

AMENDMENTS TO LB958

(Amendments to Standing Committee amendments, AM2766)

Introduced by Dungan, 26.

1 1. Strike the original sections and all amendments thereto and
2 insert the following new sections:

3 **Section 1.** Section 68-901, Revised Statutes Cumulative Supplement,
4 2024, is amended to read:

5 68-901 Sections 68-901 to 68-9,111 and section 2 of this act shall
6 be known and may be cited as the Medical Assistance Act.

7 **Sec. 2.** (1) For purposes of this section:

8 (a) Assessment tool means any standardized instrument, including the
9 InterRai assessment system or successor tools, used by the department to
10 evaluate functional eligibility, service needs, or service tier
11 assignments for medicaid or home and community-based services waiver
12 participants;

13 (b) Clinical interviewing means a type of directed conversation
14 applied in a variety of contexts, including assessment and treatment
15 planning for persons applying for, or receiving, services under the
16 medical assistance program or a home and community-based services waiver
17 authorized under section 1915(c) of the federal Social Security Act, as
18 amended. Clinical interviewing may include the use of standard assessment
19 materials but allows the interviewer, based on training and patient
20 responses, to determine the questions to ask, clarify ambiguities, and
21 adapt the questions to the patient's comprehension in order to enhance
22 understanding; and

23 (c) Waiver participant means an individual applying for, or
24 receiving, services under a home and community-based services waiver
25 authorized under section 1915(c) of the federal Social Security Act, as
26 amended.

1 (2) The department shall ensure that all employees and contractors
2 who administer or utilize assessment tools for waiver participants
3 receive training in clinical interviewing techniques. Such training shall
4 include, but not be limited to:

5 (a) Proper administration of assessment tools;

6 (b) Techniques for adapting questions to the comprehension and
7 communication needs of the individual being assessed;

8 (c) Methods for clarifying ambiguous or incomplete responses; and

9 (d) Procedures that ensure accurate and complete assessment results.

10 (3) The department shall communicate eligibility determinations,
11 service tier assignments, and service hour determinations to a waiver
12 participant, or a parent or legal guardian of a waiver participant, in a
13 timely, clear, and specific manner. Such communication shall include:

14 (a) A complete explanation of the assigned service tier and
15 eligibility determination;

16 (b) A clear and precise explanation of the assessment tool results;
17 and

18 (c) Information regarding the right to appeal the determination.

19 (4)(a) Services authorized under a waiver shall be based upon
20 individualized assessments of medical necessity, functional need, and
21 health and safety requirements, as determined through the person-centered
22 planning process in accordance with federal home and community-based
23 services waiver regulations.

24 (b) The department shall ensure that services are sufficient in
25 amount, duration, and scope to reasonably serve the needs of participants
26 and prevent unnecessary institutionalization, hospitalization, or risk of
27 serious harm.

28 (c) Nothing in this section shall be construed to limit the state's
29 obligation to comply with federal medicaid requirements governing
30 comparability, reasonable standards, and protection of the health and
31 welfare of waiver participants.

1 (5) If a determination results in a reduction of a waiver
2 participant's service tier, authorized service hours, or service
3 provision, the department shall conduct an immediate supervisory review
4 of the assessment and determination prior to final implementation of the
5 reduction.

6 (6) No later than August 1, 2026, and August 1, 2027, the department
7 shall submit a report electronically to the Legislative Oversight
8 Committee of the Legislature, the Health and Human Services Committee of
9 the Legislature, and the office of the Public Counsel regarding the
10 implementation and use of assessment tools for waiver participants. The
11 report shall only apply to the developmental disability waiver using
12 intermediate level of care criteria and shall include, but not be limited
13 to:

14 (a) The metrics used in the assessment tools;

15 (b) An explanation of nonproprietary algorithms, case-mix
16 methodologies, or scoring matrices used to determine eligibility or
17 service tiers;

18 (c) The number and percentage of waiver participants whose service
19 tiers remained the same, increased, or decreased, and the reasons for
20 such changes;

21 (d) Aggregate assessment results compared to previous years'
22 assessments and service tier determinations;

23 (e) Any identified disparities, trends, or implementation
24 challenges;

25 (f) Any other information necessary to evaluate the effectiveness,
26 accuracy, and fairness of the assessment tools;

27 (g) The ways in which the department is complying with the federal
28 Ensuring Access to Medicaid Final Rule, including requirements related to
29 grievance procedures, critical incident reporting, and appeal processes
30 for waiver participants; and

31 (h) The procedures implemented by medicaid managed care contractors

1 relating to grievances, critical incidents, and appeals for waiver
2 participants.

3 **Sec. 3.** Section 68-908, Revised Statutes Cumulative Supplement,
4 2024, is amended to read:

5 68-908 (1) The department shall administer the medical assistance
6 program.

7 (2) The department may (a) enter into contracts and interagency
8 agreements, (b) adopt and promulgate rules and regulations, (c) adopt fee
9 schedules, (d) apply for and implement waivers and managed care plans for
10 services for eligible recipients, including services under the Nebraska
11 Behavioral Health Services Act, and (e) perform such other activities as
12 necessary and appropriate to carry out its duties under the Medical
13 Assistance Act. A covered item or service as described in section 68-911
14 that is furnished through a school-based health center, furnished by a
15 provider, and furnished under a managed care plan pursuant to a waiver
16 does not require prior consultation or referral by a patient's primary
17 care physician to be covered. Any federally qualified health center
18 providing services as a sponsoring facility of a school-based health
19 center shall be reimbursed for such services provided at a school-based
20 health center at the federally qualified health center reimbursement
21 rate.

22 (3) The department shall maintain the confidentiality of information
23 regarding applicants for or recipients of medical assistance and such
24 information shall only be used for purposes related to administration of
25 the medical assistance program and the provision of such assistance or as
26 otherwise permitted by federal law.

27 (4) The department shall provide the maximum amount of retroactive
28 coverage for each medical assistance eligibility category as permitted by
29 section 71112 of the federal One Big Beautiful Bill Act, Public Law
30 119-21, as such section existed on January 1, 2026.

31 (5) (4) The department shall prepare an annual summary and analysis

1 of the medical assistance program for legislative and public review. The
2 department shall submit a report of such summary and analysis to the
3 Governor and the Legislature electronically no later than December 1 of
4 each year. The annual summary shall include, but not be limited to:

5 (a) The number and percentage of applications approved and denied;

6 (b) The number of eligibility determinations, including the number
7 and percentage of those individuals remaining enrolled, terminations, and
8 other determinations;

9 (c) The number of case closures in the medical assistance program
10 and the Children's Health Insurance Program and the specific reason for
11 the closure broken down by (i) eligibility category, including program
12 type, (ii) local public health district or other geographic area, and
13 (iii) race or ethnicity, if available;

14 (d) The number of medical assistance program and Children's Health
15 Insurance Program enrollees broken down by (i) eligibility category,
16 including program type, (ii) local public health district or other
17 geographic area, and (iii) race or ethnicity, if available;

18 (e) The number and percentage of redeterminations or renewals
19 processed ex parte, broken down by (i) eligibility category, including
20 program type and (ii) race or ethnicity, if available;

21 (f) The average number of days required to process applications for
22 the medical assistance program and Children's Health Insurance Program,
23 separating the data by applicants with modified adjusted gross income and
24 nonmodified adjusted gross income eligibility;

25 (g) The rate of re-enrollment within ninety days of termination and
26 within twelve months of termination, broken down by (i) eligibility
27 category, including program type, (ii) local public health district or
28 other geographic area, and (iii) race or ethnicity, if available;

29 (h) The average client call duration;

30 (i) The client call abandonment rate;

31 (j) The number of requests for a fair hearing separated by (i)

1 eligibility category and program type, (ii) outcome, and (iii) amount of
2 time until final disposition; ~~and~~

3 (k) A link to the medical assistance program fair hearing decisions
4 that have been redacted to protect private and health information, which
5 shall be posted on the department's website; -

6 (l) The status of community engagement requirements, including:

7 (i) A description of the plans to implement community engagement
8 requirements for medicaid recipients, including the authority and
9 effective date for the requirements and the recipients subject to the
10 requirements;

11 (ii) The number of denied applications and renewals for failure to
12 meet community engagement requirements;

13 (iii) The number of applications and renewals denied because the
14 community engagement requirement verification could not be completed;

15 (iv) The number of applications and renewals which required the
16 recipient to submit additional information relating to compliance with
17 community engagement requirements;

18 (v) The number of applications and renewals approved because the
19 applications and renewals received an exemption, the type of exemption,
20 whether or not the exemption was applied automatically, and whether or
21 not the recipient was required to take action to receive the exemption;

22 (vi) The number of applications and renewals approved because the
23 applications and renewals complied with the community engagement
24 requirement, disaggregated by the compliance activity type, whether or
25 not compliance was determined automatically, and whether or not the
26 recipient was required to take further action in order to be approved;

27 (vii) The number of applications and renewals denied or terminated
28 due to a failure to meet community engagement requirements in which the
29 recipient was re-enrolled within ninety days and the number of such
30 applications and renewals in which the recipient was re-enrolled within
31 twelve months;

1 (viii) A list of data sources the department uses to verify
2 compliance or exemption status; and

3 (ix) A list of external vendors contracted by the state to assess
4 compliance with, or exemption from, community engagement requirements,
5 including a link to each vendor's current contract;

6 (m) The number of identified cases of concurrent enrollment and
7 external vendors contracted by the state to identify concurrent
8 enrollees, including a link to each vendor's contract. For cases
9 terminated for concurrent enrollment, the rate of re-enrollment within
10 ninety days after the date of termination and the rate of re-enrollment
11 within twelve months after the date of termination; and

12 (n) A description of cost sharing, premiums, copays, and deductibles
13 for goods and services provided under the medical assistance program,
14 including (i) the amounts of the cost sharing, premiums, copays, and
15 deductibles and (ii) the payment source for collected cost sharing.

16 **Sec. 4.** Section 68-9,106, Revised Statutes Cumulative Supplement,
17 2024, is amended to read:

18 68-9,106 The Nebraska Prenatal Plus Program is created within the
19 Department of Health and Human Services. The purpose of the Nebraska
20 Prenatal Plus Program is to reduce the incidence of low birth weight,
21 pre-term birth, and adverse birth outcomes while also addressing other
22 lifestyle, behavioral, and nonmedical aspects of an at-risk mother's life
23 that may affect the health and well-being of the mother or the child.
24 ~~This program shall terminate on June 30, 2028.~~

25 **Sec. 5.** Section 68-9,107, Revised Statutes Cumulative Supplement,
26 2024, is amended to read:

27 68-9,107 Services eligible for reimbursement for at-risk mothers
28 under the Nebraska Prenatal Plus Program include, but are not limited to:
29 (1) Six or fewer sessions of nutrition counseling; (2) psychosocial
30 counseling and support; (3) general client education and health
31 promotion; (4) a minimum of two breastfeeding support sessions; and (5)

1 targeted case management.

2 **Sec. 6.** Section 68-9,109, Revised Statutes Supplement, 2025, is
3 amended to read:

4 68-9,109 The Department of Health and Human Services shall
5 electronically submit a report to the Legislature on or before December
6 15 of each year beginning December 15, 2024, through December 15, 2034
7 ~~2029~~, on the Nebraska Prenatal Plus Program which includes (1) the number
8 of mothers served, (2) the services offered, and (3) the birth outcomes
9 for each mother served.

10 **Sec. 7.** Sections 4, 5, 6, and 8 of this act become operative three
11 calendar months after the adjournment of this legislative session. The
12 other sections of this act become operative on their effective date.

13 **Sec. 8.** Original sections 68-9,106 and 68-9,107, Revised Statutes
14 Cumulative Supplement, 2024, and section 68-9,109, Revised Statutes
15 Supplement, 2025, are repealed.

16 **Sec. 9.** Original sections 68-901 and 68-908, Revised Statutes
17 Cumulative Supplement, 2024, are repealed.

18 **Sec. 10.** Since an emergency exists, this act takes effect when
19 passed and approved according to law.