LB777
2026

LEGISLATURE OF NEBRASKA

ONE HUNDRED NINTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 777

Introduced by Cavanaugh, M., 6.

Read first time January 07, 2026

Committee: Health and Human Services

A BILL FOR AN ACT relating to the Medical Assistance Act; to amend section 68-908, Revised Statutes Cumulative Supplement, 2024; to add eligibility and reporting requirements for the Department of Health and Human Services as prescribed; and to repeal the original section.

Be it enacted by the people of the State of Nebraska,

LB777
2026

Section 1. 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 federal law.

(5) ~~(4)~~ The department shall prepare an annual summary and analysis of the medical assistance program for legislative and public review. The department shall submit a report of such summary and analysis to the Governor and the Legislature electronically no later than December 1 of

LB777
2026

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 time until final disposition; ~~and~~

(k) A link to the medical assistance program fair hearing decisions

LB777
2026

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 compliance or exemption status; and

(ix) A list of external vendors contracted by the state to assess

LB777
2026

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. 2. Original section 68-908, Revised Statutes Cumulative Supplement, 2024, is repealed.