Medical Care Advisory Committee
Meeting Minutes
Thursday, March 21, 2024

The Medical Care Advisory Committee (MCAC) met on Thursday, March 21, 2024, from 3 to 5 p.m. CST at the Loren C. Eiseley Branch Library in Lincoln, Nebraska. The meeting was held in person and virtually.

MCAC members in attendance: Jennifer Hansen, Philip Gray, Karma Boll, Amy Nordness, Kelly Weiler, Shawn Shanahan, Vietta Swalley, Bradley Howell, Kenny McMorris, and Dave Miers.

DHHS employees in attendance: Dr. Elsie Verbik, Jordan Himes, Nikkola Bales, and Matt Ahern.

Members of the public in attendance: Dr. Deb Esser, Dr. Christopher Elliott, and Dr. Julie Fedderson.

MCAC members not in attendance: Jason Gieschen, Felicia Martin, Michaela Call, Staci Hubert, and John Andresen.

I. Openings and Introductions

The meeting was called to order by Amy at 3:04 p.m. CST.

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

II. Introduction of New MCAC Members

Amy: We have a lot of new faces today, I want to take a second to introduce our new members. Joining the board this year as provider representatives are Bradley Howell, Dave Miers, and John Andresen. Joining the board as member representatives are Jennifer Hansen and Philip Gray. I appreciate all of you for being willing and able to serve on this committee, we're excited to have some new ideas and perspectives.

- Open Positions
  - We still do have one provider and one member position open. Ideally, we are hoping to get a perspective that we do not already have. From providers, we are looking for representation from the dental community. From an advocate standpoint, we hope to bring someone on with a Deaf/HoH background or a current Medicaid member.

- Finalize the Executive Committee
    - I want to nominate Vietta Swalley for the vice chair role. Do you accept?
        - Vietta: Yes
    - With no opposition, Vietta Swalley is the vice chair for 2024.

III. Review and Approval of January 18, 2024, Draft Minutes

The board has no revisions for the minutes, Amy asks for a motion to approve the minutes.

- Karma makes a motion to approve the minutes, Vietta seconds. The motion passes.

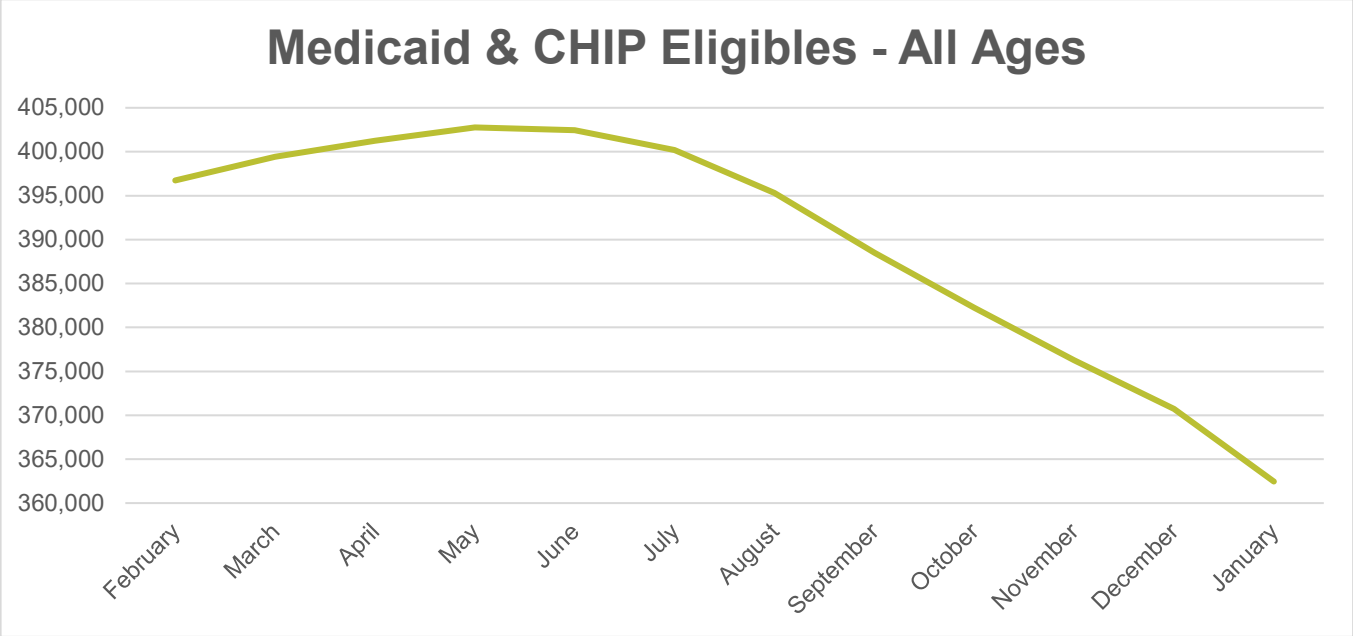
IV. Medicaid and Long-Term Care (MLTC) Business Updates

Enrollment and Unwind Updates:

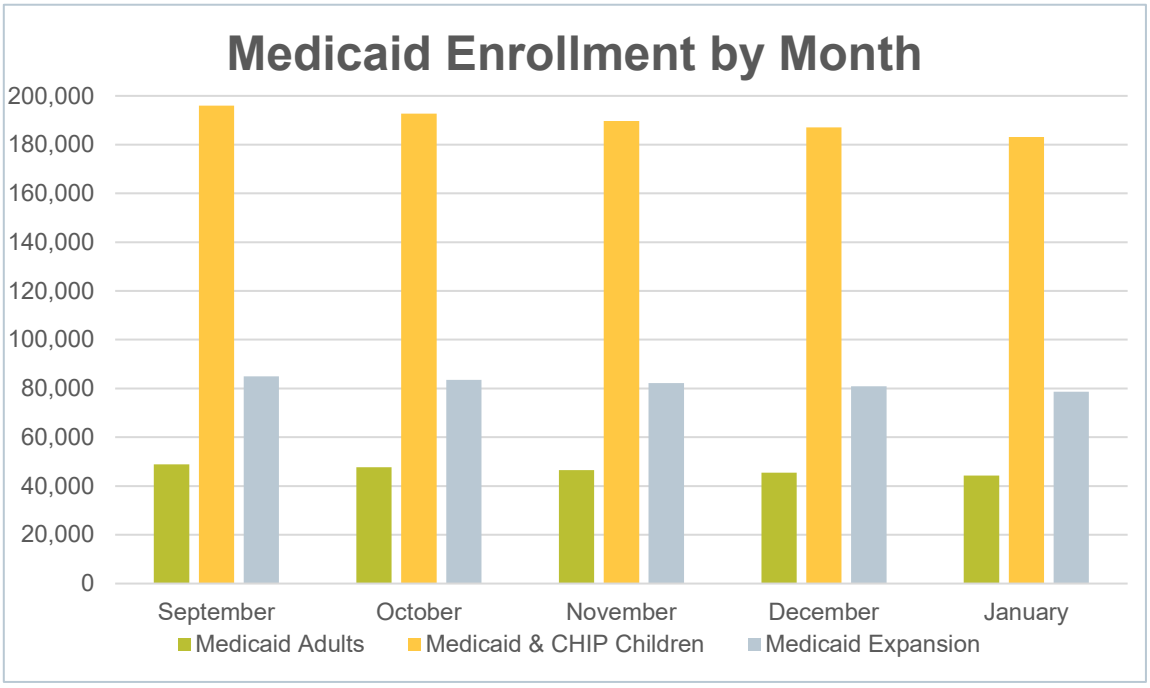
Jordan: The data we received last meeting was through November, the current data is now through January. You will see that our enrollment overall continues to decline for each enrollment type as a result of the unwind which we will get into in a moment.

Eligibility Group	September	October	November	December	January
Medicaid Eligibles - Aged/Blind/Disabled	58,536	58,220	57,783	57,189	56,425
CHIP	42,440	42,032	41,733	41,320	40,366
Medicaid Children	153,616	150,705	147,952	145,798	142,736
Medicaid Expansion	85,022	83,564	82,272	80,919	78,610
Other Adult	48,902	47,708	46,510	45,479	44,318
Total Medicaid & CHIP Members	388,516	382,229	376,250	370,705	362,455

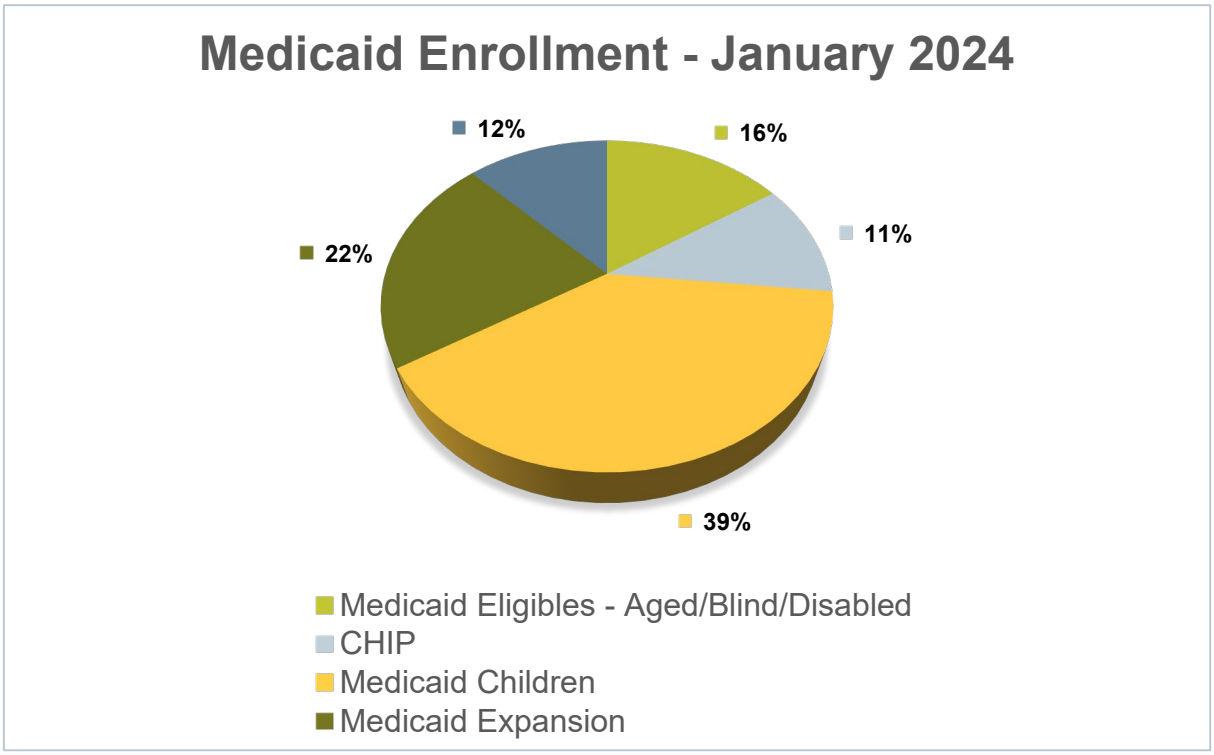
Jordan: Moving onto the second set of data here, I went ahead and provided a full 12 months of data so we can see the trend over the course of a year. We see that enrollment is dramatically decreasing as a result of that unwind.



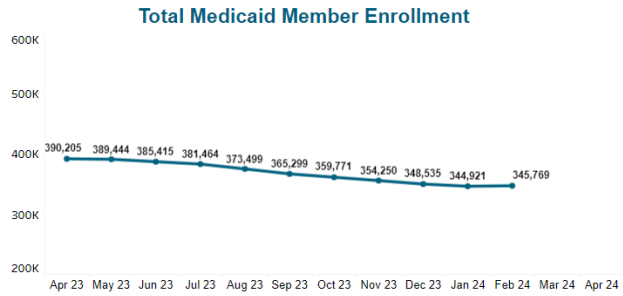
Jordan: In our third table, you can see that while enrollment continues to decrease, the drop between December and January is not as large as it was in previous months. Again, this is because we have gotten over that 3-month period where we had an excessive number of renewals to complete.

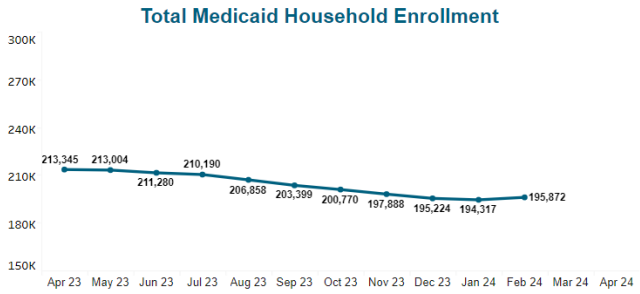


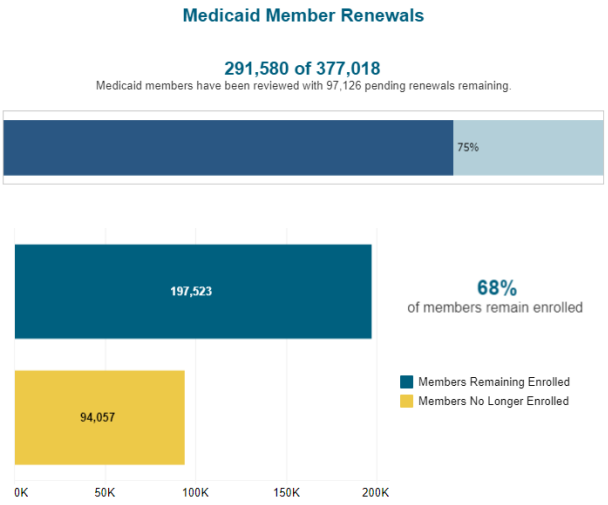
Jordan: Finally, we have the last table for you all. This table visualizes total enrollment in January 2024 as a percentage. Despite previous concerns with the unwind and children potentially losing coverage, you will find that our Medicaid and CHIP children continue to be our largest population at about 50% of our enrollees.

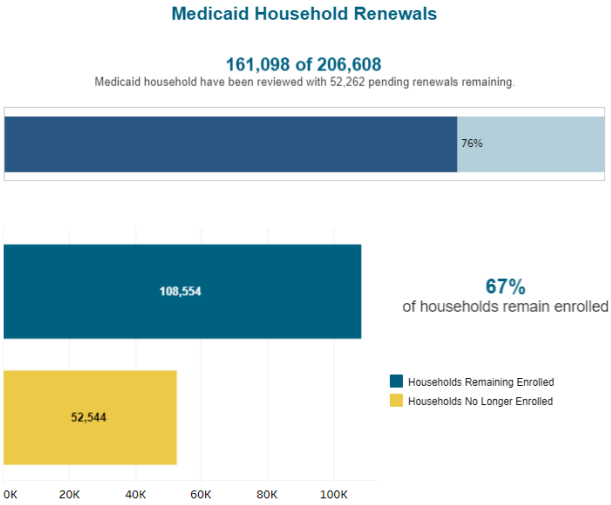


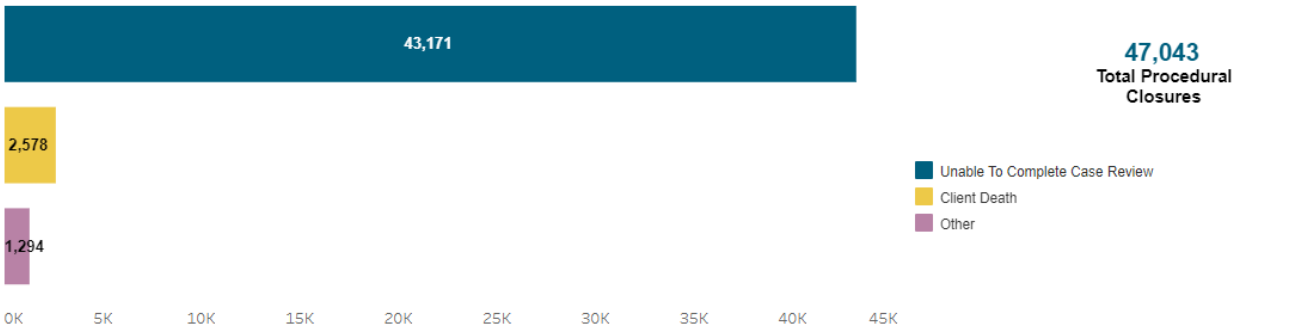
Jordan: As I alluded to at the beginning, I am going to pull up the [Medicaid Unwind Dashboard] for you all to view.











So, a brief description of the unwind. During the COVID-19 pandemic, it was a federal requirement that all people enrolled in Medicaid maintain their eligibility until the pandemic was over. This is called the continuous coverage requirement. The continuous coverage requirement ended on March 1, 2023, kicking off the unwind. Nebraska's unwind timeline goes through April 2024.

However, as we discussed in our last meeting, it looks like we will not be able to complete all the outstanding renewals until the end of August. We are not the only state who has to amend our timeline, many have. This is because of the copious number of renewals that we need to complete. In addition, we are constantly getting new applications which also must be processed in a timely manner. Members who may fall into that category of their renewal not happening before April will simply remain on Medicaid until we can complete their renewal.

- Karma: And you may have appeals drag out through August as well. But if I am correct, last time we talked there have not been a lot of appeals.
    - Matt: That is correct.

Looking at the data here, we are currently sitting at about 345,000 Nebraskans enrolled in Medicaid. We have completed 75% of the renewals in comparison to the 61% that were completed when we met in January. We are making good progress. As we have previously discussed, we currently have a dis-enrollment rate of 32%. This may be people who no longer qualify, are no longer Nebraska residents, have passed away, or failed to complete their renewal. Based on national data, we anticipated this to be between 10 to 20% but as you know that was just a guess. As Nebraska currently stands, our dis-enrollment rates are much lower than other states and the national average.

You will find that our dis-enrollment (about 158,000) does not match the total above which reflects that only about 44,000 people have been dis-enrolled. This is because the total enrollment at the top of this dashboard reflects everyone currently enrolled in Medicaid, including new members or members who lost coverage and are now back on Medicaid.

Jordan: Finally, looking at the dis-enrollment of households, you will see that this data nearly mirrors that of individual members as we often have many members in the same household. I do want to point out that, for example, if a parent is no longer eligible but their children are still on Medicaid our data shows that the entire household was dis-enrolled. This is why you will see some differences here. Are there any questions regarding the data shown here?

- Amy: Will you keep the chart going through August for those who are dis-enrolled after April, or will you add them all to the April data?
    - Matt: We will extend this graph out to include data for each month through that anticipated August timeline.
- Vietta: Are there still a lot of outstanding renewals? We still have quite a stack of people who we have not heard back on their renewal.
    - Jordan: Yes, though not as many as there were a month or so ago. Our review process is taking longer than usual, this is because of the number of reviews we have to complete in addition to the new applications. In addition, our review process was delayed from the beginning. At the start of the unwind we chose to give members 45 days rather than 30 to provide their information as we recognize many of our members have not yet been through this process.

    - Matt: Yes, this process is picking up because we are also over that amount of having upwards of 48,000 renewals to complete a month.
- Philip: Are these two data sets the same?
    - Jordan: No, the public dashboard is updated on the 15th of each month. Whereas the data that is pulled specifically for this group I get about the 5th of the month of our meeting, so this data was pulled around March 5. The data pulled for the meeting is cumulative and includes all of our enrollment broken down by category rather than being unwind-specific. The cumulative data is also retroactively updated meaning that if you are looking at it in comparison to the last meeting's report it will look slightly different, by a few hundred members. This provides the most accurate data to the board.
- Karma: In Nebraska, we chose to keep renewals on the same schedule as they would normally be processed while other states went on a different schedule correct?
    - Matt: Yes, we chose to put the member's needs first to make this as easy as possible on them.
- Vietta: I saw that CMS has been sending notices to the states and providing data regarding terminations. But it looked like we were doing pretty well.
    - Matt: Yes, there were a few things that CMS changed in terms of their interpretation of certain renewal types so we had to change the way we were approaching those renewals.
- Kelly Weiler: Is it possible to get the dis-enrollment information (for example: closed due to no response, death etc.) by eligibility category?
    - Matt: I'm not sure if that would be particularly beneficial seeing as there are so many eligibility categories. However, it may make sense to break the information into groups like age or income something where we would have a larger population to look at.
    - Kelly: Maybe I phrased my question wrong. Looking at the data provided it looks like about 12,000 kids were dis-enrolled from September to January. What does the dis-enrollment look like within that category? With children being such a large category of enrollees, I'm curious what happened here. Do we know why they were disenrolled? Do we have information on if the child went to a health exchange plan or if they were enrolled under commercial insurance or do we not know? I think knowing that could help us internally focus on community outreach a bit more,
        - Matt: I think it is worth looking into, why don't we take that back and see what additional information we can provide here.

MCPAR Data:

Jordan: Quick for you all, I apologize for those who are virtual and do not have this data in front of them. We were notified earlier this week that CMS requested the following data sets to be provided to the MCAC board:

- Managed Care Program Annual Report (MCPAR) for Nebraska: Medicaid Dental Benefit Program – December 2023
- Managed Care Program Annual Report (MCPAR) for Nebraska: Medicaid Dental Benefit Program – December 2022
- Managed Care Program Annual Report (MCPAR) for Nebraska: Nebraska Medicaid Heritage Health Program – June 2023

This data has also been made available on our Dental Benefits Manager web page and on the Heritage Health page.

These reports outline takeaways from the Heritage Health and dental programs from 2023 and 2022. Again, I'm sorry that I couldn't get these reports sent out before our meeting today. I will send a follow-up email to you all with copies of these reports and the links to the websites they are published.

2024 Legislative Session:
Matt: I have a few bills that I wanted to flag for everyone. We are getting further into the process now so the number of bills we are tracking is decreasing. We are currently watching the following bills:

- LB62: This bill would provide translation and interpretation services for medical assistance. At its core, LB62 is for interpreter services that are needed for medical care. When there is a patient that needs interpreter services, we would pay the provider to help offset the expense of providing the services.
    - LB913 and LB1237 have been added as amendments to this bill. The amendments would make sure that some of the unwind data is included in the annual Medicaid report and discusses medical coverage for 599 CHIP moms.
        - At this time, LB913 has not been officially adopted as an amendment but is currently pending. That provides coverage for 599 CHIP moms. Right now we cover prenatal care for women in the state who are undocumented and cannot qualify for Medicaid as a result of their immigration status. We are able to cover that care because we are covering the children. These moms are not part of the 12-month expansion for mothers in the state. LB913 would add postpartum care for 12 months for 599 CHIP moms.
    - The interpretation that CMS has provided of the bill is that any provider that accepts federal funding for Medicare or Medicaid must make interpretation services available and funding for that is included in the payment they receive. They also say if you would like to pay them you can also do that.
    - Our current approach is that payment is payment in full and that includes the necessary interpreter services. However, I understand there are differences in how we could approach this.
    - In addition, currently our MCOs make interpreters available for our members, in person or virtually. That is handled by our MCOs without an additional appropriation. This bill would take what is being covered there and make it a rate that Medicaid needs to pay out to the provider rather than the member going through their MCO.
- LB130: This is an increased payment for nursing facilities. The federal government allows for a tax to be implemented up to 6% of their billings. We can then take that assessment and match it with federal dollars and pay it back out. This would allow us to enhance what we are getting from the federal government. We already have this in place but the goal is to increase the actual amount, leaving a 5% rate increase for the nursing facilities.
- LB204: This is to provide reimbursement for pharmacy dispensing fees under the Medicaid assistance program. This bill would increase the amount we are paying for the dispensing fees. The fees can range depending on the MCO but this would increase

the base dispensing fee to $10.38 based on a cost study done in Iowa. The initial bill was to do that for all pharmacies. It has since been amended to provide the increased payout only for independent pharmacies. In this bill, independent pharmacy is defined as a company with six or fewer locations.

- LB358: This bill is to increase dental service reimbursement by 25%. It is currently in the final read.
- LB857: This would create a prenatal plus program, based on a model rolled out in Colorado. The key part of this is targeted case management and nutrition services. Each of the plans provides care and case management for women. The difference is this model would pay for targeted case management in a decentralized way. It would not be done through the health plans. We would be paying facilities to hire a care and case manager. We would also start paying for those nutrition services.
    - An amendment was made to include LB 933. This is centered around continuous glucose monitoring (CGM). At this time, we do cover CGM devices but the bill slightly changes the eligibility criteria. We currently have specific criteria for getting a CGM meaning that the patient would need to meet a certain severity to qualify. This would expand so that if a patient has diabetes at all they would be able to have a CGM. The focus of the bill is largely on gestational diabetes which we cover. I think, if implemented, there is an unintended consequence of covering CGM devices for everyone.
- LB905: This bill passed the final read today. It would require Medicaid to submit a waiver for medical respite care. This is not identified as a pilot but would largely structure the approach as a pilot. There would be one agency in Omaha and one in Lincoln that would carry this out. The idea is that people who are homeless and are being discharged from the hospital need some level of ongoing care, stabilization, and monitoring and need a landing place to go. For example, if they are coming off surgery and still need to dress their wounds, they could get this support. One of the benefits is that it would have a big impact on readmission rates.
- LB1087: We talked about this some earlier. To date, the hospitals have not taken advantage of the tax and, in turn, the reimbursement. The idea is that we would max out the tax assessment (up to 6%) and then match it with federal funding to give back to them. Looking at recent data, that would likely net an additional billion dollars a year for hospitals. There are a lot of advantages that can be taken to improve aspects of the healthcare system without us having to appropriate that money. This one also passed today.
- LB1215: This one primarily focuses on Public Health, not necessarily our stuff. The core is to change various provisions for healthcare facilities. Medicaid gets tied into this one because of the amendments.
    - Amendments were made to include LB1106 and LB1107. Both deal with moms, one is to increase lactation counseling from five to 10 visits. We do not feel that will have an impact on us. In the history of utilization, we have never had anyone use more than 4 visits. The other deals with breast pumps. We currently pay for the rental of a hospital-grade breast pump. It is about $300 a month. In addition, all the MCOs buy breast pumps for mothers though it is not hospital-grade. This bill would enable us to pay for those breast pumps ($150-$160) so the mother has it. Both amendments make sense to us.

Matt: Those are the bills that we have been keeping track of, are there any questions on those?

- Karma: We have had prior conversations about this (LB905), this fits that. I am interested in this.
- Amy: Do you anticipate that we have the people to provide the services?
    - Matt: This is part of a pilot program in Omaha. It may be that staff still needs to be developed in Lincoln. What we want to see is what does this look like in these facilities and what does it look like to expand? The intention is to be similar to assisted living so the population would not be as medically needy.
- Kenny: I wanted to add that Charles Drew Health Center is part of this pilot. We are working with the health systems and a local homeless center to really look at those patients who are chronically homeless. We've been piloting this model for a couple of years to service that bridge gap. My FQHC is designated as a healthcare facility for the homeless at a federal level so we have had this working relationship with Sienna Francis House over the years. Ultimately, the goal is to look at how we provide care to this population, and I think doing this in a thoughtful intentional way can really effect healthcare outcomes. Our goal is to establish ongoing care and healthcare homes so we can keep the subset of this population out of the emergency room. Our hope is to develop a model that is sustainable for the community. This is a best practice, it has been duplicated across the country so we hope to have an impact here locally.
    - Matt: That's awesome, thank you Kenny for chiming in and providing us with that background, and thank you for your work on that pilot.
    - Karma: Maybe at some point, you can speak to us as part of the educational opportunities.

2024 New MCO Contract Implementation Update:
Matt: So far, we have been doing well. There have been some growing pains as there will be when expanding a new service line for all the MCOs. The readiness review process went well and each of the plans is actively working to include dental and credential providers. Molina is getting started up and last had to submit paperwork to us in February to provide us with more information on their implementation. There are no large concerns. There have been a few issues with claims as Molina gets squared away but they are doing well responding to those issues.

V. Project Discussion

Amy: Switching gears here, we are going to get some updates on the projects this committee has been working on. There are two projects that we have been working on over the past few years, Nursing Home Staffing and Dental Student Reimbursement. We have done a lot of work on these topics in the past as we had two committee members who were actively advocating for these topics. Those members are no longer with us but we have seen good movement in dental reimbursement to be specific as the workgroup was working with legislators to get a bill drafted. But to start, Karma can you begin with updating us on the Maternal and Newborn Health Project?

Maternal and Newborn Health:
Karma: We have not met since the last meeting, we will be meeting next week. We've expanded who is participating in this group. Dr. Verbik recommended adding one of her nurses

to this group so they will be joining us as well. I will be soliciting from everyone in the group if they have any new material or topics to talk about.

Dental Student Reimbursement:
Amy: I think that this has a nice momentum where we can build a dental project off of this. I think that if we're able to get a dental representative on the committee it might draw up a new perspective. I continue to hear challenges from parents and providers about dental access.

- Karma: Everyone thinks the issue is in rural parts of the states but it is everywhere, it is in Lincoln and Omaha and it's not just Medicaid.
- Vietta: We had to hire two retired dentists, that's the only way we can get coverage. We think the increased fees will help, right?
    - Amy: We hope so, I think eliminating the cap will help too. I was on a call recently with California. They are doing a combined approach of behavioral health and dental for disabled members. The goal is to do a better job in the office to prevent sedation appointments by desensitizing the process. The process might take a few more visits to work up to getting dental work done rather than jumping straight in. I wouldn't want to start anything until we have a dental representative.
- Karma: It would be nice to see data across the state for dental access, and how long appointment waits are.
    - Matt: Yeah we can look at that, I would need to see what that access looks like.
- Dr. Verbik: With dental integration, I am hopeful that we will slowly and steadily increase our dental network. All of our relationships are built on trust, these things do take time so I would ask for patience. But I do believe in my spirit that dentists will gradually return to Medicaid and we will be able to build up our dental networks so we have enough providers available to take care of our population.

  Each MCO now has a dental director and team devoted to building those relationships within the network. I do want to focus on building a dental home. Over the past 10 to 15 years, we have done a very good job at establishing medical homes for patients. We need to do the same at establishing dental homes for children before they turn one year old as a baby also needs to have a family dentist. The American Academy of Pediatric Dentistry has established that before the baby's first birthday, they should be evaluated by their family dentist.

  I recognize that we need dentists, but the point is to establish those relationships and build trust between the family and the dentist. We need help from the clinicians to begin dental referrals during the 6- or 9-month appointment so a dental home can be established. The baby will have no symptoms, but they may be teething and may have pain. What that appointment establishes is the relationship and healthy oral health habits.
    - Amy: I do think the changes happening will make changes moving forward. Matt, I'm wondering for an educational topic, looking at the data about dental access that you currently have.
        - Matt: I know the MCOs give access to data quarterly so maybe we should look at that every 6 months or so.
        - Karma: We can look to see if are we getting more dentists and specialists in.

        - Amy: If we don't have all the right data then we can analyze what else we need to make sure we have a good understanding of the current status.
- Philip: I know we have the student reimbursement, but does that ensure coverage?
    - Matt: We have the current program helping with dental reimbursement in rural areas. The thing is, it does not set a standard as to how many patients the provider sees. It is whether they are enrolled or not. That is what this project was looking at, setting a requirement of how many patients are seen by that dentist. The problem is that we still face just as big of a dental care gap in North Omaha as we do in Scottsbluff.
        - Amy: Dr. Jessica Meeske was on this committee and was the head of this project, she is currently working with legislators to draft a bill to take to a future session. The bill would hopefully clarify the guidelines to how many people are seen rather than just being enrolled as a provider.
- Matt: We do know that the MCOs are continuing to work with dental providers to regain the amounts that were previously credentialed, especially in rural populations. But we also know that we had a fair number of new dentists who have never participated in the program credential. So some of the plans were able to recruit a specialty dentist or general dentists who have not yet participated in the program.
- Kenny: I do want to put on our radar the role that public health hygienists play in this. When talking about the integration of physical, dental, and behavioral health, there are some things we have done historically. This is related to the screening and assessment of behavioral health as it relates to our dental patients. In addition, Charles Drew has a mobile dental van that goes to about 15 public schools annually. We have found that if you keep the checks with those kids you develop those oral hygiene behaviors. Albeit this is around first and second grade, but it does help with the conversation with parents who will ultimately make that decision. I think as we talk about dentists, public health hygienists play a significant role and there is a workforce shortage in that area. Let's make sure that as we continue with building dental care, we include hygienists in that conversation.

Other Potential Projects:

Amy: With our new membership, there may be different types of projects we want to take on. I want to open the discussion now to talk about what you are passionate about or what challenges you're seeing.

- Philip: I would like us to evaluate the standard of the letters that are going out to members. Is the information provided appropriate and timely? I'm not certain what is in the letters anymore but there are federal standards that say the letter has to be self-sufficient. These standards ensure that the member can read and understand the letter in whole without being required to call and ask questions to understand the information. I would like us to take a look at that and evaluate if Medicaid is living up to these state and federal standards.
    - Amy: I'm wondering if that would be a good educational topic, is that something we can do?
    - Jordan: Yes, and I can also provide some additional background to this from MLTC's standpoint. In January 2023 we met with advocates, members, stakeholders, and UNMC to discuss the notices that go out. Since that meeting, we have taken the feedback and we have been holding meetings to discuss changing these letters. In our discussions, we have learned that our ability to

change these letters is quite limited due to current system capabilities. This has caused us to make, essentially, a 6-year action plan of items that can be updated now and items that need to wait due to those system limitations. The information we received in that meeting was invaluable and because of these limitations, we are making changes to the materials we can in the meantime to help make them more accessible.

- Philip: I am talking specific to the decision-making notice, what data do we use to make these decisions and what information is provided to the member? As a former parent, I don't see the notices anymore, but I know that in the past this was an issue for parents and members.
- Matt: We do need to improve on these notices, which is what Jordan is working on right now. We looked at them and evaluated what components can be addressed now and what we cannot address right now. The ones that are tied to the regs are the disclosure stuff and nuances of how well this information makes sense. This is something we are having difficulty pulling out of the system. There are some aspects of the notices that we can work on now and others that cannot be altered because of the system we use. I think it would be appropriate for us to bring those findings to this group. We could bring an example of notices or letters, as a group we can flag the things we feel are out of compliance and compare that to the regulations that are in place. MLTC can then provide information on what can be worked on now and which has to be long-term.
    - Amy: I think this could be perfect for future education and then this may turn into a project.

- Dave: What is the state doing to message and educate for suicide awareness? Does the state have information on deaths of Medicaid members and what subset of that is due to suicide?
    - Dr. Verbik: We collaborate closely with the Behavioral Health (DBH) and Public Health (DPH) Divisions regarding suicide. Each MCO has their data regarding the Medicaid members and then DBH also has data that is external to Medicaid. Patient education on suicide is an ongoing effort for all of the MCOs that includes suicide awareness, prevention, and mental health management. For MLTC, we educate members through the MCOs.

      During the implementation of the 988 lines, DBH, DPH, and MLTC did a collaborative intensive initiative. As far as suicide data specific to Medicaid, the MCOs would have the most relevant data on suicide. Regarding maternal mental health and mortality, that is a separate subset. Some rates were published recently, and we were notified that there was an error in the statistical calculation of that data, that showed a rise in the rate. Once the error was corrected, maternal mortality rates remain stable. However, this data would encompass more than suicide rates in mothers. If you want that data, I can provide it to you but I want to adequately answer your question.
    - Karma: I have been in managed care, through multiple organizations for years. All of the MCOs have information that is provided to members to educate them on suicide awareness. In addition, there are resources in their member handbook and there is an emergency number on their member ID cards. When there is a mental health and member safety concern, we have case management

teams with behavioral health clinicians who can step in and assist the member. Once that individual is identified, the MCO tries to engage them with case management. If that person calls after hours in crisis to talk with their case manager, our phone lines transfer them to a crisis line. I'm sure Dr. Verbik would agree that all MCOs have a similar process in place.
        - Dr. Verbik: Yes, and to specify, this is across the age spectrum. The Division of Children and Family Services (CFS) would also make us aware of a particular patient case. When we are made aware, we work with the MCO, our doctors, nurses, care and case management and our behavioral health support systems to support that patient in their environment. We consider this a critical incident, like a red flag. As outlined in their contracts, providers are required to report suicide to the MCOs, who then gather that data and send it to us.
    - Karma: I'm pretty sure the MCOs also have free communication materials that providers can take to message those topics in person as well.
- Jennifer: I do have a special interest in the Medicaid HBCS waivers. I'm not sure how or if it would fit into our initiatives. The new family support waiver could help a group of young minors on Medicaid and change their health outcomes.
    - Matt: I think we could reach out to the Division of Developmental Disabilities (DDD) as they are the ones who implement the waivers. I'm sure that we could reach out to one of their deputies and have them come speak to the programs.
        - Amy: And that Jennifer, might then spur a project in the future but we can start with that as an educational opportunity to do a deep dive.
    - Jennifer: I also serve on the governor's Developmental Disabilities Advisory Committee, and they oversee that waiver. I know there were some questions about the possible Medicaid services to be implemented on that waver rather than as Long-Term services and support. It seems like there is overlap and that could bring exciting changes.

VI. Future Educational Opportunities

Amy: There has been a lot of overlap between these educational opportunities and the projects. Those ideas are as follows: notice revisions, waivers, dental access and data across the state, data on suicide awareness, I want to see if there are any other ideas out there. I do have one for Nikkola and Jordan. As the listening session wraps up, would you be willing to bring feedback to this group to hear the themes across all the listening sessions?

- Jordan: Yeah, that is something we message publicly, and would be happy to provide that information to the group. At the end of each of our tours, we publish a written report that outlines the key points we hear during the sessions. To also increase awareness of these tours and improve transparency, Nikkola developed a webpage that houses the tour information and the reports from previous sessions. We would be happy to prepare that information for our next meeting.

VII. Confirm the Next Meeting Time and Location

The next meeting date and time will be moved back a week to May 23, 2024, from 3 to 5 p.m. in room 206 at the Downtown Branch Library in Omaha, Nebraska. This change accommodates the Tribal Consultation being held on May 16.

VIII. Open Discussion

Vietta: Matt, I don't know if you can provide us with an update on the Change Healthcare stuff and what CMS has been messaging.

- Matt: I would imagine that a lot of you are aware or saw in the news recently that there was a data breach with Change Healthcare. Their organization does a lot of things. In Nebraska, the work primarily as a clearinghouse for providers to submit claims though. During the data breach, they shut down which created problems for quite a few of our providers who only work with them to submit claims. In talking to other colleagues and other states, it seems that we were hit a lot less than others.

  Another thing to keep in mind is that they are owned by the United Health Group which owns United HealthCare, one of our MCOs. With that said, all of our MCOs contract with Change Healthcare at some level. The plans however have still been able to get things done and have been working with their providers that use Change Healthcare to get them up and going on a different platform so they can submit their claims. The plans are willing and able to help pay some money to providers that need it. There is still a certain percentage of our providers who are choosing to wait to submit their claims until Change Healthcare is back. A concern we are addressing is if any of our member's data was compromised. I don't think that data is out yet. I believe they are now fully open for processing claims, it started with the pharmacy then other providers.

IX. Adjournment

Vietta makes a motion to adjourn which is seconded by Philip at 4:47 p.m. CST.