Medical Care Advisory Committee
DRAFT Meeting Minutes
Thursday, May 23, 2024

The Medical Care Advisory Committee (MCAC) met on Thursday, May 23, 2024, from 3 to 5 p.m. CST at the Downtown Branch Library in Omaha, Nebraska. The meeting was held in person and virtually.

MCAC members in attendance: Philip Gray, Jennifer Hansen, Josh Sharkey, Shawn Shanahan, Vietta Swalley, John Andresen, Bradley Howell, Staci Hubert, Dave Miers, Amy Nordness, Heidi Stark, Kelly Weiler

DHHS employees in attendance: Charity Menefee, Matthew Ahern, Dr. Elsie Verbik, Jordan Himes, Jennifer Clark

Members of the public in attendance: Dr. Christopher Elliott, Kimbra Brooks

MCAC members not in attendance: Michaela Call, Karma Boll, Felicia Martin, Jason Gieschen, Kenny McMorris

I. Openings and Introductions

The meeting was called to order by Amy at 3:01 p.m. CST.

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

Introduction of New MCAC Members:

- Dr. Heidi Stark, Provider Representative
- Josh Sharkey, Member Representative

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

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

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

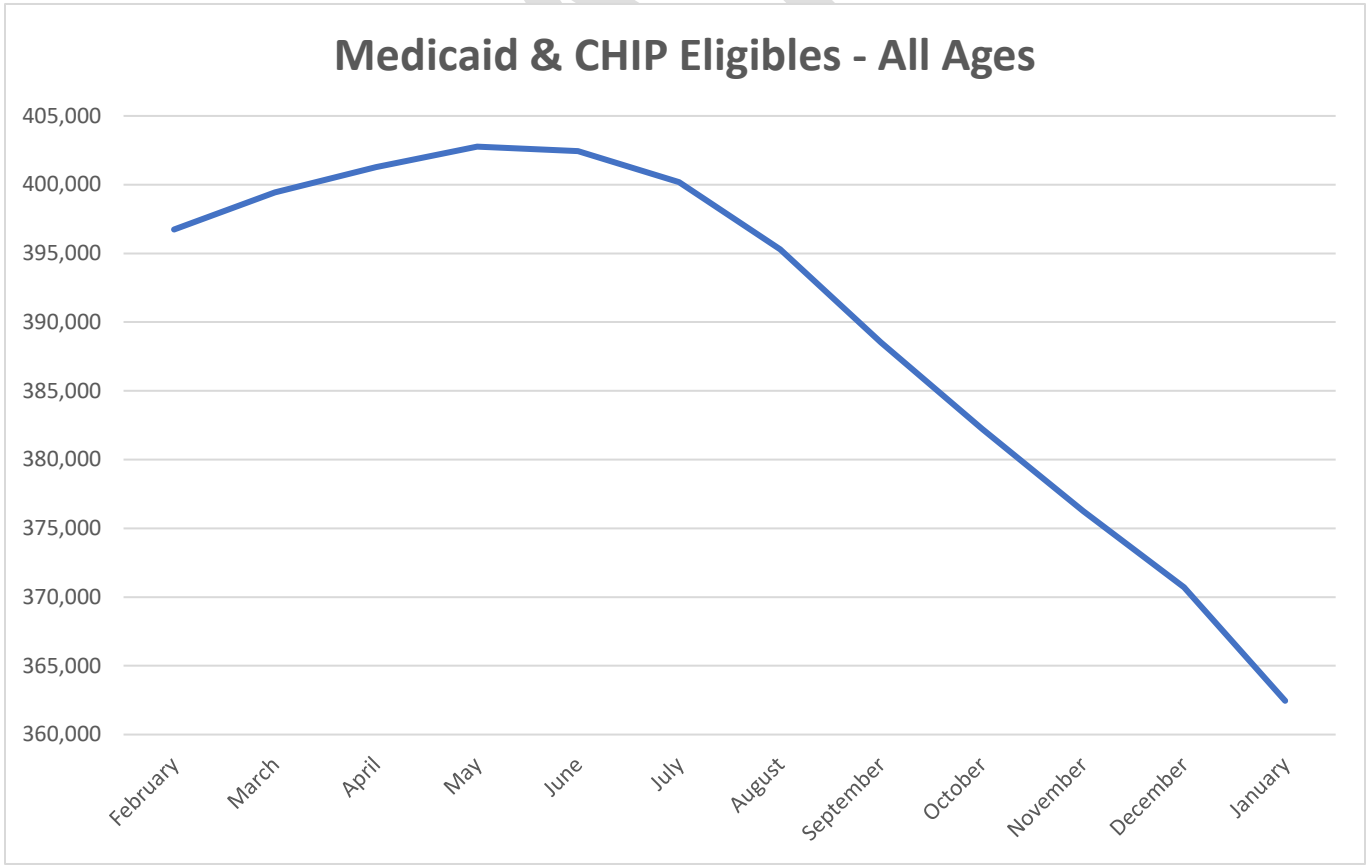
III. Medicaid and Long-Term Care (MLTC) Business Updates

Enrollment and Unwind Updates:

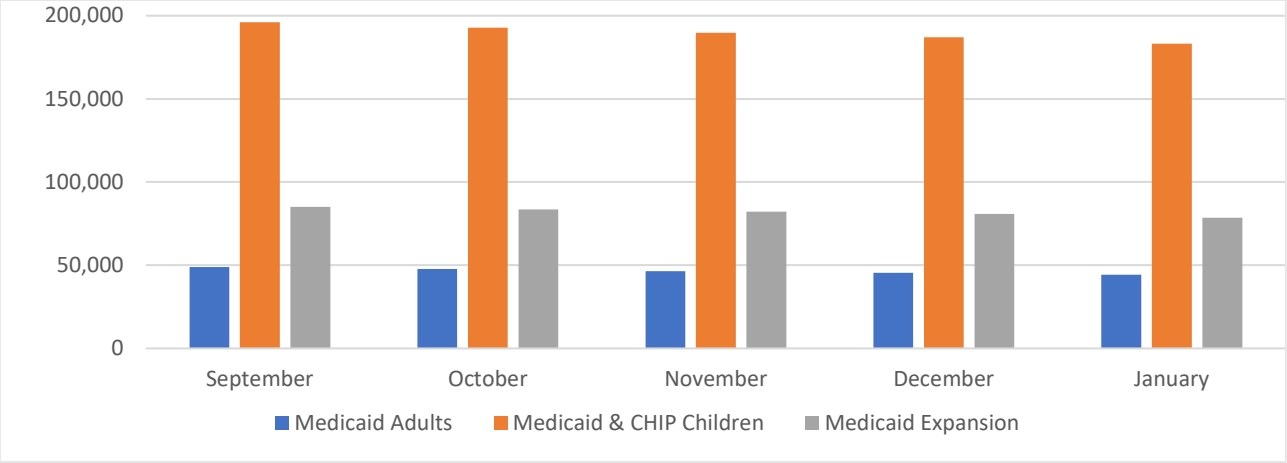
Jordan: This month's update remains similar to previous updates we have reviewed. Medicaid and CHIP children continue to be our largest eligibility category. As we previously discussed, there is still a very limited change to our aged, blind, and disabled categories as their medical need and resources are unlikely to change dramatically.

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

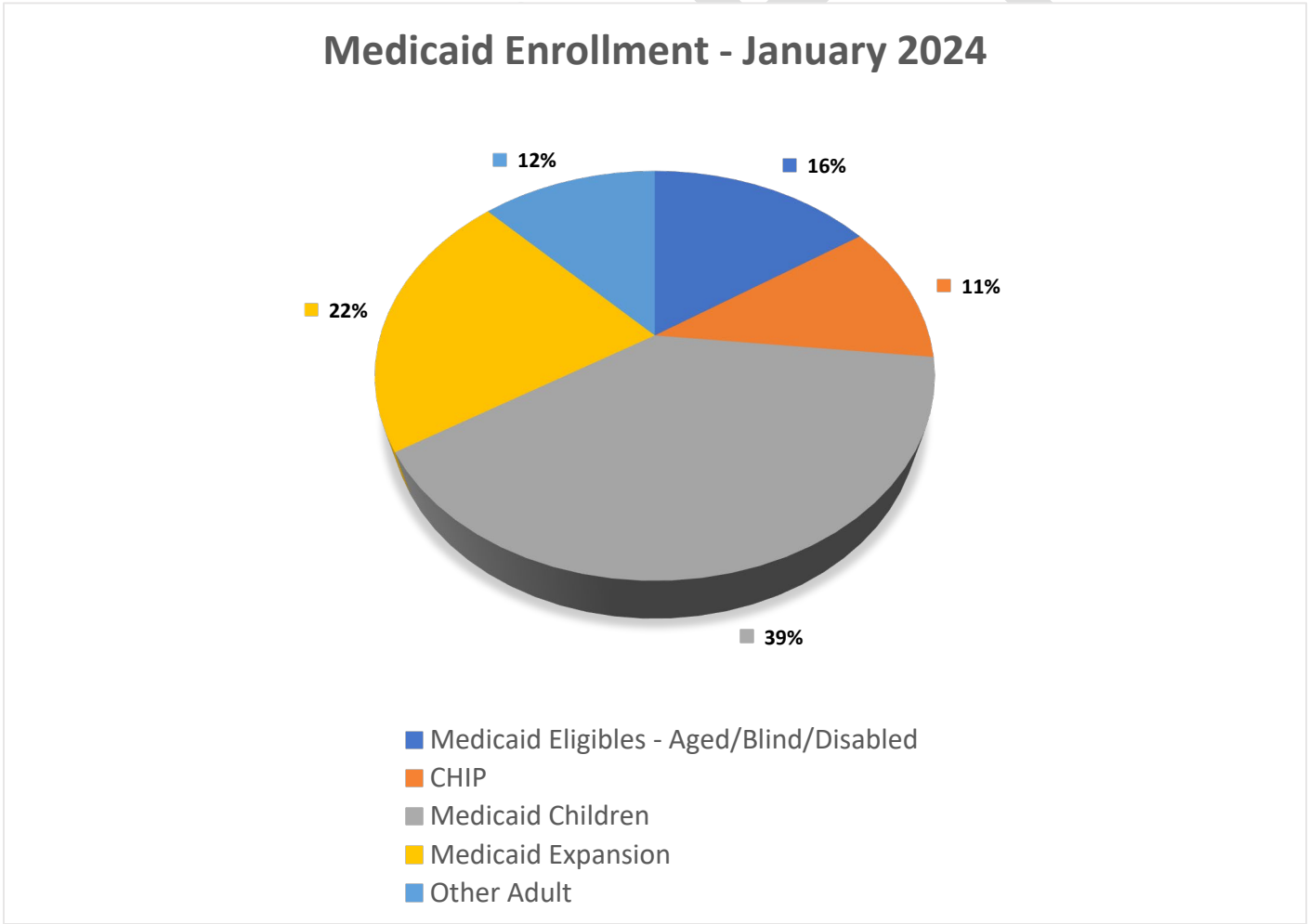
From September 2023 to January 2024, our enrollment has reduced as a result of the unwind. This change was anticipated. These changes continue to mirror what we have seen in the past, you can expect this to continue through the end of August as we complete the outstanding renewals from the unwind.



Looking at these select enrollment categories side-by-side, over the past few months, enrollment has decreased at a regular cadence, nothing out of the ordinary.



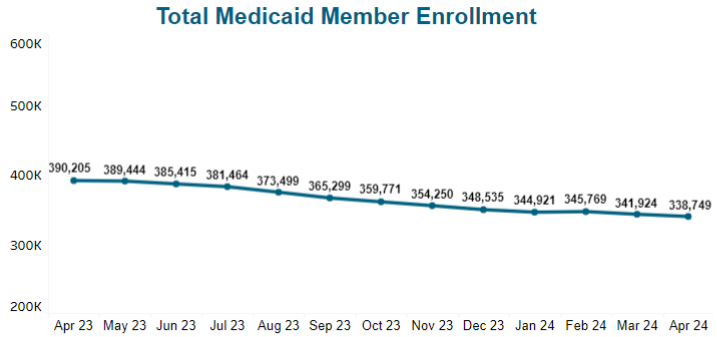
Also made available to you all is a pie chart of the eligibility categories broken down by percentage.

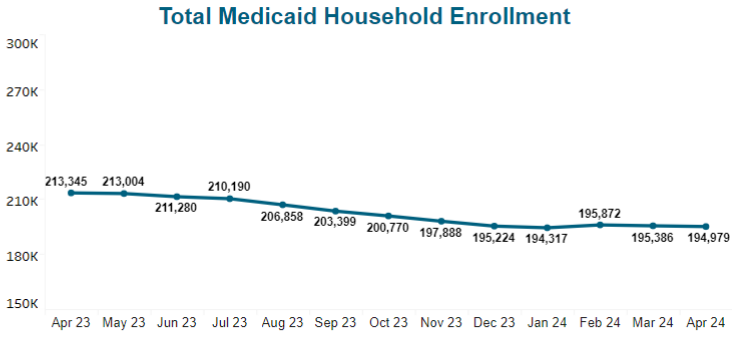


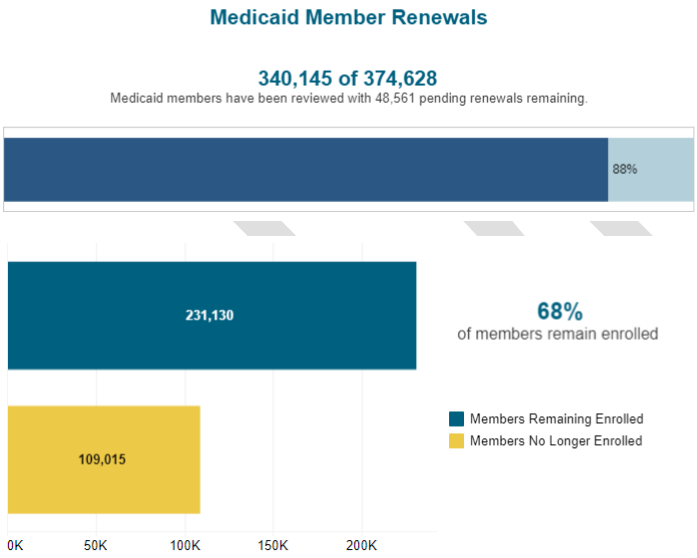
Moving on to the Nebraska Medicaid Unwind Dashboard, we have seen a total change of about 60,000 members or so in eligibility since the beginning of the unwind in April 2020. This includes members who have been disenrolled and new or returning members being found eligible throughout this time.

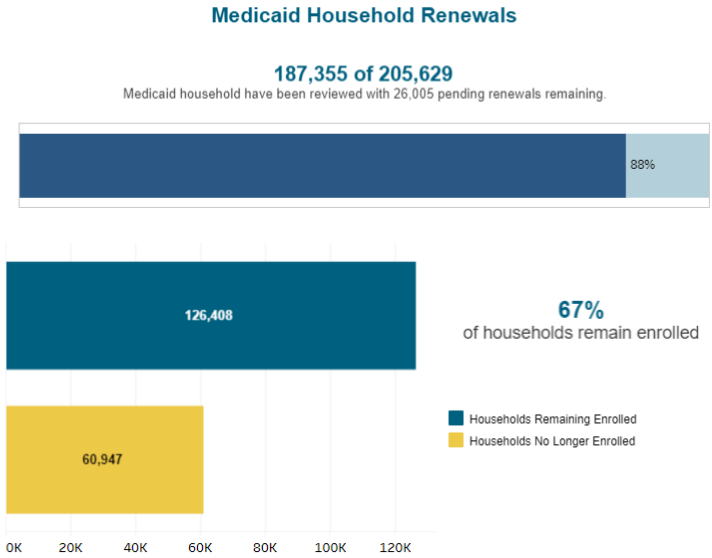
As we discussed during our last meeting, we will continue to review eligibility as part of the unwind through the end of August. We still have about 48,000 cases that need to be reviewed as part of this process. This dashboard will continue to be updated.

We continue to remain the same with about 68% of members and households remaining enrolled with Nebraska Medicaid. The slight difference here is that if one person in the household is found ineligible, the entire household is marked as disenrolled even though others were eligible and remained on Medicaid. This is purely an error in pulling data and is not affecting member enrollment for those who are still eligible.









Are there any questions on this month's data?

- Phil: Why are members no longer qualifying for Medicaid?
    - Matt: We can confirm that 51% of people who have been disenrolled no longer meet income requirements. A little less than about 49% of folks were disenrolled because they didn't respond. We assume there is a sizable amount of folks in

that group who no longer qualify and they know it so they do not want to go through the busy work to tell us they don't qualify.

We have been through significant campaigns with Creighton, UNMC, the managed care organizations (MCOs), and other community stakeholders to get the word out. We have seen hardly any return mail which we think is positive which is a very good thing. I understand that 49% may seem very high but the reality is that we do not have people coming back in once they are disenrolled, so we have a very low churn rate.

Additionally, we are the fifth-best state in the country for member retention. In other states, the average number of people who lost Medicaid coverage due to failure to respond is about 70%.

Debrief: 2024 Legislative Session:
Matt: We have a few bills to cover that passed this legislative session and will have an impact on the Medicaid program here in Nebraska.

- LB62: Provider Coverage of Translation & Interpretation Services (Effective Date: July 1, 2024)
    - It is permissible for us to now reimburse the providers directly. At this time, we reimburse the use of translation and interpretation services through the MCOs. The provider community shared that this is not necessarily meeting their needs as they have already established good pathways for their interpreters. We are developing a code to add to our fee schedule so the doctor will bill for the office visit and the additional code and they will submit it. We would pay the claim for the visit and we would also pay a portion for the interpreter as outlined in the bill.
        - Amy: That is a short timeline, is there anything you are leaning towards right now?
            - Matt: We have looked at national standards and things that are happening in other states that we will reference, though we are still ironing out all of the details. You are right that it is a short turn around. We will likely get something in place by July 1 and then make improvements and update regulations by January 2025.
- LB204: Provide for Reimbursement for Pharmacy Dispensing Fees (Effective Date: July 1, 2024)
    - This increases the pharmacy dispensing fee to $10.58 for independent pharmacies (6 or fewer locations). There is an expectation that next year we will do a cost study and then set our own rate. The $10.58 comes from Iowa's cost study done last year.
- LB358: Increase Dental Services Reimbursement (Effective Date: July 1, 2024)
    - This is an increase of 12.5% for dentists, while not likely what they would like to see this is moving in a good direction. Two years ago we increased rates by 10% and last year the Legislature increased it by another 3%. Over these years it is a significant increase.
- LB857: Nebraska Prenatal Plus Program (Effective Date: October 1, 2024)
    - This is based on a care model in Colorado. This includes a number of services that we already cover but it does expand coverage to nutrition services. It also

will improve targeted case management. Care and case management is currently provided through our MCOs. But this would make it so the OBGYN can dedicate a nurse in their facility to manage the care and case management and they would get a payment from MLTC per member per month.

- LB905: Medical Respite Care
  - This is an interesting bill that I think makes a lot of sense. It is targeted at unhoused individuals who are being discharged from the hospital. You can imagine that if you do not have a safe place to go you could not adequately tend to your wound and you may be much more likely to end up back in the emergency room. What this does is it provides a place for them to stay with limited medical care during the healing time to ensure a smooth transition. At this time, it targets two locations, one in Lincoln and one in Omaha. As a model, I think this makes sense. You may be surprised but Nebraska is not just Omaha and Lincoln so as we have been going across the state and messaging this, we have received questions about how this impacts or affects rural areas. This sets up a pilot test to analyze data and see if it is working. If it is, I don't see why this can't be rolled out across the state.
- LB1087: Hospital Quality and Access Assessment Act (Effective When Signed: March 24, 2024)
  - There is a federal law that allows us to apply a "tax" of up to 6% to the hospitals. We then take the money that comes from the hospitals, we send it to the federal government, which matches it at a rate of 58%, and then send it back to us. This will give us another billion dollars to pay to hospitals each fiscal year. Often we look at big fancy hospitals and think they make a ton of money. While there may be some that are, the reality is that is not often the case. The majority of our hospitals are struggling. We are able to take this funding and send it back to hospitals. We are tracking this return by institution, it pays back out based on the number of Medicaid patients seen. Reimbursement is not going to be 1:1 but it will go based on the Medicaid utilization. The bill outlines that we frontload those payments so we are not waiting for the federal reimbursement for this to start. I will flag that there is about $50 million allocated for improving hospitals throughout the state. These are ongoing conversations but we will share more of those details in the future.
    - Brad: I am the administrator of a very small hospital in Western Nebraska, this is a very big deal for rural hospitals and will be a significant help to provide care for these communities. We have a large Medicare and Medicaid population in our communities. Our building was built in the 70s and there have been a few upgrades but it is not like the hospitals in Lincoln and Omaha. It will enable us to provide better care to our communities.
- LB1215: Coverage of Breast Pumps & Lactation Counseling (Effective Date: January 1, 2025)
  - We already cover these things but the amount of visits for lactation counseling was increased from 5 to 10. We do currently cover breast pumps but at the moment it is only the rental of a hospital-grade pump which costs us about $300 per month. You can buy a high-quality personal-use pump for about $150 and then the member owns it for future use.

Are there any questions on these changes?

- Kimbra: Can you speak to LB933?
    - This bill was aimed at targeting gestational diabetes for moms while they are pregnant. We already provide coverage for moms with gestational diabetes, but our regulations didn't explicitly outline it. This bill also ties the medical necessity criteria with Medicare criteria. This will relax the threshold for receiving a continuous glucose monitor (CGM), thus expanding access. We fashioned our criteria off Medicare but made some changes based on how they were structured. Largely, the individual had to have diabetes that had filing use of insulin or have difficulty monitoring without a CGM. There is some concern about the expansion but we think we will see a limited impact on here.

Follow-up on outstanding questions:

- **Can MLTC provide additional data on the dis-enrollment of children from the program?**
    - Matt: I did do a quick check into this to make sure I understood. We have seen that children's enrollment has decreased by about 13%, not nearly the same reduction that we saw for the larger group. This makes sense as this group tends to be the same in situation.
- **How will the elimination of the DDD registry work and what coordination will be required?**
    - MLTC still does an initial review for Medicaid and there is a handoff between the divisions. There will be a change on program staff and we will continue to staff accordingly.

IV. CMS Final Rule & MACPAC Recommendations: MAC & BAC

Jordan: We wanted to take a moment today to draw your attention to changes coming from the Centers for Medicaid and Medicare services (CMS) which will affect the MAC.

On April 22, 2024, the Centers for Medicare and Medicaid Services (CMS) issued a final rule on Ensuring Access to Medicaid Services (CMS-2442-F). This final rule includes significant regulatory revisions for states' Medicaid programs that will impact the access, payment, loss ratio, quality strategy and review, and Children's Health Insurance Program (CHIP).

These changes appear to result from reviews CMS has run on multiple states. CMS found that many states have not yet implemented the MCAC which has been a requirement for some time now. Other states that have implemented a MCAC, do not receive member or member advocate input, only that of providers. These changes from CMS are aimed to increase member engagement, visibility, and understanding in each state.

I wanted to take the time today to outline what to expect of these changes and in our next meeting we will present a more robust timeline of what these changes will look like.

Medicaid Advisory Committee (MAC):

CMS issued the following changes to the existing Medical Care Advisory Committee (MCAC):

- **Basis and Purpose**: Effective July 9, 2025

- Renames the MCAC to the Medicaid Advisory Committee (MAC): This name change will be relevant during the next meeting.
- Expand the committee's scope to provide recommendations on all elements of state Medicaid. The MAC must work with state officials to determine specific topics that the committee will advise on; topics include:
    - Additions or changes to services;
    - Coordination of care;
    - Quality of services;
    - Eligibility, enrollment, and renewal;
    - Communications provided by the state agency and its Managed Care Organizations (MCOs) to members and providers;
    - Cultural understanding, language access, disparities, and biases; and,
    - Access to services

- **Membership and Composition:** Effective July 9, 2025
    - Over three years, 25% of MAC members representing Medicaid members must also serve on the Beneficiary Advisory Committee (BAC).
        - **First Year**: By July 9, 2025, 10% of MAC committee members representing Medicaid Members must also serve on the BAC. In Nebraska, this equates to about 1 MAC member.
        - **Second Year**: By July 9, 2026, 20% of MAC committee members representing Medicaid members must also serve on the BAC. In Nebraska, this equates to about 2 MAC members.
        - **Third Year**: By July 9, 2027, 25% of MAC committee members representing Medicaid members must also serve on the BAC. In Nebraska, this equates to about 3 MAC members.
        - **Continuing Membership**: After the phase up to 25% of MAC members serving on the BAC, 25% of MAC members must continue to serve on the BAC for the duration of the committee.

Beneficiary Advisory Committee (BAC):
CMS issued guidance outlining the state's requirement to establish a Beneficiary Advisory Committee (BAC). This committee must be implemented by July 9, 2025.

- **Meetings**: The BAC must meet separately and in advance of MAC meetings and will advise the state on matters of concern related to policy development and administration. The BAC may decide if their meetings will be held publicly.
- **Committee Membership**: Committee members must be Medicaid members or advocates for Medicaid members.
- **Transparency**: A separate BAC website will be created to accompany the currently existing MAC webpage. The webpage will include the following:
    - Bylaws
    - Application/Conflict of Interest
    - Meeting Information

        - Meeting Agendas and Minutes
        - Upcoming Meeting Date, Time, and Location Information
    - List of Members
- **Implementation Timeline**: A timeline must be outlined and made public

Annual Reporting:
CMS will require states to publicly publish annual reports summarizing MAC and BAC activities. The first annual report must be published on or before July 9, 2026.

Each report must be reviewed by the MAC before finalization and publication. CMS wants this report to promote transparency and accountability at the state level by giving the public a view of the MAC and BAC's impact on state policymaking.

- Required Reporting Topics
    - Meeting Dates
    - Recommendations Made: The state must include responses to the recommendations

These reports will not be generated by the MAC, DHHS will complete these reports and the MAC will review them to ensure accuracy and transparency.

Other Requirements Outlined:
The following requirements are already being met by Nebraska.

- **Minimum Requirements for MAC membership**: 25% of MAC members must be member representatives or Medicaid members. Nebraska's bylaws require 51% of MAC membership to represent Medicaid members.
- **Making Meeting Information Public**: States will be required to make MAC and BAC meetings public. This includes bylaws, meeting schedules, agendas, minutes, and membership lists.
- **Public MAC Meetings**: At a minimum, states must hold MAC meetings quarterly and make at least two MAC meetings per year open to the public. Public meetings must include a public comment period. All MAC meetings are currently public and have a public comment period.
    - **Accessibility**: States must make reasonable accommodations to ensure that individuals with disabilities and limited English proficiency can attend and participate. Participation in MAC and BAC committees must be made available online or over the phone.

Staffing and Support: Requires states to provide staff that support the planning and execution of the MAC and BAC. Nebraska Medicaid currently has the MLTC Communications Team manage the MAC.

MACPAC Report on MCACs:
You may remember that MACPAC joined us about a year ago to talk with some of our state officials and our board members. They also talked with many other states regarding their approach to engagement for the MCAC committee. I suggest you all take a look at this report as it does reference Nebraska. It is very well thought out and provides great insight for further

engaging with our members, something that I think should be kept in mind and applied during the implementation of the BAC.

MACPAC Report: https://www.macpac.gov/wp-content/uploads/2024/03/Chapter-1-Engaging-Beneficiaries-through-Medical-Care-Advisory-Committees-to-Inform-Medicaid-Policymaking.pdf

I understand this is a lot of information so if you would like to email me questions regarding these changes after the meeting you are welcome to do so.

V. Car Seat/Pack and Play Funding

Shawn: I had a few questions and was hoping to get your input on some changes we have seen in the last few months. Nebraska Children and Families and myself presented to the board in December. One of the funds we were using at that time was helping provide car seats and pack and plays at the hospital for families in need. That funding ended in December and it has had a negative impact on new parents and the hospital.

After speaking with the MCOs, we did learn that mothers on Medicaid qualify for car seats which is fantastic. However, the reality is that we have about 15 births a year where the mother has not received any prenatal, need but has not signed up for Medicaid, or they are only eligible for CHIP and not full Medicaid coverage. When we have births under these conditions, we cannot get them on Medicaid and provide them with the proper resources in time for discharge.

As you may know, we cannot discharge if we do not have a safe car seat to send the child home in so it is having a real impact on the ability to discharge and is impacting the cost of care. Other rural hospitals have some of the same concerns. Is there an advisory board that we can go to and ask for funding to have these resources on hand? Or is there an alternative method or another way to help these new parents in the best way possible when the need is urgent?

- Amy: Is anyone else seeing trouble with this? Or do you have feedback or concerns?
- Matt: It sounds like you explored all of the necessary pathways. If they end up in a hospital not on Medicaid, I'm not sure how quickly we can engage the MCOs to get those mothers up and going ASAP. I do not see a different pathway from a Medicaid standpoint aside from continuing to try to get eligibility established as early in the pregnancy as possible, though there is difficulty there. I'm not sure if there are other grant opportunities out there. I don't want to volunteer for the Division of Public Health, but they have similar funding.
    - Charity: I have taken a note and I will try to see if there is anything we can do to help but I'm not sure.

Shawn: Again, I respect what we can and cannot do and I know that we have guidelines we have to adhere to. I also know that it is costing all of us more money to keep patients hospitalized for an additional 2 days as we try to figure out how to remove these barriers. I know this is an issue with some of our rural communities so it may be about problem solving as a whole.

- Matt: The reality is that if we do not toss it out and see we don't know if we have exhausted all of our resources. I have personally been in this situation where we had our baby and happened to buy the cheapest car seat we could afford but it wasn't adequate for our child and were told last minute that we could not be discharged because of that. We had to scramble and find one on Craigslist that we could afford but not every family can make that happen.

- Staci: It seems like we usually have a group of pharmacies that does training on this. We could touch base with them and if they are getting a script for discharge medications for the mom and/or baby, maybe we could see if there is a solution that way. We do see this issue at the pharmacy as well.
- Vietta: There used to be a Healthy Start Program for children that provided something like this. I think it ended but you might want to reach out to Jodi at the Santee Health center. She does a women and children program there and when I was leaving today car seats were being delivered. You may want to talk to her about that program.

VI. Projects

Amy: We did want to hear from Karma on the subgroup but she could not make it today so we will hear from them next time.

I wanted to do a quick update from our last discussion. We talked a lot about different ideas. I think the best way to proceed is get all of that information and then establish what we want to focus on and where we think we can make an impact. Now that we are a full committee, I want to ensure that we are taking the perspectives of everyone into account, not just a select number of people.

VII. Debrief: Nebraska Medicaid Listening Tour

Jordan: We just completed our spring listening tour, these tours are held biannually. During these sessions, we plan various topics to discuss with meeting attendees. This spring, we saw some of the best turnouts we have ever seen for these sessions we consider a huge win. The continued and increasing engagement of members, providers, and stakeholders in imperative to ensuring a well-rounded program for Nebraskans.

This spring we brought the following topics for discussion:

- COVID-19 Unwind: We covered an update of the status of the unwind and what our successes have been throughout the process. We also discussed changes that folks may see as we complete the remainder of the reviews and completely return to normal operations. Provider bulletins and health plan advisories are expected to be published on some of these changes.
- Telehealth Coverage: Last year, we received quite a few questions regarding telehealth coverage changes that were seen as a result of the unwind. We took those frequently asked questions and published responses but continued to cover the topic to ensure that we cleared up any outstanding confusion.
- 2024 Changes: We responded to some frequently asked questions on the changes since their implementation and directed folks to our new online and print resources.
    - Continuous Eligibility for Postpartum Mothers: https://dhhs.ne.gov/Pages/Maternal-Health.aspx
    - Dental Coverage: https://dhhs.ne.gov/Pages/Medicaid-Dental-Care.aspx
- iServe: We continue to make changes to iServe since its publication last year and wanted to gather input on the software. We got lots of great feedback and were able to confirm that this change has been very beneficial for members and community support specialists.
- Legislative Bills: This presentation was similar to what you all just received from Matt, he also covered the majority of the questions we received regarding this topic.

All of these topics are decided based on recent changes, frequently asked questions, and prior community engagement. As I said, our engagement on this tour was successful and we feel that these topics continued to be of importance for attendees.

The remainder of these meeting times is dedicated to attendees, allowing them to ask questions directly to the MCO Plan Presidents and Interim Director Matt Ahern. The most common topics for discussion were:

- Dental
- Postpartum Coverage
- Behavioral Health Services
- LB905: Medical Respite Care
- Transportation Barriers

You all have been provided a draft copy of the FAQ document we publish at the end of each listening tour. We will be finalizing this and publishing it on our public website at: https://dhhs.ne.gov/Pages/MLTC-Listening-Tour.aspx

VIII. Setting the next educational session

Jordan: Our next session will cover the notice review and the waivers provided by the Division of Developmental Disabilities. The following meeting will cover the dental and mental health data provided by our MCOs.

IX. Confirm the Next Meeting Time and Location

The next meeting will be held on July 18, 2024, from 3 to 5 p.m. in Lincoln. If anyone would like to "host" a meeting in their area, please get in touch with Jordan or Amy to set a meeting date.

X. Open Discussion

Amy: I want to open this up for comment from anyone attending this meeting, are there any topics you want to discuss?

- No comment from attendees

XI. Adjournment

John makes a motion to adjourn which is seconded by Philip at 4:51 p.m. CST.