for the specific reasons for the case closure broken down by eligibility category, race/ethnicity, sex, age, county classification, and local health district.

Nebraska Medicaid had 427,722 enrollees representing the unique number of beneficiaries with Medicaid eligibility for at least one month between July 2024 and June 2025. Please reference Appendix 6 for enrollment broken down by eligibility category, race/ethnicity, sex, age, county classification, and local health district.

DHHS estimates that Nebraska Medicaid had an average ex parte rate of 34% for renewals. DHHS is only able to provide an average ex parte rate at this time as the information captured in the Medicaid eligibility system provides a proxy for whether a renewal was completed ex parte. DHHS started implementing federally required system changes to comply with ex parte requirements in August 2025 and expects to complete the system changes by the December 2026 federal deadline. DHHS will provide the requested information once the required system changes are implemented.

Nebraska Medicaid's average monthly median processing days for MAGI and Non-MAGI initial applications were 13 days and 12 days respectively.

For SFY25, of the 100,190 Nebraska Medicaid beneficiaries who lost Medicaid coverage, Nebraska Medicaid received a total of 399,073 client calls and answered 345,704 (87%) with 52,300 (13%) abandoned calls. The average client call duration was 9 minutes, and the average client call wait time was 6 minutes.

For SFY25, Nebraska Medicaid received 332 fair hearing requests, representing 348 individuals, for Medicaid eligibility and State Review Team (SRT) disability related determinations. Please reference Appendix 6 for a breakout by eligibility category, outcome, and average number of days until final disposition.

The following web page on the department's website includes the Nebraska Medicaid's program fair hearing decisions that have been redacted to protect private and health information: https://dhhs.ne.gov/Pages/Medicaid-Fair-Hearing-Decisions.aspx.

Benefits Package

Federal Medicaid statutes mandate that states provide certain services, while also allowing states the option to provide additional services. The Nebraska Medical Assistance Act (Neb. Rev. Stat. §§ 68-901 to 68-975) and the Medicaid State Plan outline the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska. These mandatory and optional services are noted below in Table 4.

Table 4. Federal Medicaid Mandatory and Optional Services Covered in Nebraska

Mandatory Services	
Certified Pediatric and Family Nurse Practitioner Services	Medical Transportation Services
Family Planning Services	Nurse Midwife Services
Freestanding Birth Center Services (when licensed or otherwise recognized by the state)	Nursing Facility Services
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT, health check)	Physician Services
Home Health Services	Services Provided by Clinics • Rural Health Clinics • Federally Qualified Health Centers (FQHC)
Hospital Services • Inpatient • Outpatient	Tobacco Cessation Counseling for Pregnant Women
Laboratory and Radiology (X-ray) Services	Nurse Practitioner Services
Interpretation Services	

Optional Services	
Ambulance Services	Podiatry Services
Chiropractic Services	Prescribed Drugs
Dental Services	Private-Duty Nursing Services
Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies	Adult Psychiatric, Substance Use Disorder, and Medicaid Rehabilitation
Hearing Aid Services	Screening Services (Mammograms)
Hospice Services	Services Provided by Clinics • Community Mental Health Centers • Indian Health Service (IHS) Facilities
Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/DD) Services	Therapies • Physical • Occupational • Speech Pathology • Audiology
Mental Health and Substance Abuse Services for Children and Adolescents (aged 0-20)	Vision Care Services
Personal Assistance Services	

Nebraska Medicaid evaluates covered services to ensure that comprehensive healthcare services are provided to Nebraskans as efficiently as possible, aligning with best medical practices. MLTC collaborates with sister divisions, providers, beneficiaries, managed care partners, and other stakeholders to identify potential service gaps and policy implications. Through these evaluations and legislative mandates, Nebraska Medicaid has made programmatic changes in SFY25 to the service array:

Justice Involved Youth and Young Adults

The Consolidated Appropriations Act, 2023 (CAA), Section 5121 requires Medicaid and CHIP programs to have a plan in place and in accordance with such plan, to provide – in the 30-day period before and after an eligible juvenile is released from incarceration – screenings, diagnostic services, and targeted case management services, including referrals to the appropriate care and services available near their home or residence.

MLTC is focused on developing its implementation plan for Sec. 5121. Included in this plan are State Plan and Managed Care Organization (MCO) contract amendments, technology system enhancements, and new provider payment methodologies, among other components. State staff are meeting with representatives from the Centers for Medicare & Medicaid Services (CMS) to communicate the state's readiness to implement Sec. 5121. Similarly, MLTC developed a survey to send carceral facilities across Nebraska to help the Medicaid program plan for implementation. The goal of this initiative is to help justice-involved youth and young adults return from incarceration healthier and better equipped to participate in their communities.

Certified Community Behavioral Health Clinics (CCBHCs)

Nebraska has submitted a state plan amendment to create Certified Community Behavioral Health Clinics (CCBHCs) in accordance with the passage of LB276 (2023) and the associated Nebraska Revised Statute §§ 71-832 to 71-837. CCBHCs will provide integrated, comprehensive health services with a focus on behavioral health. CCBHCs will provide a broad range of mental health and substance use services, including screening, diagnosis, and outpatient treatment, primary care screenings, community and employment support, and around the clock crisis care to any Nebraskans who may need mental health or substance use disorder assistance. This program will be implemented January 1, 2026.

Interpretation Services

At the beginning of SFY2025, Medicaid authorized coverage of interpretation services that are provided in conjunction with another Medicaid-covered service. Enrolled Medicaid providers who require interpretation to effectively deliver health care services may bill Medicaid for services provided by an interpreter who is a staff member of the billing provider or an individual, agency, or phone service contracted with the billing provider. Interpretation services may include verbal translation and sign language interpretation. Fees for interpretation services will be paid to the Medicaid-enrolled health care provider.

Prenatal Plus Program

Effective January 1, 2025, Medicaid implemented the Nebraska Prenatal Plus Program in accordance with the passage of LB857 (2024) and the associated Nebraska Revised Statute §§ 68-9,105 to 68-9,110. The Prenatal Plus Program offers targeted case management, nutrition counseling, psychosocial counseling and support, general client education and health promotion, and breastfeeding support to pregnant women who are determined by a health care provider to be at risk of having a negative maternal or infant health outcome.

Service Delivery

Nebraska covers Medicaid and CHIP services primarily through Heritage Health, a capitated managed care program designed to integrate medical, behavioral, dental, and pharmacy needs. MCOs are responsible for managing and providing specific Medicaid-covered services and use population health and care management strategies to manage their member population in quality and cost-conscious

manners. Nationally, 42 other states (including the District of Columbia) contract similarly with MCOs to cover Medicaid services using a managed care delivery system.

Nebraskans on Medicaid receive physical health, behavioral health, dental services, and pharmacy benefits under Heritage Health. In SFY25, three MCOs provided healthcare services to Medicaid beneficiaries: Nebraska Total Care, UnitedHealthcare Community Plan, and Molina Healthcare.

Heritage Health focuses on improving the health and wellness of Medicaid beneficiaries by increasing access to comprehensive health services in a cost-effective manner. Managed care oversight is a top priority with monthly performance reports from the MCOs.

These performance metrics include:

- Member engagement;
- Provider engagement;
- Network adequacy;
- Claims adjudication;
- Care management;
- Quality of care;
- Utilization management; and
- Financials.

Nebraska Medicaid also uses a Quality Performance Program (QPP) that allows MCOs to earn back a portion of revenue, which the Department requires held back, upon successful achievement of Department-established administrative and clinical metrics.

Medicaid beneficiaries enrolled in home and community-based waiver programs and those living in long-term care settings such as nursing homes or intermediate care facilities (ICF) still have certain services provided via fee-for-service (FFS). While physical and behavioral health, dental services, and pharmacy services are delivered through the Heritage Health MCOs, the management and reimbursement of all Medicaid long-term services and supports (LTSS) remain FFS in Nebraska Medicaid.

Quality Measurement and Performance

Nebraska Medicaid utilizes a variety of national quality measures to assess program success. These measure sets include:

- Centers for Medicare and Medicaid Services (CMS) Adult Core Set;
- CMS Child Core Set;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Healthcare Effectiveness Data and Information Set (HEDIS®); and
- Dental Quality Alliance (DQA).

These quality measurement sets allow Nebraska Medicaid to compare the program and individual MCOs to their respective peers across the nation, as well as give insight into beneficiary experiences. All the quality measurement sets come from external measure stewards and are curated by their respective organizations. The CMS Adult and Child Core Sets and CAHPS survey are required reporting by CMS, the HEDIS measures are required as part of the MCO's accreditation, and the DQA measures are considered best practice measurements for dental services.

Below in Tables 5 and 6 are a selected set of measures that generally align with either the Nebraska Medicaid Quality Strategy or with other current initiatives. All measures are annually collected either from the CAHPS survey or from the HEDIS measures. The CAHPS survey allows Nebraska Medicaid to assess beneficiary satisfaction while the HEDIS measures primarily measure the MCOs' performance

and, by extension, the vast majority of beneficiaries receiving services via managed care and the overall program.

Table 5. CAHPS Survey, 2024

CAHPS Child Survey	2024 Statewide*
Getting Needed Care (Usually + Always)	87.9%
Getting Care Quickly (Usually + Always)	87.3%
Health Plan Customer Service (Usually + Always)	90.2%
Rating of All Health Care (9 + 10)	75.0%
Rating of Health Plan (9 + 10)	77.3%
CAHPS Adult Survey	**2024 Statewide***
Getting Needed Care (Usually + Always)	85.7%
Getting Care Quickly (Usually + Always)	85.1%
Health Plan Customer Service (Usually + Always)	88.8%
Rating of All Health Care (9 + 10)	53.7%
Rating of Health Plan (9 + 10)	61.5%
*These performance metrics include UnitedHealthcare, Nebraska Total Care, and Molina Healthcare of Nebraska.	

Table 6. Quality Measures, 2024

Quality Metrics Maternal Health	2024
Prenatal and Postpartum Care: All Ages - Timeliness of Prenatal Care (PPC): The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP.	88.3%
Prenatal and Postpartum Care: All Ages - Postpartum Care (PPC): The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	82.5%
Quality Metrics Child	**2024**
Well-Child Visits in the First 30 Months of Life: Well-Child Visits in the First 15 Months (W30): The percentage of children who had six or more well-child visits with a primary care practitioner (PCP) during the last 15 months.	63.4%
Well-Child Visits in the First 30 Months of Life: Well-Child Visits for Age 15 Months–30 Months (W30): The percentage of children who had two or more well-child visits with a primary care practitioner (PCP) during the last 15 months.	71.3%

Quality Metrics Child	2024
Child and Adolescent Well-Care Visits (WCV): The percentage of adolescents ages 12-17 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.	58.4%
Quality Metrics Child	**2024**
Immunizations: Combo 10 in Children (CIS): The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	35.0%
Immunizations: Combo 2 in Adolescents (IMA): The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series (i.e., at least two doses) by their 13th birthday.	30.0%
Oral Evaluation, Dental Services (OEV): The percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.	49.7%*
Lead Screening in Children (LSC): The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	73.9%
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD): The percentage of children ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Initiation Phase: Beneficiaries receiving a follow-up visit with a prescribing provider within 30 days of receiving their medication.	47.5%*
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD): The percentage of children ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Continuation and Maintenance Phase: Beneficiaries who continue taking ADHD medication during the nine months after the initiation phase and receiving two additional follow up visits within those nine months.	51.1%*

Quality Metrics Adult	2024
Controlling High Blood Pressure (CBP): The percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	59.9%
Glycemic Status Assessment for Patients with Diabetes (GSD): The percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at <8.0%.	50.3%
Breast Cancer Screening (BCS): The percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer.	53.0%

Quality Metrics Adult	2024
Follow-Up After Hospitalization for Mental Illness - Total Ages 6 and Older (FUH): The percentage of discharges for beneficiaries age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. 30 Day Follow-Up	64.8%
Follow-Up After Emergency Department Visit for Mental Illness - Total Ages 6 and Older (FUM): The percentage of emergency department (ED) visits for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. 30 Day Follow-Up	59.0%
Plan All-Cause Readmissions: Observed Readmission Rate (PCR): For beneficiaries ages 18 to 64, the rate of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	9.9%*
*Due to some measure criteria involving a continuous enrollment requirement or a lookback period ranging prior to January 1, 2024, Molina Healthcare of Nebraska was unable to report these measures.	

Providers

MLTC makes at-risk per member per month capitation payments to the MCOs. The MCOs leverage provider and value-based contracts to deliver health care to Medicaid beneficiaries.

In October 2025, there were 69,649 Medicaid providers, accounting for both in and out-of-state providers. Provider details, including the type of practice and number of in-state and out-of-state providers are noted in Appendix 7.

The Nebraska Medicaid program uses different methodologies to reimburse for Medicaid services via FFS:

- Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule;
- Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee;
- Inpatient hospital services are reimbursed based on a prospective system using either a

diagnosis-related group (DRG) or per diem rate;
- Critical access hospitals (CAH) are reimbursed on a per diem based on a reasonable cost of providing services;
- Federally qualified health centers (FQHCs) are reimbursed via the alternative payment methodology;
- Rural health clinics (RHCs) are reimbursed their cost directly or at a prospective rate depending on whether they are independent or provider-based;
- Outpatient hospital reimbursement is based either on a prospective system using Enhanced Ambulatory Patient Groups (EAPGs) or on a percentage of the submitted charges;
- Nursing facilities are reimbursed at a daily rate based on appropriations and relative facility cost, beneficiary level of care, and quality of care;
- Intermediate care facilities for persons with developmental disabilities (ICF/DDs) are reimbursed on a per diem rate based on a cost model; and
- HCBSs, including assisted living costs, are reimbursed at reasonable fees as determined by Medicaid.

As specified in Table 7 below, Medicaid rates across-the-board remained unchanged in FY24-25 and did not receive an increase. In FY25-26, rates across-the-board also remain the same and will see no increase.

Each MCO must have an adequate provider network and may negotiate reimbursement rates with providers in its network.

Table 7. Nebraska Medicaid Rate Changes

SFY	Rate Increase
2013	Rates increased to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013.
2014	Rates increased to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014.
2015	Rates increased to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased to 2% to a maximum of 100% of Medicare rates.
2016	Rates increased to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased to 2% to a maximum of 100% of Medicare rates.
2017	Rates increased to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF/DD providers. Other Medicaid services rates increased to 2% to a maximum of 100% of Medicare rates.
2018	No rate changes were implemented.
2019	No rate changes were implemented.
2020	Rates for Medicaid services increased by 2.0%. Rates for Behavioral Health services received an additional 2.0% increase. Nursing Facilities received a specified appropriation increase of $21.25 Million for increasing rates and utilization changes.
2021	Rates for Medicaid services increased by 2.0% Rates for Behavioral Health services received an additional 2.0% increase. Nursing Facilities also received a specified appropriation increase of $14.45 million for increasing rates and utilization changes.

2022	Rates for Medicaid services increased by 2.0% Nursing Facilities also received a specified appropriation increase of $12.28 Million for increasing rates and utilization changes.
2023	Rates for the majority Medicaid services increased by 2.0%. Rates for Dental services increased by 10%. Rates for Behavioral Health services increased by 17%. Nursing Facilities also received a specified appropriation increase of $73.19 Million for increasing rates and utilization changes.
2024	Rates for Medicaid services increased by 3.0%
2025	No rate changes were implemented.
2026	No rate changes were implemented.

Vendor Expenditures

Federal and state governments finance Medicaid and CHIP jointly, with the federal government matching state spending at a rate known as the Federal Medical Assistance Percentage (FMAP). FMAP is based on each state's per capita income relative to the national average and is highest in poorer states, varying from 52.5 percent to 82.86 percent. Nebraska's FMAP in federal fiscal year (FFY) 2025 was 57.52 percent for Medicaid and 70.26 percent for CHIP. For the upcoming FFY26, Nebraska's FMAP will be 55.94 percent for Medicaid and 68.05 percent for CHIP. Table 8 shows the FMAP for Medicaid and CHIP for FFY16 through FFY26.

Table 8. Nebraska FMAP Rates

Federal Fiscal Year	Medicaid FMAP	CHIP FMAP
FFY16	51.16%	88.81%
FFY17	51.85%	89.30%
FFY18	52.55%	89.79%
FFY19	52.58%	89.81%
FFY20	54.72%	79.80%
FFY21	56.47%	69.53%
FFY22	57.80%	70.46%
FFY23	57.87%	70.51%
FFY24	58.60%	71.02%
FFY25	57.52%	70.26%
FFY26	55.94%	68.05%

Total SFY25 vendor payments for Medicaid and CHIP expenditures were $4,017,254,261. This includes the cost of drugs, inpatient and outpatient hospital care, payments to physicians and practitioners, and early and periodic screening, diagnostic, and treatment (EPSDT). A&D Waiver includes $409,551,107 expenditures, a 24.49 percent increase from SFY24. These expenditures include payments to vendors only; no adjustments, refunds, or certain payments for premiums or services paid outside of the Medicaid Payment System (MMIS) or N-FOCUS.

Appendix 8 shows the expenditure distribution to vendors arranged by service type.

Not all Medicaid and CHIP expenditures have been detailed in Appendix 8. Several other transactions are highlighted below:

- Drug rebates are reimbursements by pharmaceutical companies to Medicaid and CHIP that reduce individual drug costs to a more competitive or similar price offered to other large drug payers, such as insurance companies. In SFY25, Medicaid received $365.4 million in drug rebates, a 3.50 percent decrease from the $378.7 million in rebates received in SFY24;
- Disproportionate share hospital (DSH) payments are additional payments to hospitals serving many Medicaid and uninsured patients. In SFY25, Medicaid paid $202.7 million through the DSH program, a 1.48 percent decrease compared to $205.7 million paid in SFY24;
- Medicaid pays the Medicare Part B premium for beneficiaries that are dually eligible for Medicare and Medicaid. In SFY25, Medicaid paid $80.8 million for Medicare premiums, a 4.57 percent increase from the $77.2 million for Medicare premiums paid in SFY24; and
- Medicare Part D Phased-Down state contributions ("clawback") are required monthly payments to CMS for each person dually eligible for Medicare and Medicaid. Funding for this comes entirely from state general funds, and is meant to cover part of the savings to the Medicaid program for prescription drug costs that Medicare pays for dually eligible individuals enrolled in Part D. In SFY25, clawback payments totaled $86.7 million, a 3.44 percent increase from the $83.9 million paid in SFY24. The clawback payment amount per person is based on a complex formula that takes into account the cost of drugs and the federal matching rate.

As noted in Appendix 8, most of MLTC's expenditure comes in the form of capitation payments for managed care. Appendices 9 and 10 note the relative cost of services covered via capitated managed care.

Appendix 11 compares vendor expenditures from SFY24 and SFY25.

Long-Term Care Services

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY25, Medicaid expenditures for LTC services totaled $1.49 billion, an increase of 10.49 percent from $1.36 billion in SFY24. These services are tailored to multiple levels of beneficiary needs, ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings, from an individual's home to small group settings with community support or nursing facilities. Home and community-based care is generally less expensive and offers greater independence for the consumer than facility-based care.

For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care. Efforts to promote home and community-based alternatives to facility care are resulting in a gradual rebalancing of LTC expenditures.

Table 9 below defines the LTC service categories. Appendix 12 shows the cost of Medicaid expenditures for LTC services.

Table 9. Definitions of Long-Term Care Service Expenditure Categories

Category	Definition
Nursing Facility	Payment made to nursing facility services for aged and disabled Medicaid-eligible beneficiaries.

Category	Definition
ICF-DD	Payment made to intermediate care facility services for intellectually and developmentally disabled Medicaid-eligible beneficiaries.
DD Waivers	Payment made for an array of home and community-based services for intellectually and developmentally disabled Medicaid-eligible beneficiaries; Medicaid offers three waivers for this population.
Home Health/Personal Assistance Services	Payment made for community-based care covered under the Medicaid State Plan to support Medicaid-eligible beneficiaries living independently in their own home.
A&D Waiver	Payment made for an array of home and community-based services for aged and disabled Medicaid-eligible beneficiaries to support living independently in their own home.
Waiver Assisted Living	Payment made for the assisted living service within the Aged and Disabled waiver, payment allows beneficiaries to continue living in the community rather than in a nursing facility. This includes services provided through the TBI waiver.

Highlights and Accomplishments

Beneficiary Advisory Committee (BAC)

MLTC worked throughout SFY25 to establish Nebraska's Beneficiary Advisory Committee (BAC), with the first official meeting scheduled for July 2025. The BAC consists of current and former Medicaid beneficiaries as well as caregivers and family members of beneficiaries. The purpose of the committee is for beneficiaries to share their lived experience and provide input on policies and processes to increase health equity through access to and quality of services.

Through targeted outreach efforts across the state, MLTC recruited a wide pool of applicants and selected a committee of 10 individuals that represent a diverse range of geographic locations, Medicaid groups, ages, and backgrounds. A portion of BAC members will also serve on the existing Medicaid Advisory Committee (MAC), which includes Medicaid beneficiaries, Medicaid providers, DHHS representatives (as non-voting members), a community-based organization representative, and an MCO representative.

To combat economic and geographic barriers to participation, MLTC established a compensation process that allows qualifying MAC and BAC members to be paid hourly for their time spent at meetings and reimbursed for travel and accommodation expenses.

Tribal Health Outreach

MLTC is committed to fostering a collaborative relationship with Nebraska's Tribal members and providers. DHHS and MLTC host monthly calls and quarterly consultations with Tribal partners.

Through these communications, MLTC worked with Tribal providers and stakeholders to establish guidance for providing specific services such as dentures and other dental services, interim services, and non-emergency medical services (NEMT). DHHS also established data sharing agreements with the Tribes in Nebraska to leverage partnerships with the Tribes. These data sharing agreements help ensure up-to-date beneficiary information and continuity of coverage for Tribal Medicaid beneficiaries.

Additionally, MLTC worked with Tribal providers, the MCOs, and stakeholders to operationalize changes to federal policy to allow for coverage and reimbursement of services provided outside of Tribal clinics – also known as the "Four Walls Rule."

Understanding that the Tribes each possess their own unique set of needs for health care delivery, MLTC worked with other DHHS divisional Tribal liaisons to begin an ongoing series of one-on-one Tribal consultation meetings with each of the Tribes in Nebraska. At the consultations, DHHS representatives and Tribal liaisons meet with representatives from individual Tribes to listen to their priorities and identify strategies to support Tribal health care access. The first consultation took place from May 28 through May 29, 2025, with the Winnebago Tribe of Nebraska.

Centralized Provider Credentialing

During SFY25, DHHS's contracts with the Heritage Health MCOs streamlined the way that the MCOs provide credentialing services for providers. Nebraska Medicaid providers now undergo a single credentialing process to enroll with all three MCOs – Molina Healthcare, Nebraska Total Care, and UnitedHealthcare – making it easier for providers to enroll with Nebraska Medicaid.

The Heritage Health MCOs have contracted with Verisys to establish the centralized credentialing process. Providers now must only submit one credentialing application for all MCOs, reducing time spent on applications. The process also streamlines communication between the MCOs and providers during the credentialing process, with Verisys acting as an intermediary. Verisys follows up with providers on incomplete applications, reaching out to the provider to obtain any additional materials needed.

Hospital Directed Payment Program

In accordance with LB1087, signed into law on March 27, 2024, and the associated Nebraska Revised Statute §§ 68-2101 to 68-2109, the Hospital Quality Assurance and Access Assessment Act allows Nebraska to receive additional federal Medicaid dollars through the Hospital Directed Payment Program.

The initial period of the program was approved by the CMS on June 27, 2025. DHHS estimates that because of this program, Nebraska hospitals will receive nearly $3.3 billion in additional revenue through calendar year 2027.

The program will benefit Nebraskans by increasing health care access, strengthening rural hospitals, improving mental health care support, and increasing employment opportunities for health care professionals.

SUD Waiver Renewal

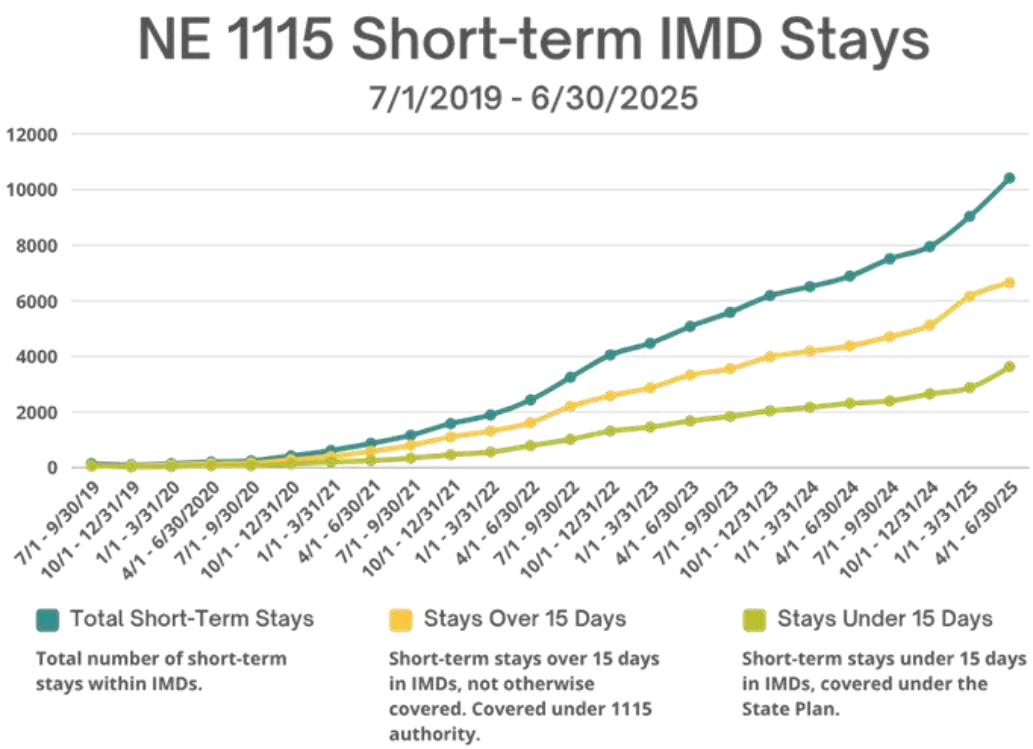
DHHS submitted the Nebraska Section 1115 Substance Use Disorder (SUD) Demonstration Waiver Renewal application to CMS on June 30, 2023. The 1115 SUD demonstration waiver, effective July 1, 2019, provides DHHS with the authority to receive federal Medicaid financial participation (FFP) for the

coverage of SUD treatment-related stays in Institutions for Mental Diseases (IMDs) for adults ages 21-64. More specifically, the authority allows the state the flexibility to include in managed care capitation rate development IMD stays that exceed the 15-day limit found in 42 CFR 438.6(e). DHHS requested renewal of the waiver for an additional five (5) year period, July 1, 2024, through June 30, 2029.

On June 17, 2024, DHHS received a one-year temporary extension to the 1115 SUD Demonstration Waiver, extending the initial waiver period an additional year, July 1, 2024, through June 30, 2025.

On June 25, 2025, DHHS received the five-year approval, extending the Nebraska Substance Use Disorder Program from July 1, 2025, through June 30, 2030. DHHS did not request any changes to the waiver authority in the application and does not expect to make any changes to the SUD demonstration program at this time.

As of June 30, 2025, Nebraska Medicaid has been able to cover 6,650 IMD stays not otherwise covered without the 1115 SUD waiver, which has brought services at the appropriate level of care to 4,881 Medicaid beneficiaries.



Conclusion

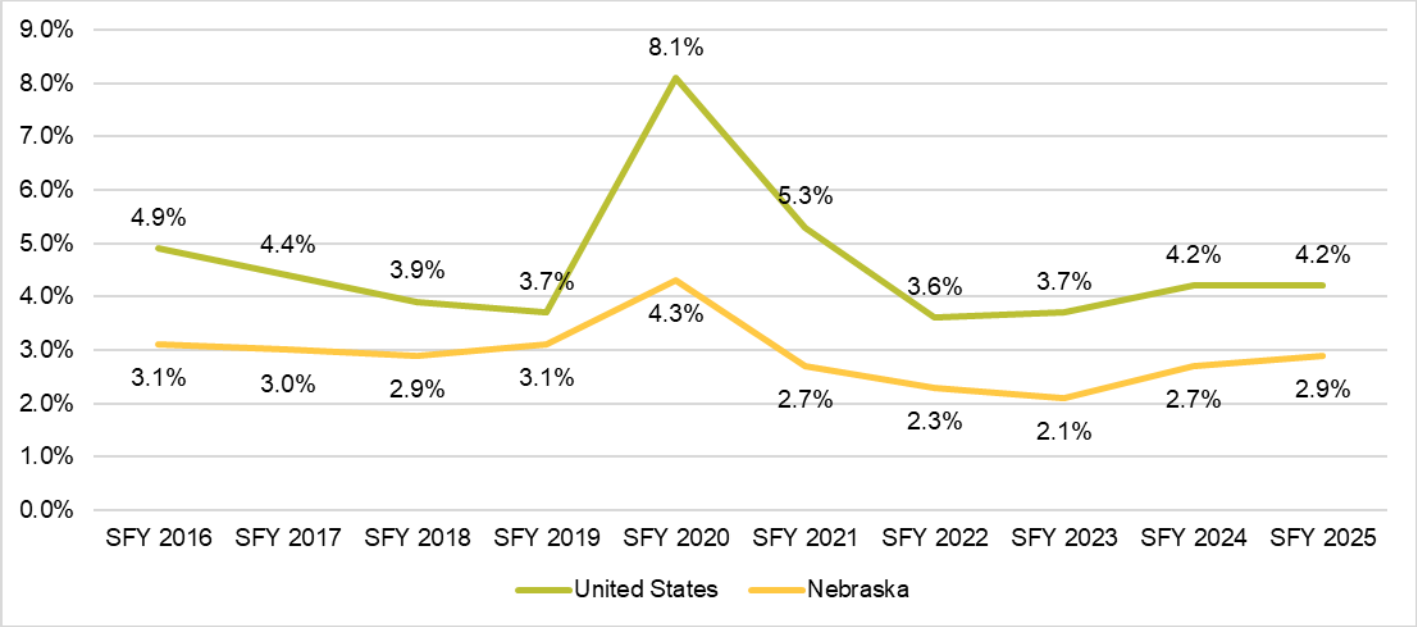
MLTC is committed to supporting the delivery of quality health care to Nebraskans. To meet this commitment to all of Medicaid's stakeholders, including beneficiaries, providers, and taxpayers, MLTC strives to constantly improve all aspects of operations.

From a focus on beneficiary and stakeholder engagement through the BAC and Tribal consultations, to a streamlining of processes with centralized provider credentialing, MLTC positions itself strategically to constantly improve upon customer services, delivery systems, and program processes. MLTC demonstrates a purposeful effort to align the DHHS's motto of "helping people live better lives."

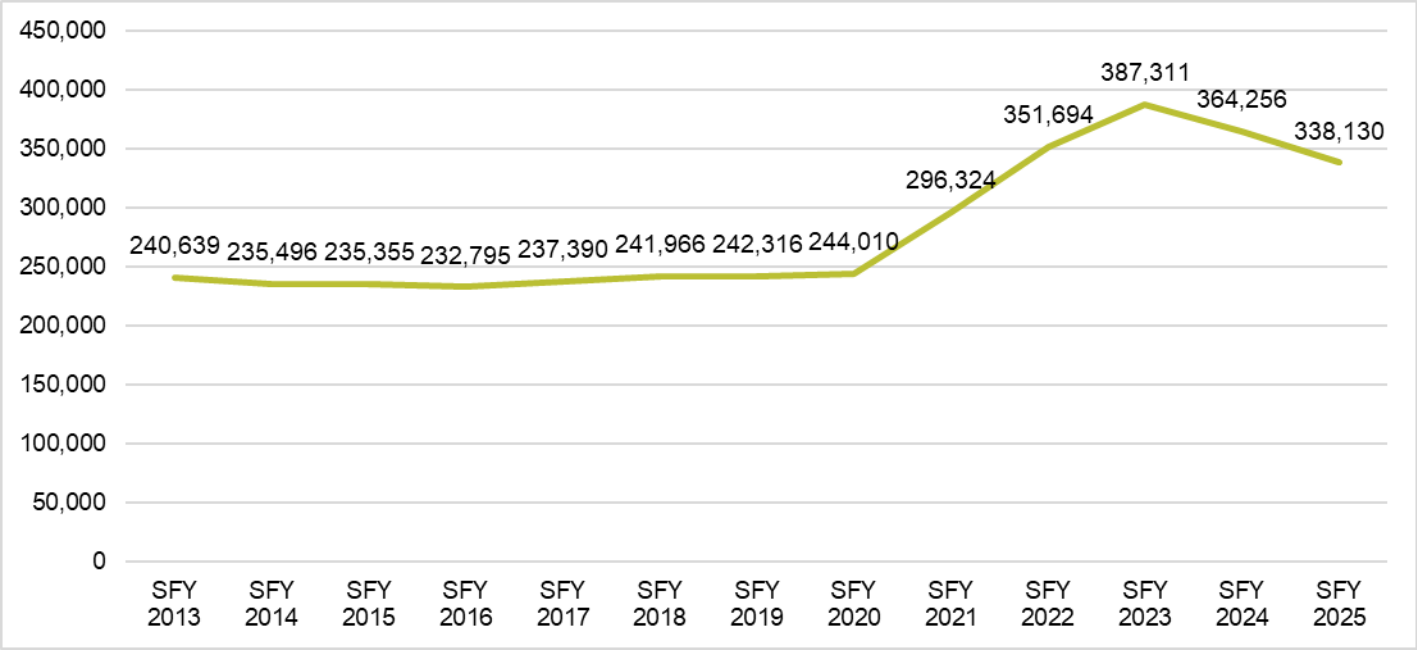
Looking forward, MLTC will continue to engage with stakeholders meaningfully to swiftly address challenges and provide the best possible heath care for Nebraskans.

Appendix

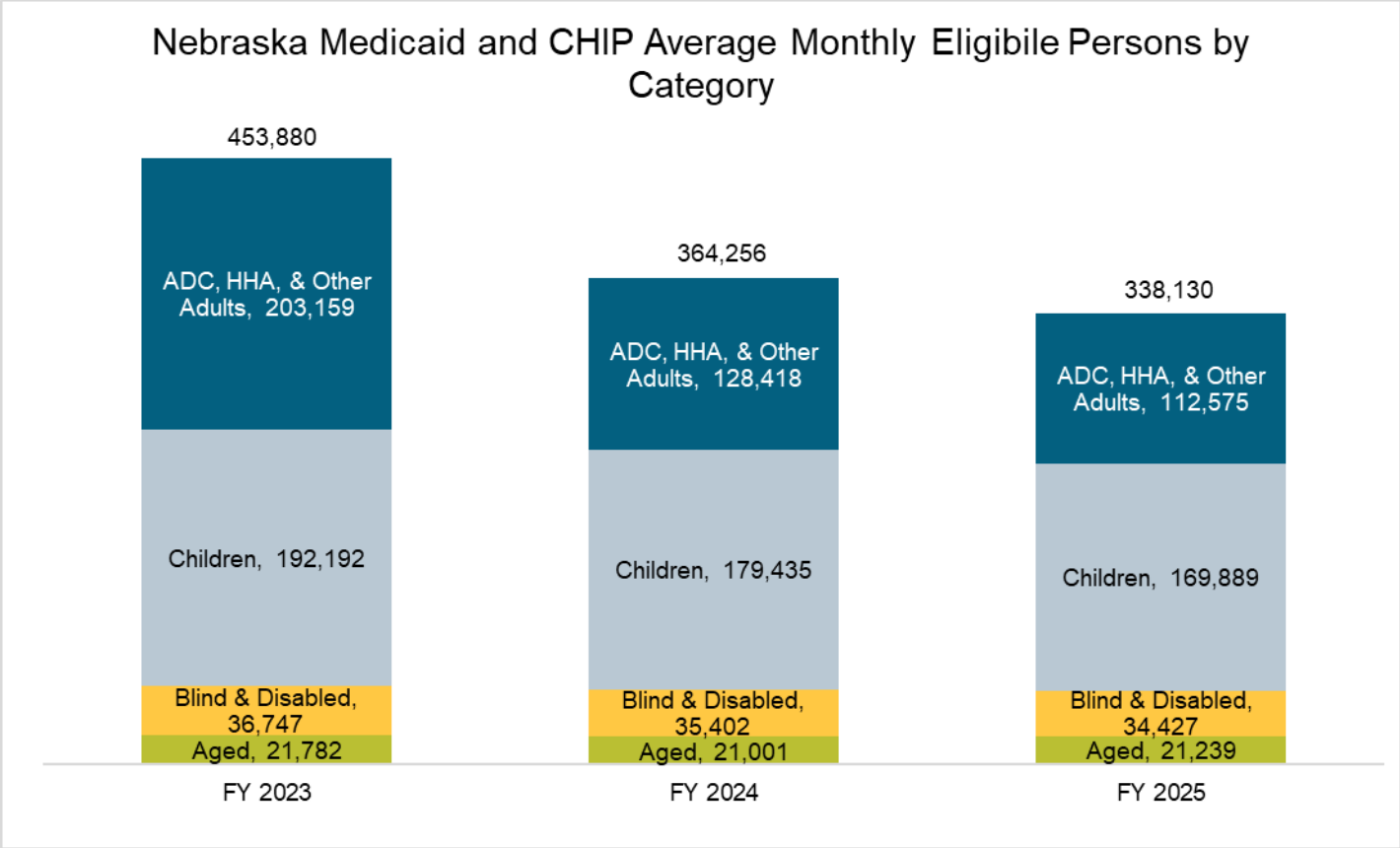
Appendix 1. Average Unemployment Levels by State Fiscal Year (SFY)



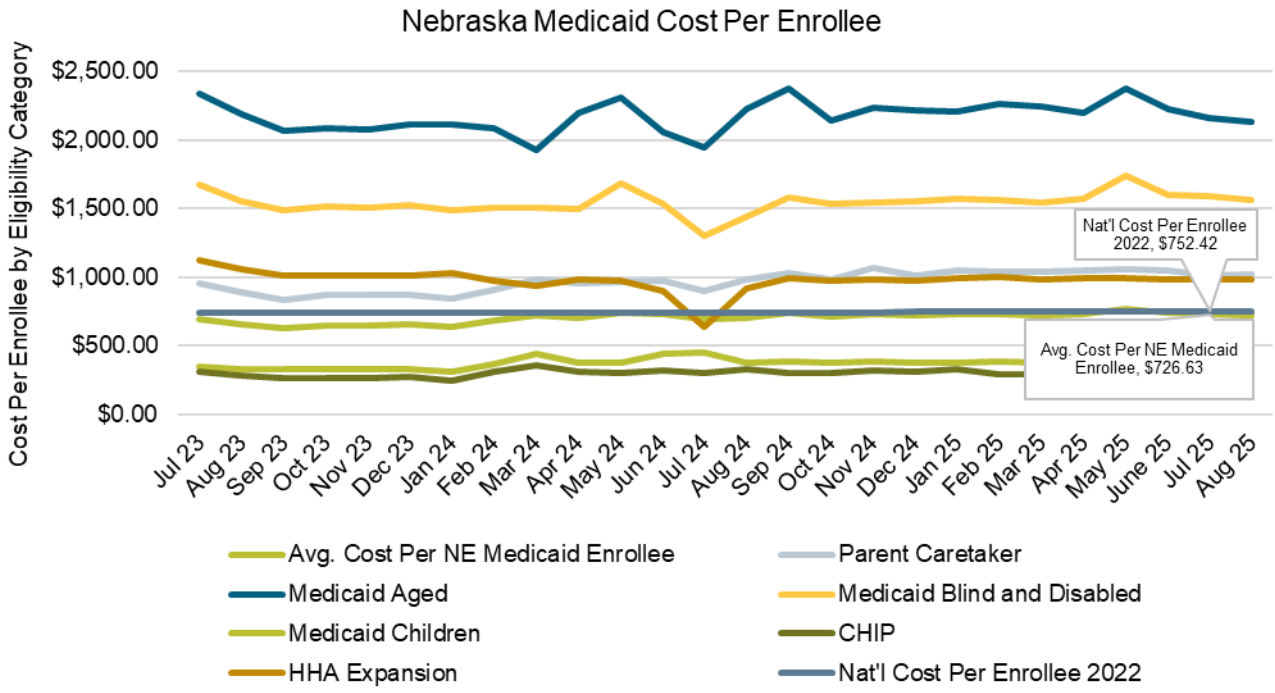
Appendix 2. Average Monthly Nebraska Medicaid Beneficiaries by State Fiscal Year (SFY)



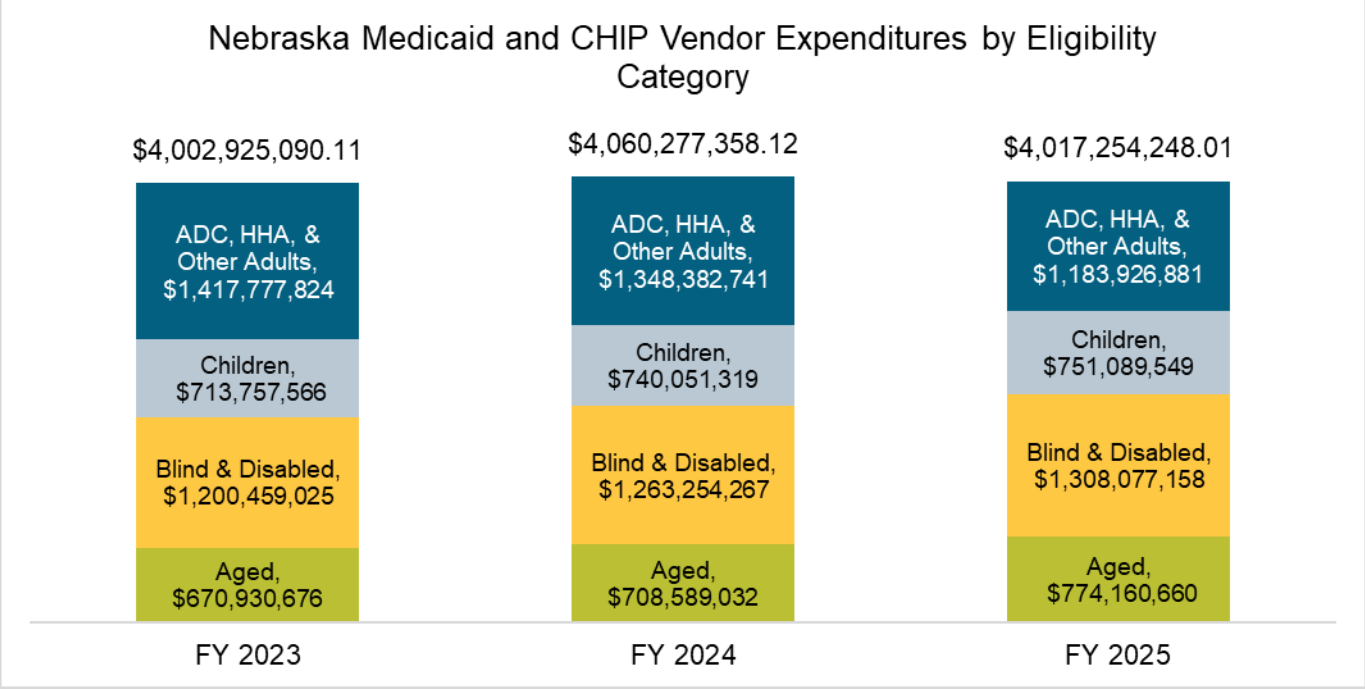
Appendix 3. Average Monthly Nebraska Enrollment for Medicaid and CHIP by Category



Appendix 4. Nebraska Medicaid Average Cost per Enrollee



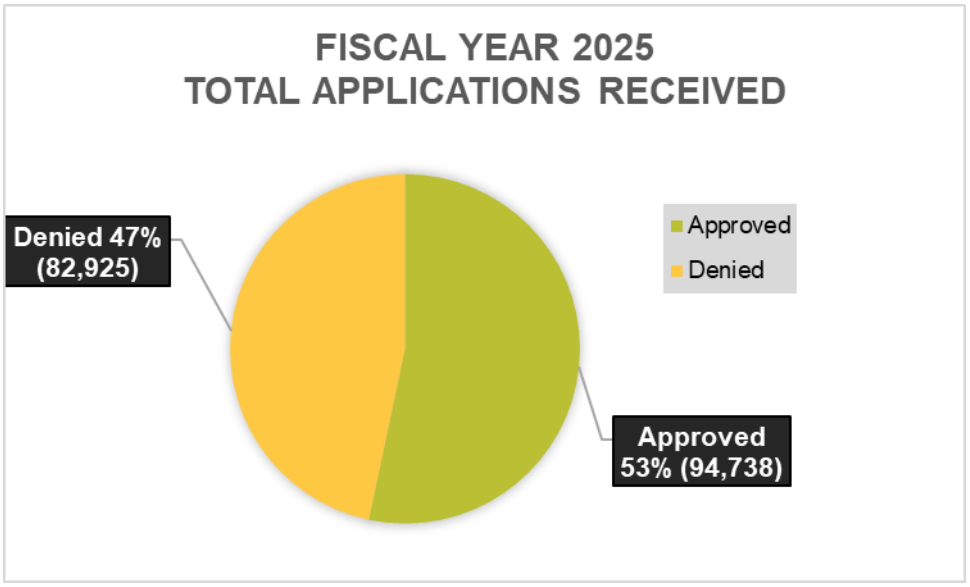
Appendix 5. Nebraska Medicaid and CHIP Annual Cost by Eligibility Category



Appendix 6. Nebraska Medicaid Annual Summary

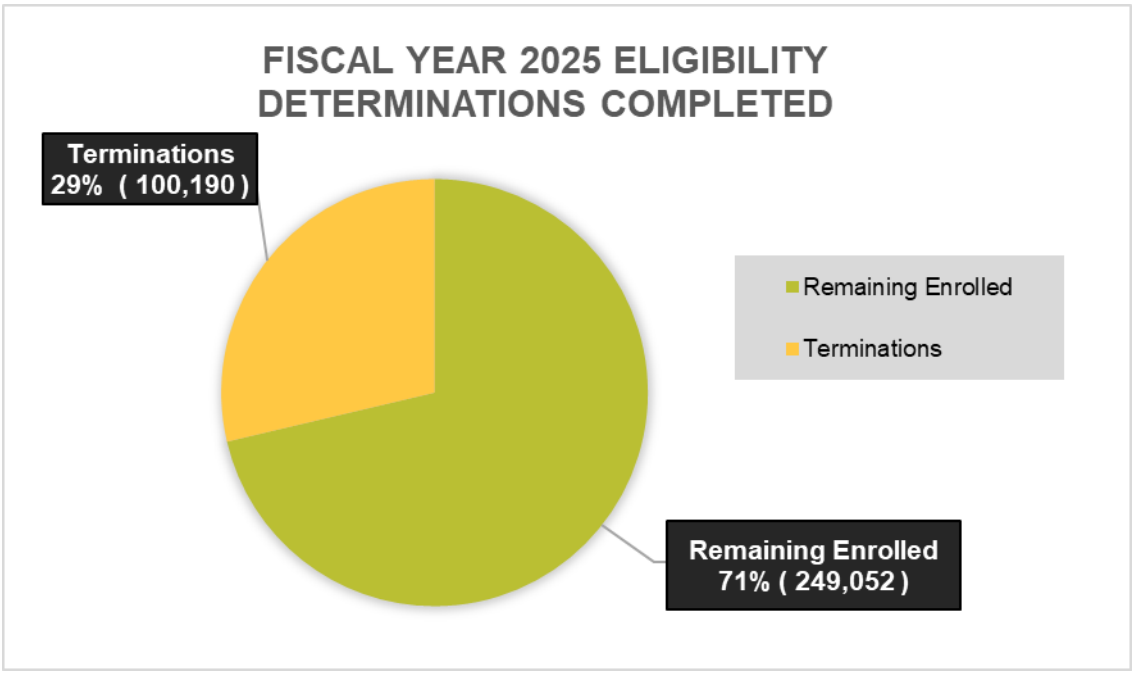
a) Applications

For SFY25, Nebraska Medicaid received a total of 177,663 initial applications, averaging 14,805 applications per month.



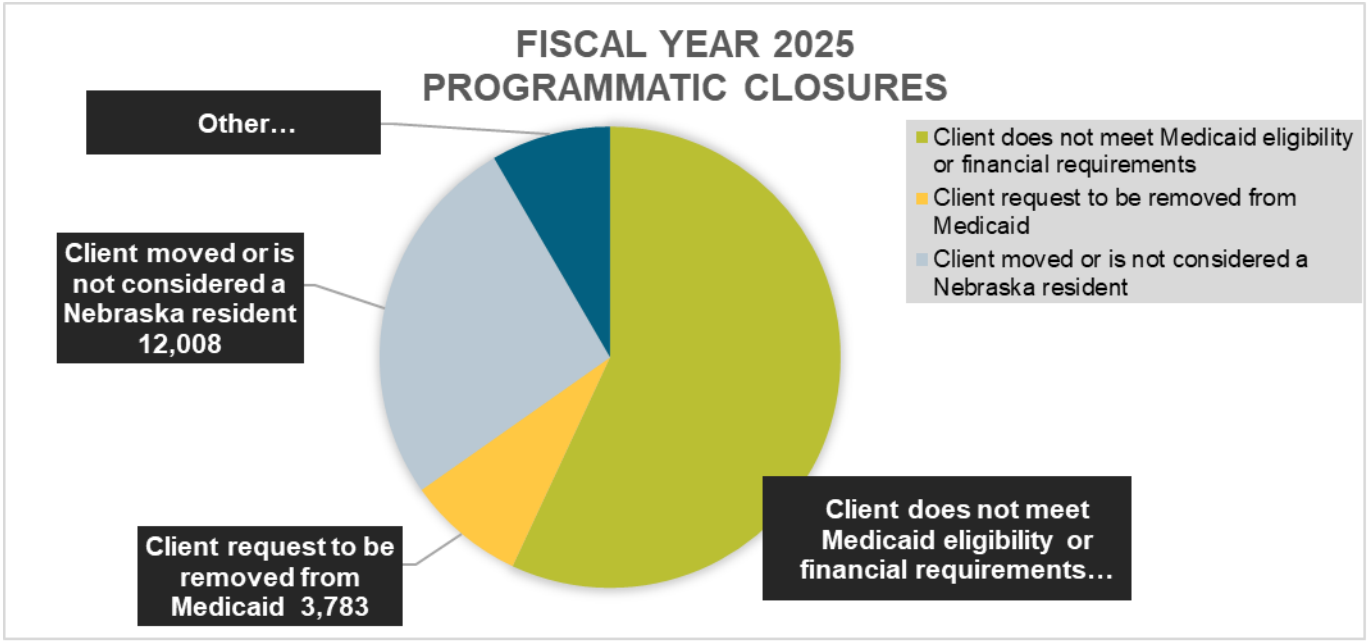
b) Eligibility Determinations (Renewals)

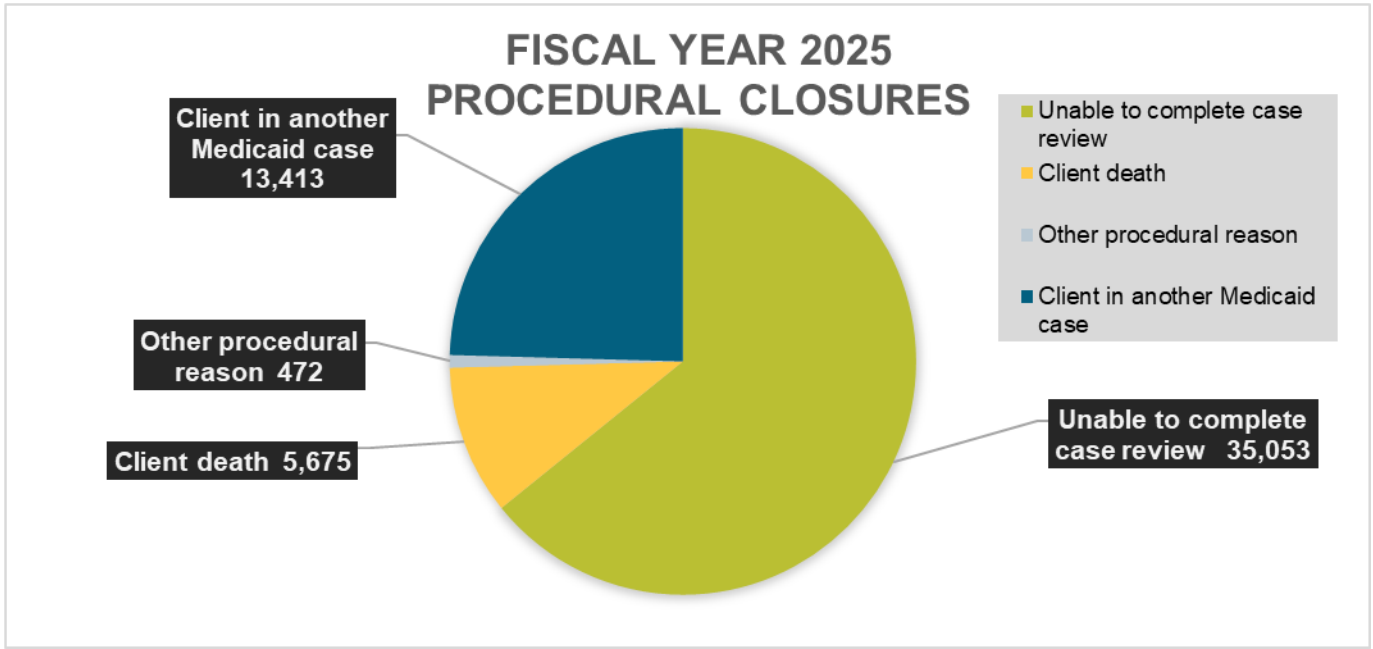
For SFY25, Nebraska Medicaid completed 349,242 eligibility determinations, also known as Medicaid renewals.

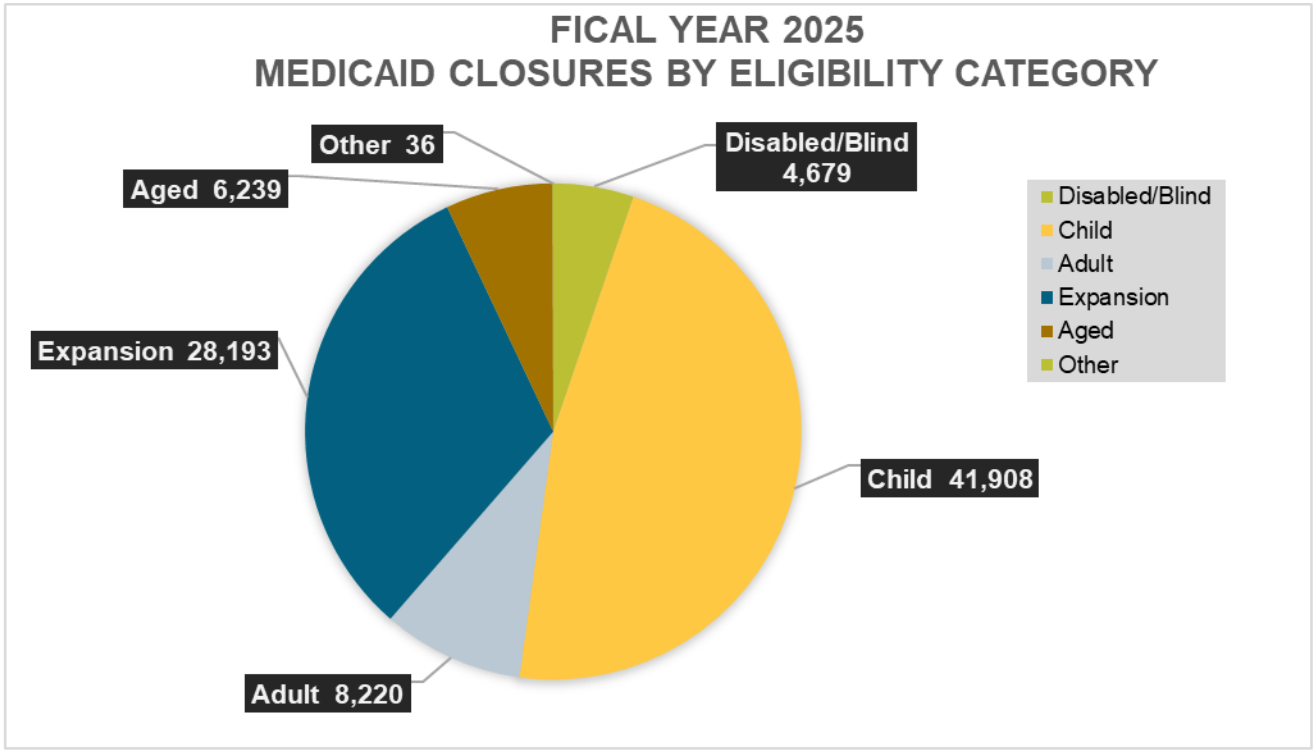


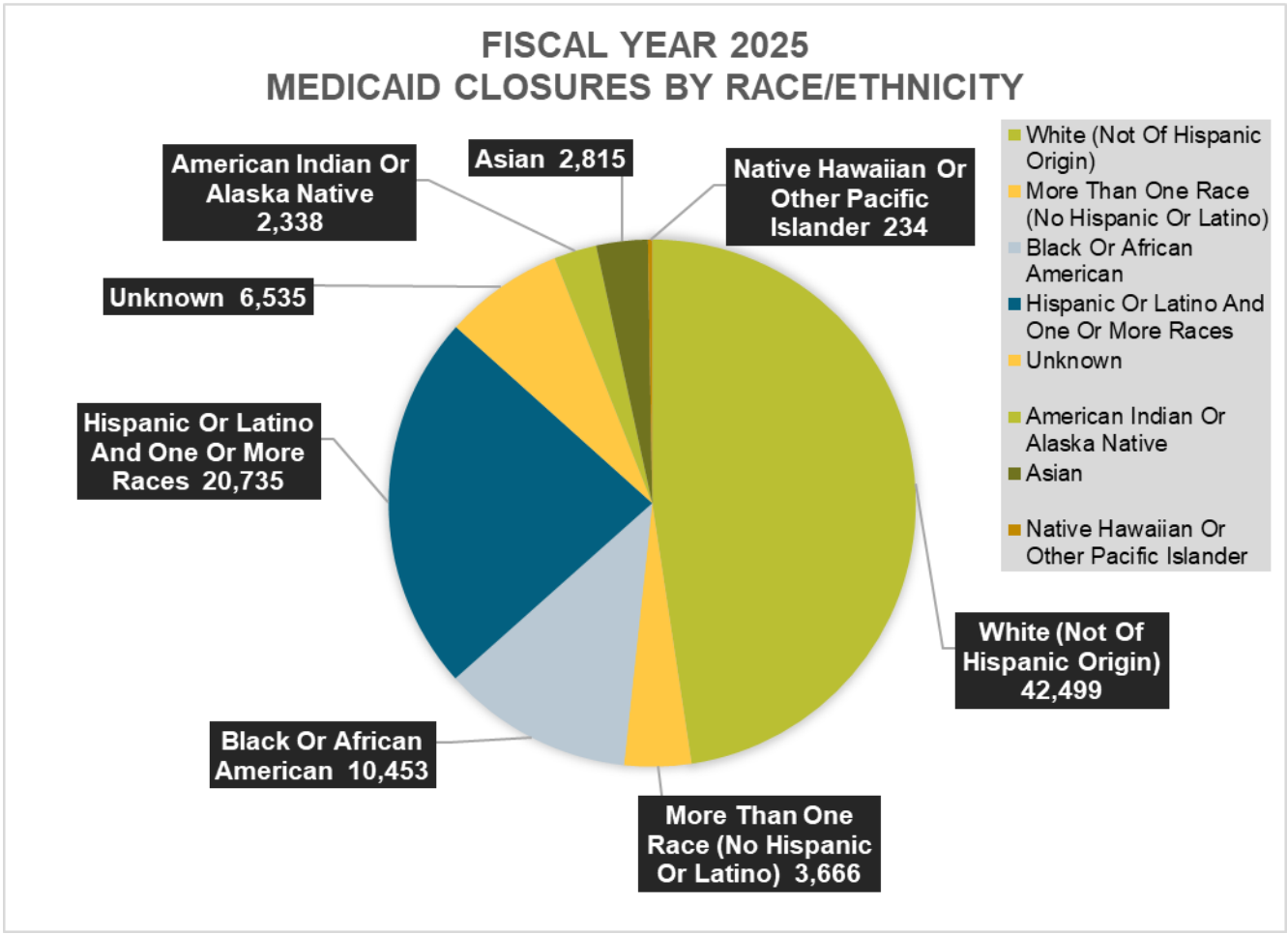
c) Case Closures

For SFY25, Nebraska Medicaid had 100,190 case closures (terminations resulting from a Medicaid renewal). 45% or 45,577 beneficiaries were closed for programmatic reasons, and 55%, or 54,613 beneficiaries, were closed for procedural reasons.
Please note that some beneficiaries had more than one termination during SFY25 and the demographic charts below reflect a distinct count of 89,275 beneficiaries.

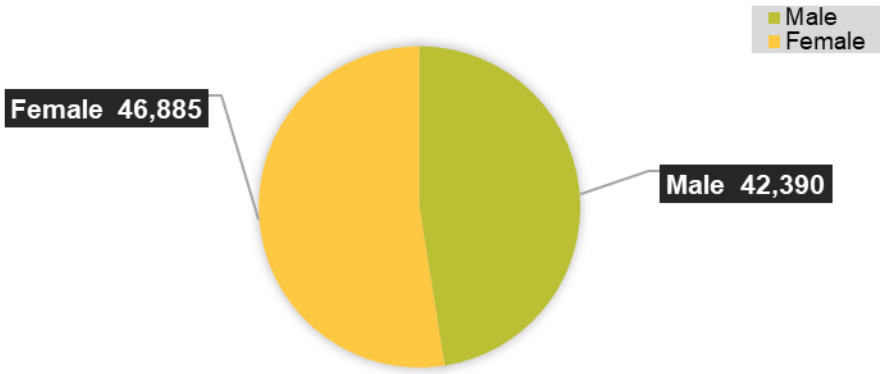




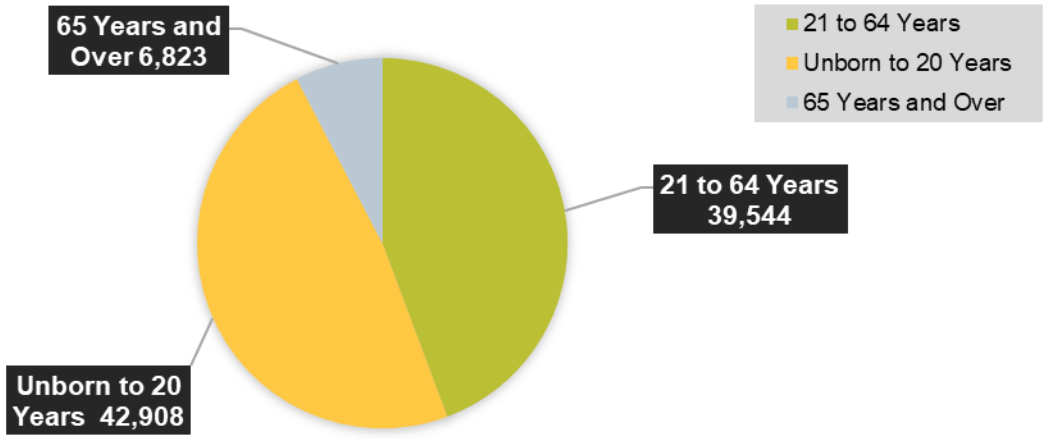

FICAL YEAR 2025
MEDICAID CLOSURES BY ELIGIBILITY CATEGORY
Other 36
Disabled/Blind 4,679
Aged 6,239
Expansion 28,193
Child 41,908
Adult 8,220
Disabled/Blind
Child
Adult
Expansion
Aged
Other


FISCAL YEAR 2025
MEDICAID CLOSURES BY RACE/ETHNICITY
American Indian Or Alaska Native 2,338
Asian 2,815
Native Hawaiian Or Other Pacific Islander 234
Unknown 6,535
Hispanic Or Latino And One Or More Races 20,735
White (Not Of Hispanic Origin) 42,499
Black Or African American 10,453
More Than One Race (No Hispanic Or Latino) 3,666
White (Not Of Hispanic Origin)
More Than One Race (No Hispanic Or Latino)
Black Or African American
Hispanic Or Latino And One Or More Races
Unknown
American Indian Or Alaska Native
Asian
Native Hawaiian Or Other Pacific Islander

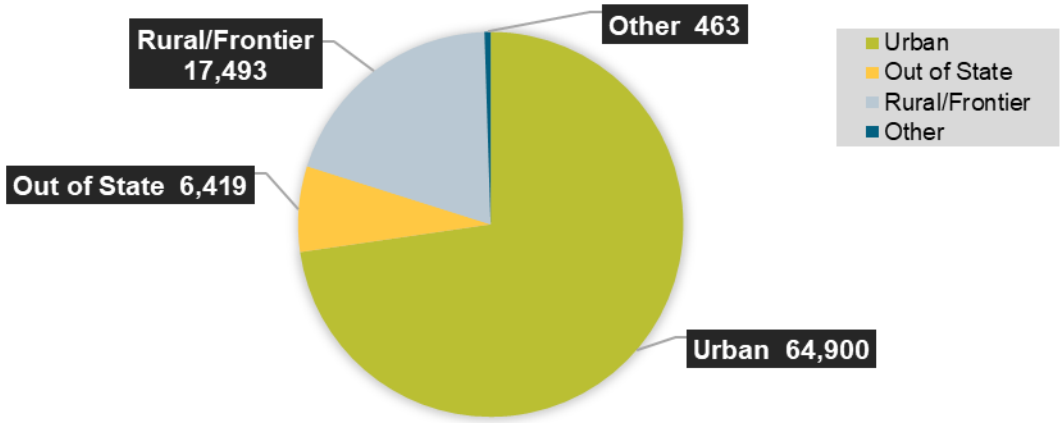
FISCAL YEAR 2025
MEDICAID CLOSURES BY SEX

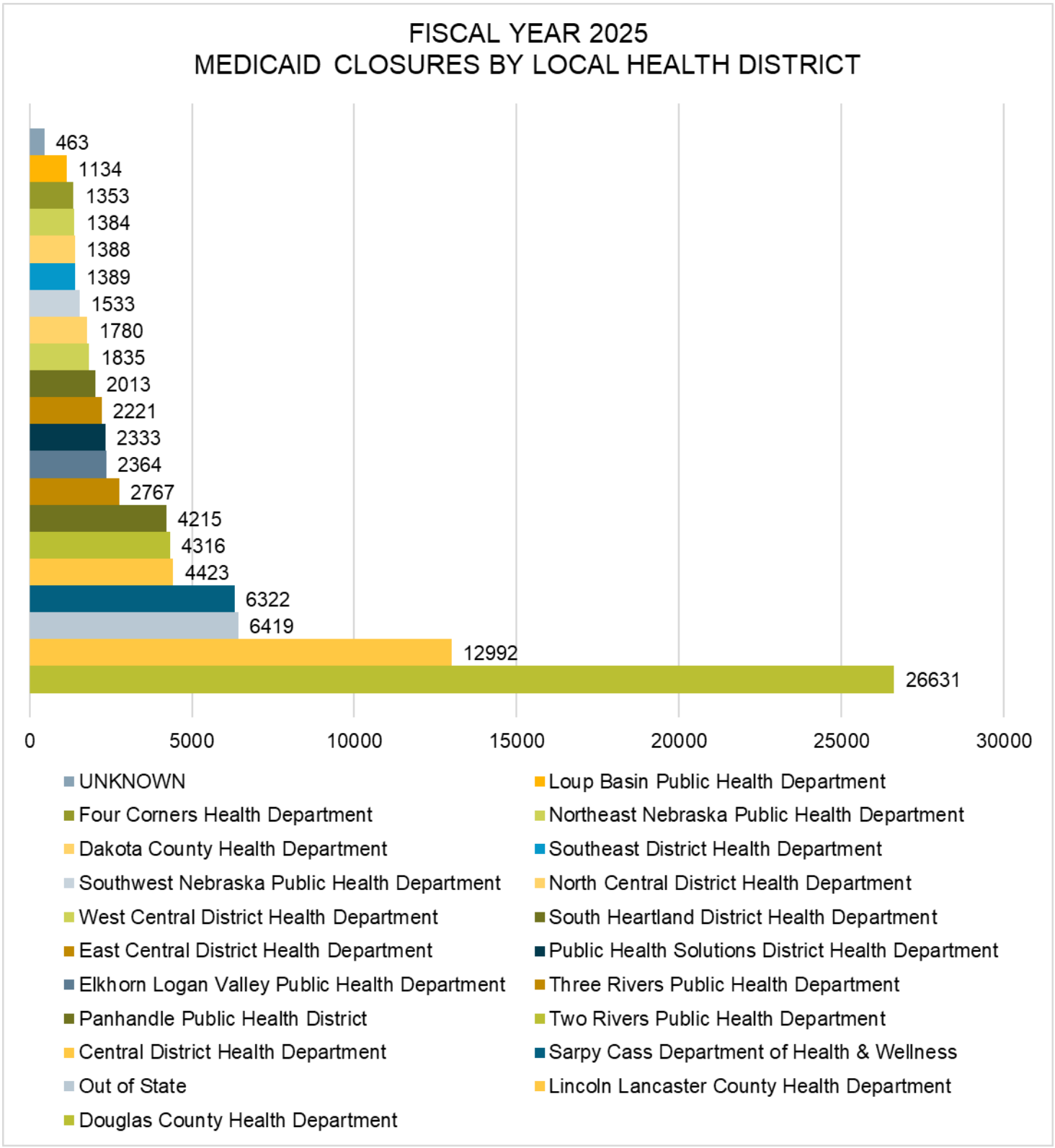


FISCAL YEAR 2025
MEDICAID CLOSURES BY AGE RANGE



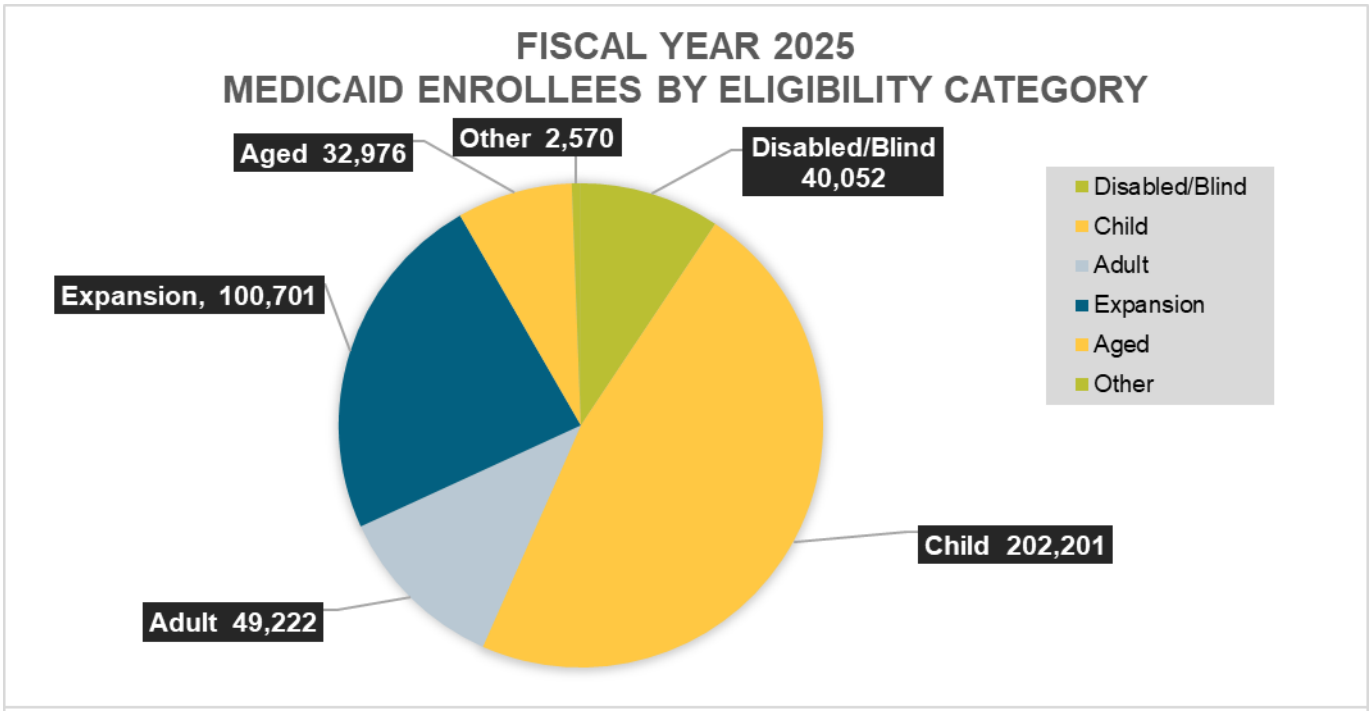
FISCAL YEAR 2025
MEDICAID CLOSURES BY COUNTY CLASSIFICATION

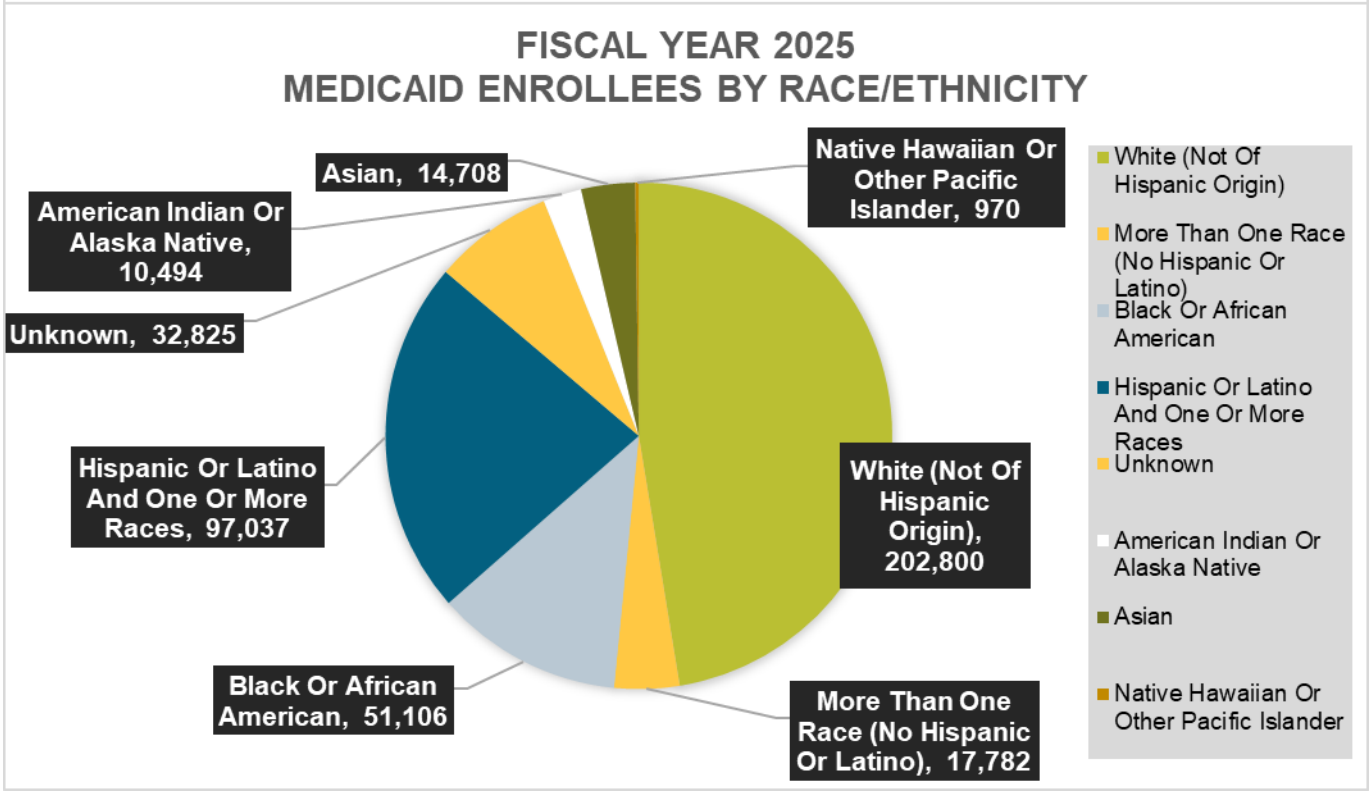



FISCAL YEAR 2025
MEDICAID CLOSURES BY LOCAL HEALTH DISTRICT
463
1134
1353
1384
1388
1389
1533
1780
1835
2013
2221
2333
2364
2767
4215
4316
4423
6322
6419
12992
26631
0
5000
10000
15000
20000
25000
30000
UNKNOWN
Loup Basin Public Health Department
Four Corners Health Department
Northeast Nebraska Public Health Department
Dakota County Health Department
Southeast District Health Department
Southwest Nebraska Public Health Department
North Central District Health Department
West Central District Health Department
South Heartland District Health Department
East Central District Health Department
Public Health Solutions District Health Department
Elkhorn Logan Valley Public Health Department
Three Rivers Public Health Department
Panhandle Public Health District
Two Rivers Public Health Department
Central District Health Department
Sarpy Cass Department of Health & Wellness
Out of State
Lincoln Lancaster County Health Department
Douglas County Health Department

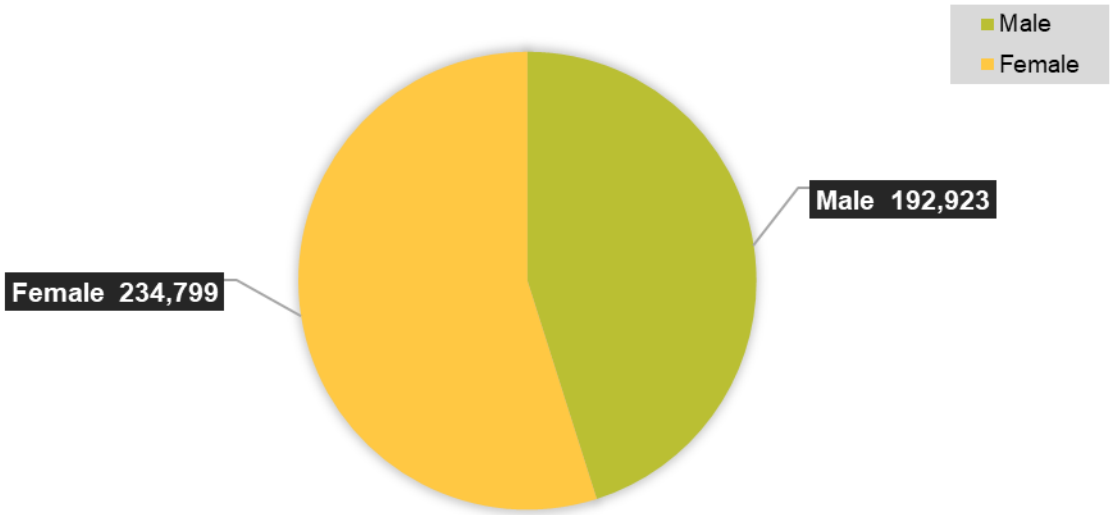
d) Enrollees

For SFY25, Nebraska Medicaid has 427,722 enrollees, representing the unique number of beneficiaries with Medicaid eligibility for at least one month between July 2024 and June 2025.

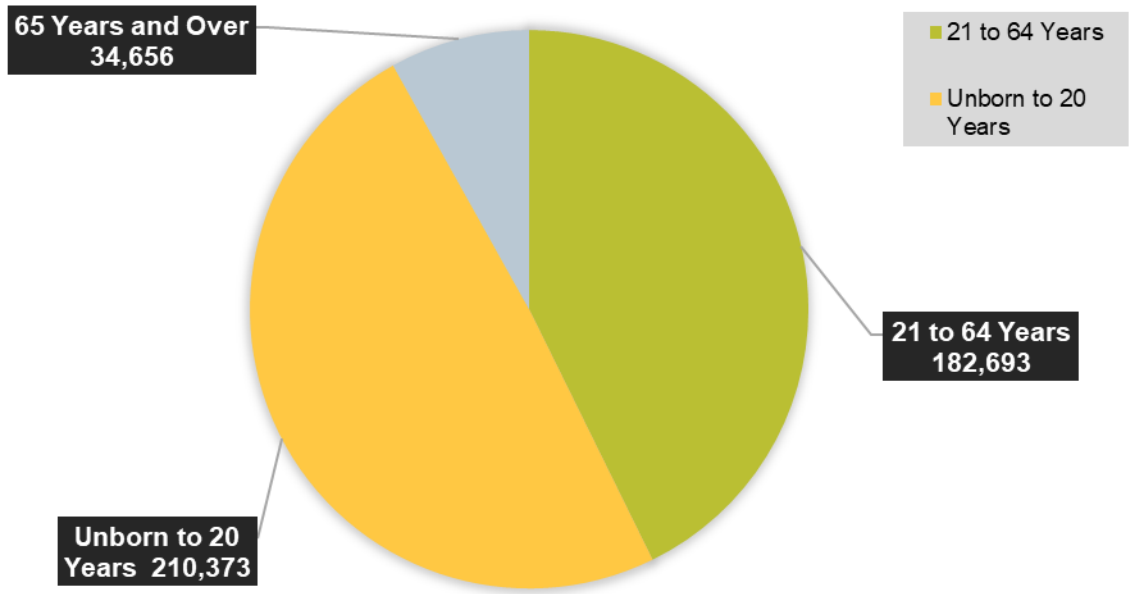


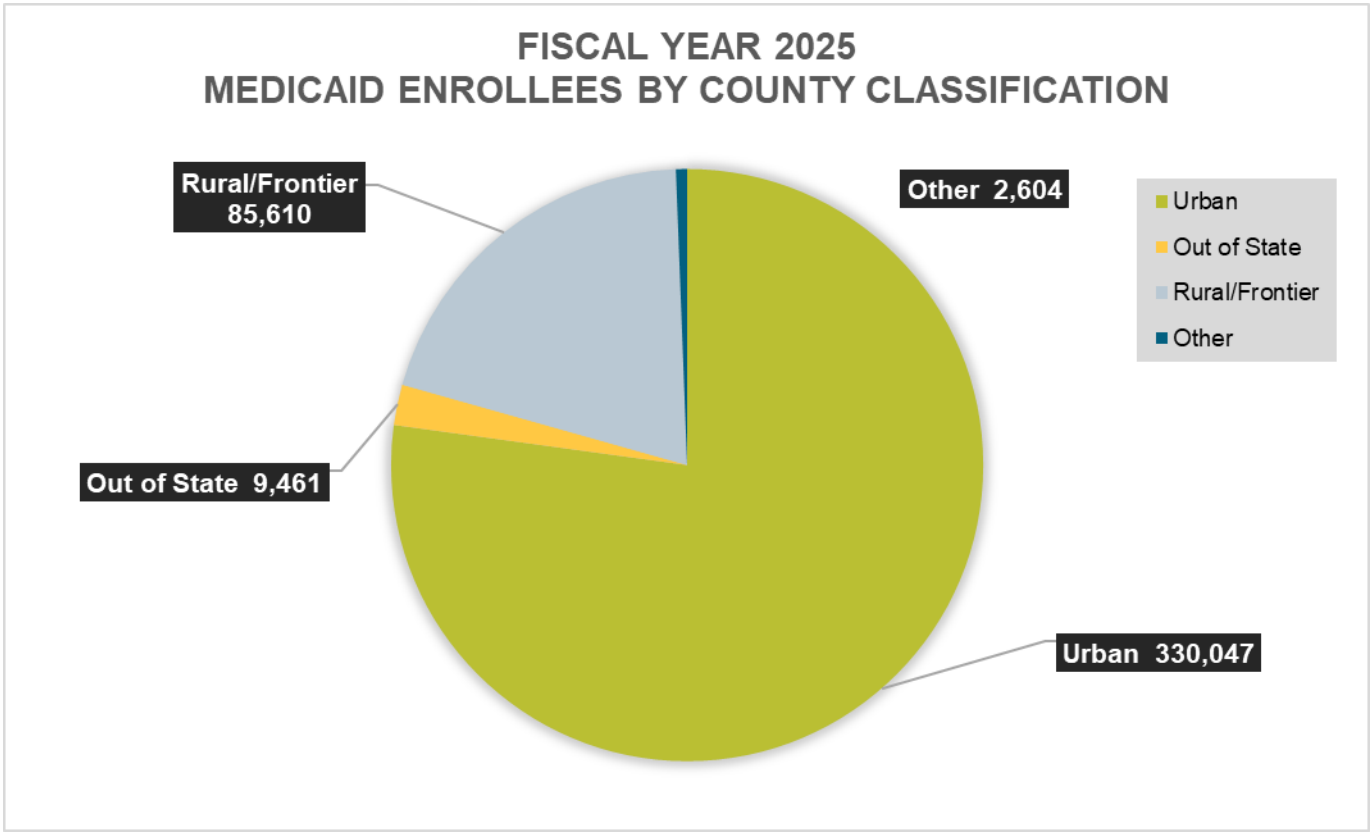


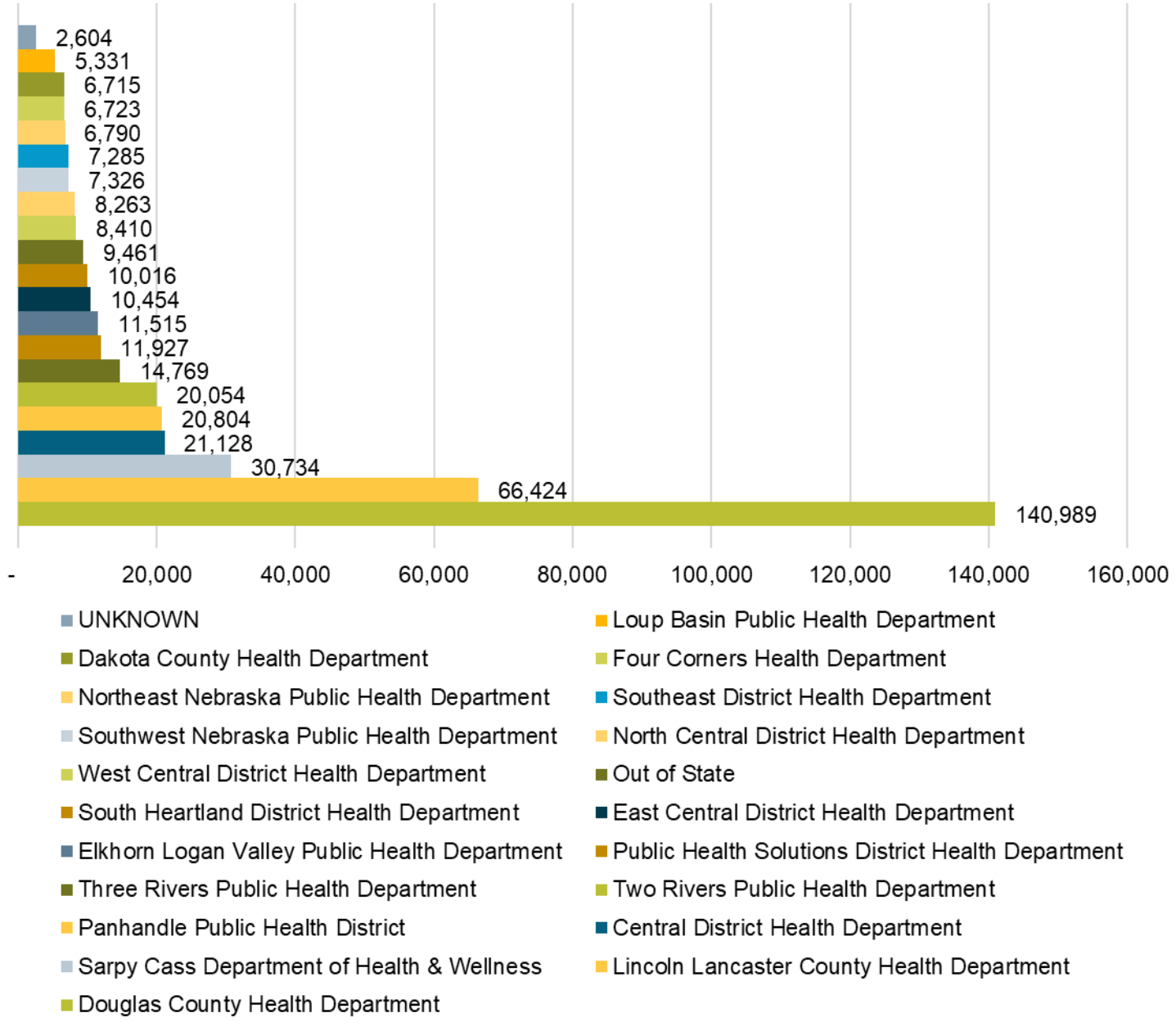
FISCAL YEAR 2025
MEDICAID ENROLLEES BY SEX



FISCAL YEAR 2025
MEDICAID ENROLLEES BY AGE RANGE




FISCAL YEAR 2025
MEDICAID ENROLLEES BY COUNTY CLASSIFICATION
Rural/Frontier
85,610
Other 2,604
Out of State 9,461
Urban 330,047
Urban
Out of State
Rural/Frontier
Other

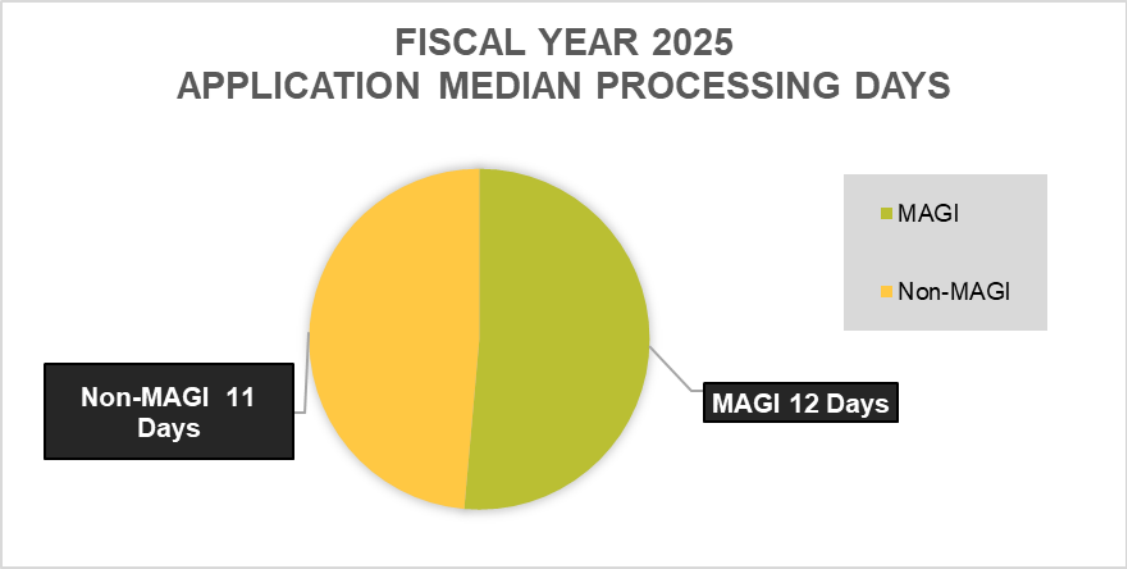


e) Ex Parte Renewals

An ex parte Medicaid renewal is a process that allows states to verify a beneficiary's Medicaid eligibility without requiring the beneficiary to submit documentation or complete a form. This is primarily done by using electronic data sources to confirm eligibility. DHHS estimates that Nebraska Medicaid had an average ex parte rate of 34% for renewals. DHHS is only able to the average ex parte rate at this time as the information captured in the Medicaid eligibility system

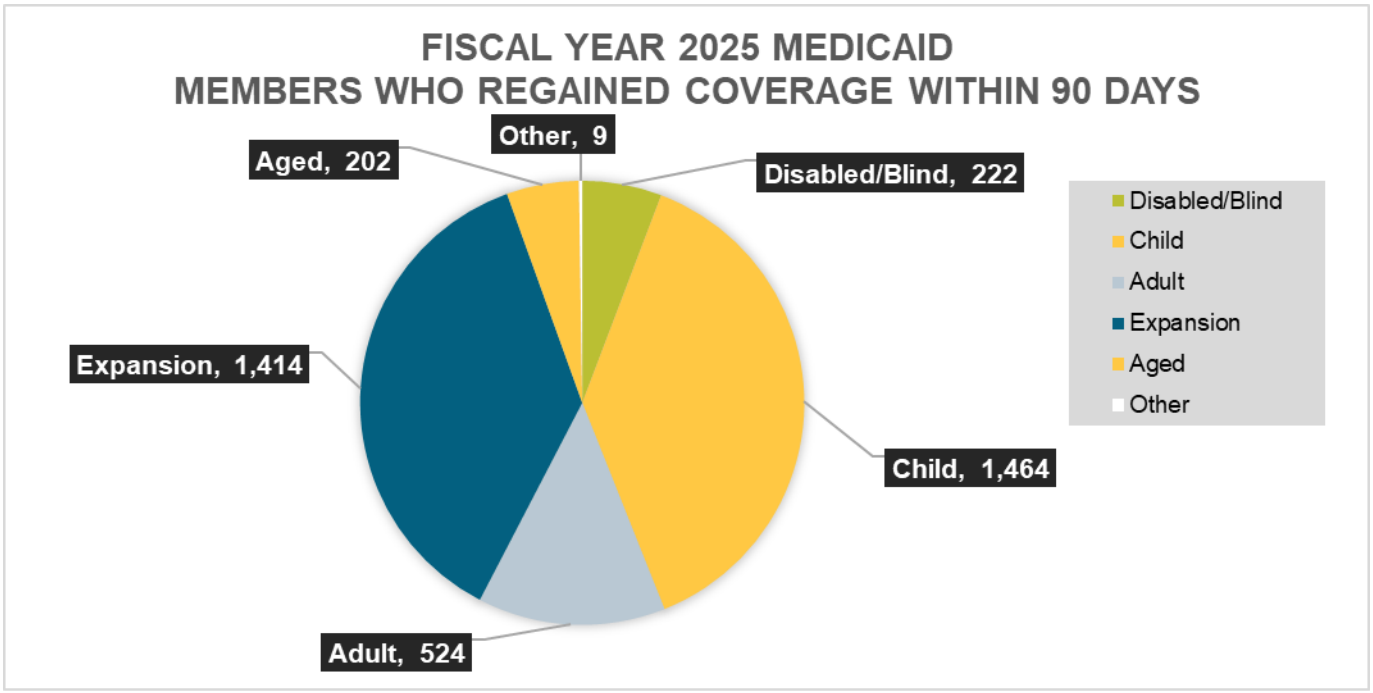
provides a proxy for whether a renewal was completed ex parte. DHHS started implementing federally required system changes to comply with ex parte requirements in August 2025 and expects to complete the system changes by the December 2026 federal deadline. DHHS will provide the requested information once the required system changes are implemented.

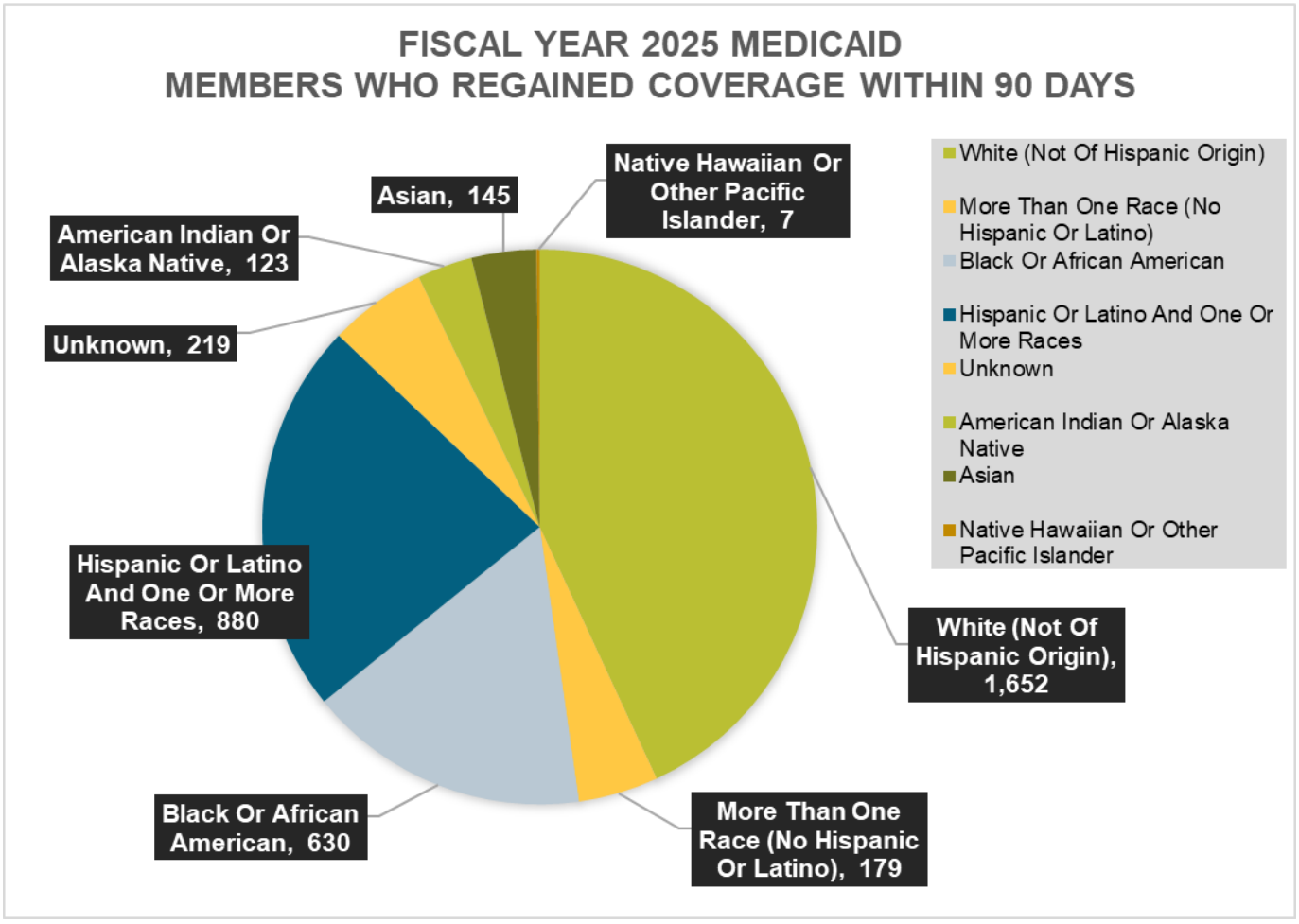
f) Application Processing Times
For SFY25, Nebraska Medicaid's average monthly median processing days for MAGI and Non-MAGI initial applications were 12 days and 11 days respectively. Median is defined as the number of calendar days elapsed between the day the Medicaid agency received the application and the day the final determination was made.



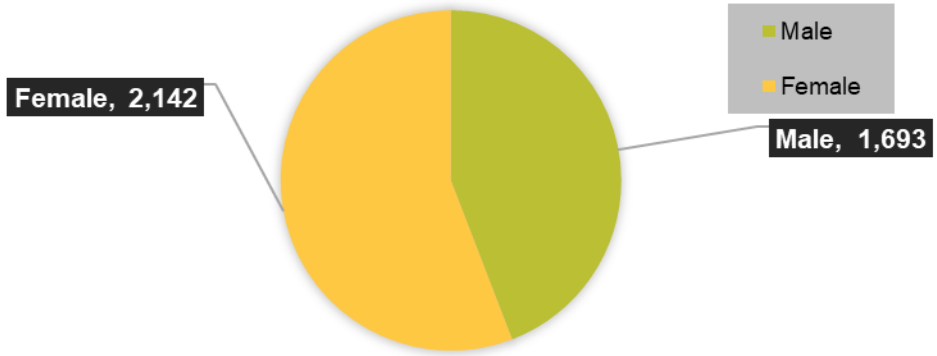
g) Rate of Re-Enrollment
For SFY25, of the 100,190 Nebraska Medicaid beneficiaries who lost Medicaid coverage, 4% or 3,620 beneficiaries regained coverage within twelve (12 months), and 4% or 3,835 regained coverage within ninety (90) days.

Demographics for Beneficiaries Regaining Coverage within 90 Days

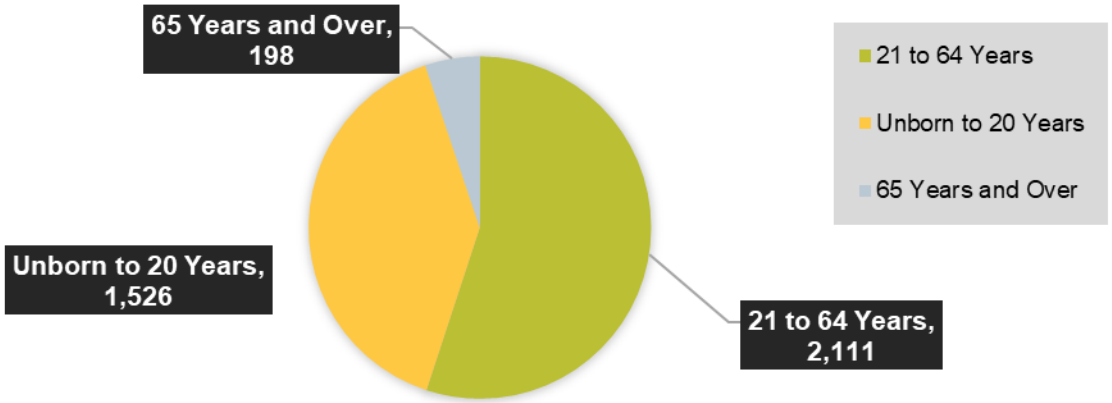

FISCAL YEAR 2025 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS
Other, 9
Aged, 202
Disabled/Blind, 222
Expansion, 1,414
Child, 1,464
Adult, 524
Disabled/Blind
Child
Adult
Expansion
Aged
Other


FISCAL YEAR 2025 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS
Native Hawaiian Or Other Pacific Islander, 7
Asian, 145
American Indian Or Alaska Native, 123
Unknown, 219
Hispanic Or Latino And One Or More Races, 880
White (Not Of Hispanic Origin), 1,652
Black Or African American, 630
More Than One Race (No Hispanic Or Latino), 179
White (Not Of Hispanic Origin)
More Than One Race (No Hispanic Or Latino)
Black Or African American
Hispanic Or Latino And One Or More Races
Unknown
American Indian Or Alaska Native
Asian
Native Hawaiian Or Other Pacific Islander

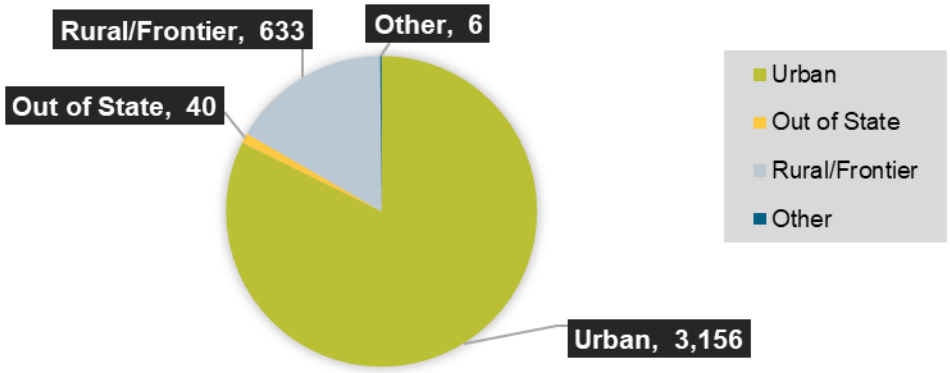
FISCAL YEAR 2025 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS

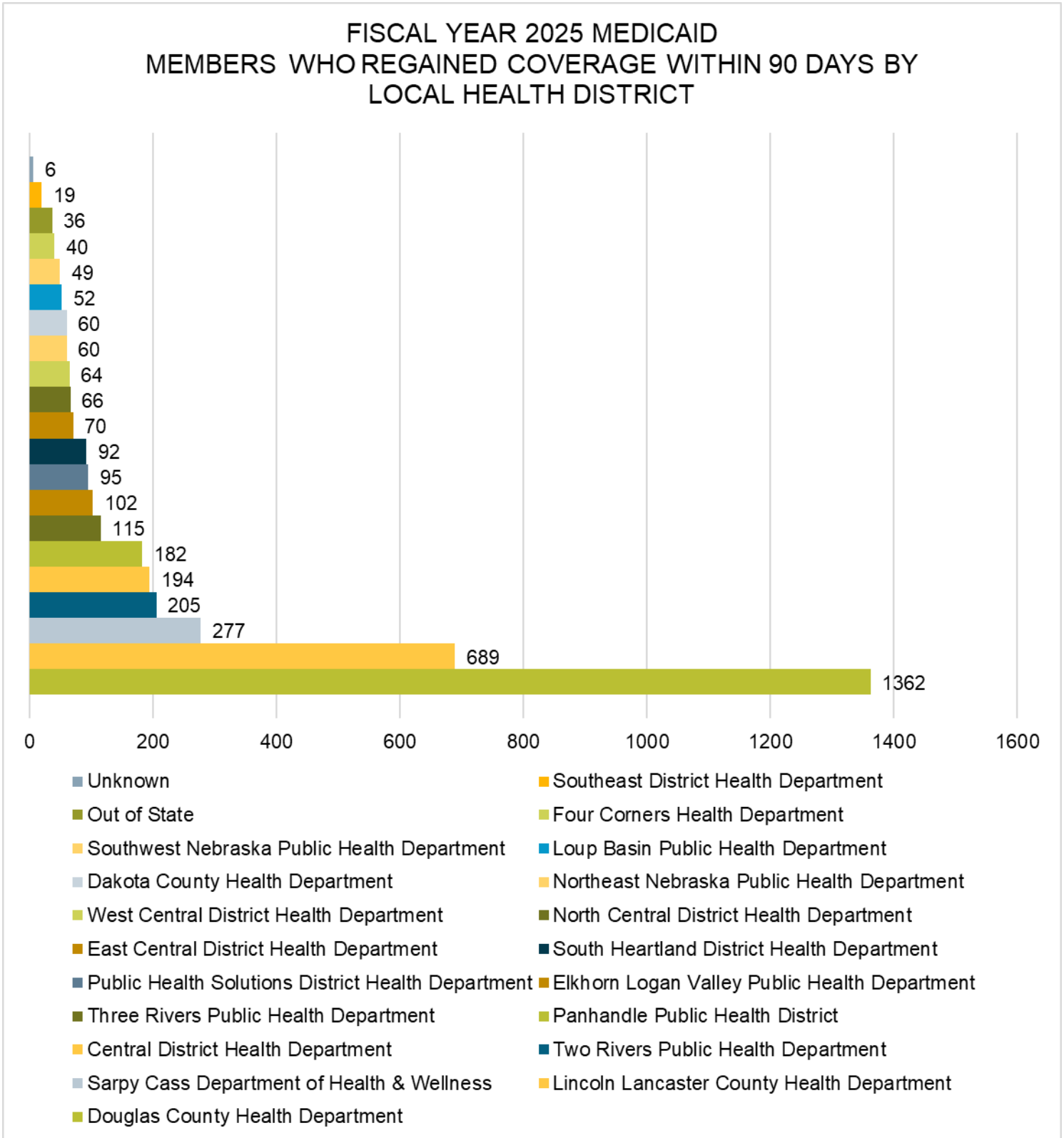


FISCAL YEAR 2025 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS

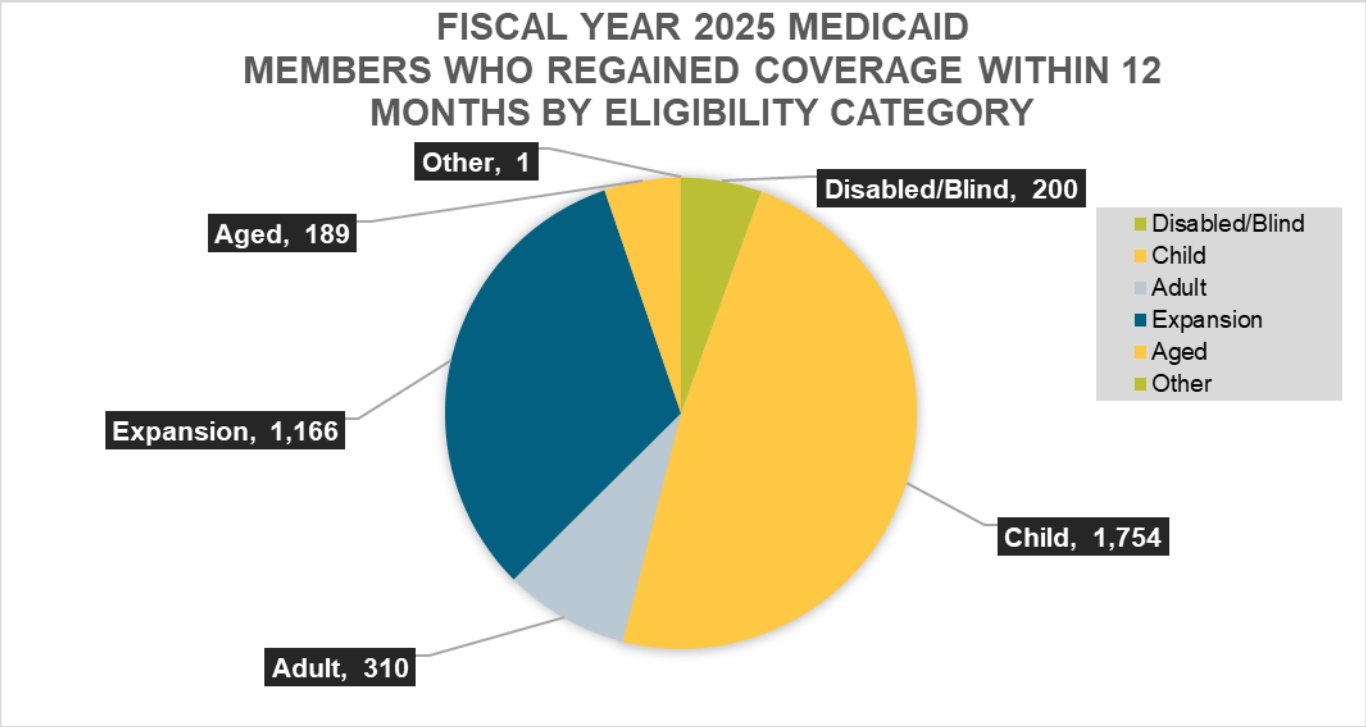


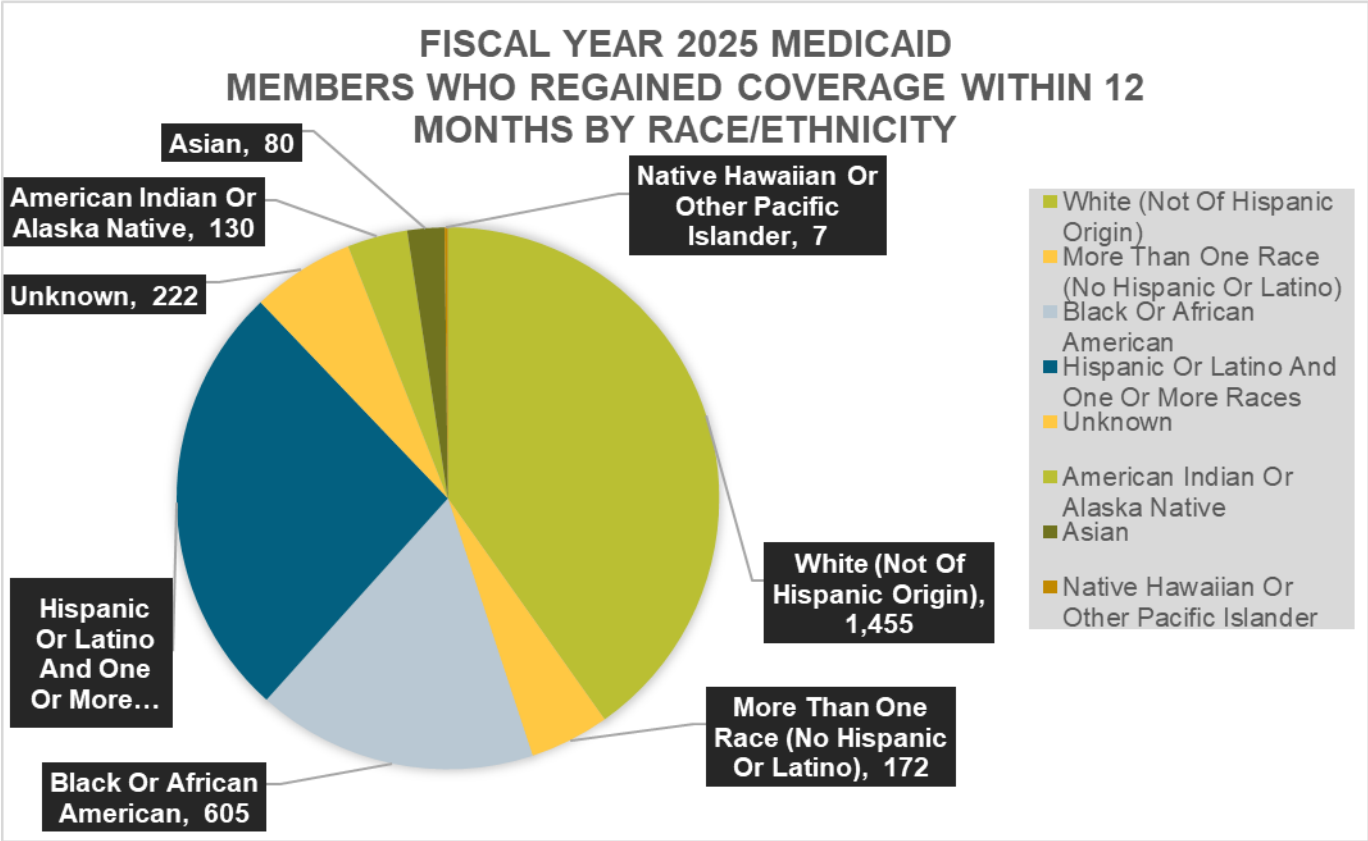
FISCAL YEAR 2025 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS



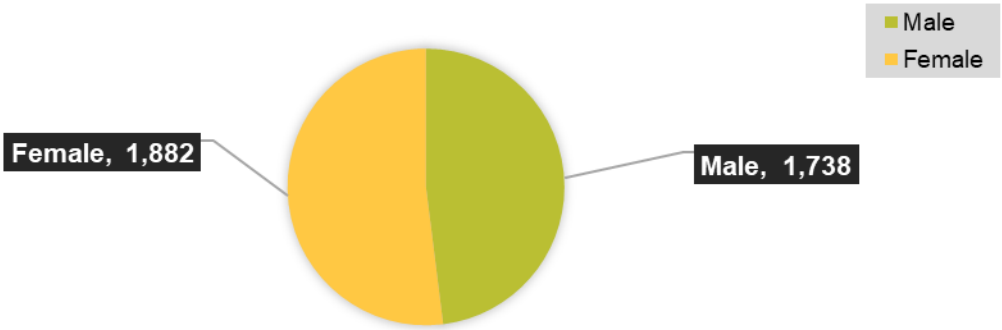

FISCAL YEAR 2025 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS BY
LOCAL HEALTH DISTRICT
6
19
36
40
49
52
60
60
64
66
70
92
95
102
115
182
194
205
277
689
1362
0
200
400
600
800
1000
1200
1400
1600
Unknown
Southeast District Health Department
Out of State
Four Corners Health Department
Southwest Nebraska Public Health Department
Loup Basin Public Health Department
Dakota County Health Department
Northeast Nebraska Public Health Department
West Central District Health Department
North Central District Health Department
East Central District Health Department
South Heartland District Health Department
Public Health Solutions District Health Department
Elkhorn Logan Valley Public Health Department
Three Rivers Public Health Department
Panhandle Public Health District
Central District Health Department
Two Rivers Public Health Department
Sarpy Cass Department of Health & Wellness
Lincoln Lancaster County Health Department
Douglas County Health Department

Demographics for Beneficiaries Regaining Coverage within 12 Months

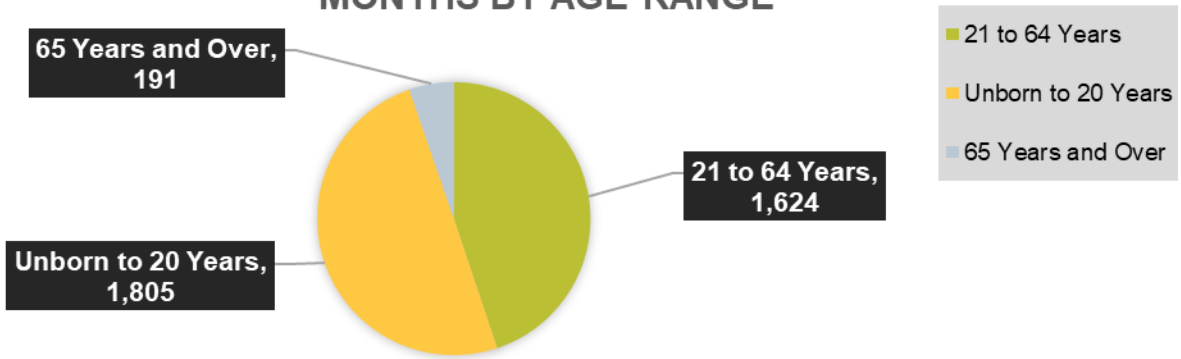




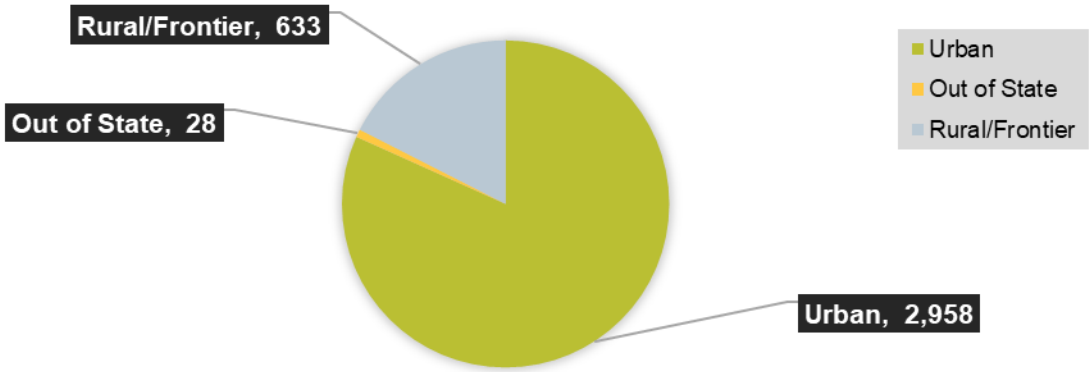
FISCAL YEAR 2025 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY SEX

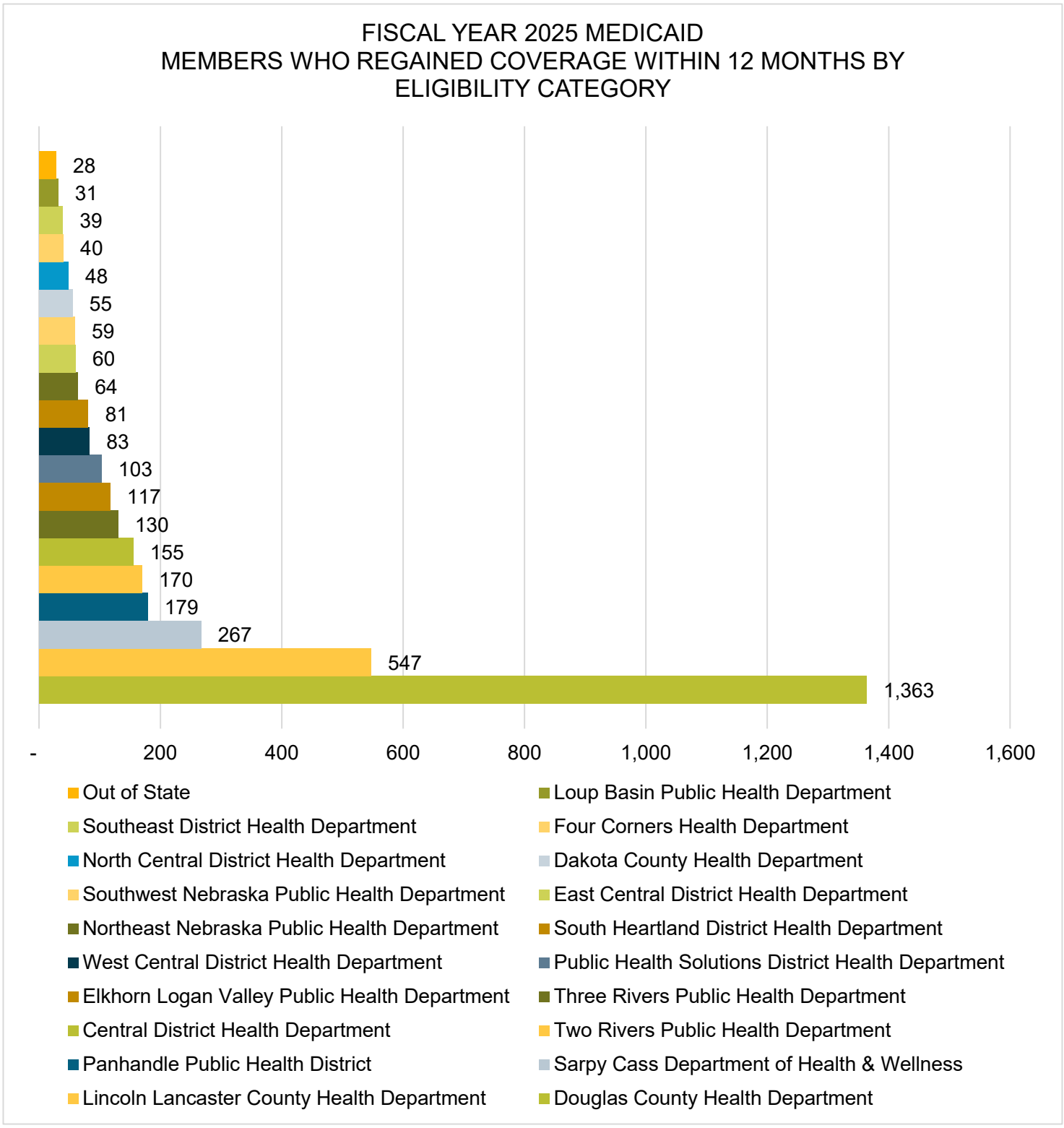


FISCAL YEAR 2025 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY AGE RANGE



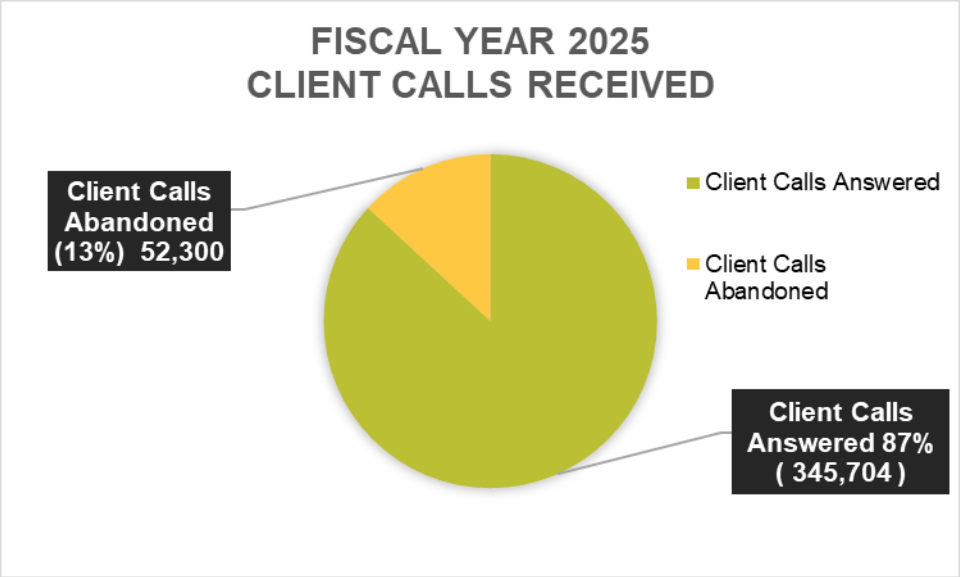
FISCAL YEAR 2025 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY COUNTY CLASSIFCATION CATEGORY




FISCAL YEAR 2025 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY
ELIGIBILITY CATEGORY
28
31
39
40
48
55
59
60
64
81
83
103
117
130
155
170
179
267
547
1,363
-
200
400
600
800
1,000
1,200
1,400
1,600
Out of State
Loup Basin Public Health Department
Southeast District Health Department
Four Corners Health Department
North Central District Health Department
Dakota County Health Department
Southwest Nebraska Public Health Department
East Central District Health Department
Northeast Nebraska Public Health Department
South Heartland District Health Department
West Central District Health Department
Public Health Solutions District Health Department
Elkhorn Logan Valley Public Health Department
Three Rivers Public Health Department
Central District Health Department
Two Rivers Public Health Department
Panhandle Public Health District
Sarpy Cass Department of Health & Wellness
Lincoln Lancaster County Health Department
Douglas County Health Department

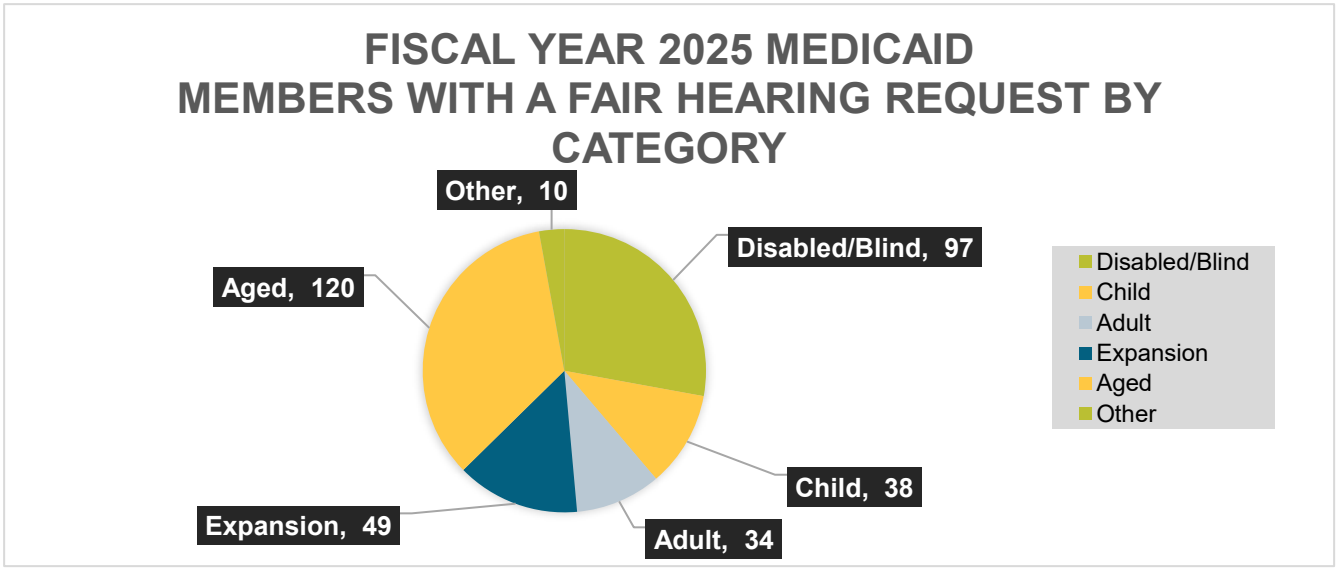
h) Client Call Information

For SFY25 Nebraska Medicaid operated four (2) call centers; 1 state administered call center and 1 (contracted) external call center. Nebraska Medicaid received a total of 399,073 client calls and answered 345,704 (87%) with 52,300 (13%) abandoned calls. The average client call duration was 9 minutes, and the average client call wait time was 6 minutes.

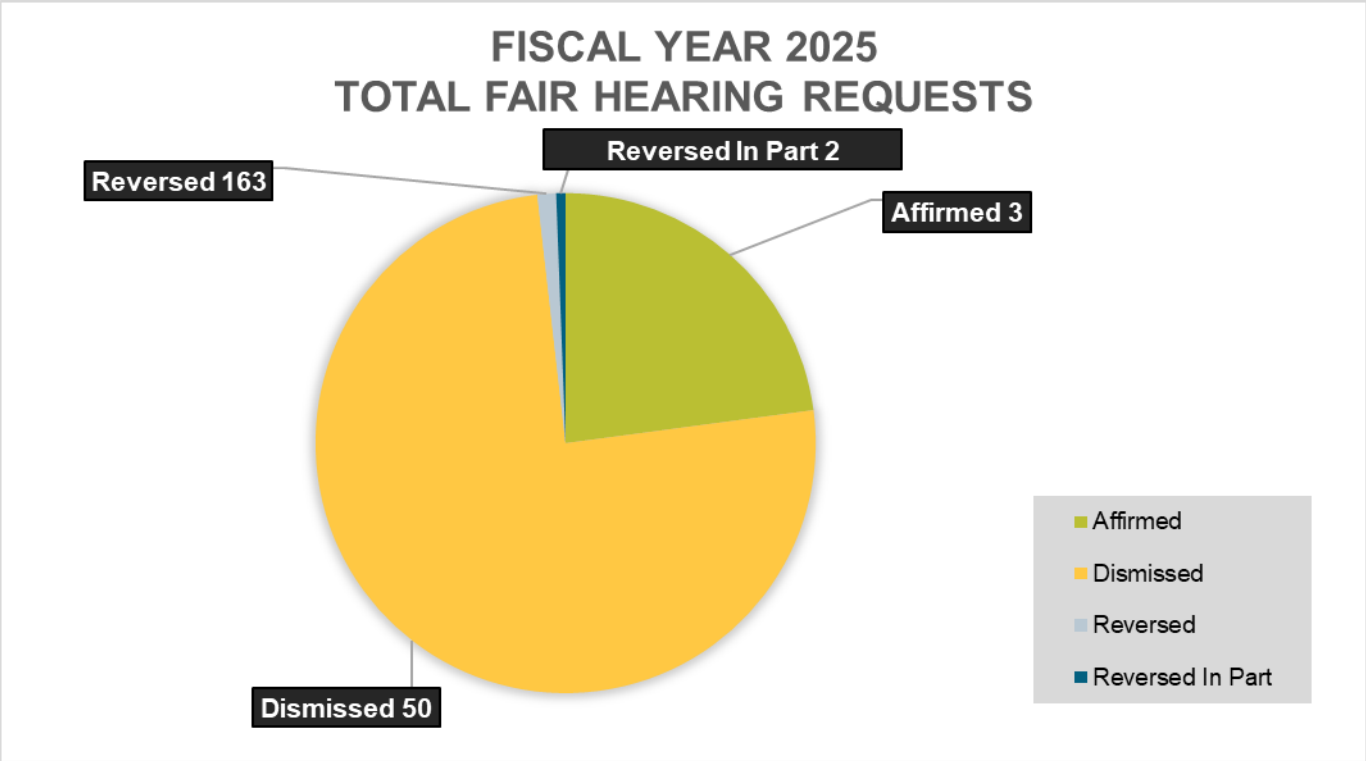


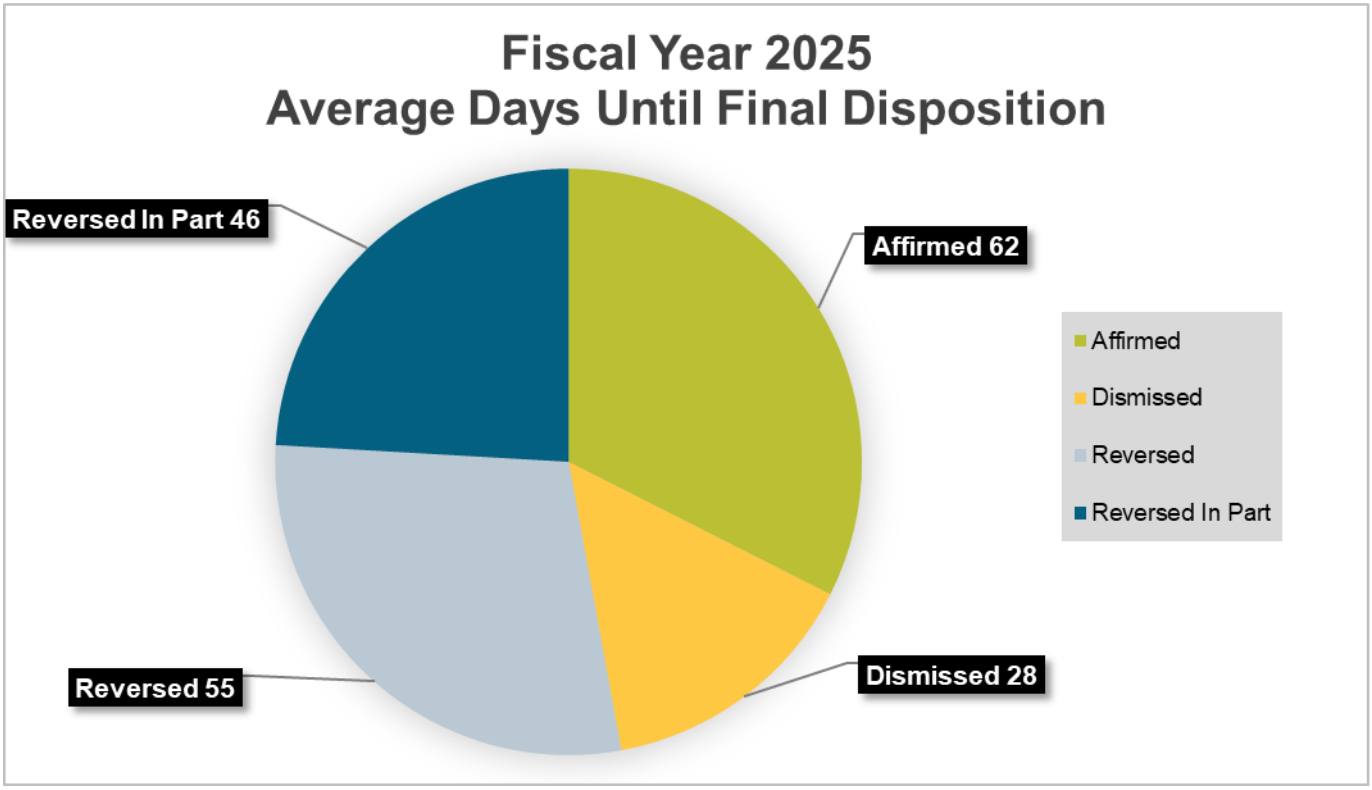
i) Fair Hearings

For SFY25 Nebraska Medicaid received 332 fair hearing requests for Medicaid eligibility and State Review Team (SRT) disability related determinations. Following is a breakout by eligibility category, please note that a single fair hearing request may include more than one person and each person may be in a different eligibility category. There are 348 individuals represented in the 332 fair hearing requests.



For fair hearing requests resulting in a dismissal, affirmation, reversal, or partial reversal following is a breakout by outcome and the number and average days from receipt of the fair hearing request until final disposition.





Appendix 7. Nebraska Medicaid Providers by Type

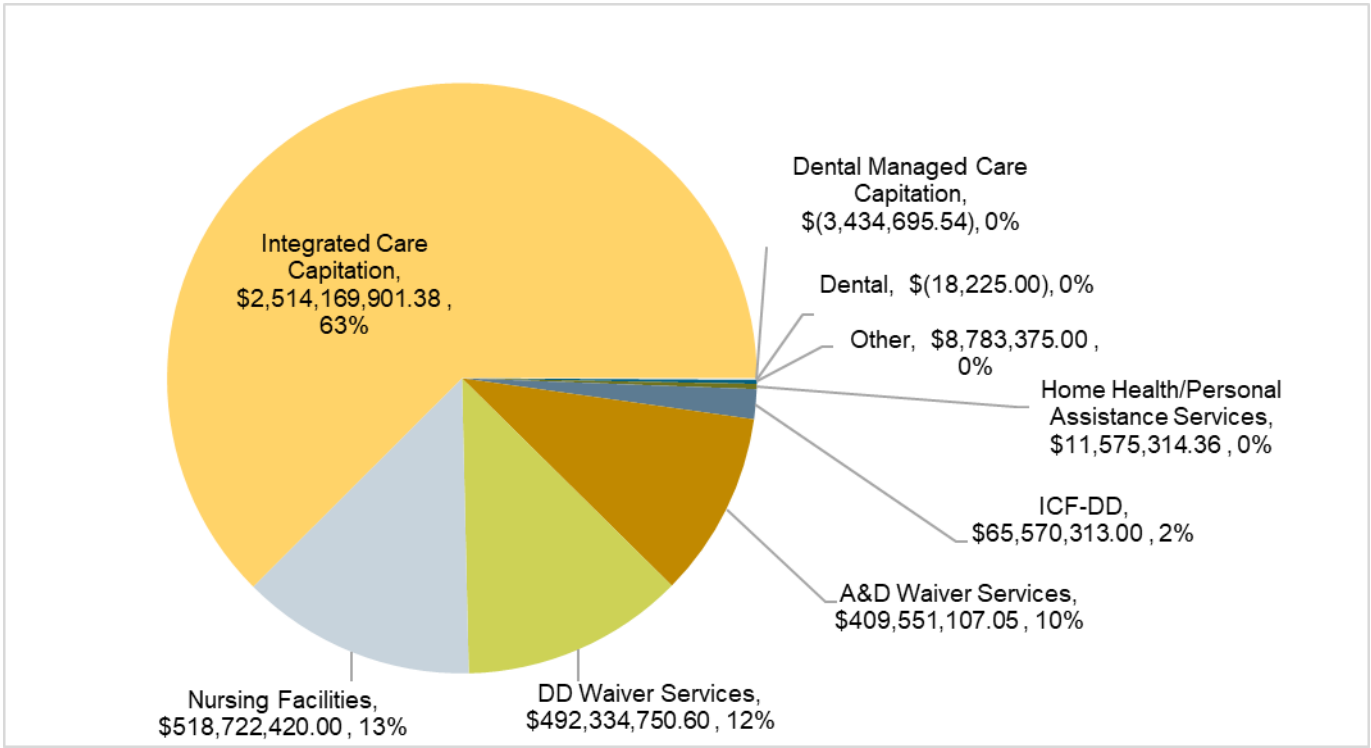
Provider Type Description	Nebraska	Out of State
Ambulance (specialty 59)	319	85
Ambulatory Surgical Centers (ASC)	53	10
Assertive Community Treatment (ACT) MRO Program	3	0
Assisted Living (specialty 75)	225	0
Case Management	16	0
Clinic (CLNC) (Hospital Based Clinic, Licensed Mental Health Centers)	326	208
Day Rehabilitation (DAYR) MRO Program	10	0
Day Treatment Provider (DAY)	20	0
Dialysis Centers (specialty 68)	37	15
Federally Qualified Health Center (FQHC)	63	19
Freestanding Birth Centers	2	1
Home Health Agency (HHAG)	73	6
Hospice (HSPC)	42	3
Hospice in Nursing Facility (specialty 82)	724	0
Hospitals (HOSP)	222	621
Indian Health Hospital Clinic (IHSH)	1	4
Intermediate Care Facility (specialty 88)	12	8
Laboratory (LAB) (Independent)	16	346
Medicaid in Public Schools Direct Care Staff (specialty 49)	258	0
Medicaid in Public Schools Transportation (specialty 49)	3	0
Medically Monitored Inpatient Withdrawal (MMIW)	2	0
Multi-Systemic Therapy	5	0
Non-Emergency Medical Transportation (specialty 94-96)	156	31
Nursing Homes (specialty 87)	1152	18
Opioid Treatment Program (OTP)	4	1
Optical Supplier (OPTC)	40	2
Orthopedic Device Supplier (ORTH)	7	10
Other Prepaid Health Plan (OPHP)	4	3
Pharmacy (PHCY)	466	306
Professional Clinic (PC)	2941	650
Professional Resource Family Care	4	1
Psychiatric Residential Treatment Facility	1	41
Qualified Health Maintenance Organization (QHMO)	5	3
Rental and Retail Supplier (RTLR)	145	240
Residential Rehabilitation (REST)	13	3
Rural Health Clinic-Independent (IRHC)	14	9
Rural Health Clinic-Provider Based (PRHC) (Less Than 50 Beds)	120	9
Rural Health Clinic-Provider Based (RHCP) (Over 50 Beds)	5	2
Substance Abuse Treatment Center (SATC)	51	6

Provider Type Description	Nebraska	Out of State
Therapeutic Treatment Home (THGH), Formerly-Treatment Group Home (TGH)	1	5
Treatment Crisis Intervention (TCI)	5	0
Tribal 638 Clinic (T638)	14	0

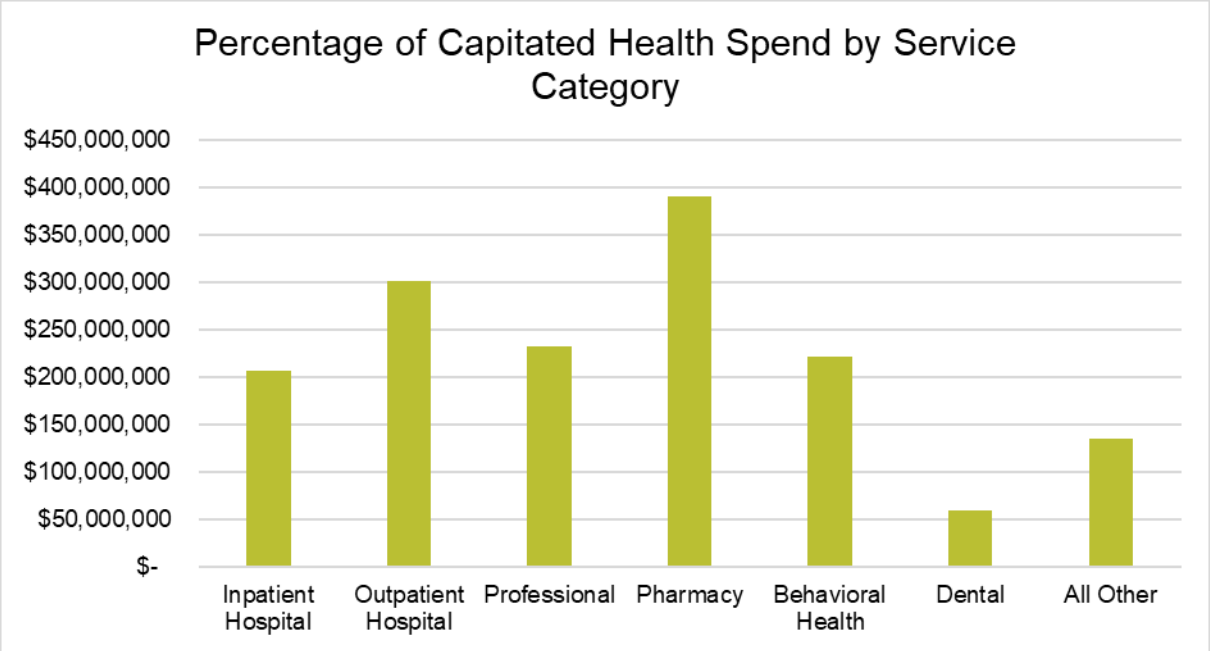
Provider Type Description	Groups		Group Members		Solo Providers	
	In State	Out of State	In State	Out of State	In state	Out of State
Physicians (MD)	279	289	8875	2862	77	119
Doctors of Osteopathy (DO)	4	4	1098	132	5	16
Doctors of Chiropractic Medicine (DC)	351	17	582	12	116	7
Optometrists (OD)	245	19	351	19	48	0
Doctors of Podiatric Medicine (DPM)	71	10	104	8	15	0
Anesthesiologist (ANES)	171	61	1071	464	9	8
Dispensing Physician (MD)	0	0	23	0	0	0
Physician Assistant (PA)	0	0	1971	185	0	0
Nurse Midwife (NW)	0	0	67	14	0	0
Nurse Practitioner (NP)	167	10	3530	325	106	18
Registered Nurse (RN)	0	0	829	4	4	0
Licensed Practical Nurse (LPN)	0	0	191	0	0	0
Registered Physical Therapist (RPT)	347	25	1559	39	11	5
Personal Care Aide (PCA) - Schools (specialty 87)	0	0	4888	0	0	0
Community Treatment Aide/Peer Support	0	0	710	0	0	0
MHSA Direct Care Staff	0	0	658	0	0	0
Licensed Mental Health Practitioner (LMHP)	0	0	1706	14	56	10
Provisional Mental Health Professional/Masters Level Equivalent (MHP)	0	0	2701	2	135	0
PhD Intern	0	0	18	0	0	0
Licensed Independent Mental Health Practitioner	401	24	2525	0	448	30
Doctor of Dental Surgery - Dentist (DDS)	287	33	1077	47	206	9
Licensed Dental Hygienist (LDH)	11	0	85	0	5	1
Community Support (CSW) MRO Program	40	0	949	1	0	0
Adult Substance Abuse	40	12	0	0	0	0
Pharmacist (PHMS)	0	0	99	0	0	0
Peer Support Specialist	0	9	89	0	0	0
Psychological Assistant/Associate	0	0	3	0	0	0

Provider Type Description	Groups		Group Members		Solo Providers	
	In State	Out of State	In State	Out of State	In State	Out of State
Provisionally Licensed PHD-PPHD	0	0	157	1	1	0
Provisionally Licensed Drug & Alcohol Counselors (PDAC)	0	0	336	0	0	0
Hearing Instrument Specialist (HEAR)	27	3	87	3	5	1
Licensed Medical Nutrition Therapist (LMNT)	31	1	125	2	8	0
Specially Licensed PHD/Psychology Resident (SPHD)	0	0	8	0	0	0
Licensed Psychologist (PHD)	81	3	506	38	57	0
Speech Therapy Health Service	148	15	1672	7	15	1
Occupational Therapy Health Services (OTHS)	164	9	996	25	4	0
Licensed Drug & Alcohol Counselor (LDAC)	0	0	325	2	0	0
Board Certified Behavior Analyst (BCBA)	0	0	394	0	2	3
Board Certified Associate Behavioral Analyst (BCABA)	0	0	19	0	0	0

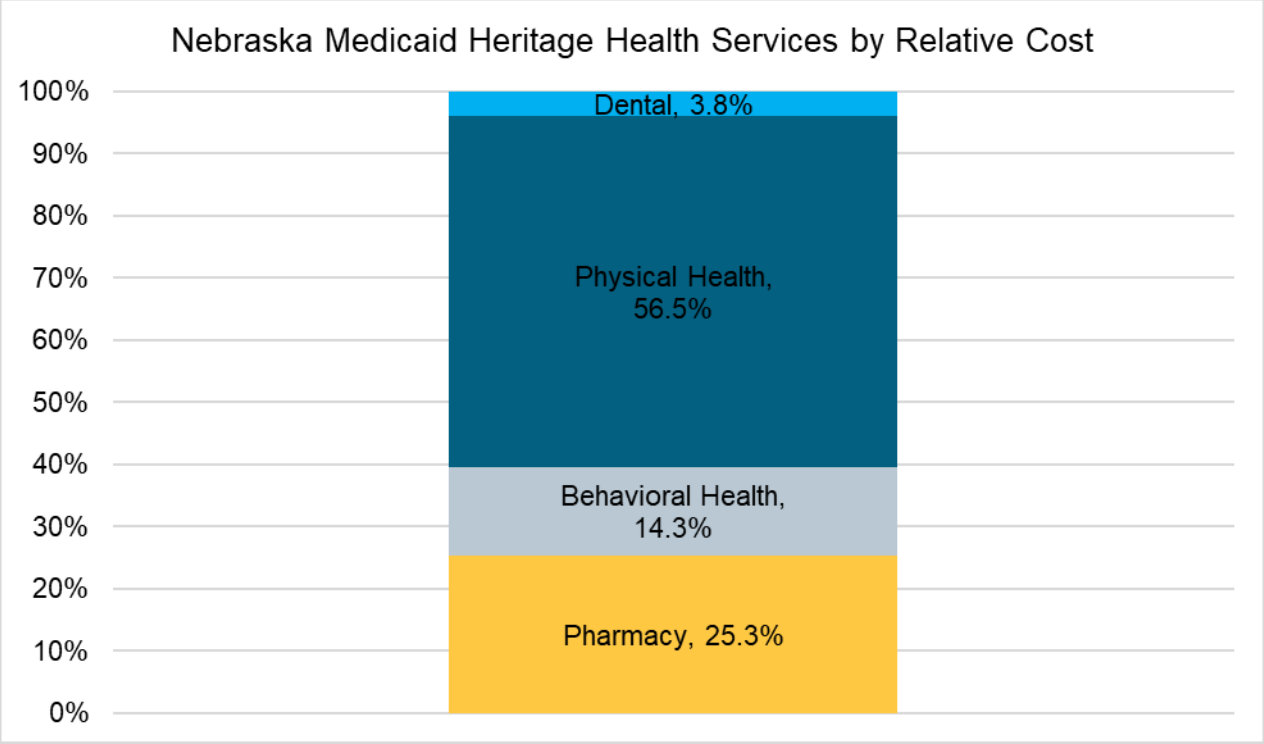
Appendix 8. SFY25 Medicaid and CHIP Expenditures by Service



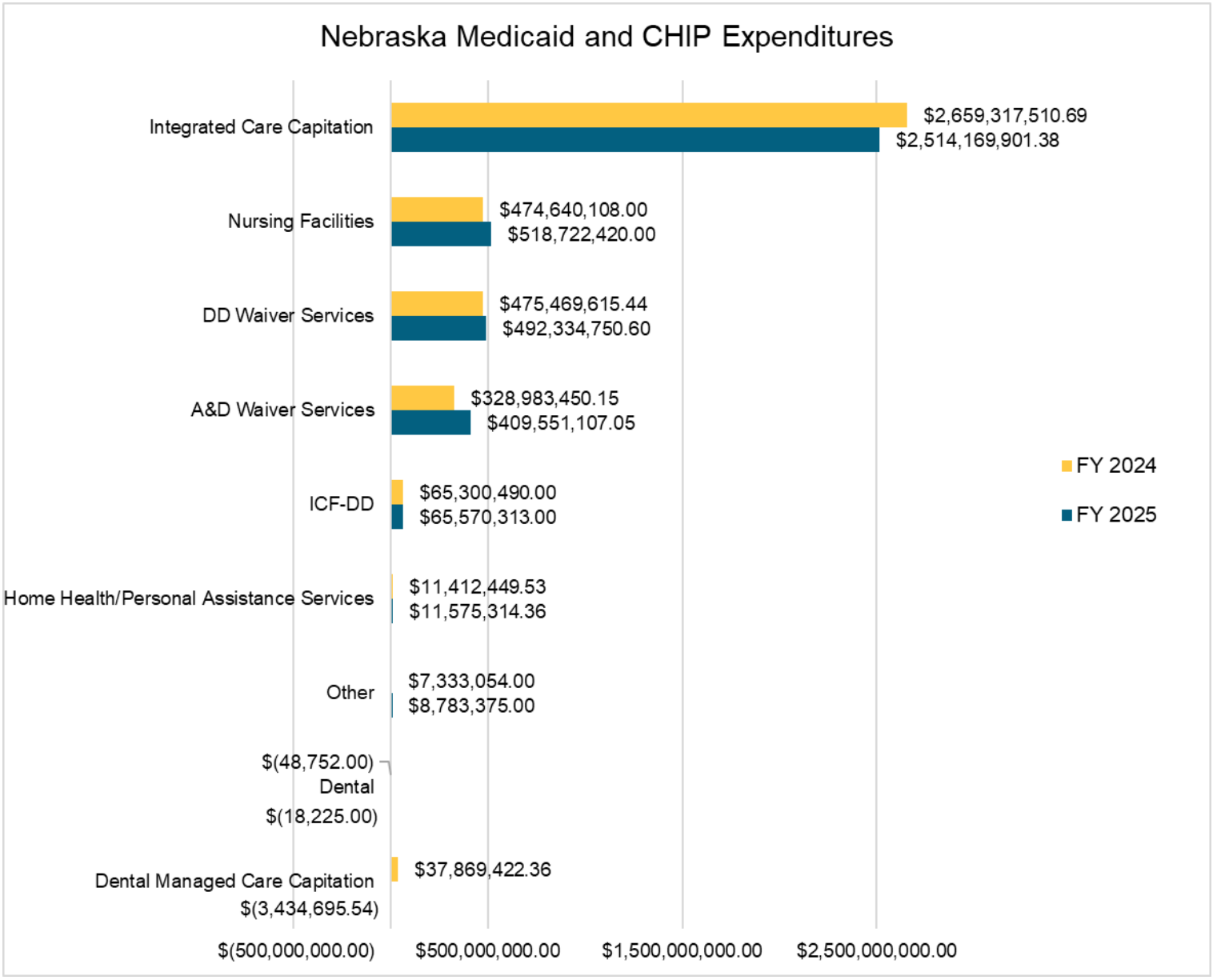
Appendix 9. Percentage of Capitated Health Spend by Service Category



Appendix 10. Heritage Health Medical Services by Relative Cost



Appendix 11. Medicaid and CHIP Expenditures, SFY24 and SFY25



Appendix 12. SFY25 Medicaid Expenditures for Long-Term Care Services