

**ONE HUNDRED NINTH LEGISLATURE - SECOND SESSION - 2026**  
**COMMITTEE STATEMENT (UPDATED)**  
**LB958**

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**Hearing Date:** Thursday February 26, 2026  
**Committee On:** Health and Human Services  
**Introducer:** Cavanaugh, M.  
**One Liner:** Provide a requirement for the Department of Health and Human Services relating to 1915(c) waivers and define nursing facility level of care under the Medical Assistance Act

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

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**Vote Results:**

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

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**Testimony:**

**Proponents:**

Senator Machaela Cavanaugh, M.  
Alana Schriver  
Teresa Scheart  
Angela Cornett  
Aaron Kuecker  
Shelley Gillen  
Michelle Zephier  
Anna Keyzer  
Stacy Pfeifer  
Joni Thomas  
Dominic Gillen  
Kathryn Thompson  
Kristen Larsen

Kathy Hoell\*

**Opponents:**

Tony Green

**Neutral:**

**Representing:**

Opening Presenter  
Nebraska Association of Service Providers  
family/self  
self  
self  
self/son Will  
self  
myself + my family Simon Keyzer my disabled son  
self  
self  
self  
NCDD Nebraska Council on Developmental Disabilities  
Self

**Representing:**

Department of Health and Human Services

**Representing:**

\* ADA Accommodation Written Testimony

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

LB 958 amends the Medical Assistance Act to prohibit the Department of Health and Human Services from submitting an application for a 1915(c) waiver or a state plan amendment relating to cost limits, service hours, or eligibility criteria. A new definition of nursing facility level of care is also provided.

Section by Section Summary:

Section 1: Amends section 68-901 to add new section 2 to the Medical Assistance Act.

Section 2: A new section which prohibits the Department of Health and Human Services from submitting an application for a 1915(c) waiver or an amendment to an existing 1915(c) waiver that introduces an individual cost limit, reduces the aggregate number of service hours, or narrows eligibility criteria, without legislative approval.

Sec. 3: Amends section 68-907 by defining nursing facility level of care as a Medicaid recipient who requires assistance with two or more activities of daily living, regardless of the cost of providing such assistance, in a community setting if the aggregate cost of the waiver program remains cost-neutral.

Sec. 4: Repealer

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**Explanation of amendments:**

AM2766 is a white copy committee amendment that strikes the original sections and inserts LB 958, as amended, and LB 777, as amended.

Section by Section Summary:

Section 1: Amends section 68-901 to add new section 2 under the Medical Assistance Act. (LB 958)

Section 2: A new section that defines assessment tool as any standardized instrument, including the InteRAI assessment system or successor tools, used by the the Department of Health and Human Services to evaluate functional eligibility, service needs, or service tier assignments for Medicaid or home and community-based services waiver participants. In addition, clinical interviewing is defined as 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 also include the use of standard assessment materials that 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. Lastly, waiver participant is defined as 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.

In addition, the Department of Health and Human Services is required to ensure that all employees and contractors who administer or utilize assessment tools for waiver participants receive training in clinical interviewing techniques. Such training shall include, but not be limited to proper administration of assessment tools, techniques for adapting questions to the comprehension and communication needs of the individual being assessed, methods for clarifying ambiguous or incomplete responses, and procedures that ensure accurate and complete assessment results. Also, the Department of Health and Human Services is required to 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 complete explanation of the



assigned service tier and eligibility determination, a clear and precise explanation of the assessment tool results, and information regarding the right to appeal the determination.

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. The Department of Health and Human Services 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. 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. If a determination results in a reduction of a waiver participant's service tier, authorized service hours, or service provision, the Department of Health and Human Services is required to conduct an immediate supervisory review of the assessment and determination prior to final implementation of the reduction.

No later than August 1, 2026, and August 1, 2027, the Department of Health and Human Services 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 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 the following: The metrics used in the assessment tools; an explanation of nonproprietary algorithms, case-mix methodologies, or scoring matrices used to determine eligibility or service tiers; the number and percentage of waiver participants whose service tiers remained the same, increased, or decreased, and the reasons for such changes; aggregate assessment results compared to previous years' assessments and service tier determinations; any identified disparities, trends, or implementation challenges; any other information necessary to evaluate the effectiveness, accuracy, and fairness of the assessment tools; the ways in which the Department of Health and Human Services is complying with the federal Ensuring Access to Medicaid Final Rule, including requirements relating to grievance procedures, critical incident reporting, and appeal processes for waiver participants; and the procedures implemented by Medicaid managed care contractors relating to grievances, critical incidents, and appeals for waiver participants. (LB 958 as amended)

Section 3: Amends 68-908 by requiring the Department of Health and Human Services to 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.

Also, the committee amendment amends this section to add requirements to the Department of Health and Human Services annual summary and analysis of the medical assistance program. The first new requirement consists of the status of community engagement requirements which include the following: 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; the number of denied applications and renewals for failure to meet community engagement requirements; the number of applications and renewals denied because the community engagement requirement verification could not be completed; the number of applications and renewals which required the recipient to submit additional information relating to compliance with community engagement requirements; 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; the number of applications and renewals approved because the applications and renewals complied with community engagement requirements, 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; 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; a list of data sources the Department of Health and Human Services uses to verify compliance or exemption status; and 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.

In addition, the second new annual summary requirement is 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 and for cases terminated for concurrent enrollment, the rate of enrollment within ninety days after the date of termination and the rate of re-enrollment within twelve months after the date of termination.

The third and last new annual summary requirement is a description of cost-sharing, premiums, copays, and deductibles for goods and services provided under the medical assistance program, including the amounts of cost-sharing, premiums, copays, and deductible and the payment source for collected cost-sharing. (LB 777 as amended)

Section 4: Repealer

Section 5: Emergency clause

Testifiers on LB 777:

Proponents

Dr. Chris Acker CHI Health, NE Hospital Association  
Megan Connelly Children's Nebraska, Nebraska Hospital Association  
Ann Anderson Berry Nebraska Medical Association  
Marshall Biven self  
Kelsey Arends Nebraska Appleseed

Opponents            None

Neutral

John Meals Department of Health and Human Services

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Brian Hardin, Chairperson

