

**ONE HUNDRED NINTH LEGISLATURE - SECOND SESSION - 2026**  
**COMMITTEE STATEMENT**  
**LB1091**

---

**Hearing Date:** Wednesday February 18, 2026  
**Committee On:** Health and Human Services  
**Introducer:** Bostar  
**One Liner:** Provide requirements for the Department of Health and Human Services for long-term care clients with special needs under the medical assistance program

---

**Roll Call Vote - Final Committee Action:**  
Advanced to General File with amendment(s)

---

**Vote Results:**

**Aye:** 7 Senators Hardin, Ballard, Fredrickson, Hansen, Meyer, G., Quick, Riepe  
**Nay:**  
**Absent:**  
**Present Not Voting:**

---

**Testimony:**

**Proponents:**

Senator Eliot Bostar  
Nash Mahupete  
Brent Shanholtz  
Christopher "Chris" Lee  
Maria Lighthall  
Aaron Mason

**Representing:**

Opening Presenter  
President, CEO, QLI, Quality Living, Inc.  
Ambassador Health  
Madonna Rehabilitation Hospitals  
Quality Living, Inc. QLI  
self

**Opponents:**

Robert Bell

**Representing:**

Nebraska Association of Medicaid Health Plans

**Neutral:**

**Representing:**

\* ADA Accommodation Written Testimony

---

**Summary of purpose and/or changes:**

LB 1091 amends §68-994 of the Medical Assistance Act which stated that until July 1, 2023, the Department of Health and Human Services (DHHS) shall not add long-term care services and supports to the Medicaid managed care program. It defined long-term care services and supports to include services of skilled nursing facilities, nursing facilities, assisted-living facilities, and home and community-based services. LB 1091 provides a substantial new framework consisting of new subsections (2) and (3) added to this section. The new language adds legislative intent, definitions, and a set of permanent, ongoing protections for a specific population — "long-term care clients with special needs."



The Legislature declares its intent that long-term care clients with special needs receive services in a way that preserves continuity of care, program stability, and specialized oversight, and that their care not be run through the utilization management approaches typical of managed care. DHHS must permanently exclude skilled nursing and nursing facility services for this population from Medicaid managed care enrollment. A "long-term care client with special needs" is defined as a Medicaid recipient whose medical or nursing needs are complex or intensive enough to exceed what ordinary nursing facilities typically provide. These services must continue to be paid through fee-for-service Medicaid or another non-risk-based system — not through managed care. Providers cannot be required to enroll with a managed care organization just to serve this population. Managed care organizations may still coordinate non-nursing benefits or provide wraparound services for these clients, as long as they bear no financial risk and exercise no utilization management over the provider. DHHS must implement all of this without increasing General Fund expenditures above what managed care would have cost, and must adopt rules and regulations and amend managed care contracts within six months after the bill's effective date.

---

**Explanation of amendments:**

AM 2381 is a white copy amendment that replaces the bill and narrows the protections established in LB 1091 in several key ways. While it retains the core requirement that skilled nursing and nursing facility services for special needs long-term care clients be excluded from Medicaid managed care and reimbursed through fee-for-service or another authorized delivery system, it removes the requirement that such a system be non-risk-based. The amendment softens the legislative intent section by stripping out language that discouraged replicating managed care utilization models, eliminates the fiscal guardrail requiring cost neutrality relative to managed care, and converts the DHHS rulemaking obligation from mandatory to discretionary. The six-month deadline to amend managed care contracts is preserved. The result is to maintain the structural separation of this population from managed care enrollment, while affording DHHS significantly more flexibility in how it designs and administers the alternative delivery system.

---

Brian Hardin, Chairperson

