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AMENDMENTS TO LB958

Introduced by Health and Human Services.

1. Strike the original sections and insert the following new sections:

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

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

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

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

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

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

(2) The department shall ensure that all employees and contractors

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who administer or utilize assessment tools for waiver participants receive training in clinical interviewing techniques. Such training shall include, but not be limited to:

(a) Proper administration of assessment tools;

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

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

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

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

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

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

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

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

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

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

(5) If a determination results in a reduction of a waiver

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participant's service tier, authorized service hours, or service provision, the department shall conduct an immediate supervisory review of the assessment and determination prior to final implementation of the reduction.

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

(a) The metrics used in the assessment tools;

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

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

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

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

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

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

(h) The procedures implemented by medicaid managed care contractors relating to grievances, critical incidents, and appeals for waiver

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participants.

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

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

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

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

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

(5) ~~(4)~~ The department shall prepare an annual summary and analysis of the medical assistance program for legislative and public review. The

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department shall submit a report of such summary and analysis to the Governor and the Legislature electronically no later than December 1 of each year. The annual summary shall include, but not be limited to:

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

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

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

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

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

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

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

(h) The average client call duration;

(i) The client call abandonment rate;

(j) The number of requests for a fair hearing separated by (i) eligibility category and program type, (ii) outcome, and (iii) amount of

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time until final disposition; ~~and~~

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

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

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

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

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

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

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

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

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

(viii) A list of data sources the department uses to verify

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compliance or exemption status; and

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

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

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

Sec. 4. Original sections 68-901 and 68-908, Revised Statutes Cumulative Supplement, 2024, are repealed.

Sec. 5. Since an emergency exists, this act takes effect when passed and approved according to law.