Medical Care Advisory Committee
Meeting Minutes
Thursday, October 19, 2023

The Medical Care Advisory Committee (MCAC) met on Thursday, October 19, 2023, from 3 p.m. to 5 p.m. CST at the Charles H. Gere Branch Library in Lincoln, Nebraska. The meeting was held in person and virtually.

MCAC members in attendance: Karma Boll, Frank Herzog, Vietta Swalley, Jason Petik, Kenny McMorris, Shawn Shanahan, Jason Gieschen, Kelly Weiler.

DHHS employees in attendance: Dr. Kevin Bagley, Matt Ahern, Jordan Himes, Joe Wright, Nikkola Bales, Dr. Elsie Verbik.

Members of the public in attendance: Tyler Andersen, Kelsey Arends, Kent Rogert.

MCAC members not in attendance: Dr. Jessica Meeske, Staci Hubert, Amy Nordness, Melanie Davis, Felicia Martin, Michaela Call.

I. Openings and Introductions

The meeting was called to order by Karma at 3:00 p.m. CST.

- The Open Meetings Act was made available for attendees.
- Jordan welcomed the meeting attendees and ran through the roll call.

II. Review and Approval of August 25, 2023, Draft Minutes

Karma asks for a motion to approve the minutes because the board does not have any revisions.

- Frank moves to approve the minutes, Vietta seconds. The motion passes.

III. Medicaid and Long-Term Care (MLTC) Business Updates

Enrollment Updates:

Jordan: In previous meetings, we were having issues pulling this specific set of data. I'm happy to announce that we have all the correct data to show you. I'm happy to send this data out to

anyone who requests it between now and our next meeting. We see a slight increase in our Medicaid/CHIP eligibles between March and June. In June, our enrollment was at 397,735. Moving down the table, you can see a similar trend. We have seen some slight decreases as well. For example, Medicaid parents and caretaker adults decreased very slightly in June. There was also a very slight decrease in Medicaid and CHIP children in June as well. These are extremely minimal differences across the months we've been tracking. You will find that Medicaid and CHIP Children make up more than 50% of our current enrollees, which is following a similar trend as it has in the past. Overall, we haven't seen much change in the data over the past couple of months. Regarding our Medicaid enrollment by month, you will find that Medicaid expansion numbers continue to remain the same, with a slight increase. We can also pull up the Unwind data if anyone is interested in more up-to-date information.

- Karma: Do we think expansion going up contributed to the Unwind?
    - Dr. Bagley: There are a couple of factors affecting expansion. First, most Medicaid members are just now hitting their renewals. We expanded in October 2020 since it's part of the annual renewal cycle. You're just now starting to see the numbers from the October, November, and December renewal dates. You're starting to see those members hit their renewals. We haven't seen a substantive decrease in enrollees in the months covered in this latest report. July, August, and September are when we began to see decreases in overall enrollment. It will be interesting to see how the dynamic changes over time. Our initial estimates had closer to 100,000 individuals being enrolled through Medicaid expansion. However, we never came close to these estimates. I assume we won't hit this estimate in the near future. We will probably see a net decrease overall, but I don't know by how much.
- Frank: Those people are probably easier to track down.
    - Dr. Bagley: I would say yes, with some caveats. One problem we run into isn't even finding the correct address for members, it's getting them to respond. Our return mail rate is about 3%. That's not to say the mail always reaches the right place, but the low return rate indicates that we are reaching the right address.
- Frank: Do you have data on what the response rate is?
    - Dr. Bagley: I don't have comprehensive data on the response rate at the moment. It will be an interesting piece to see as the months go on. As we look at households, I think where we see the most confusion is in households where we see different types of eligibility. Some people may be coming in as a parent, caretakers, or relatives. Someone else may be coming in through child benefits or disabled benefits. All the criteria are slightly different for each of those options. For example, you might see a parent say, "I know I don't qualify for Medicaid anymore because of my income." However, the child might still qualify for Medicaid because their income threshold is 200%. We want to emphasize to Medicaid members that they should send back their information because someone in your household might still qualify for Medicaid, but no one will if we don't have the most up-to-date information. The other piece of messaging we're trying to push is that

Medicaid is always open. If, for whatever reason, you lost Medicaid eligibility, if something has changed, you can always reapply. You could theoretically reapply the next day. I'll call out one more thing. We've had a discrepancy in our total enrollment numbers. Many people aren't being included on our dashboard. There may be a range of 8,000 to 9,000 people not being included in our Medicaid Unwind dashboard. We're trying to figure out how we navigate through this. With that being said, we are starting to see our enrollment numbers drop much more since July, August, and September. We're decreasing around 8,000 net individuals each month. To put this into perspective, the total disenrollment is considerably higher than 8,000. We're seeing people apply at a large rate. We're seeing many applications come into our system. Although we're seeing people go out through these renewals, we're also seeing people come into Medicaid. These aren't necessarily people re-enrolling in Medicaid.

- Frank: Do you have any idea why you're seeing more applications for Medicaid? Maybe it's a result of your messaging efforts. There has been public advertising on a scale I haven't seen.
    - Dr. Bagley: I don't have an exact reason as to why. The economy isn't doing poorly. The economics in Nebraska are such that I'm surprised to see an uptick in enrollment.
    - Matt: There's a lot of coverage in the media about Medicaid and eligibility. I wouldn't be surprised if this messaging is helping.
    - Karma: More awareness could lead to an increase in applications.
    - Dr. Bagley: The other aspect of this is the latent group of individuals for whom we know eligibility exists, but, for one reason or another, haven't applied. We may be seeing more of this latent group apply. There are so many factors that could result in this increase.
- Karma: In our last meeting, we were discussing people who could appeal their decisions. It doesn't seem like many people have tried to appeal.
    - Dr. Bagley: Correct, we've seen a very low number of appeals. This could be because the individuals who are getting denied for not meeting the financial criteria for Medicaid are very straightforward. Whereas if they receive a denial based on not returning their paperwork, my guess is they are much less likely to appeal a decision that they didn't feel like they had the ability or time to respond to. I believe that if we see this group re-enroll in Medicaid, it will be due to an emergent situation. For example, a prescription bill. One of the areas we're working on is looking at the characteristics of the crowd we are losing. About half are children, but this is expected given our demographics. But is this different than other years? Another aspect is that many people who aren't responding to our requests for additional information may be getting coverage from their employer. We also know of people who haven't filed a claim in over a year. We have people that have been in the system long enough that they have stabilized from our care,

so you're seeing a much lower average acuity of people coming into the system. This is because they've been in services long enough that they have stabilized.
    - Karma: Or they gained employment in that long window of time. They could be catching up.
        - Dr. Bagley: Yes. 15% of the denials we have each month are due to people not responding. Another 15% are due to people not meeting the financial criteria. Of the 15% of people who didn't respond, how many have been newly employed? How long has it been since these people have filed a claim? I'm certain, though anecdotally, that many of the denials from not responding are due to people not going through the effort of filling out paperwork to confirm something they already know, meaning they may have healthcare coverage through their employer or have improved their financial means. If we can figure out which group to make outreach to, then we will. We're just not hearing back from many people filing claims. We still have members using the system, but with just enough infrequency that they haven't figured out they don't have coverage right now. Our chronic care group has multiple monthly medications and will run into this very soon.
- Karma: In my opinion, it will be interesting to see how many members leave compared to the influx of members we've seen. It's an interesting dynamic that I didn't think we would see.
    - Dr. Bagley: I agree. Every year, we get an influx of marketplace appeals. In years past, pre-COVID, this was a huge amount of work that would come in around the end of the quarter. During COVID, these numbers weren't as high, but still significant. Given the changes in the past three years, I'm not sure how high this number will be. This is a big wildcard. We may see a big influx of applications near the end of the year.
- Karma: It will be interesting to see if this is just a brief surge, or if it's a trend that follows through the end of the year.
    - Dr. Bagley: Please continue to ask questions and look at our dashboard. We are always happy to provide more details if possible.

Review of Legislative Bills:

- Dr. Bagley: The first payments have already been made in accordance with LB1014. I'm not aware of what the status is on payments two and three. We don't foresee an outstanding issue with making those payments.
    - Frank: Has there been any change in authority or payment timelines?
        - Dr. Bagley: I'll have to follow up on what the status and timeline are, but as far as I'm aware, there hasn't been a change in authority. I will add that there is a federal proposed rule on staff ratios. I know this is causing some issues in our nursing facilities. It's a tight market, and they are concerned

whether they can meet staffing requirements. We can hold on to this discussion until later.

COVID-19 Public Health Emergency (PHE):

Karma: Nate isn't present to discuss this topic. Is there anything regarding the unwind we would like to elaborate on?

- Dr. Bagley: There are two pieces to what we broadly call the unwind and the Public Health Emergency. One is the continuous enrollment requirement, which gets much of the national media attention. The other side is changes to policy flexibilities that existed during the PHE. Some were heavily utilized, others were not. Trying to unwind all these flexibilities and answer various questions is an area of focus. Telehealth is one that's been at the forefront. I will share that we've put out updated guidelines on telehealth across all of the services that were available under the PHE. We've removed telehealth availability for some services. We're getting a lot of feedback from providers on some of those changes. The feedback we've received implies that we've made a mistake in removing telehealth availability from some services and the standard of care has shifted over the last three years. Many have said telehealth is a very effective way to conduct services. Many providers have evolved their practices through Telehealth. It's on us as an agency to catch up to this standard of practice. We're trying to adjust telehealth to the appropriate flow. We've heard some feedback already and we're going to take these comments back to discuss.
    - Karma: This will be an ongoing dialogue to find what the correct balance for telehealth should be. In terms of access, it helps the rural frontier areas.
        - Dr. Bagley: Yes. What I learned in the virtual listening tour was valuable. For us, it's about finding the right balance between access and fidelity of care. With the caveat that telehealth doesn't necessarily decrease the fidelity of care, but sometimes it could. We're trying to understand the trade-off and make a decision from there. There have been some seismic shifts associated with Telehealth in the past few years. We haven't always seen it.
    - Karma: Is CMS taking any positions on telehealth?
        - Dr. Bagley: They are. We tend to refer to their decisions.
            - Matt: However, their decisions have changed a few times. As we've been revising our policies, they have revised theirs. In some instances, it makes sense to refer to them, and in others, it merits additional caution.
        - Dr. Bagley: Yes. We try to keep up with their changes. However, Medicare has a different set of populations with different kinds of needs than the Medicaid audience. We tend to think about our populations and whether telehealth flexibility needs to be different for our populations.

- Frank: The rural areas are getting to a point where healthcare is difficult to access. Telehealth may not be quite as appropriate or as good as seeing a provider, but it's better than nothing.
    - Dr. Bagley: Yes, and that goes back to balance. The difference between 80% of the outcome and 0% is vast. 80% is still better than 0%.
- Karma: When I did nurse training, it was important that I had hands-on time with the patient. We have to change our mindset with the technologies we have.
    - Dr. Bagley: Yes. Interestingly, during our virtual listening tour, we had an occupational therapist tell me that they could look at my office and do an assessment of my environment. What they said is true. The point that has been raised in a couple of different areas, coming up with the ADA and physical therapy, is that one of the struggles these therapists have had in the past is getting caregivers the proper information to perpetuate those services. This allows the patient to do what they do at the physical therapist's office at home. By having these appointments done via Telehealth when appropriate, they are seeing much higher rates of engagement of the caregivers because they must. All of a sudden, the outcome may be better in some instances since you are getting the caregiver involved in a place you haven't before. This is the struggle. How do we ensure we are not disenfranchising people by not taking access away, but also paying for the outcomes we need to get?

Managed Care Organization (MCO) Contract Update:
Matt: We are on track with the implementation of the new contracts from managed care. As a recap, we had an RFP go out for procurement for bidders. Through that process, we are integrating dental in with the physical health, behavioral health, and pharmacy rather than having an ongoing standalone dental benefit manager. So, MCNA who was our dental benefit manager is transitioning out. Dental services will move on to our MCOs. Nebraska Total Care and United Healthcare will continue as MCOs in our market. Healthy Blue was an incumbent and didn't win the bid. Molina Healthcare won the bid. Starting January 1, the new contract position will take place, with Healthy Blue exiting and Molina Healthcare entering. Open enrollment starts on November 1. At that time, the members will have the option to choose whatever plan they elect to choose. Anyone who was on Healthy Blue, and did not elect a new MCO, will transition to Molina. We're in the thick of the review process right there. Our teams are reviewing hundreds of documents being submitted by the plans and their preparations. We're beginning to start the process of evaluating network adequacy as they've been working to build their networks both for dental but also for physical health, behavioral health, and pharmacy. We're moving forward and everything is going accordingly.

- Karma: One other thing I'd like to point out if I'm not mistaken, is that members have open enrollment where they can switch health plans anywhere, they'd like to go. Do they also have a window of time where they can go back without cause and re-elect?

    - Matt: I believe so. I believe it's a 90-day reconsideration period.
- Frank: Is there anything available after the 90-day reconsideration period? For example, if a medical emergency occurs.
    - Matt: There's an allowance for cause. There aren't likely to be situations that would cause someone to change, but there are pathways available.
    - Dr. Bagley: Even if it weren't a medical issue, we could see a case of two people who got married and have different Medicaid providers. We'd want to align those.
- Frank: One of the providers had better access to motorized wheelchairs. If someone had a sudden need for that, would they be able to change promptly?
    - Matt: That decision would be made on a case-by-case basis.

IV. Project Discussion

Karma: As we usually discuss, we want to see if we can move these projects forward to make a difference for Nebraskans on Medicaid.

Dental Student Reimbursement:

Karma: Dr. Meeske is not here, so we will table this discussion for the next meeting

Nursing Home Staffing:

Frank: Originally, this was scheduled to come out in February of this year. The proposed rule came out in September, and November 6 is the ending date for comments on the proposed rules. From my perspective, there is good and bad. First, there is something on paper that is being proposed, but unfortunately, the standard, from my point of view and others with nursing experience, is lower than we were expecting. Around 20 years ago, a study released, and has been replicated, showed that an appropriate level of staffing for nurses in nursing homes is four hours per resident day. Of those four hours, the whole group needs, on average, about half of a day is RN time, and about three and a half on average is spent with nursing aids. The standard that came out that is being proposed is three hours compared to four and has broken up two and a half hours of nurse aid and .5 hours for nursing. This came as a bit of a disappointment. To put it in perspective, the current standards are that nursing homes must provide enough care to ensure the safety of their residents. In my opinion, this is nebulous. There are a lot of facilities that make great attempts, but this has been a considerable problem for more than 20 years with not having enough staff. This is recognized by nursing homes, even those that don't agree with a fixed standard. The residents in the last 20 years, in many cases, have more problems, are frail, and are living day-to-day. They are in a nursing home because they cannot live with their family anymore. Even assisted living is often too great of a stretch for these people. They need to have people to help them out, and even have someone to help them with their meals, the toilet, and so on. They also need nursing staff to help them when experience shortness of breath. This is just one type of medical emergency that needs the expertise of an RN. In a nursing facility, these things happen all the time. These proposals, from my point of view, are very necessary. There's also a proposed requirement to expand the time needed for RNs. The standard that is being proposed in this rule is 24/7 care, always having one RN on duty.

- Jason: It's interesting hearing this conversation. In Sydney, we have a 63-bed long-term care facility that is not skilled. We adhere strictly to the requirement of caring for the patient's needs. We have a 5-star rating. Adhering to the patient's needs, in our case, is done through staffing appropriately, additional nursing, aid, and everything that goes into the care of these individuals. Where I get skittish is when I start hearing about mandatory staffing requirements for facilities. I'm sure we can discuss this topic on both sides. The problem I have with mandates is our leasing comes to us and they are not funded. We are already paid $30 a day per resident funded by Medicaid, even though we have a provider tax from the state. So, first, where do I get the money to pay for these staffing levels when we have more than one eight-hour shift? The first eight-hour shift is for MRN, but we also have a DON who's in the building eight hours a day. So, from a dollar standpoint, where am I going to receive the funding to help pay for these mandated expenses? Secondly, if I had people to hire, show me where they are at. We are at an all-time low in terms of the ongoing nursing shortage. No one is going into nursing anymore due to COVID-19. We have more people retiring from nursing and fewer people going into it. So, as well intended as these mandates may seem, there's a lot to the practicality of it, that will make it very difficult. I think this is why you see some pushback. I think this is an interesting discussion point, and I enjoy hearing your side of the issue.
    - Frank: First, if you operate a 5-star facility, you are to be commended, because that's not an easy designation to get. Second, there are some exceptions in the proposed rules. There is a delayed period for them to come into effect to give time for the facilities to get up to the standards proposed. There's also the possibility of a 100-million-dollar investment to train more nurses and improve the workforce. If you are in a rural area, there are exceptions, especially if you can't find staff.
        - Karma: Are those exceptions just for rural areas?
            - Frank: They aren't just for rural areas, but they do have an emphasis on rural areas.
                - Karma: Thank you, there are shortages across the state.
    - Frank: I do understand what you're saying that it may be difficult. But there is a whole wealth of data that shows there is a minimum staffing level required to give the residents the care that they need. There must be a sweet spot here. In my opinion, there must be some kind of change, because the system hasn't worked. I'm sure you have more time in nursing homes than I have, but I've been going to nursing homes for 17 years and seeing call lights being on for 45 minutes. There are sometimes residents in bathrooms hoping to get out. In its current form, I don't believe it works.
- Jason: I completely agree that there are circumstances that are not ideal for the residents. Even in our facility, I see things we need to improve on. If there is going to be a mandate, what will the state do to fund that mandate? Half of the hospitals in the state of Nebraska are losing money. I'd guess the nursing homes are also losing money. Our nursing home in Sydney loses three-quarters to a million and up to $1.2 million a year. We are building a brand-new facility, but it's only because it's attached to the hospital.

This allows us to subsidize those dollars to push this project forward. If we are going to institute these staffing mandates, there needs to be something put in place to help subsidize these things. Facilities are already upside down when it comes to Medicaid and funding. As more and more people age out, the payer shifts to more Title 19 and more Medicaid. If this is going to be the case and this is going to be the payer source, how is it going to move forward? The logical end to this, in my mind, is that these individuals will go more to the states. I don't believe anyone will have the dollars to take this on.
    - Frank: Some facilities are doing okay.
        - Jason: Yes, there are.
    - Shawn: I am from Fremont and, Jason, and I are in a similar position. We have the nursing home attached to our hospital and the loss is significant and the hospital carries it. We can't maintain these losses on an ongoing basis. I hope that there is further discussion, and I hope there's a conversation on support.
- Karma: Jason, I have a thought to bounce off with you. Part of this is if they mandate the staffing ratios and it carries a large financial burden on your facilities, but you also have to bake into this what COVID-19 did to the hourly rates of staffing. There's been a 20% increase in salaries compared to pre-COVID-19 salaries. These increases will not go back.
    - Jason: This is correct.
    - Frank: We were talking about money earlier, and there is a significant amount of money in the state for both incentivizing direct care staff to stay and giving them increases. This will go on for a few years. There are more in this proposal.
- Karma: At one point, we had some dialogue into ways to get more nurses and aids in the system. We talked before about looking at different models. Some of this money can go to the facilities to develop different career pathways so facilities can create their staff.
    - Dr. Bagley: All of these are options. I will share some thoughts. Jason, your point about the unfunded mandate aspect of this proposal is very well taken on my part. Without stating our thoughts on the regulation, you are seeing high rates of proposed regulations from the federal government. These are well-intentioned. I'm being purposefully neutral here, but the message the federal government is giving to us is that these changes are long overdue. For us, it's decades' worth of changes that we are trying to make now. Yes, making them decades ago would have been better, but now is the next best time. With the long-term care space, almost 75% of long-term services and support are paid for by Medicaid. What we will see is the additional cost associated with compliance will have to be consistently taken by the Medicaid program. The ARPA dollars are timely, but they are also time-limited. Hopefully, we are using them to lay the foundation for future improved processes and improved opportunities, pathways, and models of care.
        - Karma: It's important to look at highly successful organizations to see what they're doing.

    - Dr. Bagley: When we talk about the staffing issue, particularly for rural areas, part of it is an economic development issue. We're seeing increasingly, particularly with young people, leaving rural parts of the state and either coming to Lincoln and Omaha or leaving the state entirely. Are we creating the economic development conditions in rural parts of the state to maintain the level of employment needed to maintain these facilities? I share all this to say that we have been paying a lot of attention to the Medicaid program. No matter our opinion on the regulations, I'm sure the federal government will be pushing hard to have the final rule released quickly. There is a lot that goes into this. We are trying to plan for contingencies, whatever they may be.
- Matt: From the Medicaid policy side of things, as our team reviews these regulations, we are looking into the impact regarding access to care and quality of care. We're trying to find the right balance. Our policy team has been having ongoing and active conversations with their colleagues around the state, across different states, and in nationwide conferences. Some of the feedback we're getting is that there's such a significant response that there's likely to be significant revisions to these rules. It may be that what we are looking at right now looks different from what we receive in the future. We will be looking at assessing the impact and making comments when appropriate.
- Frank: I want to make sure the side of the resident in the home is a big part of the decision. What's currently in place isn't working. Our parents will be in a nursing home one day, and it is not easy for them there. It may take more money to accomplish these tasks. I don't have insight into the financial book of each facility. I know there is a significant potential problem for private and equity ownership of nursing homes. Their goal is to satisfy shareholders and make profits. I think this needs to be factored in. There needs to be greater visibility into the financial conditions.
    - Karma: No matter what side you're on, the federal government doesn't want our facilities to be where they were around three years ago when multiple facilities closed. You can't worry about the quality of care if there is no care.
        - Dr. Bagley: We continue to see facilities close. It doesn't serve the state. I will say that it's not just a census issue. We've seen facilities close that have a nearly full census. I don't have a perfect solution, but we need to pay attention to it.
    - Karma: I remember having a dialogue about repurposing space. Are there some populations that are not being served?
        - Dr. Bagley: We've had many conversations surrounding these topics. How do we create opportunities for a diversified revenue stream for nursing facilities? Federal regulatory structure tends to have them isolated from the rest of healthcare spaces. I don't think this serves communities. I will share that a couple of months ago, Senator Ricketts had good conversations with our stakeholders and providers to find out what issues are affecting our process of getting people from hospitals to the appropriate facilities in the post-acute state. We discussed nursing homes closing and other issues.

There are varying opinions, but also a consensus that we need to do better. What better looks like isn't too different amongst people. The main difference is how we get there. Ideally, the location of services isn't as relevant as the quality. We can serve people safely in their homes in a lot of cases. However, they still need the right support system. Nursing homes are necessary and an integral part of continuing care. We need to find ways to serve people in the ways they want to be served. It is big and expensive.

- Frank: One aspect that is affecting us now is that baby boomers are advancing in age. They are well past 65 and are moving towards 85. These are the people you see in the nursing homes. They don't want to be there, but it's often the last resort.
    - Dr. Bagley: I've shared with a lot of people that the highest risk of homelessness is the nursing home population. One of the most important services nursing homes provide is housing.
- Frank: I take it that Nebraska Medicaid hasn't submitted comments to the proposed mandates.
    - Matt: No but our evaluation of it should come from leadership near the end of the month. This will be an analysis.
- Frank: Does Nebraska Medicaid generally comment on every proposal?
    - Dr. Bagley: Often, we don't provide an official comment. Over the past couple of years, I've had a great relationship with the director of CMCS, which is Medicaid, and CHIP Services, which is a part of CMS.
- Karma: Thank you for the dialogue and all the input.
    - Jason: I appreciate the conversation as well. I know it's difficult. We will talk about it again.

Maternal and Newborn Health:

Karma: Our first meeting with the maternal health workgroup was on August 29. We did a review of a lot of documentation, research, and more. We looked at the big picture of Nebraska's maternal and newborn health. This includes the March of Dimes information. We also looked at the website of the Nebraska Perinatal Quality Improvement Collaborative, which has been around for many years. It does a lot of worthwhile things and creates many worthwhile educational materials. Several of us had the opportunity to go to the Maternal Health Symposium in Columbus. I thought that was wonderful. We also looked at the Nebraska Medicaid website regarding information on maternal and infant health. There are many resources on the website. Shawn, this is where I'll have you speak up.

- Karma: First, will the Maternal Health Symposiums continue going forward?
    - Dr. Bagley: Yes. We haven't formally planned another time and location, but we've had conversations with the College of Public Health in UNMC as well as others. We are looking into ways to accomplish this in a very collaborative way.
        - Karma: I think our workgroup could collaborate with that as well, adding another component. We will be looking forward to leveraging this relationship.

Shawn: There is funding from the Nebraska Children's and Family Foundation that is funding community collaboratives across the state. Their overall goal is prevention on a higher level of care, preventing kids from entering child welfare, providing funds and support for maternal and newborn health, and improving the well-being of children at the time of birth. Fremont is one of the lucky communities where we have collaboratives. I have reached out to the Nebraska Children's and Family Foundation to see if they can bring a representative to our upcoming meeting in December. They can share more about the work that they're doing across the state. Additionally, we can learn if our work fits the work that they do. We can also learn how they measure success and outcomes, new funding opportunities, and how we partner with different communities to improve care for moms and babies.

- Karma: Thank you for that excellent explanation, Shawn. The other thing you mentioned, which is a wonderful idea, is inviting the three MCOs to participate in this dialogue. You also thought the Division of Public Health could be leveraged. You have to include all organizations to improve the outcomes for maternal health across the state.
    - Shawn: A true collaborative has outcomes, work groups, churches, businesses, non-profits, funders, and so much more sitting on the table for the same goal. They have formed a community and structure to help people. They're leveraging different funding sources to get the most dollars and use it efficiently. We as a hospital just partnered with the coalition. They used grant money to purchase car seats, onesies, Pack 'n Plays, blankets, and more so that any mom who is in crisis at the time of birth can receive these items, no questions asked. Also, our recipient just received a grant so our OB/GYN nurse navigators paid $50 on the grant for services and support. We also, as the foundation, just agreed and are funding more than three visits to at-risk families and families in poverty after Medicaid does their three visits to provide safety and overall well-being. We focus on leveraging the money, getting the outcomes collectively, and working as a collaboration on the same outcome. I was waiting for a possible date change in December before sharing with this group.
- Karma: Shawn, we would like you to speak in December. We can also have the MCOs there and get them to look at the bigger picture. We need to learn how to leverage our resources to get to the right people. We're charged. We're taking this one and running with it. We also looked at other objectives and resources but concluded that many things require legislative changes. Outside of that, the sky is the limit.
    - Dr. Bagley: We will welcome recommendations. I can't make a legislative change, but I can certainly share these recommendations. If there are recommendations that come out of this, then we will take them to the right people.

- Karma: One of the other things we talked about is not getting the early notification for pregnancy. Dr. Verbik, I will let you speak to this.

    - Dr. Verbik: Regarding the unbundling, we have talked about it several times. We need to look and see if it's an opportunity or if it's not feasible. Some providers say it will be difficult for them to unbundle. In other words, their rationale is that they feel it will be hard to unbundle because some of them don't have coding experts. It requires them to unbundle and bill every maternal service they provide. They prefer to bundle to reduce hardships. We will keep looking at this and see if it is an opportunity. What people have talked about instead is that if unbundling is difficult for providers, then the use of CPT2 codes could help. Some CPT2 codes can be used, it will just be a claim. That will capture the very first prenatal visit. That's what we want to know, that hospitals have a pregnant patient in their clinic. This can be sent to the MCO, and this patient can be flagged for additional care. There are options on the table.
        - Karma: Another thing we can do is work with the MCOs on stipends. It's in everyone's best interest to identify pregnant patients during the first trimester. There is plenty of opportunity.
- Dr. Bagley: For people not aware, as of January 1, we will have continuous eligibility postpartum. This is exciting. The legislation in the past required 6 months. The level of efforts to do 6 months vs 12 months wouldn't have made sense. In talking with the governor, he felt like it was important for us to take care of the moms. The 12-month continuous eligibility will start January 1.
    - Karma: I would suggest that if the state could measure and monitor the impact of this extension, then we can find worthwhile results.
        - Dr. Bagley: I hope this will. I think the other piece is whether we will see the level of utilization we hope to see in terms of our postpartum population. Can we leverage access in the postpartum period for services like behavioral health? They may not be necessary for everyone, but we want to see if there is an increase in the utilization of these services. We anticipate thousands of moms being covered, who otherwise wouldn't have been before this extension.
- Shawn: Who will take the lead in inviting the MCOs to our next meeting in December?
    - Jordan: I will make sure to take the lead and invite these people.
    - Dr. Bagley: Susan Bockrath would be the first person to talk to. For the MCOs, I can find the right person to contact.
- Karma: Did we want case management involved or did we want higher up involved?
    - Dr. Verbik: We want the chief medical officers and the chief nursing officers. They may want two of their lead case managers. We can also invite high-risk maternity nurse leaders. At least the CMOS and CNOs.
- Dr. Verbik: After the Maternal Health Symposium, we debriefed with each of the CMOs and CNOs and talked through our opportunities and what we learned. The three CMOs and CNOs are very strong together. The maternal health focus has been at the forefront in the past couple of months. We are so delighted by all the momentum behind maternal health with local health departments, DPH, Medicaid, our MCOs, and more. We now

need to connect the dots, so our efforts are synergistic. I just want you to know that we have been working in-house very closely to get the frontiers going and go forward with the action steps.
    - Karma: The symposium was so powerful. We can work in concert with one another and leverage our relationships.

Other Potential Projects:
Karma: I want to offer this time to see if there is anything you all have thought of that you believe would make a worthwhile project. Does anyone have any suggestions for educational topics? If you do, share them with me or Jordan. Seeing no other suggestions at this time, we will proceed with these three.

V. Suggestions for Future Educational Opportunities
Karma: We have identified one and this will be in our December meeting.

VI. Discussion of New Members and Vacant Positions
Karma: How many vacant positions do we have?

- Jordan: We have three open positions. Two of them are provider positions and one position is a member representative.
    - Dr. Bagley: We are actively working on this, and we will have more updates to come.
- Tyler: I did submit my application. I am awaiting a response.
    - Dr. Bagley: Thank you, Tyler, we appreciate it. One of the questions we always ask ourselves as we go through is if we have a broad representation across providers and members. As we evaluate applications, it's mostly a function of whether we have a broad array of opinions. Tyler, I appreciate you being here. Regardless of if we have someone as a member of the community, these are public meetings. We want people with feedback and thoughts to share. I appreciate your patience and we will follow up.
    - Jordan: I apologize, Tyler. I saw your email the other day and I responded, but it may not have gone through.
        - Tyler: Thank you all very much.
- Dr. Bagley: On the note of proposed regulations. One regulation includes provisions for how we conduct our advisory committee. Some provisions speak directly to representation from our members. There are specific requirements around it. I believe the way we've set things up currently would meet those requirements. I don't think we would need to change anything. It's important to note that there is specific language surrounding beneficiary representation.
    - Karma: We will need to make sure we check the boxes going forward.
        - Matt: We'll see what the language looks like, but it wouldn't take too much for us to check any box we need. This is barring the final language from the proposal.

VII. Confirm the Next Meeting Time and Location

Jordan: The next meeting date and time will be December 14 from 3 to 5 p.m. at a location in Lincoln. Please provide your suggestions about locations, including opportunities to host our group. A virtual option will remain available.

VIII. Open Discussion

Karma: Are there any topics that someone would like to bring up for discussion?

- Vietta: There was something about children on Medicaid for 2024. Do you have specific information about this?
    - Dr. Bagley: In addition to the 12-month eligibility post-partum, federal law now states we need 12-month eligibility for children. What this means is that any child that's eligible as of January 1 will have their 12 months of eligibility applied, but it won't necessarily apply from January. It will apply from when the last renewal review was. Regardless of changes in circumstances during those 12 months, children will continue to be eligible. I'll give a stark example for demonstration purposes. Say we have a family that makes 75% of the federal poverty level, that child qualified. Let's now say both parents are doing well and now make 250% of the federal poverty level, the child will still have coverage for 12 months from their review period.
- Member of the public (did not self-identify): I want you to elaborate on your changes to Telehealth,
    - Dr. Bagley: There have been areas where we've pulled back on the Telehealth front. Some codes have not. Since then, we have received a lot of feedback, and the areas I've seen the most feedback have been about outpatient therapy, specifically physical therapists, and occupational therapists, and applied behavioral analysis treatment. We've pulled back on these, but we've heard that the standard of care has shifted dramatically since then. We are trying to see where these shifts are so we can appropriately apply them. If there are areas where providers and members feel like we've missed the mark, call us out on it. Send us an email, give us a phone call, and tell us what we missed. CMS is trying to be well-intentioned with their rules, but they don't always get it right. The same applies to us. We often don't know if there's an issue until someone brings it up. We may end up disagreeing with the feedback, but it at least informs us of people's thoughts.

IX. Adjournment

Vietta makes a motion to adjourn which is seconded by Frank at 4:40 p.m. CST.