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State/Territory Name: NE

State Plan Amendment (SPA) #: 25-0003

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Financial Management Group

June 4, 2026

Drew Gonshorowski, Director
Division of Medicaid and Long Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

RE: TN 25-0003

Dear Mr. Gonshorowski:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Nebraska state plan amendment (SPA) to Attachment 4.19-A NE-25-0003, which was submitted to CMS on December 23, 2025. This plan amendment proposes an update to inpatient hospital care.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of December 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,



Rory Howe
Director
Financial Management Group

Enclosures

<p>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES</p>	<p>1. TRANSMITTAL NUMBER <div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> 2 5 — 0 0 3 </div> </p> <p>2. STATE <div style="display: flex; justify-content: space-around; border: 1px solid black; padding: 2px;"> N E </div> </p> <p>3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="checkbox"/> XIX <input type="checkbox"/> XXI </p>
<p>TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES</p>	<p>4. PROPOSED EFFECTIVE DATE December 1, 2025</p>
<p>5. FEDERAL STATUTE/REGULATION CITATION 42 CFR Part 447, Subpart C</p>	<p>6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)</p> <p>a. FFY <u>2026</u> \$ <u>0</u> b. FFY <u>2027</u> \$ <u>0</u></p>
<p>7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Att. 4.19-A, Pgs 1, 1a, 1c, 1d, 1e, 2, 3, 5, 6, 10, 12, 13, 14, 15, 15a, 15b, 16, 17, 17a, 18, 19, 20, 21, 21a, 21b, 22, 23, 24, 25, 26, and 27</p>	<p>8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Att. 4.19-A, Pgs 1, 1a, 1c, 1d, 1e, 2, 3, 5, 6, 10, 12, 13, 14, 15, 15a, 15b, 16, 17, 17a, 18, 19, 20, 21, 21a, 21b, 21c (delete), 22, 23, 24, 25, 26, and 27</p>
<p>9. SUBJECT OF AMENDMENT Inpatient Hospital Care</p>	

10. GOVERNOR'S REVIEW (Check One)

<p><input type="radio"/> GOVERNOR'S OFFICE REPORTED NO COMMENT</p> <p><input type="radio"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED</p> <p><input type="radio"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL</p>	<p><input checked="" type="radio"/> OTHER, AS SPECIFIED: Governor has waived review</p>
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<p>11. SIGNATURE OF STATE AGENCY OFFICIAL <div style="background-color: black; height: 20px; width: 100%;"></div> </p>	<p>15. RETURN TO Dawn Kastens Division of Medicaid & Long-Term Care Nebraska Department of Health and Human Services 301 Centennial Mall South Lincoln, NE 68509</p>
<p>12. TYPED NAME Drew Gonshorowski</p>	
<p>13. TITLE Director, Division of Medicaid & Long-Term Care</p>	
<p>14. DATE SUBMITTED December 23, 2025</p>	

FOR CMS USE ONLY	
<p>16. DATE RECEIVED 12/23/2025</p>	<p>17. DATE APPROVED</p>

PLAN APPROVED - ONE COPY ATTACHED	
<p>18. EFFECTIVE DATE OF APPROVED MATERIAL 12/1/2025</p>	<p>19. SIGNATURE OF APPROVING OFFICIAL <div style="background-color: black; height: 20px; width: 100%;"></div> </p>
<p>20. TYPED NAME OF APPROVING OFFICIAL Rory Howe</p>	<p>21. TITLE OF APPROVING OFFICIAL Director, FMG</p>

22. REMARKS

Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for Nebraska Medicaid excluding Nebraska Medicaid Managed Care Program's (NMMCP) capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

This subsection applies to hospital inpatient discharges occurring on or after October 1, 2009.

Payment for hospital inpatient services provided to Nebraska Medicaid eligible clients is a prospective using methods established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

For rates effective October 1, 2009, and later, each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio.

Definitions: The following definitions apply to payment for hospital inpatient services.

Allowable Costs: Those costs as provided in the Medicare statutes and regulations for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance cost.

Transmittal # NE 25-0003
Supersedes
Transmittal # 09-10

Approved June 4, 2026

Effective 12/1/2025

APR DRG (All-Patient Refined Diagnosis-Related Group): The All- Patient Refined Diagnosis-Related Group (APR DRG) grouper is a software application that assigns patients into categories based on severity of illness and risk of mortality

Base Year: The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

Budget Neutrality: Payment rates are adjusted for budget neutrality such that estimated expenditures for the current rate year are not greater than expenditures for the previous rate year, trended forward.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in this chapter to be eligible for additional payments above and beyond the initial diagnosis-related group payment.

Critical Access Hospital: A hospital certified for participation by Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Direct Medical Education Cost Payment: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.

Disproportionate Share Hospital (DSH): A hospital located in Nebraska is deemed to be a disproportionate share hospital by having -

1. A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
2. A low-income utilization rate of 25 percent or more.

Distinct Part Unit: A Medicare-certified hospital-based substance use disorder, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

2. The total amount of the hospital's charges for hospital inpatient services attributable to indigent care in ending in the calendar year preceding the Medicaid rate period, less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to indigent care does not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third-party payors, such as HMO's, Medicare, or Blue Cross.

Medicaid Allowable Inpatient Charges: Total claim submitted charges less claim non-allowable amount.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.

Medicaid Inpatient Utilization Rate: The ratio of (1) allowable Medicaid inpatient days, as determined by Nebraska Medicaid, to (2) total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out-of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

Medicaid Rate Period: The period of July 1 through the following June 30.

Medical Review: Review of Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay, completeness, adequacy, and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

Medicare Cost Report: The report filed by each facility with its Medicare fiscal intermediary. A hospital that does not participate in the Medicare program will complete the Medicare cost report in compliance with Medicare principles and supporting rules, regulations, and statutes. The hospital will file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees.

National Weights: The 3M APR-DRG National Weights are calculated using the Nationwide Inpatient Sample (NIS) released by the Healthcare Cost and Utilization Project (HCUP).

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 14-002

Approved June 4, 2026

Effective 12/1/2025

New Operational Facility: A facility providing inpatient hospital care which meets one of the following criteria:

1. A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;
2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.

Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating costs, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Transmittal # NE 25-0003
Supersedes
Transmittal # 09-10

Approved June 4, 2026

Effective 12/1/2025

Peer Group: A grouping of hospitals or distinct part units of a hospital for the purpose of determining payment amounts. Hospitals are grouped with similar characteristics, licenses, Medicare certification, and/or classifications in the CMS IPPS Impact File.

- Peer Group 1 Metro Acute Hospitals
- Peer Group 2 Urban Acute & Regional Rural Referral Hospitals
- Peer Group 3 Rural Acute Hospitals
- Peer Group 4 Indian Health Service & Beatrice Development Center Hospitals
- Peer Group 5 Mental Health (Psychiatric) Inpatient Hospitals
- Peer Group 6 Physical Rehabilitation Hospitals
- Peer Group 7 Critical Access Hospitals
- Peer Group 9 Long-Term Acute Care Hospitals
- Peer Group 10 Children's Hospitals

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The hospitals in Peer Group 1 Metro, Peer Group 2 Urban/Regional Rural Referral, Peer Group 3 Rural, Peer Group 5 Mental Health, Peer Group 9 Long-Term Acute Care Hospitals and Peer Group 10 Children's will have the same base payment or per diem amount.

Reporting Period: Same reporting period as that used for its Medicare cost report.

Resource Intensity: The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

Risk of Mortality (ROM): The likelihood of dying.

Severity of Illness level (SOI): The extent of physiologic decompensation or organ system loss of function.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 14-002

Approved June 4, 2026 Effective 12/1/2025_____

Payment for Peer Groups 1, 2, 3, and 10 (Metro Acute, Other Urban Acute, Rural, and Children's): Peer Group 1 Metro, Peer Group 2 Urban/Regional Rural Referral, Peer Group 3 Rural and Peer Group 10 Children's for inpatient acute care services are made on a prospective per discharge basis.

For inpatient services that are classified into a DRG, the total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
 - a. Direct Medical Education Cost Payment;
 - b. Indirect Medical Education Cost Payment; and
 - c. A Cost Outlier Payment.

For inpatient services that are classified into a transplant DRG, the total per discharge payment is the sum of –

1. The Cost-to-Charge Ratio (CCR) Payment amount; and
2. When applicable – Direct Medical Education Cost Payment.

Determination of Operating Cost Payment Amount: The hospital operating cost payment amount for discharges are classified into a diagnosis-related group (DRG) and is calculated by multiplying the peer group base payment amount by the applicable 3M APR-DRG national weight.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 14-002

Approved June 4, 2026

Effective 12/1/2025

Calculation of the All-Patient Refined-Diagnosis Related Groups Weights:
The Department uses the All-Patient Refined Diagnosis-Related Groups (APR-DRG) and 3M APR-DRG standard national weights to determine DRG classifications. The Department will periodically update to the most current available APR-DRG grouper and national relative weights version.

Transmittal # NE 25-0003

Supersedes

Approved June 4, 2026 Effective 12/1/2025

Transmittal # NE 14-002

Calculation of Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges for DRGs classified as non-transplant. Peer Group Base Payment Amounts effective July 1 of each year are calculated for Peer Group 1, 2, 3, and 10 hospitals based on the Peer Group Base Payment Amounts multiplied by the DRG budget neutrality factor. The agency's Peer Group Base Payment Amounts are set as of each July and effective for services provided on or after that date. Peer Group Base Payment Amounts 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.

The Peer Group Base Payment amount effective July 1, 2022 will be increased by 3%, effective July 1, 2023.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 23-000

Approved June 4, 2026 Effective 12/1/2025

Calculation of DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a DRG meeting or exceeding Medicaid criteria for cost outliers for each DRG classification. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus \$30,000 for all trauma, neonate and nervous system APR-DRGs at severity level 3 and at severity level 4. For all other APR-DRGs, the outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus \$51,800. Cost of the discharge is calculated by multiplying the Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is 80% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85% of the difference between the hospital's cost for the discharge and the outlier threshold.

Hospital Specific Medicare Outlier CCRs: On July 1 of each year, the Department will extract from the Centers for Medicare and Medicaid Services Web Pricer Inpatient Prospective Payment System hospital-specific Medicare operating and capital outlier cost-to-charge ratios effective October 1 of the year preceding the start of the Nebraska rate year to calculate the cost-to-charge ratio outlier. Hospitals excluded from the Medicare prospective payment system under 42 CFR § 412.23 will have a provider-specific cost-to-charge ratio calculated using all-payer data from their Medicare cost report. An out-of-state hospital's outlier cost-to-charge ratio is the average of in-state hospitals within the same peer group. The cost-to-charge ratio outlier is not subject to Nebraska Legislative appropriations.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 14-002

Approved June 4, 2026 Effective 12/1/2025

Calculation of Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the DRG. Capital-related payment per diem amounts are calculated for Peer Group 1, 2, 3, and 10 hospitals based on the Capital-related payment per diem amounts effective July 1st and annually thereafter are increased by legislative appropriations.

Capital-related payment per diem amounts effective July 1, 2022 will be increased by 3%, effective July 1, 2023.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 23-0009

Approved June 4, 2026 Effective 12/1/2025

Budget Neutrality Factors: Peer Group Base Payment Amounts, are multiplied by budget neutrality factors, determined as follows:

Develop Fiscal Simulation Analysis: The Department will develop a fiscal simulation analysis using Nebraska Medicaid inpatient fee-for-service paid claims data from SFY 2011. The fiscal simulation analysis includes discharges grouped into a DRG and excludes all psychiatric, rehabilitation and transplant discharges.

In the fiscal simulation analysis, the Department will apply all rate year payment rates before budget neutrality adjustments to the claims data and simulate payments.

Determine Budget Neutrality Factors: The Department will set budget neutrality factors in fiscal simulation analysis such that simulated payments are equal to the claims data reported payments.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 14-003

Approved June 4, 2026 Effective 12/1/2025

Facility Specific Upper Payment Limit: Facilities in Peer Groups 1, 2, 3, and 10 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services shall not exceed 110% of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Nebraska Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital-related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Nebraska Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A reconciliation will be made within 6 months following receipt by the Department of the facility's settled cost report. Facilities will have 30 days to make refunds to Nebraska Medicaid, when notified that an overpayment has occurred. Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110% of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

Transmittal # NE 25-0003

Supersedes

Approved June 4, 2026 Effective 12/1/2025

Transmittal # NE 14-002

Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

Inpatient Admission After Outpatient Services: A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a patient is admitted as an inpatient within three calendar days of the day that the hospital outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

Readmissions: Nebraska Medicaid adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All Nebraska Medicaid patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

Interim Payment for Long-Stay Patients: Nebraska Medicaid's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days.

To request an interim payment, the hospital shall send a completed Form HCFA-1450 (UB-92) for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to the Department of Health and Human Services Finance and Support.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 14-002

Approved June 4, 2026 Effective 12/1/2025

The hospital will be notified in writing if the request for interim payment is denied.

Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement "from" and "to" dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

Payment for Certified Registered Nurse Anesthetist (CRNA) Fees: A certified registered nurse anesthetist (CRNA) provider may choose to retain their billing privileges and submit claims directly for certified registered nurse anesthetist charges, which would follow the Anesthesia fee schedule. The critical access hospital may also elect one of the following two options to bill for certified registered nurse anesthetist professional fees on behalf of the certified registered nurse anesthetist provider. Certified registered nurse anesthetist providers in either circumstance must reassign billing privileges to the critical access hospital. In cases when Medicare is the primary payer, the provider must follow Medicare billing requirements. In either option below, the certified registered nurse anesthetist provider must not separately bill for charges that occurred in the critical access hospital for which they have reassigned billing privileges:

- (A) A critical access hospital may choose to bill on a professional claim form for both inpatient and outpatient certified registered nurse anesthetist services. Reimbursement will follow the Nebraska Medicaid Anesthesia fee schedule; or
- (B) The critical access hospital may bill on an institutional claim form for both inpatient and outpatient professional certified registered nurse anesthetist costs using revenue code 964 (certified registered nurse anesthetist professional fees). Reimbursement will be based on critical access hospital inpatient or outpatient applicable rates and are subject to cost settlement.

The Department will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that the Department will, at a minimum, identify as hospital acquired conditions (HAC), those diagnoses codes that have been identified hospital acquired conditions by the Centers for Medicare and Medicaid Services (CMS) when not present on hospital admission. Any diagnosis code(s) which are flagged as hospital acquired will be excluded from the final claim APR-DRG determination.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Nebraska Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

X Hospital-Acquired Conditions as identified by Medicare.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

TN # NE 25-0003

Supersedes

Approval Date June 4, 2026

Effective Date 12/1/2025

TN # NE 11-07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

Non-Payment for Hospital Acquired Conditions (HAC):

The Department will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that the Department will, at a minimum, identify as a hospital acquired conditions (HAC), those diagnoses codes that have been identified as hospital acquired conditions (HAC) by the Centers for Medicare and Medicaid Services (CMS) when not present on hospital admission. Any diagnosis code(s) which are flagged as hospital acquired will be excluded from the final claim APR-DRG determination.

Non-Payment for Other Provider Preventable Conditions

The provider may file a separate claim for the same Nebraska Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report other provider preventable conditions.

Prohibition on payments for PPC, and HAC, shall not result in a loss of access to care or services for Nebraska Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid proportionate share hospital payments.

TN # NE 25-0003

Supersedes

Approval Date June 4, 2026

Effective Date 12/1/2025

TN # NE 11-07

Payments for Psychiatric Services: Payments for psychiatric discharges are made on a prospective per diem.

Tiered rates will be used for all acute psychiatric inpatient services. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payment is made for the day of admission, but not the day of discharge.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of psychiatric hospital services. The agency's fee schedule is set as of each July and is effective for psychiatric hospital 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.

Inpatient psychiatric hospital rates, including free-standing psychiatric hospitals, are periodically rebased. Each rebasing occurrence utilizes Medicare cost reports and allowable costs from all in-state Medicaid-enrolled inpatient psychiatric hospitals to determine prospective fee schedule rates for all Medicaid-participating inpatient psychiatric hospitals. Allowable costs are those costs provided in the Medicare statutes and regulations for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance costs.

Free-standing psychiatric hospitals that do not have ancillary services on-site, such as pharmacy or laboratory, shall not include these ancillary costs on their cost report. The provider of these ancillary services shall bill Medicaid for the ancillary services provided to inpatients.

Effective July 1, 2023, the transplant DRG DME rates will be increased by 3%.

Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid and in page 10 of this section in the State Plan.

Payment for Services Furnished by a Critical Access Hospital (CAH): Payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers. Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital-to-hospital inpatients.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 23-0009

Approved June 4, 2026 Effective 12/1/2025

Payment for Psychiatric Adult Inpatient Subacute Hospital Services: Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all-inclusive per diem, with the exception of physician services. Per diem payment amounts are subject to annual adjustment. On July 1, 2022, there will be a 17% rate increase. On July 1, 2023, there will be a 3% rate increase.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of psychiatric adult inpatient acute and subacute hospital services. The agency's psychiatric adult inpatient acute and subacute hospital service rates are set as of each July and effective for services provided on or after that date. Psychiatric adult inpatient acute and subacute hospital service 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.

Transmittal # NE 25-0003
Supersedes
Transmittal # NE 23-0009

Approved June 4, 2026 Effective 12/1/2025

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of IMD services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date. All rates are published on the agency's website and can be found here: <https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>

Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital (DSH) if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for Nebraska Medicaid. This requirement does not apply to a hospital:
 - a. The inpatients of which are predominantly individuals under 18 years of age; or
 - b. Which does not offer non-emergency obstetric services to the general population; or
 - c. For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures;
2. Only Nebraska hospitals which have a current enrollment with Nebraska Medicaid will be considered for eligibility as a Disproportionate Share Hospital; and
3. When notified by Nebraska Medicaid that the hospital qualifies as a Disproportionate Share Hospital (DSH), each hospital must certify to Nebraska Medicaid that it has incurred costs for the delivery of uncompensated care which are equal to or exceed the amount of the DSH payment.

Disproportionate Share Eligibility Calculation: To calculate eligibility, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a Disproportionate Share Hospital will be calculated using the following data:

1. Medicaid inpatient utilization rate: To determine the Medicaid Inpatient Utilization Rate, the denominator will be the total days as reported on the Medicare Cost Report. The numerator will be the sum of each hospital's Medicaid days, which includes the MMIS non-managed care claims file data run 150 days after each hospital's fiscal year end, managed care days (for hospitals that submit a disproportionate share hospital survey), and out-of-state days reported before the federal fiscal year for which the determination is made.

TN No. NE 25-0003

Supersedes

Approval Date June 4, 2026

Effective Date 12/1/2025

TN No. MS-02-08

2. Low income utilization rate: To determine the Low-Income Utilization Rate, data from the Nebraska Accounting System will be used to calculate the Low-Income Utilization Rate for State-Owned Institutions for Mental Disease. For all other hospitals, the hospital's certified report of total revenue, Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

Disproportionate Share Hospital Upper Payment Limit and Uncompensated Care Calculation:
The Disproportionate Share Hospital upper payment limit and the uncompensated care calculation is the sum of the Medicaid shortfall plus the cost of uninsured care.

1. The Department will calculate the Medicaid shortfall as follows:
 - a. The Department will determine the costs of Medicaid fee-for-service and managed care inpatient services by:
 - (1) Calculating a hospital's routine cost per day for each cost center (e.g. Adult, Pediatrics, etc.) from the CMS 2552 cost report by dividing the total costs by the total days, and
 - (2) Multiplying the cost per day times the number of Medicaid allowable days provided during the same fiscal year as the filed cost report, and paid up to 150 days after the end of the fiscal year,
 - b. The Department will determine costs of Medicaid fee-for-service and managed care outpatient services by:
 - (1) Calculating a hospital's ancillary cost to charge ratio from the CMS 2552 cost report, and
 - (2) Multiplying the total Medicaid allowable charges times the ancillary cost to charge ratio.
 - c. The total Medicaid cost is the sum of the inpatient and outpatient costs for each hospital.
 - d. The Medicaid shortfall is determined by subtracting the total allowable Medicaid payments from the total Medicaid cost.
2. The Department will calculate the cost of uninsured care by using each hospital's charges for services provided to uninsured patients as filed and certified to the Department for the same fiscal year as the CMS cost report used in determining costs. The Department will convert each hospital's charges to cost for uninsured patients by multiplying the charges by the overall cost-to-charge ratio determined using each hospital's CMS 2552 report for the same fiscal year used in determining cost.
3. The Medicaid upper payment limit and the uncompensated care amount shall be the sum of the Medicaid shortfall plus the cost of uninsured care.

Disproportionate Share Payments: Disproportionate share payments will be made each federal fiscal year (FFY) following receipt of all required data by the Department. The total of all disproportionate share payments must not exceed the limits on disproportionate share hospital funding as established for this State by the Centers for Medicare and Medicaid Services (CMS) in accordance with the provisions of the Social Security Act, Title XIX, Section 1923. Payments determined for each federal fiscal year will be considered payment for that year, and not for the year from which proxy data used in the calculation was taken.

TN No. NE 25-0003

Supersedes

Approval Date June 4, 2026

Effective Date 12/1/2025

TN No. MS-06-02

To calculate payment, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination will be applied.

The Department will make a disproportionate share hospital payment to hospitals that qualify for a payment under one of the following pool distribution methods.

Basic Disproportionate Share Payment (Pool 1): Pool 1 consists of eligible hospitals in Peer Groups 2, 3, and 7 that are not eligible under Pool 6.

Total funding to Pool 1 will be \$1,000,000. In FFY 2008 and following years, this amount will be increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment as follows:

1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 1.
2. Second, the ratio resulting from such division will be multiplied times the total funding for Pool 1 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under section 1923 (f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 1, the additional funds will be redistributed prorata to eligible hospitals within Pool 1.

Basic Disproportionate Share Payment Pool 2:

Pool 2 consists of eligible hospitals in Peer Groups 1, 2, and 3 that are also eligible under Pool 6.

Total funding to Pool 2 will be \$3,154,000 for FFY 2007, and \$2,654,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment for Pool 2 as follows:

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Approval Date June 4, 2026

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1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 2.
2. Second, the ratio resulting from the division will be multiplied times the total funding for Pool 2 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 2, the additional funds will be redistributed prorata to eligible hospitals within Pool 2.

Disproportionate Share Payment for Hospitals that Primarily Serve Children (Pool 3): Pool 3 consists of the hospital in peer group 10 that both primarily serves children age 20 and under, and has the greatest number of Medicaid days.

Total funding for Pool 3 will be \$3,138,000 for FFY 2007, and \$3,638,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). A hospital eligible for payment under this pool will not be eligible for payment under any other pool. If payment to the hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.

Disproportionate Share Payment for State Owned Institutions for Mental Disease (IMD) Hospitals and for eligible hospitals in Peer Group 4 (Pool 4): Pool 4 consists of state owned institutions for mental disease and other eligible hospitals in Peer Group 5.

Total funding for Pool 4 will be \$1,811,337 annually. The Department will calculate payments as follows:

1. Each eligible hospital must certify in writing to the Nebraska Medicaid its charges for uncompensated care for the hospital's fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospital's cost to charge ratio.
2. Payment to each hospital will be equal to the cost of its uncompensated care.

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3. If the total of all disproportionate share payment amounts for Pool 4 exceeds the federally determined disproportionate share hospital limit for Nebraska, the will be reduced prorata.

Non-Profit Acute Care Teaching Hospital Affiliated with a State-Owned University Medical College (Pool 5): Pool 5 consists of the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this pool may be eligible for payment under Pool 6.

Total funding to Pool 5 will be \$15,000,000. For FFY 08 and following years the funding will be increased annually by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the DSH payment to Pool 5 as an amount equal to the cost of its uncompensated care. If the payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(f) of the Social Security Act, the payment will be reduced.

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Supersedes

TN No. MS-06-02

Approval Date June 4, 2026

Effective Date 12/1/2025

Uncompensated Care Pool (Pool 6): Pool 6 consists of hospitals that provide services to low-income persons covered by a county administered general assistance (GA) program; or hospitals that provide services to low-income persons covered by the state administered public behavioral health system.

Total funding to Pool 6 will be the remaining balance of the total (federal and state) DSH funding minus the funding for Pools 1, 2, 3, 4, and 5, The Department will calculate payments as follows:

1. DSH payments to a hospital under all other pools will be subtracted from the hospital's DSH upper payment limit before allocating payments under Pool 6.
2. The costs for uncompensated care resulting from participation in county administered general assistance (GA) program will be reported by the county; and costs for the state administered public behavioral health system will be reported by each hospital. Reported costs will be subject to audit by the Department.
3. A ratio for each hospital will be determined based on the uncompensated cost for each hospital to the total of uncompensated cost for all hospitals in Pool 6.
4. The ratio for each hospital will be multiplied times the available funding to the Pool to yield each hospital' annual payment amount.
5. The total computable payment will be commensurate with the charges for uncompensated care resulting from participation in county administered general assistance (GA) program; or the state administered public behavioral health system.
6. If payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(g) of the Social Security Act, the payment will be reduced to the payment limit.
7. If payments to hospitals under this pool exceed the total allotment to Nebraska, the payments will be reduced prorata.

Limitations on disproportionate share payments:

- (1) No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923 (g)(1)(A) of the Social Security Act.
- (2) Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act.

TN No. NE 25-0003

Supersedes

TN No. NE 11-16

Approval Date June 4, 2026

Effective Date 12/1/2025

Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals, except that out-of-state hospitals do not receive direct medical education (DME) cost payments, indirect medical education (IME) cost payments or graduate medical education payments. Payments for services are determined by assigning out-of-state hospitals to the appropriate Peer Group.

- (A) Peer Group 1: Metro Acute Care Hospitals, Peer Group 2: Urban Acute Care & Regional Rural Referral Hospitals, Peer Group 3: Rural Acute Care Hospitals, and Peer Group 10: Children's Hospitals;
 - (i) Operating costs payment amounts are calculated based on the appropriate Peer Group base payment amount;
 - (ii) Capital-related cost payment are made based on the appropriate Peer Group capital per diem rate;
 - (iii) Outpatient rates will be the average of the in-state Peer Group;
 - (iv) Cost-to-charge ratio (CCR) outlier will be the average in-state by Peer Group; and
 - (v) Cost-to-charge ratio (CCR) transplant will be the average in-state by Peer Group;
- (B) Peer Group 5: Mental Health or Psychiatric Hospitals: tiered rates per diem will be used for all psychiatric services and are the same of the in-state hospitals;
- (C) Peer Group 6: Physical Rehabilitation Hospitals: payments are made on a prospective per diem for rehabilitation hospitals are based on average of the in-state rehabilitation hospitals per diem rates;
- (D) Peer Group 7: Critical Access Hospitals (CAH);
 - (i) Acute per diem payment will be the average of in-state hospitals;
 - (ii) Bassinet or nursery per diem will be the average of in-state hospitals; and
 - (iii) Outpatient rates will be the average of in-state critical access hospitals (CAH); and
- (E) Peer Group 9: Long-Term Acute Care Hospitals (LTACH): payments are made on a prospective per diem for long term acute care hospitals are based on average of the in-state rehabilitation hospitals per diem rates.

TN No. 25-0003

Supersedes
TN No. 11-16

Approval Date June 4, 2026 Effective Date 12/1/2025

Rate-Setting Following a Hospital Merger: Hospitals that have combined into a single entity shall be assigned a single combined weighted average for each of the following: direct medical education amount, if applicable, indirect medical education amount, if applicable, cost-to-charge ratio, outpatient percentage, capital amount, and any other applicable rates or add-ons. The weights shall equal each hospital's base year Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the current fiscal year rates which were calculated for each hospital.

Rate-Setting for a New Operational Facility: The Department shall establish a prospective per discharge rate for a new operational facility. The rate will be the average peer group rate for the respective peer group for the new facility.

TN No. NE 25-0003

Supersedes

TN No. MS-02-08

Approval Date June 4, 2026

Effective Date 12/1/2025

Depreciation: The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

Recapture of Depreciation: A hospital which is sold for a profit and has received Nebraska Medicaid payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department; or
2. The product of
 - a. The ratio of Medicaid allowed inpatient days to total inpatient days; and
 - b. The amount of gain on the sale as determined by the Medicare intermediary.

$$\frac{\text{\# of Medicaid Inpatient Days}}{\text{Total \# of Inpatient Days}} \times \text{Gain on Sale in \$} = \text{Recapture Amount}$$

The year(s) for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.

Adjustment to Rate: Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current and/or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital shall refund the overpayment amount as determined by the Department. If the rate adjustment results in increasing a hospital's rate, the Department shall reimburse the hospital for the underpayment amount.

Lower Levels of Care: When the Department determines that a client no longer requires inpatient services but requires nursing facility level of care and there are no nursing facility beds available when the determination is made, or when the transfer requires the appointment of a public guardian and the appointment of a public guardian has been approved, but the State Court Administrator is unable to appoint a public guardian, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. A prior authorization is required.

Access to Records: Hospitals shall make all records relating to the care of Medicaid patients and all other cost information available to the Department, its designated representatives or agents, or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

Hospitals shall allow authorized representatives of the Department, the federal Department of Health and Human Services, and state and federal fraud and abuse units at any reasonable time during normal working hours upon written notice by Nebraska Medicaid at least one working day in advance to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department.

Audits: The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

Provider Appeals: A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date.

TN No. NE 25-0003

Supersedes

TN No. MS-02-08

Approval Date June 4, 2026

Effective Date 12/1/2025

Request for Rate Adjustments: Hospitals may submit a request to the Department for an adjustment to their rates for the following:

1. An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate if the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate.
2. Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate for extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. extraordinary circumstances are limited to -
 - a. Changes in routine and ancillary costs, which are limited to -
 - (1) Intern and resident related medical education costs; and
 - (2) Establishment of a subspecialty care unit;
 - b. Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.
3. Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:
 - a. One-time occurrence;
 - b. Less than twelve-month duration;
 - c. Could not have been reasonably predicted;
 - d. Not of an insurable nature;
 - e. Not covered by federal or state disaster relief;
 - f. Not a result of malpractice or negligence.

In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital.

If an adjustment is granted, the peer group rates will not be changed.

TN No. NE 25-0003

Supersedes

TN No. MS-02-08

Approval Date June 4, 2026

Effective Date 12/1/2025

In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following:

1. Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, the rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards, or extraordinary circumstances beyond the hospital's control.
2. Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.

Requests for rate adjustments must be submitted in writing to the Medicaid Division, Nebraska Department of Health and Human Services. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, the Department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Department's receipt of the request. Regardless of the Department's decision, the provider will be afforded the opportunity for a conference if requested for a full explanation of the factors involved and the Department's decision. Following review of the matter, the Administrator shall notify the facility of the action to be taken by the Department within 30 days of receipt of the request for review or the date of the conference, except in circumstances where additional information is requested or additional investigation or analysis is determined to be necessary by the Department.

If rate relief is granted as a result of a rate adjustment request, the relief applies only to the rate year for which the request is submitted (except for corrections of errors in rate determination). If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.

Under no circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology. The Department's decision regarding rate adjustment requests is final and non-appealable.

TN No. NE 25-0003

Supersedes

Approval Date June 4, 2026

Effective Date 12/1/2025

TN No. MS-02-08