Medicaid Advisory Committee
Meeting Minutes
Thursday, March 20, 2025

The Medicaid Advisory Committee (MAC) met on Thursday, March 20, 2025, from 3 to 5 p.m. CST at the Loren C. Eisley Branch Public Library in Lincoln, Nebraska. The meeting was held in person and virtually with a call-in option also available.

MAC members in attendance: Amy Nordness, Dave Miers, Jennifer Hansen, John Andresen, Josh Sharkey, Kelly Weiler, Michaela Call, Philip Gray, Vietta Swalley

Managed Care Organization (MCO) representatives in attendance: Chris Elliot (Nebraska Total Care), Jeremy Sand (United Healthcare), Julie Fedderson (United Healthcare), Tim Easton (Nebraska Total Care)

Department of Health and Human Services (DHHS) employees in attendance: Bailey Reigle, Celia Wightman, Drew Gonshorowski, Dr. Elsie Verbik, Gillian Daniel, Jacob Kawamoto, Jarren Breeling, Jennifer Clark, Jennifer Menebroker, Kristen Smith, Matt Ahern

Members of the public in attendance:
Cindy Kadavy (NHCA), Kelsey Arends (Nebraska Appleseed), Mary Woodhead (Rickets), Ned Stringham (NE Psychological Association), Sarah Maresh (Nebraska Appleseed)

MAC members not in attendance: Bradley Howell, Heidi Stark (planned absence), Kenny McMorris, Shawn Shanahan

I. Openings and Introductions

The meeting was called to order by Vietta at 3:06 p.m. CST.

- The Open Meetings Act was made available for attendees.
- Vietta welcomed the meeting attendees and Celia ran through the roll call.
    - Celia shared the “MAC member representation” survey with MAC members to determine which membership category(ies) members fulfill. The purpose of the form is to determine the representative composition of the Nebraska Medicaid Advisory Committee (MAC) and ensure that it is following federal regulations as we recruit to fill open positions. The membership categories listed on the form include:
        - Current or former Medicaid member/beneficiary

        - Family member of caretaker of current or former Medicaid member/beneficiary
        - Medicaid managed care organization (MCO)
        - Clinical provider or administrator
        - State, local, or community-based organization (CBO) representative
        - State agency
        - Other (specify)
    - After selecting the category(ies), members were asked to specify the name of the organization they work or volunteer for, if applicable.
    - Members were asked if they represent any organization in an official capacity on the MAC.
- Matt Ahern informed meeting attendees of a change in future meeting formats.
    - Due to the Nebraska Open Meetings Act, only half of all MAC meetings can have a virtual option, meaning the MAC can only have offer a virtual option on three out of six annual meetings. Since there have already been two MAC meetings this year with a virtual option, Matt asked MAC members if they had a preference as to which of the remaining meetings for 2025 would have a virtual option.
        - Members discussed options and several members agreed that it would be best to have a virtual option on the November meeting because of the possibility of inclement winter weather.

II. Review and Approval of January 16, 2025, Draft Minutes

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

III. Follow Up Items from the January MAC Meeting:

Jacob delivered the following responses to outstanding items from the January 16, 2025, MAC meeting.

MAC bylaws vote and recommendations:

- **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.

- **Medicaid and Long-Term Care (MLTC) Response to recommendations:**
  - MLTC agrees to revisit the topic six months after the Access Final Rules take effect to assess whether they feel they voice of Medicaid members is being adequately represented.
  - The bylaws have been updated to memorialize June 17, 2024 as the effective date for varying length of member terms.

Questions and comments from Access to Waiver Services and Disability Determinations Sub-committee:

- ***What if Division of Developmental Disabilities (DDD) says that an individual is eligible, but MLTC says they are not eligible, or vice versa?***
  MLTC Response: If DDD determines that an individual is eligible for waiver services, but MLTC determines that they are not eligible for Medicaid, or vice versa, it's important to understand that eligibility for Medicaid is a prerequisite for waiver services. Medicaid funds the waiver service, so if an individual is not eligible for Medicaid, they cannot receive waiver services, regardless of their eligibility status with DDD.
  An individual can be eligible for both Medicaid and waiver services, but they cannot be eligible for waiver services without Medicaid eligibility. In cases where Medicaid eligibility has not been determined, the individual should apply for Medicaid coverage to ensure they are eligible for the waiver.
  To clarify, the eligibility for waiver services involves meeting three points:
  1. The statutory criteria for DD services (83-1205).
  2. The Level of Care (LOC) requirements.
  3. Medicaid eligibility.

  If an individual meets the first two points (DD criteria and LOC), but not the third (Medicaid eligibility), they cannot participate in the Medicaid waiver program. This distinction can often be confusing for families, so it's important to communicate this clearly.
  In cases where an individual is found eligible for waiver services, but Medicaid eligibility has not been determined, they should apply for Medicaid as the next step. Additionally, we provide resources for families, including the DD Services Eligibility brochure, videos on our website, and direct outreach letters that inform families of the need to apply for Medicaid before proceeding with waiver services.
- ***How are the two departments coordinating to work together?***
  MLTC Response:
  a. There is an internal group that meets together to try to close gaps in information, such as notice of decision. This group consists of:
     i. Medicaid eligibility operations
     ii. DD service coordination
     iii. DD eligibility and enrollment unit

iv. HBCS program management
v. Medicaid strategic initiatives administrator
vi. The group also loops in Medicaid policy staff and DD policy staff as needed

b. The group utilizes process mapping as a part of their coordination together.
c. The Divisions have continued find areas to improve coordination in day-to-day operations and processes. As a recent example, Medicaid has identified a number of long-term care case types that will be exempt from the deprivation review. This is a time-consuming review, and as a result of these exemptions DD determinations will no longer be contingent on, or delayed by, the deprivation review for these applicable Medicaid cases when eligibility determinations are needed from Medicaid.

- ***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***.
  MLTC Response: This is a known issue, and DHHS divisions continue to find ways to resolve it.
- ***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.***
  MLTC Response: All Medicaid notices, including those for FSW and Katie Beckett, state that households must report changes in income within 10 days, even when the guardian's income will not affect the child's eligibility.
- ***Has the staffing for the State Review Team (SRT) increased since moving under DDD?***
  MLTC Response: SRT staffing has not increased, however, temporary assistance has been provided by qualified teammates to ensure determinations are completed in a timely manner. DDD continues to seek opportunities and changes that will streamline the process for families and increase timely determinations.

Recommendations from the Access to Waiver Services and Disability Determinations Sub-committee:

- 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 Waiver services.

MLTC response to Recommendations:

- MLTC is working closely with DDD and HCBS program management to close gaps in information and streamline processes (see response to question 2 above).
- MLTC would like to coordinate a time during a future MAC meeting for the sub-committee to formally present their findings and elaborate on their recommendations.
    - We will coordinate with MLTC eligibility staff to attend the presentation so that they can respond to questions from the MAC and use the feedback as they continuously work improve processes.
- The subcommittee can also reach out to Celia at DHHS.MACandBAC@nebraska.gov to coordinate further communications.

IV. Review Committee Seat Openings

Vietta reminded the group that there are two openings for MAC members.

- Celia shared the aforementioned "MAC member representation" survey would help MLTC assess applicants and recruit for the correct members that will allow the MAC to be in compliance with the membership requirements laid out in the Access Rule from Centers for Medicare and Medicaid Services (CMS).

V. Beneficiary Advisory Committee (BAC) Update

Celia shared the following updates about the BAC:

The BAC is a committee, composed exclusively of Medicaid enrollees and their families or caregivers, which will identify critical issues to present to the MAC and provide direct feedback to help influence Medicaid policy and administration. Some members of the BAC will also serve on the MAC, making up at least 10% of the MAC by this July and 25% of the MAC by July 2027.

Applications for the committee are live on the BAC webpage of the Medicaid website. You can email DHHS.MACandBAC@nebraska.gov with any additional questions.

The tentative implementation schedule for the BAC is as follows:

- Applications posted: March 7, 2025
- Application deadline (to be considered for the July 2025 cohort): May 9, 2025
- Member selection: May 15, 2025
- Orientation meeting: June 26, 2025

Celia asked the following questions to the group:

Q: Although it will ultimately mainly be the decision of BAC members, does the MAC have any recommendations for how the BAC will bring information and recommendations to the MAC?

A: Some MAC members said that they would like to let the BAC drive how they prefer to bring information to the MAC.

Q: As we work to coordinate meeting times for the MAC and the BAC, do you have any recommendations on the day and time to hold the BAC meeting to make it the least burdensome for members serving on both the

MAC and the BAC? For example, would it be ideal to have both meetings on the same afternoon of the same month with an hour break in between? Would it be ideal to stagger the meetings and hold them on alternating months?

A: Some members of the group expressed a preference for having the MAC and BAC meetings on the same day.

A: Many members expressed willingness to adjust the MAC meeting time to accommodate the schedules of members who will serve on both the MAC and the BAC.

A: Some members said that an hour break in-between may cause too long of a time commitment for members serving on both the MAC and the BAC. Some members agreed that a 15–20-minute break between the two meetings could be sufficient.

VI. Educational Discussion – Centralized Credentialing

Tim Easton (Nebraska Total Care) shared a presentation on centralized credentialing provider training for Nebraska managed care organizations (MCOs).

- View the presentation slides at this link, which is available on the MAC webpage.

Meeting attendees asked the following questions after the presentation:

Q: How does it work for someone who works at two sites but for the same entity?

A: That person would need only one credentialling.

Q: How does someone with a temporary license get credentialed?

A: This would fall under licensing.

Q: If a bill passes that lets students provide psychological services how will this impact credentialing?

A: MLTC and public Health would work together to determine the process and if that provider type can provide services

VII. Sub-Committees

The Access to Waiver Services and Disability Determinations sub-committee (Philip and Jennifer) shared a report of observations and recommendations that they compiled after sending out a survey to families who had applied for waiver services. See the report below:

We conducted two fact-gathering efforts: the first before the State Review Team (SRT) was moved to the Division of Developmental Disability and the second after the transfer. We previously reported on our first effort.

Key Findings:

1. **Confusion About the Process:**
    - There appears to be confusion surrounding the process, particularly regarding the eligibility criteria and medical decisions. Parents seemed unaware there are two separate eligibility criteria and two separate medical decisions.

- Notices from the SRT and the application forms themselves were often confusing for parents.

2. **Inconsistent Medical Record Requests:**
   - Obtaining medical records was inconsistent. In some cases, the SRT requested records directly, while in other cases, parents were required to obtain paper records.

3. **Issues with MCO Eligibility Cards:**
   - There were long waits, up to several months, to receive MCO eligibility cards after the application was approved.
   - There did not seem to have a clear way to request the cards.
4. **Inconsistent Decision Notice:**
   - While most parents received a written decision notice, some did not. One parent mentioned their denial notice did not explain the reasons for the denial.

Recommendations:

Based on suggestions from parents and our observations, we are proposing the following suggestions:

1. **Coordinate the Sending of Applications and Notices:**
   - Ensure that application forms and notices are sent together to streamline communications.
2. **Include a Cover Letter:**
   - Add a cover letter that includes a list of all necessary forms and provides a brief explanation of the process. This would help parents understand what is needed and reduce confusion.
3. **Create a Specific Application for the Family Support Waiver (FSW):**
   - Consider creating a specific application form for the Family Support Waiver (FSW). The general application forms requests information about family income, wages, and the number of family members. While this supports the Department's goal of making accurate decisions, it confuses parents since the FSW is primarily concerned with the child applicant's income and medical condition.
4. **Clarify the Decision Notices:**
   - Ensure that decision notices are clear, consistent, and include explanations for denials to help parents understand the reasoning behind the decision.
5. **Review the MCO Eligibility Notification Process**
   - Meet with the Medical Care Organizations to look for ways to improve the timely mailing of MCO cards.
   - Develop a system for parents to request the MCO card if it is not received after the application has been approved.

Discussion from the committee at large:

One member shared that as a foster parent they are confused about the new process. Their DDD worker is very knowledgeable and helpful, but there is only so much information that she can give them. The member also shared that they received a form only two weeks before having to make a decision on it. They had to hastily decide and hope that it was for the best.
Jennifer: It seems like the underlying issue is that the process is not properly catered to children. It is a system designed for adults that is being used for children. A parent's income should not impact their child's benefits for this service, but they are still required to submit it
Kristen: Katie Beckett has seen a lot of success for families.
Phil: He would like to see the DDD advisory group and the MAC get together to exchange ideas.

Meeting attendees asked the following questions after the presentation:

Q: Amy asked if the subcommittee needs any official support from the MAC at large to advance this.

A: Phil requested that the group reads over the report and decide if the goals are reasonable. He would like the state to have an opportunity to look over the report and see what they suggest.

A: Jennifer said she would like to hear follow up from DDD and other agencies.

Q: Vietta asked if this report will be sent to the group.

A: MLTC will attach the sub-committee report to the MAC meeting invitation for the May 15, 2025, meeting.

Q: Jennifer asked, with recent changes approved in the cost-effectiveness form, what will the Katie Beckett application process look like for families now?

A: Matt said MLTC is still working through the exact operations for the cost effectiveness calculation. MLTC may be able to use historical data to speak to cost effectiveness comparisons.

VIII. Open Discussion / Public Comment

Matt gave an overview of legislative bills that MLTC is currently tracking.

- Some of the important themes of the bills were: administrative bills, rate increases, and justice involved bills.
- Two bills would expand upon expectation from the federal Consolidated Appropriations Act of 2023, which requires that Medicaid engages with incarcerated youth 30 days prior to and 30 days after their release to help pay for their assessment services and coordination of care or care management
    - **LB 96 –** would expand coverage for pre-release services to include justice-involved adults rather than just youth. Medicaid would also be required to provide coverage of health-related social needs. There would be coverage of housing and food supports for a period of time as they transition out of the justice system. If this bill were to pass, it would require an 1115 waiver to be submitted by the state.

    - **LB 318 –** would require full Medicaid coverage for incarcerated Medicaid-eligible youth who are pre-adjudication. If this bill were to pass, it would require an 1115 waiver to be submitted by the state.
- **LB 210 –** relates to health information exchange. It would require DHHS to apply tax to the health information exchange. This would allow some latitude to apply fees and pass on some expense. There are some components that DHHS has expressed opposition to. There is a provision that makes on-time payment of fees a requirement to do business in the state, which could get in the way of licensure for hospitals, healthcare facilities, or insurance plans if they have a billing dispute.
- **LB 283 –** addresses eligibility operations. It would require DHHS to implement express lane eligibility for Medicaid and CHIP by using SNAP data for initial eligibility determinations, redeterminations, automatic enrollment, and renewals.
- **LB 380 –** would set payment guardrails and audit functions for MCOs. This would limit the "look-back window" and bring it in line with Medicare.
- **LB 610 –** addresses ground emergency transportation. Several years ago, a bill passed that required a supplemental payment for ground emergency medical transportation, but it was done in a way that the Centers for Medicare and Medicaid Services (CMS) would not allow Nebraska DHHS to implement. LB 610 would allow us to take intergovernmental transfers of funding from governmental EMT programs. This could potentially increase the reimbursement that Medicaid could sent out for emergency medical transportation to governmental entities without any additional fund expenditure.
- **LB 527 –** could allow Medicaid to apply a tax of up to six percent to Health Maintenance Organizations (HMOs), or potentially even to all health insurance plans. This could be used to offset Medicaid funding. As Medicaid faces a decrease in its federal match rate within the next few years, it will cause a significant concern in terms of budget shortfall. This could allow Medicaid to utilize some of that tax to offset the budget shortfall.

IX. Confirm the Next Meeting Time and Location

Celia confirmed that the next meeting will be held on Thursday, May 15, 2025, from 3:00 p.m. to 5:00 p.m. in Omaha, Nebraska with the exact location to be announced. There will not be a virtual option at this meeting.

X. Adjournment

The meeting was adjourned by the Committee at 5:00 p.m. CST.