

LEGISLATURE OF NEBRASKA  
ONE HUNDRED NINTH LEGISLATURE  
SECOND SESSION

**LEGISLATIVE BILL 958**

FINAL READING

Introduced by Cavanaugh, M., 6; Conrad, 46; Rountree, 3; Dungan, 26.

Read first time January 12, 2026

Committee: Health and Human Services

1 A BILL FOR AN ACT relating to public health and welfare; to amend  
2 sections 68-901, 68-908, 68-9,106, 68-9,107, and 68-1215, Revised  
3 Statutes Cumulative Supplement, 2024, and section 68-9,109, Revised  
4 Statutes Supplement, 2025; to provide for implementation of a home  
5 and community-based services waiver under the Medical Assistance  
6 Act; to provide for retroactive coverage of certain benefits under  
7 the Medical Assistance Act; to change reporting requirements under  
8 the Medical Assistance Act; to provide for reimbursement of doula  
9 services under the Medical Assistance Act; to change provisions  
10 relating to the Nebraska Prenatal Plus Program; to provide limits  
11 for crisis assistance payments under the low-income home energy  
12 assistance program; to harmonize provisions; to provide operative  
13 dates; to repeal the original sections; and to declare an emergency.  
14 Be it enacted by the people of the State of Nebraska,

1           **Section 1.** Section 68-901, Revised Statutes Cumulative Supplement,  
2 2024, is amended to read:

3           68-901 Sections 68-901 to 68-9,111 and sections 2 and 4 of this act  
4 shall be known and may be cited as the Medical Assistance Act.

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

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

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

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

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

29           (a) Proper administration of assessment tools;

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

1       (c) Methods for clarifying ambiguous or incomplete responses; and  
2       (d) Procedures that ensure accurate and complete assessment results.

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

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

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

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

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

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

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

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

30       (6) No later than August 1, 2026, and August 1, 2027, the department  
31 shall submit a report electronically to the Legislative Oversight

1 Committee of the Legislature, the Health and Human Services Committee of  
2 the Legislature, and the office of the Public Counsel regarding the  
3 implementation and use of assessment tools for waiver participants. The  
4 report shall only apply to the developmental disability waiver using  
5 intermediate level of care criteria and shall include, but not be limited  
6 to:

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

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

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

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

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

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

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

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

27 **Sec. 3.** Section 68-908, Revised Statutes Cumulative Supplement,  
28 2024, is amended to read:

29 68-908 (1) The department shall administer the medical assistance  
30 program.

31 (2) The department may (a) enter into contracts and interagency

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

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

20 (4) The department shall provide the maximum amount of retroactive  
21 coverage for each medical assistance eligibility category as permitted by  
22 section 71112 of the federal One Big Beautiful Bill Act, Public Law  
23 119-21, as such section existed on January 1, 2026.

24 (5) ~~(4)~~ The department shall prepare an annual summary and analysis  
25 of the medical assistance program for legislative and public review. The  
26 department shall submit a report of such summary and analysis to the  
27 Governor and the Legislature electronically no later than December 1 of  
28 each year. The annual summary shall include, but not be limited to:

- 29 (a) The number and percentage of applications approved and denied;  
30 (b) The number of eligibility determinations, including the number  
31 and percentage of those individuals remaining enrolled, terminations, and

1 other determinations;

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

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

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

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

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

22 (h) The average client call duration;

23 (i) The client call abandonment rate;

24 (j) The number of requests for a fair hearing separated by (i)  
25 eligibility category and program type, (ii) outcome, and (iii) amount of  
26 time until final disposition; and

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

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

31 (i) A description of the plans to implement community engagement

1 requirements for medicaid recipients, including the authority and  
2 effective date for the requirements and the recipients subject to the  
3 requirements;

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

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

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

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

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

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

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

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

30 (m) The number of identified cases of concurrent enrollment and  
31 external vendors contracted by the state to identify concurrent

1 enrollees, including a link to each vendor's contract. For cases  
2 terminated for concurrent enrollment, the rate of re-enrollment within  
3 ninety days after the date of termination and the rate of re-enrollment  
4 within twelve months after the date of termination; and

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

9 **Sec. 4.** (1) The Legislature finds that: (a) Doula services have  
10 been proven to reduce the cost of birthing and improve outcomes for  
11 mothers and infants; (b) one of the most effective services to improve  
12 labor and delivery outcomes is the continuous presence of support  
13 personnel such as a doula; and (c) support from a doula is associated  
14 with lower cesarean rates, as well as fewer obstetric interventions,  
15 fewer complications, less pain medication, shorter labor hours, and  
16 higher Apgar scores for infants.

17 (2) No later than January 1, 2029, the department shall reimburse a  
18 provider for doula services. Such reimbursement shall be paid by state  
19 funds at rates determined by the department. The department shall submit  
20 a state plan amendment, if necessary, to provide for reimbursement of  
21 doula services.

22 (3)(a) The department shall establish a work group of stakeholders  
23 and experts to develop an implementation plan, including appropriate  
24 reimbursement rates and appropriate training, certification, or  
25 experience requirements for doula services. The work group shall submit  
26 the implementation plan to the department no later than January 1, 2027.

27 (b) The work group shall be comprised of the following: (i) Thirty  
28 percent of the members shall represent the doula profession; (ii) thirty  
29 percent of the members shall represent communities of color  
30 disproportionately impacted by poor birth outcomes; (iii) ten percent of  
31 the members shall represent rural Nebraska; and (iv) ten percent of the

1 members shall have utilized doula services.

2 (c) Additional members of the work group shall include, but not be  
3 limited to: (i) Medical providers; (ii) public health professionals;  
4 (iii) representatives of tribal organizations; and (iv) community  
5 advocates.

6 (4)(a) For purposes of this section, doula means a trained  
7 professional who provides emotional, physical, and informational support  
8 for individuals before, during, and after labor and birth. This includes,  
9 but is not limited to, attending prenatal visits, support during  
10 delivery, and providing resources during the postpartum period.

11 (b) A doula shall have appropriate training, certification, or  
12 experience, as determined by the implementation plan developed by the  
13 work group described in subdivision (3)(a) of this section.

14 (c) A doula shall not perform clinical or medical tasks and shall  
15 not diagnose or treat in any modality.

16 (5) It is the intent of the Legislature to fund the state portion of  
17 reimbursement for doula services from the vital statistics subfund of the  
18 Health and Human Services Cash Fund.

19 **Sec. 5.** Section 68-9,106, Revised Statutes Cumulative Supplement,  
20 2024, is amended to read:

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

28 **Sec. 6.** Section 68-9,107, Revised Statutes Cumulative Supplement,  
29 2024, is amended to read:

30 68-9,107 Services eligible for reimbursement for at-risk mothers  
31 under the Nebraska Prenatal Plus Program include, but are not limited to:

1 (1) Six or fewer sessions of nutrition counseling; (2) psychosocial  
2 counseling and support; (3) general client education and health  
3 promotion; (4) a minimum of two breastfeeding support sessions; and (5)  
4 targeted case management.

5 **Sec. 7.** Section 68-9,109, Revised Statutes Supplement, 2025, is  
6 amended to read:

7 68-9,109 The Department of Health and Human Services shall  
8 electronically submit a report to the Legislature on or before December  
9 15 of each year beginning December 15, 2024, through December 15, 2034  
10 ~~2029~~, on the Nebraska Prenatal Plus Program which includes (1) the number  
11 of mothers served, (2) the services offered, and (3) the birth outcomes  
12 for each mother served.

13 **Sec. 8.** Section 68-1215, Revised Statutes Cumulative Supplement,  
14 2024, is amended to read:

15 68-1215 (1) For purposes of determining eligibility of a household  
16 for the low-income home energy assistance program pursuant to section  
17 68-1201 as administered by the State of Nebraska pursuant to the federal  
18 Energy Policy Act of 2005, 42 U.S.C. 8621 to 8630, the Department of  
19 Health and Human Services shall apply a household total annual income  
20 level of one hundred fifty percent of the federal poverty level published  
21 annually by the United States Department of Health and Human Services or  
22 such successor agency which publishes the federal poverty level.

23 (2) The Department of Health and Human Services shall make crisis  
24 assistance payments as necessary of no more than eight hundred dollars  
25 per program year and may authorize crisis assistance payments for more  
26 than eight hundred dollars per program year based on extenuating  
27 circumstances.

28 **Sec. 9.** Sections 4, 5, 6, 7, 8, and 10 of this act become operative  
29 three calendar months after the adjournment of this legislative session.  
30 The other sections of this act become operative on their effective date.

31 **Sec. 10.** Original sections 68-9,106, 68-9,107, and 68-1215, Revised

1 Statutes Cumulative Supplement, 2024, and section 68-9,109, Revised  
2 Statutes Supplement, 2025, are repealed.

3       **Sec. 11.** Original sections 68-901 and 68-908, Revised Statutes  
4 Cumulative Supplement, 2024, are repealed.

5       **Sec. 12.** Since an emergency exists, this act takes effect when  
6 passed and approved according to law.