Medicaid Advisory Committee
DRAFT Meeting Minutes
Thursday, January 16, 2025

The Medical Care Advisory Committee (MAC) met on Thursday, January 16, 2025, from 3 to 5 p.m. CST at the Milton R. Abrahams Branch Public Library in Omaha, Nebraska. The meeting was held in-person and virtually with a call-in option also available.

MAC members in attendance: Heidi Stark, Jennifer Hansen, Josh Sharkey, Kelly Weiler, Philip Gray, Shawn Shanahan, Staci Hubert, Vietta Swalley, Kenny McMorris

MCO representatives in attendance: Adam Proctor (Nebraska Total Care), Dr. Debra Esser (Molina Healthcare), Holly Randone (Nebraska Total Care), Jeremy Sand (United Healthcare), Megan Millea (United Healthcare), Morgan Horst (Molina Healthcare), Jonathan Rich, Keith Derks

DHHS employees in attendance: Bailey Reigle, Becky Peplinski, Celia Wightman, Charity Menefee, Drew Gonshorowski, Dinah Wetindi, Dr. Elsie Verbik, Gillian Daniel, Jacob Kawamoto, Jarren Breeling, Jennifer Clark, Matthew Ahern, Kris Radke

Members of the public in attendance: Angela Gleason, BreAnne Davenport, Chelsea Carrera, Cheri Albin, Chris Elliot, Deb Schardt, Dr. Ned Stringham, Edison McDonald, Heidi Stark, Paige Rivard, Sarah Maresh

(8 call-in/phone numbers were present for the meeting)

MAC members not in attendance: Michaela Call, Jason Gieschen, John Andresen (planned absence), Bradley Howell, Dave Miers

I. Openings and Introductions

The meeting was called to order by Amy at 3:02 p.m. CST.

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

II. Review and Approval of November 21, 2024, Draft Minutes

The Committee had no revisions for the minutes, Amy asked for a motion to approve the minutes. Jennifer Hansen made the motion; Phil Gray seconded the motion. The motion passed unanimously.

Follow Up Items from the November MAC Meeting:
Due to time constraints, this update wasn't shared at the meeting. MLTC noted that they would share the following updates:

- Cindy Kadavy with the Nebraska Health Care Association (NHCA) raised concerns at the November 2024 MAC Meeting related to access to Medicaid and Waiver services. They had seen a couple of cases where individuals applied for the Aged & Disabled (AD) Waiver and Medicaid at the same time. They voiced seeing issues where those who are applying for AD Waiver and Medicaid services and still live in their home are receiving approval and services quicker than those who are applying for both and also moving to or living in an assisted living facility (ALF).
    - **ANSWER:** The general processes for eligibility applications and determinations are the same for someone who is living at home versus someone living in an ALF. However, the budgetary requirements and standards differ based on the individual's current living arrangement (someone living at home, someone in an ALF with no Waiver, and someone in ALF with Waiver services), and so the timeframe for the eligibility determination can differ based on the individual's personal circumstances and situation. Since MLTC doesn't cover room and board, MLTC does try to prioritize and handle ALF cases on an expedited basis to avoid leaving the applicant with months of rent that MLTC can't cover and they can no longer afford.
        - Medicaid and the Division of Developmental Disabilities (DD) are continuing to coordinate their efforts for applications where individuals apply for both Medicaid and Waiver coverage (or when Medicaid-eligible individuals apply for Waiver services).

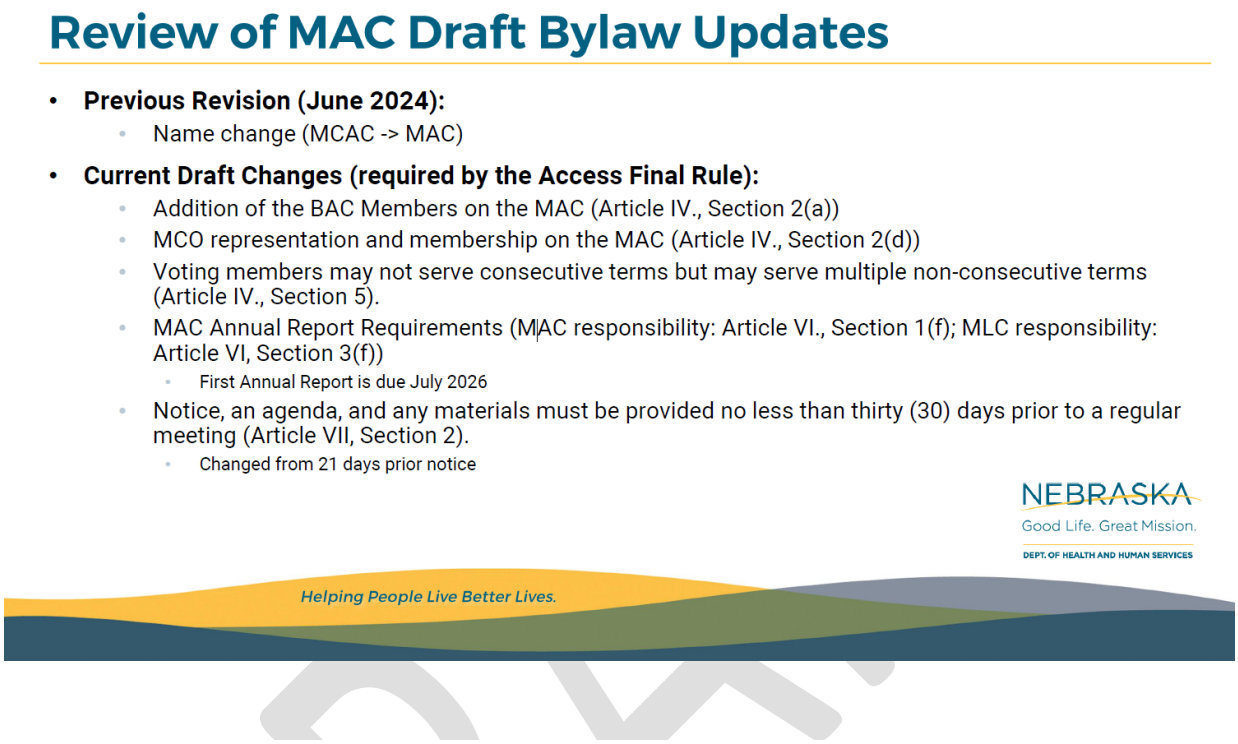
- MLTC worked with Cindy (and the provider who reported seeing these issues) to look into the cases and help address any underlying procedural problems or barriers. In both cases that were reviewed, there were procedural delays from Medicaid in getting the cases reviewed/approved (which were due in part to extremely large caseloads for field staff after the Medicaid Unwinding).
    - In the first case, the delay was with Medicaid initiating and completing the deprivation of resources review (which is required for both the Medicaid and Waiver eligibility processes). The Level of Care and all consent forms for the waivers were completed toward the end of October. However, the deprivation of resources review wasn't started until mid-November and was completed toward the end of the month. Eligibility for Medicaid and Waiver services were approved back to 11/01/24.
        - The concern from the provider was that Medicaid and Waiver approvals would be started once Medicaid and DD finished

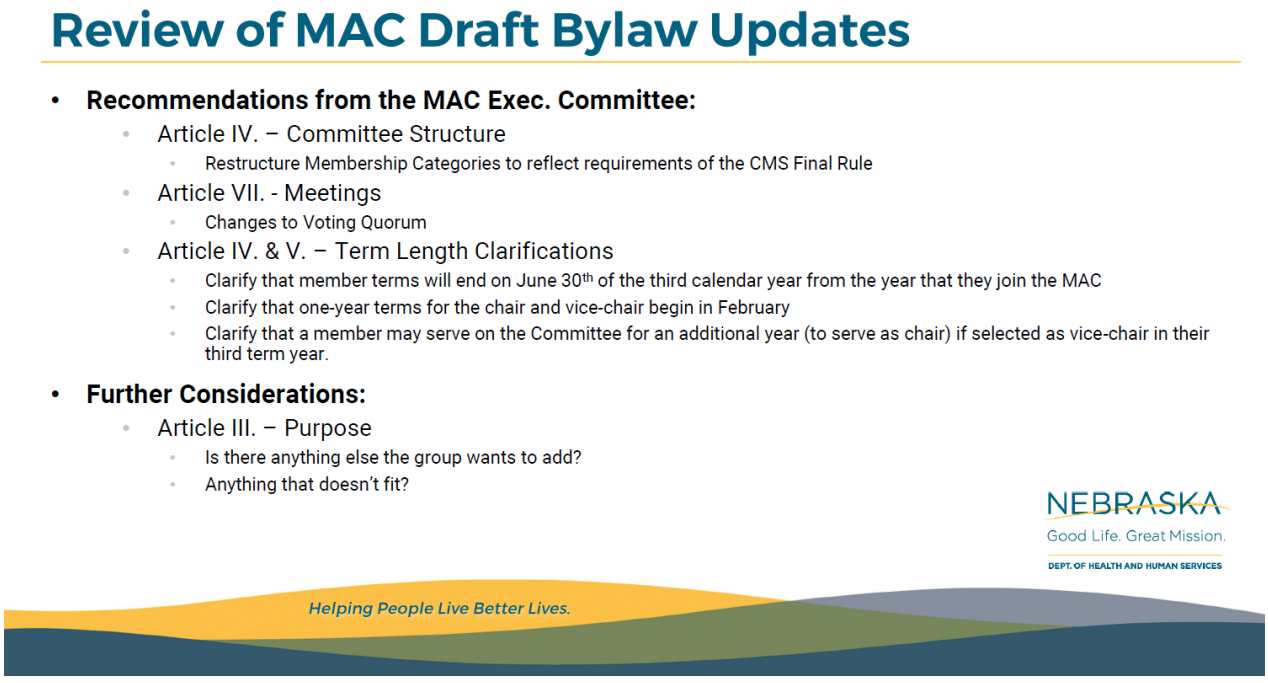
their reviews instead of when the beneficiary moved into the assisted living facility (ALF). But the reviews were completed towards the end of the month, and retroactively effective back to the beginning of the month (which is when the beneficiary moved into the ALF).

- In the second case, the beneficiary was already eligible for and receiving Medicaid and Waiver services. In late August, during their review, it was determined that more information was needed to determine eligibility, and a request was sent from Medicaid (additional requests were also sent later). It was determined toward the end of October that the necessary information hadn't been received, and so the case was closed with an effective date of December 1, 2024. However, on November 1, 2024, Medicaid received the necessary information was received, and the case was updated and re-opened on November 1, 2024. Since the case was never technically closed, and was re-opened before the scheduled closure date, there was no gap in Medicaid or Waiver coverage. Another Level of Care assessment for Waiver services was not needed either since coverage was never technically closed.
    - The concern from the provider was that the beneficiary lost eligibility as of November 1 and would lose Waiver eligibility as a result, causing the beneficiary to need a new re-evaluation for Waiver eligibility. But since the necessary information was received before the case's closure, the case technically never closed. In this case, notice of the beneficiary's closure was sent out at the end of October, but the effective date of the closure wasn't until the beginning of December.

III. Review of MAC Draft Bylaw Updates

Jacob presented the following proposed bylaw updates:





Discussion: Some members voiced concerns about the updated bylaws no longer requiring that at least 51% of Medicaid Advisory Committee (MAC) votes be made up of beneficiaries.

- **MLTC:** Prior to the federal July 2024 Access Rule, Nebraska's Medical Care Advisory Committee (MCAC) required that 51% of their voting members be made up of Medicaid beneficiaries, such as those receiving Medicaid, their family members, or their caretakers. However, to satisfy the regulations of the Access Rule, Nebraska Medicaid and Long-Term Care (MLTC) has shifted the MCAC to become the MAC and is working to establish a separate Beneficiary Advisory Council (BAC). At least 25% of the MAC must be comprised of BAC members, while the BAC is made up entirely of beneficiaries (past or present), their family members, or caregivers. The addition of the BAC will provide an avenue for beneficiaries to directly advise MLTC from the member's perspective. Given that BAC members will also sit on the MAC as voting members of the committee, MLTC anticipates that the creation of the BAC will lead to an increased focus on the member's voices and perspectives.
- Removing the requirement for at least 51% of MAC members to represent member perspectives, and the requirement for at least 25% of the MAC to be made up of BAC members by July 2027, also does not limit the number of MAC members representing Medicaid beneficiaries. Language was added to the Bylaws to explicitly allow for additional MAC members representing Medicaid beneficiaries beyond just the BAC members on the MAC. This change is also driven in part by other requirements of the Access Rule to incorporate representatives of Community-Based Organizations (CBOs) and Managed Care Organizations (MCOs) as part of the MAC.
    - One MAC member noted that they thought the implementation of the BAC could potentially elevate the voices of members since the BAC will be established to exclusively focus on the perspective of Medicaid beneficiaries and provide members the opportunity to advise the Medicaid Agency directly.
    - Those present from the MAC voiced and/or agreed with the sentiment that with these coming changes in response to the Access Final Rule, the MAC shouldn't lose its focus on the member's perspective. Everyone's interests are different, however the individuals receiving services and benefits should have their voices heard.
- **QUESTION:** Do you think the member voice will be diluted with these coming changes?
    - With the transition from the MCAC to the MAC and the BAC, committee members want to ensure that Medicaid beneficiaries are invited to the main table of discussion. One MAC member voiced that it could feel like the BAC is the "kid's table" and the MAC the "adults table."

        - Everyone present at the meeting (MAC and MLTC representatives) agreed that this dynamic is one to be avoided, and the implementation of the BAC should be carefully considered to ensure it provides meaningful engagement and feedback from members.
- As part of the discussion about bylaws, the MAC also discussed meeting quorum. The draft bylaws proposed changing quorum from 51% of MAC members to one representative from each of the following categories: member, provider, MCO, and community-based organization (CBO). The goal of this would be to make it easier for the MAC to meet quorum at meetings, as there have been instances in the past where absences have prevented the committee from meeting quorum and voting.

Member Vote: MAC members approved the proposed bylaws with a majority vote of eight in favor and one against.

- MAC members agreed to approve the bylaws with the goal of at least 51% beneficiary representation on the MAC, despite it no longer being an official requirement.
    - The MAC discussed revisiting this topic six months from the implementation of the BAC and new Access Final Rule requirements (which take effect July 2025) to assess whether they feel the voice of Medicaid members is being adequately addressed.
- The MAC members' vote also included a recommendation to edit the proposed draft bylaws to memorialize the effective date of June 17, 2024, for the varying length of member terms determined by drawing lots. This would clarify that the requirement to draw lots to determine varying term lengths is not effective every time new changes are made to the Committee's bylaws.

IV. Appointment of New Committee Vice Chair

Amy nominated Jenifer Hansen. Jennifer accepted the nomination. The MAC members voted unanimously to appoint Jenifer Hansen as committee vice chair.

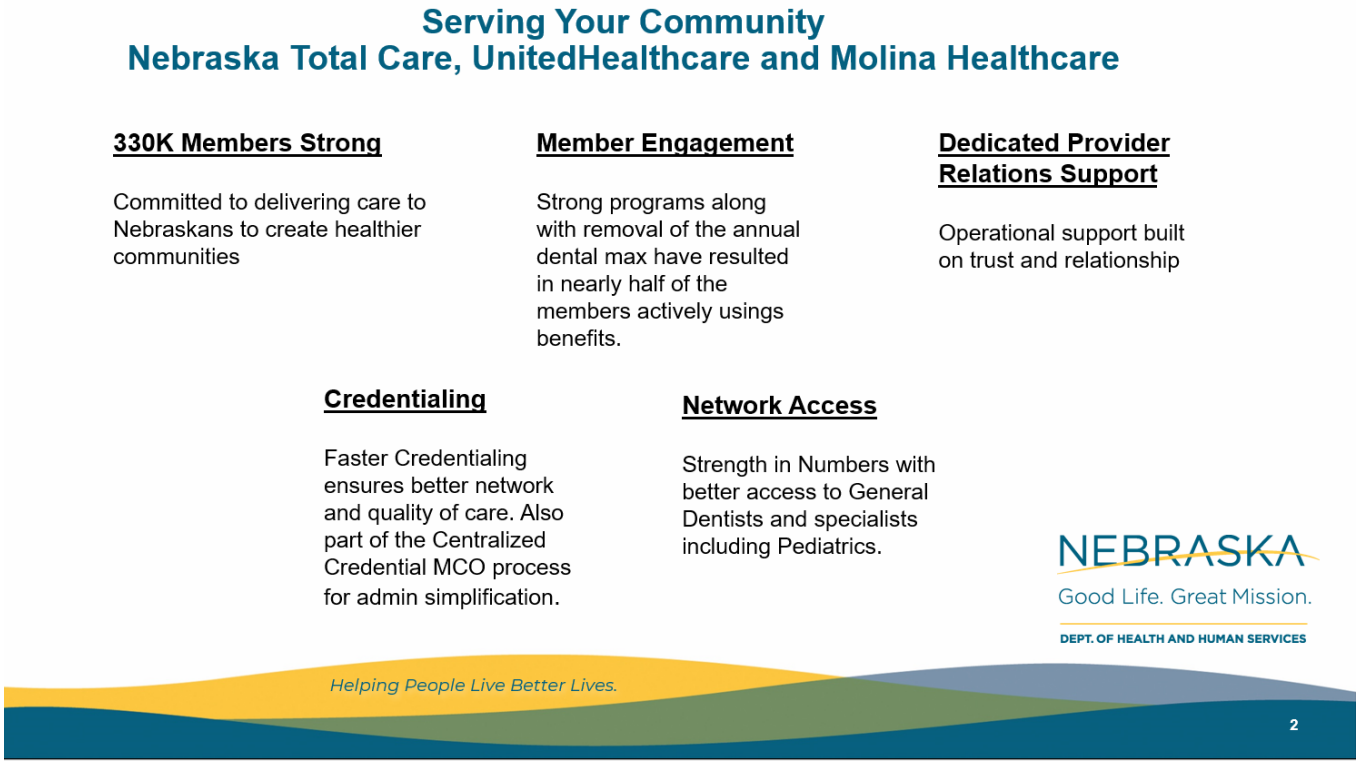
V. Review and Discussion of Current Member Terms

Amy reviewed the following member terms:

Name	Email	First Meeting	Term	Representative
Michaela Call	michaela.b.call@gmail.com	8/22/2022	Jun 2025	Medicaid Member
Philip Gray	nugrad68@icloud.com	3/21/2024	June 2027	Medicaid Member
Jennifer Hasen	jenniferl.hansen@unmc	3/21/2024	June 2027	Medicaid Member, CBO Representative
Josh Sharkey	sharkman_23@hotmail.com	23-May	June 2027	Medicaid Member
Shawn Shanahan	shawn.shanahan@nmhs.org	6/23/2022	June 2027	Medicaid Member
Vietta Swalley (Committee Chair)	vietta.swalley@ihs.gov	4/21/2022	June 2025 June 2026 -- Extension for Chair	Medicaid Member, Provider
Jason Gieschen	jasman1_84@hotmail.com	8/22/2022, Agreed to stay for full term August 2023	1st term ended August 2023, 2nd term ends June 2026	Medicaid Member
John Andresen	jandresen@childrensomaha.org	3/21/2024	June 2027	Provider
Bradley Howell	bradley.howell@rwhs.org	1/27/2022	June 2027	Provider
Staci Hubert	shubert@nesp@gmail.com	1/27/22, Agreed to stay for full term 2/17/2023	1st term ended August 2023, 2nd term ends June 2026	Provider
Kenny McMorris	kenny.mcmorris@charlesdrew.com	6/23/2022	June 2025	Provider, Advocacy Group
Dave Miers	dave.miers@bryanhealth.org	3/21/2024	June 2027	Provider
Amy Nordness (Committee Chair)	asnordness@unmc.edu	1/27/2022, Started as Chair in February 2024	June 2025, Does not roll off in 2024 due to chair role	Provider
Heidi Stark	heidi.stark@lpden.com	11/21/2024	June 2027	Provider
Kelly Weiler	kweiler@childrensomaha.org	8/24/2023	June 2026	Provider

VI. Dental access across the state

MCO representatives slides the following presentation and discussion:



Dental Utilization

With the benefit carved in effective 1/1/24, member utilization for services for the 3 MCO's had been on the rise with the 3 MCO's processing ~25K claim a month(combined).

Emergency Care Reduction – The 3 MCOs preventative care initiatives showed positive impact with non-traumatic dental emergency visits decreasing(UHC).

Pregnant Member Utilization: Quarterly claims analysis to identify High Risk Pregnant Members without a dental exam during pregnancy for Case Management outreach; Member Education on Oral Health during Pregnancy (Molina).

Mobile Dental Van – Meet Members where they are in the community to provide exams, sealants, School screening, children's prophies and Fluoride varnish services. (Nebraska Total Care).

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Helping People Live Better Lives.

3

Starting in 2024, dental benefits were administered by the MCOs instead of a separate dental benefits manager, and the MCOs saw an increase in utilization of dental services in the first 6-7 months of they year. With the removal of the previous $750 dental service cap, approximately half of all members enrolled in the Heritage Health Program have utilized dental services available to members.

Molina shared about their Provider Relations and Case Management efforts. Molina has two provider relations dental representatives, slit across the state by geographic area. They also have a dental management coordinator who helps refer individuals and cases to other case management services and teams within Molina. The dental management coordinator helps ensure that members have a dental home.

- This kind of integrated coordination helps remove barriers and to members accessing dental services.
- The MCOs have also done single-case agreements for out-of-state providers and out-of-network providers.
- Overall, the MCOs have been able to deliver more dental services through integration of the dental benefit.

Credentialing – previously, each provider would have to apply and credential with each MCO. The MCOs have been working to implement a centralized credentialling process for providers to eliminate the need to credential separately with each MCO.

- One MAC member noted that they have a friend who is a dentist who had been having trouble with the different credentialling processes, and that this would be extremely helpful.

Each MCO has provider directories and find-a-provider tools to help patients find in-network providers in their area.

- Patients can also ask about receiving services from out-of-network providers. This is especially relevant in Western NE, where there can be a hesitance among providers to contract with government insurance companies.

There are more dentists in-network with the MCOs now with the integrated dental benefit than there were when it was a carve-out benefit managed separately.

Generally, there has been positive provider feedback from the 1st year of the integrated dental benefit. The MCOs also coordinated to align codes requiring prior authorization.

One representative from the MCOs noted that Nebraska is very special when it comes to the amount of collaboration between the MCOs. All MCO representatives present – and MTLC – agreed with this sentiment.

UHC discussed their preventative care initiative and noted this had a positive impact. They referenced their Emergency Care Reduction bulletin.

- All MCOs reported a decreased number of emergency dental services under the integrated dental model.

Molina shared that a national report found only 9% of pregnant members seek preventative dental care during their pregnancy. This is a very low percentage, which can negatively impact birth rates. Finding solutions to increase this number can reduce emergency visit costs on the back end.

Nebraska Total Care (NTC) shared that their mobile dental van served 137 people in 4 communities across Western Nebraska by providing screenings, treatment, and referrals to providers.

Each MCOs teams are actively trying to encourage providers to see more Medicaid members and have been advocating for the social and business benefits associated with doing so. If more providers participate in Medicaid and provide care to beneficiaries, it would also help reduce burdens on those providers who see a high-volume of Medicaid patients.

- The MCOs are working on strengthening provider capacity. Even providers seeing 1 or 2 more Medicaid members would have a significant overall impact.

QUESTION: What are each MCOs goals moving forward?

- **ANSWER (Molina):** To grow the provider network and reduce burdens on providers providing services to a high-volume of Medicaid patients.
- **ANSWER (NTC):** Increase the provider network and talk with students at the dental schools to encourage young and future practitioners to start seeing Medicaid beneficiaries early on in their practices.
- **ANSWER (UHC):** Continue to develop provider education around medical necessity and claims submission.

Adam Proctor gave a shout out to Kenny McMorris and the FQHCs, Vietta Swalley and the IHS/Tribal partners, and Dr. Stark for their collaboration and mission-driven work to serve Medicaid members.

- Dr. Stark noted that this is her 21st year in her practice, and that she has been grateful and thankful for the MCOs partnership. Her practice sees a lot of Medicaid patients, and the MCOs have worked hard to support existing providers, kids, patients, etc. She's appreciative of all that the MCOs do to reduce administrative burdens so that the providers can focus on providing quality care to patients.
- Kenny McMorris echoed these sentiments and noted that the MCOs' responsiveness has been great. He stated that the biggest challenge has been finding clinicians, especially in rural areas.
- Deb Schardt noted that public health hygienists are also doing preventative care and mobile service delivery.

Discussion:

- **QUESTION:** Are each of the MCOs using the same rates to reimburse providers? Are there different rates for providers?
    - **ANSWER:** The base rates for all covered services across each MCO are the rates outlined in MLTC's Dental Fee Schedule. Each MCO can negotiate pricing with providers above these Fee Schedule rates, and details of such negotiations are confidential.
- **QUESTION:** Is there anything that has been done about increasing access to dental services for members with intellectual or developmental disabilities?
    - **ANSWER:** Yes. Providers have the chance to work with the MCOs on pricing and relaxing certain authorization and administrative procedures.
    - **ANSWER:** Case managers can directly call the providers to explain the extra needs that may be present in these cases. This kind of coordination was less common under the carve-out dental benefit.
- **QUESTION:** Is there a similar number of providers in-network with each of the MCOs?
    - **ANSWER:** Yes. And overall, there are approximately 300-500 new access points (depending on the MCO) under the integrated dental benefit.
- **QUESTION:** Do the MCOs report the number of denied prior authorizations?

    - **ANSWER:** Yes, this is reported to MLTC as a percentage of all prior authorization requests. Each MCO reports their numbers to MLTC separately.
        - **QUESTION:** Are those reports public?
            - **ANSWER:** That information is available to the public but must be requested from MLTC. However, MLTC does publish clinical quality data which is publicly available.
        - Each MCO also has a licensed dental advisor who practices in Nebraska and provides critical feedback to the MCO related to clinical services and appropriate delivery.
- **QUESTION:** Have members been able to find services closer to them? Is there data on this?
    - **ANSWER:** Overall, members have had to travel less due to increased access points for dental services. However, travel distances do vary from general dental services to specialist services. The MCOs are required to meet general requirements and certain access standards for general dental services. And some dentists do offer general and specialized services. But overall, members on average do have to travel father to see specialists.
- **QUESTION:** Can these mobile vans provide restorative and follow-up care? Our public health dental hygienists are already out doing the preventive items that are listed.
    - **ANSWER:** This requires a unique set-up to meet all the health and safety requirements. It is something that can be discussed for the future, but it could be difficult with the equipment they currently have.
    - **ANSWER:** Kenny McMorris noted that the Charles Drew Health Center has a bus that does both preventative and restorative care and is working on a second bus. They have been doing this since 2015 and have had a lot of success with it. He noted that it does require a unique set up but is happy to share successes and what they have learned.
- **QUESTION:** Amy noted her work with providing dental care to individuals with disabilities and asked if there is any data about access barriers to dental care for these individuals (such as the number of providers that note they are willing to see these patients, but would need extra accommodations or reimbursement, or the number of cases where they are seen at the ER or lack transportation to appointments)?
    - **ANSWER (NTC):** Previously, NTC had a list of NTC members with disabilities and select dental providers' schedules so that the MCO case management teams could reach out to the members and coordinate visits. This reduced the number of appointments that were missed for individuals with disabilities. This kind of model could work again but does require providers to participate.

Next education session
Amy shared the following educational sessions to be discussed at the next MAC meeting:

- Centralized credentialing process
- Medicaid-specific data on suicide

VII. Sub-Committees

Access to waiver services and disability – Philip and Jennifer
Philip shared the following observations and thoughts regarding the Family Support Waiver (FSW):

- The subcommittee spoke to parents of Medicaid members with disabilities and found that they were facing confusion regarding the notices they were being sent. They were receiving notices from both MLTC and the Division of Developmental Disabilities (DDD). The sub-committee recommended that information be streamlined and sent through one notice to avoid confusion. They would like to see written instructions, so people know where to get the information they need.
- Parents didn't know there were two different applications, one for Medicaid and one for home and community-based services (HCBS) waiver services. The sub-committee recommended that this information needs to be stated more clearly to ensure that caretakers understand how to apply.
- Some parents had difficulty getting MCO cards for their dependents. They were not receiving responses from MCOs because the parents weren't listed as approved to access the information, even though their dependents were minors.
- There were inconsistent and unclear entitlement dates on the notices. DDD sent notices saying that individuals were eligible, but did not include detail or written notices for the date of eligibility.
- The State Review Team (SRT) moved from being under MLTC to being under DDD. The sub-committee is still working to gather more information about this and the impact on members.
- There seemed to be confusion between the FSW and Katie Beckett program. Parents whose kids are approved for the FSW are receiving notices to report their income when it shouldn't be required.
- The Katie Beckett cost-effectiveness form and State Plan Amendments (SPAs) were confusing.
    - MLTC: The most recent SPA related to the Katie Beckett program was to eliminate the use of the cost-effectiveness form that was going to providers. There is now no longer going to be an obligation for members to get this form filled out by providers and MLTC will calculate the anticipated costs to ensure cost-effectiveness. These changes were driven in large part by the MAC's previous feedback on the Katie Beckett cost-effectiveness form.

- The sub-committee had reached out to MLTC for more information but hadn't heard back. They were in communication with DDD to organize a time to meet.
    - MLTC staff has since reached out to organize a meeting with the sub-committee.
- **QUESTION:** What if DDD says that an individual is eligible, but MLTC says they are not eligible, or vice versa? How are the two departments coordinating to work together?
    - **ANSWER:** MLTC is looking into this question and will follow up at a later date.
- **QUESTION:** Has the staffing for the SRT increased since moving under DDD?
    - **ANSWER:** MLTC is looking into this question and will follow up at a later date.
- The sub-committee made the following recommendations:
    - Provide written guidelines outlining the coordination between MLTC and DDD. Highlight processes for notices, SRT, and determining eligibility for various programs.
    - Have all notices for eligibility determinations come from one place.
    - Clearly indicate that there are two separate applications – one for Medicaid and one for HCBS Waiver services.
    - Improve notice language to be clearer to ensure that caretakers understand how to apply for Medicaid and Wavier services.

VIII. Open Discussion / Public Comment

Edison McDonald shared the following comments about the recently proposed changes to Applied Behavioral Analysis (ABA) services definitions:

- New service definitions would cap the service deliver hours which ignores the needs of children and undermines Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements.
- New restrictions on Registered Behavior Technicians (RBT):
    - Approximately 76% of current RBTs would no longer be eligible because they would be required to have a bachelor's degree, creating a significant limitation.
- Rigid family participation requirements would create an unrealistic burden in this economy.
- New service definitions would exclude schools as a setting for ABA services, which would conflict with CMS guidance. Preventing ABA in schools would limit opportunities for children who would otherwise be unable to access ABA. There are long-term benefits to ensuring more access, including rural access. Inclusion in schools would be a tremendous benefit to Nebraskans.

Edison suggested discussing ABA services at the next MAC meeting and adding it to these meetings for review and discussion before significant changes are made.

Matthew Ahern replied to Edison's comment and thanked him for his feedback. MLTC has received hundreds of comments on this proposed change and is actively looking at feedback about this topic and meeting with providers of ABA services to discuss. A lot of the issues may be related to misunderstandings in language, and language will be revised or clarified as needed. For example, schools are an appropriate setting for ABA so that will be made clear in the revision. Additionally, the requirement for RBTs to have a bachelor's degree has always technically been a requirement but may not always have been adhered to. MLTC is also looking at making changes related to this.

For updated information on ABA Medicaid Service Definitions (MSDs), refer to Nebraska Medicaid Provider Bulletin 25-02.

IX. Confirm the Next Meeting Time and Location

Jacob confirmed that the next meeting will be held on Thursday, March 20, 2025, from 3:00 p.m. to 5:00 p.m. in Lincoln, Nebraska with the exact location to be announced.

X. Adjournment

The meeting was adjourned by the Committee at 5:02 p.m. CST.