ONE HUNDRED NINTH LEGISLATURE - FIRST SESSION - 2025
COMMITTEE STATEMENT
LB380

Hearing Date: Wednesday February 26, 2025
Committee On: Health and Human Services
Introducer: Fredrickson
One Liner: Establish requirements for Department of Health and Human Services' contractors providing medical assistance services

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

Vote Results:

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

Testimony:

Proponents:	**Representing:**
Senator John Fredrickson	Opening Presenter
Annette Dubas	NE Association of Behavioral Health Organizations NABHO
Michael Wasmer	Council of Autism Service Providers
Kristen Rose	NE Association of Behavioral Health Organizations NABHO
Dru McMillan-Beeman	Leaf Collaborative
Mary Kelly	League of Women Voters of Nebraska
Spring Landfried	self
Erica Schroeder	self
Jamaal Hale	Community Empower
Heidi Smith	self

Opponents:	**Representing:**
Drew Gonshorowski	DHHS, Director Medicaid and Long Term Care
James Watson	NE Association of Medicaid Health Plans

Neutral:	**Representing:**

* ADA Accommodation Written Testimony

Summary of purpose and/or changes:
LB 380 provides Medicaid contractor requirements involving mental health and substance use disorder services. Also, this bill provides requirements regarding DHHS/Medicaid and Long Term Care Division monitoring of Medicaid

contractors providing mental health and substance use disorder services.

Sec. 1: Requires a Medicaid contractor to: not reduce DHHS-posted Medicaid rates; not impose quantitative treatment limitations, or financial restrictions/limitations on mental health/substance disorder services; maintain an adequate provider network to provide mental health and substance use disorder services; apply criteria in accordance with generally recognized standards and make utilization review policies available to the public when performing a mental health/substance use disorder utilization review; and not rescind or modify a mental health/substance use disorder authorization after a medical necessity determination, except for fraud or contract violation.

Sec. 2: Harmonizes language with Medicaid Managed Care Excess Profit Fund.

Sec. 3: Requires DHHS/Medicaid and Long Term Care Division to: require contractor compliance with federal and state laws applicable for mental health/substance use disorder services; make public the surveys, financial analyses, and contract audits and parity reports prepared by the contractor; ensure access to mental health/substance health and substance use disorder service providers; establish a monthly electronic communication system relating to any changes in managed care contracts; define network adequacy; and annually post criteria used by DHHS/MLTC to assess network adequacy and managed care organizations' compliance on DHHS website.

Explanation of amendments:
AM 728 consists of the amended version of LB 380 and the amended version of LB 381.

LB 380, as amended by AM728, strikes the requirement that a contractor shall not reduce department-posted Medicaid rates.

LB 381, as amended by AM728, changes provisions relating to program integrity contractors.

AM728 to LB 381 provides the following requirements for contractors when conducting a program integrity audit, investigation, or review: provide clear written justification to the provider for commencing an audit; review claims within 3 years from the date of the payment; furnish information sufficient to identify the location in any records request to a provider, records request shall be limited to relevant documents proportional to the services being audited; allow 90 days after the notice of overpayment to adjust a claim if a service was provided and denied; schedule onsite audits with advance notice of not less than 10 business days and establish a mutually agreed-upon time and date for the onsite audit; and provide written notification and explanation of an adverse determination that would result in partial or full recoupment of payment, including name of beneficiary, dates of service, overpayment amount, claim numbers, explanation of overpayment determination, payment method, appropriate procedure to submit claim, appeal statement, recovery method, and statement that an overpayment shall not be recouped at least 60 days from the adverse findings.

AM 728 to LB 381 provides that any provision of a contract between a third-party payer and a provider or beneficiary that violates this bill is unenforceable. The term, "start", is replaced with "commencement" as it relates to when the program integrity contractor begins work with DHHS. Language is clarified about DHHS excluding primary insurance claims from the scope of review.

AM 728 to LB 381 provides that a contract may be on a contingent fee basis if it is in compliance with federal law; no greater than 12.5% of the amounts recovered; and based on amounts recovered, not amounts identified. Current language relating these contingent fees is stricken.

AM728 to LB 381 requires the payment or fee for identification of overpayments to be the same as that for identification of underpayments in any contract between DHHS and a program integrity contractor. The contractor

shall not recover an overpayment until all appeals have been exhausted unless there is a credible allegation of provider fraud and the contractor provides a statement for the reasons for the decision, the claim is referred to DHHS for investigation, and an investigation has commenced. The contractor shall provide appeal procedures and timelines at the commencement of any audit and contact information (i.e. telephone number, email address, physical address) and shall respond to a question submitted by a provider no later than 10 business days after the date of submission.

AM728 to LB 381 provides the following definitions. Credible allegation of fraud is defined as an allegation which has been verified by DHHS, from any source including, but not limited to a fraud hotline tip or a pattern identified through audits, false claims cases and law enforcement investigation. Allegations are credible when they have indicia of reliability and DHHS has reviewed all allegation, facts, and evidence.

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to any person. It includes an act that constitutes fraud under federal or state law.

Fraud hotline tip is defined as a complaint or other communication submitted through a fraud reporting telephone number or website, including a fraud hotline administered by a health plan or the federal Department of Health and Human Services Office of Inspector General.

Brian Hardin, Chairperson