Medicaid Advisory Committee
DRAFT Meeting Minutes
Thursday, September 19, 2024

The Medical Care Advisory Committee (MAC) met on Thursday, September 19, 2024, from 3 to 5 p.m. CST at the Millard 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: Philip Gray, Jennifer Hansen, Josh Sharkey, Vietta Swalley, John Andresen, Staci Hubert, Amy Nordness, Kelly Weiler, Jason Gieschen, Dave Miers, Brad Howell, Debra Esser (Molina), Kelli Jacobs (UHC)

DHHS employees in attendance: Matthew Ahern, Wendy Walgrave, Jacob Kawamoto, Becky Peplinski

Members of the public in attendance: Deb Schardt, Ned Stringham, Edison McDonald, Kayla Rand, (one attendee was present via call-in/phone)

MAC members not in attendance: Michaela Call, Karma Boll, Shawn Shanahan, Kenny McMorris, Heidi Stark

MAC stakeholders not in attendance: Dr. Elliot (NTC)

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.
- Amy and Jacob welcomed the meeting attendees and ran through the roll call.

II. Review and Approval of May 23, 2024, Draft Minutes

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

- A member joining the meeting virtually makes a motion to approve the minutes, Vietta seconds. The motion passes.

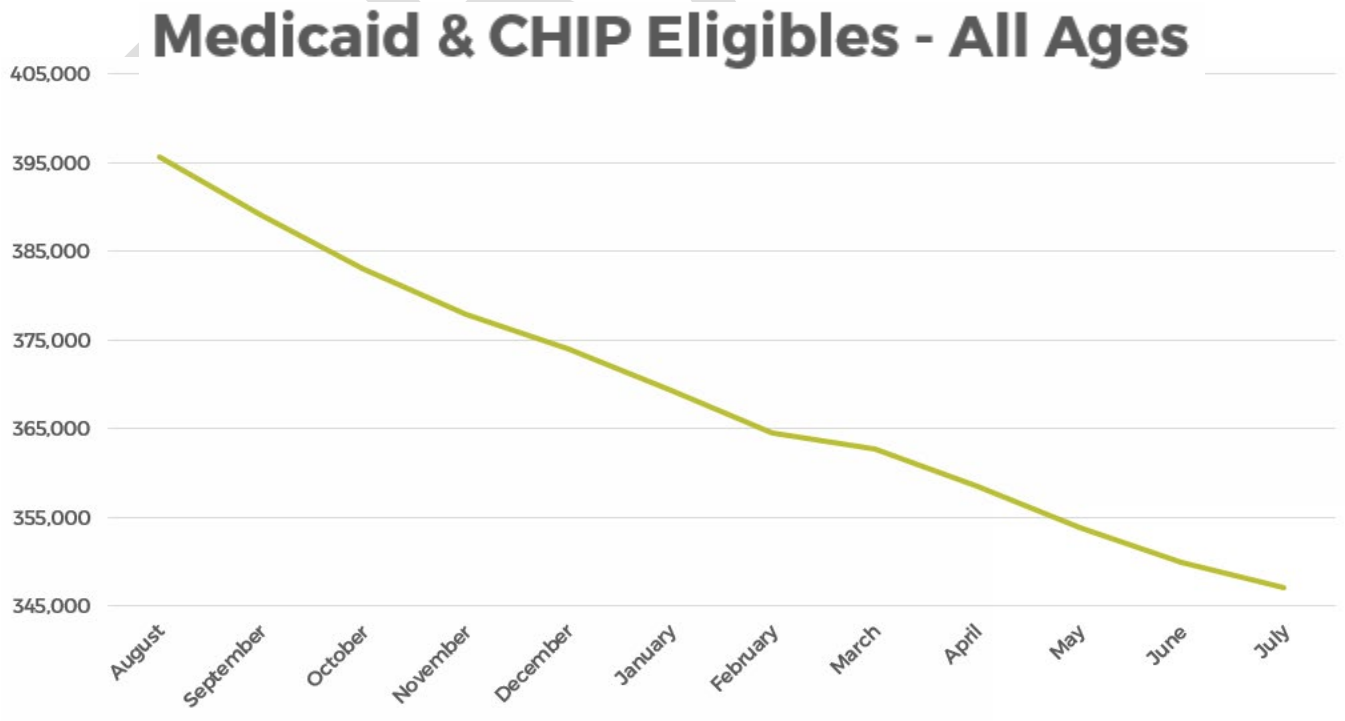
III. Medicaid and Long-Term Care Updates

Enrollment and Unwind Updates:

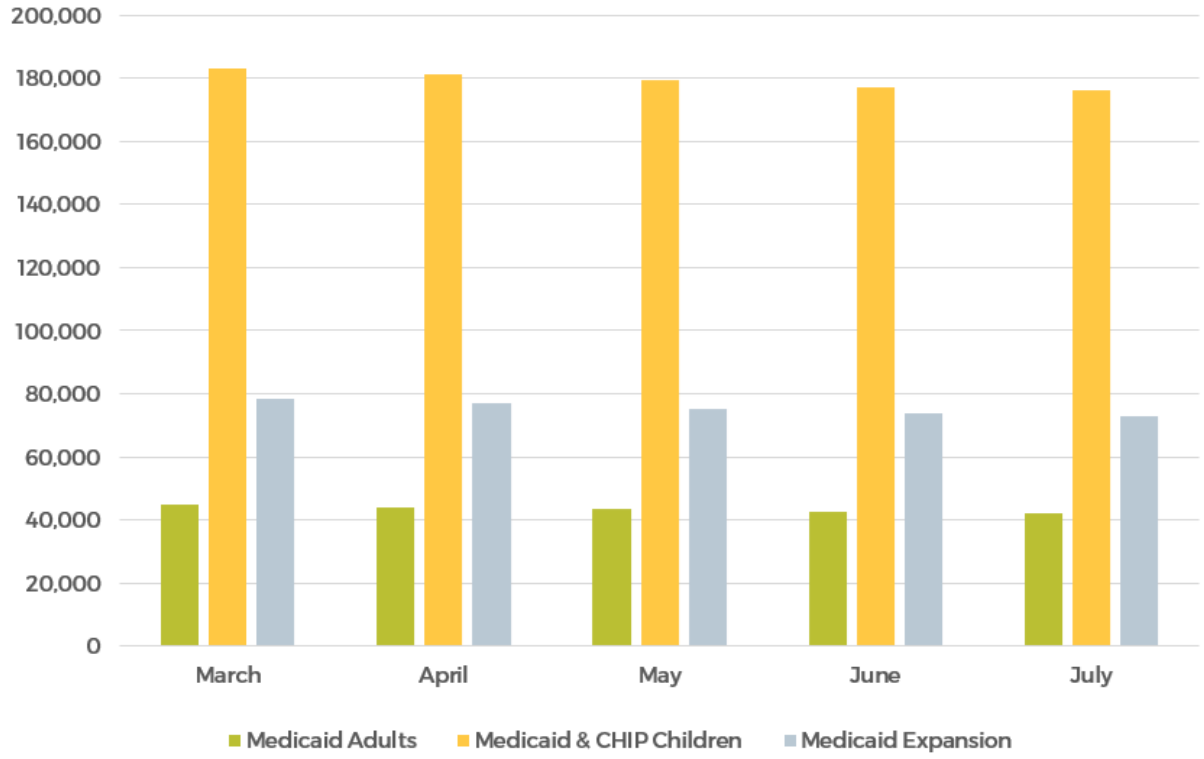
Jacob: This month's update remains similar to previous updates the group has reviewed. Medicaid and CHIP children continue to be the largest eligibility

category. As previously discussed, there is still a very limited change to Medicaid and Long-Term Care's (MLTC's) aged, blind, and disabled categories as their medical need and resources are unlikely to change dramatically. (Note: The data in following charts/graphs includes retroactive enrollment of individuals in previous months, so figures in this update will reflect higher numbers than previous updates).

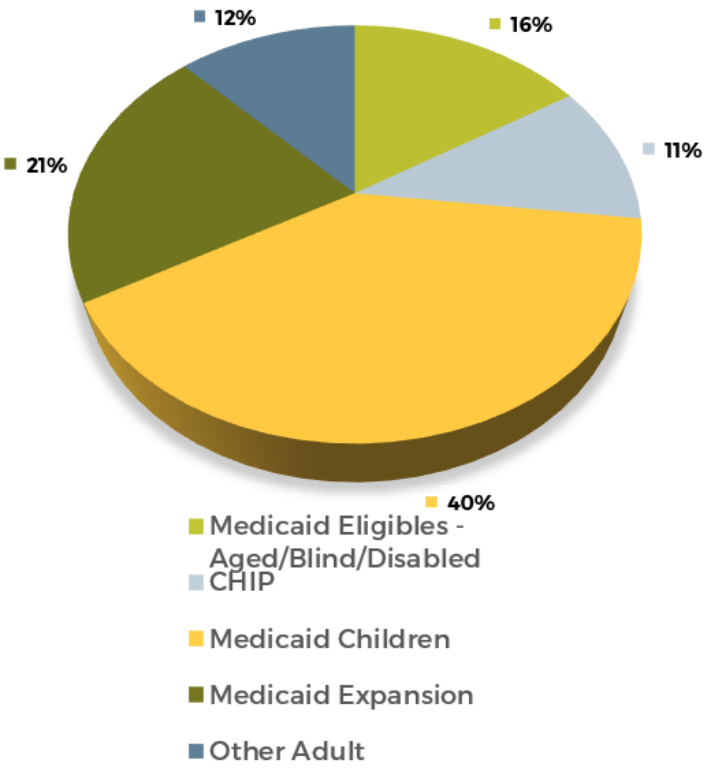
Eligibility Group	March	April	May	June	July
Medicaid Eligibles - Aged/Blind/Disabled	56,714	56,438	56,139	55,948	55,544
CHIP	39,840	39,178	38,696	38,207	38,033
Medicaid Children	143,205	141,866	140,482	139,090	138,147
Medicaid Expansion	78,191	76,852	75,085	73,845	72,940
Other Adult	44,770	44,169	43,466	42,741	42,316
Total Medicaid & CHIP Members	362,720	358,503	353,868	349,831	346,980



Medicaid Enrollment by Month



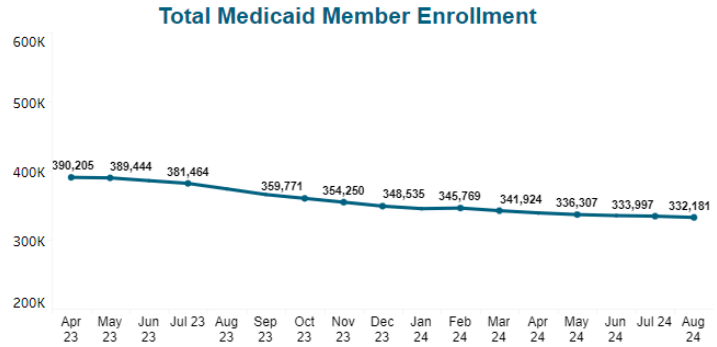
Medicaid Enrollment - July 2024

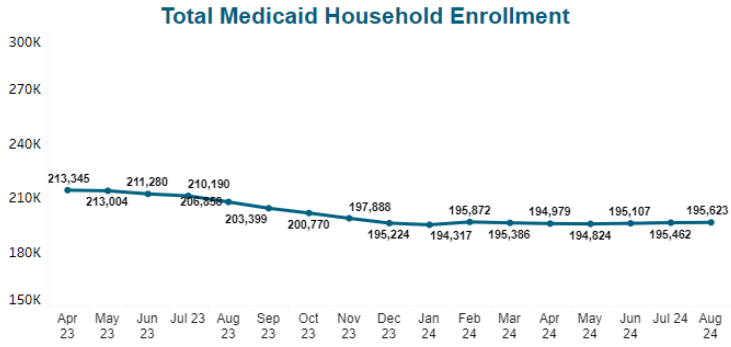


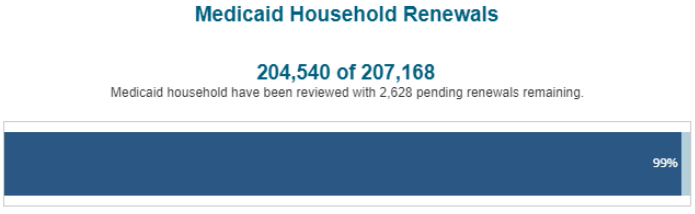
Moving on the to Nebraska Medicaid Unwind Dashboard, we have seen a total change in eligibility of about 60,000 members since the beginning of the Unwind in April 2023. This includes members who have been disenrolled and new or returning members who have been found eligible through this time.

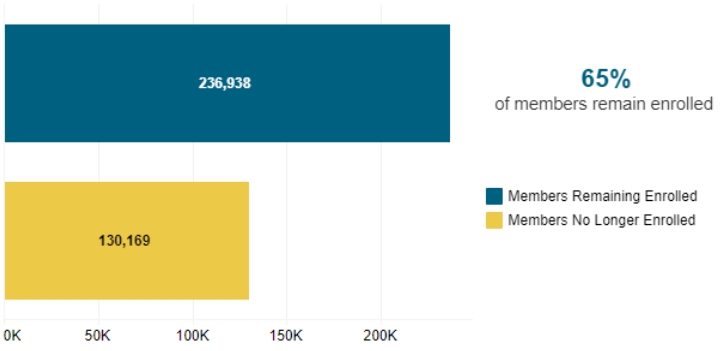
Medicaid will continue to review eligibility for any final renewals as part of the Unwind through September. At the time of this meeting, there are only a small number of cases still outstanding. MLTC's Unwinding Dashboard will continue to be updated.

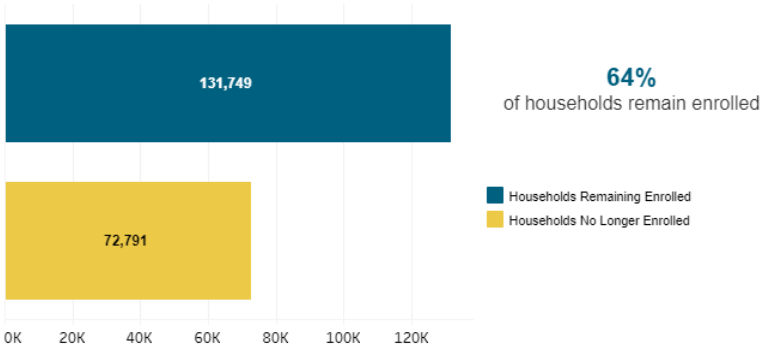
The percentage of members and households remaining enrolled with Nebraska Medicaid dropped slightly from about 68 and 67 percent to 65 and 64 percent, respectively. The slight difference between the individual vs household figures is due to the fact that if one person in the household is marked as disenrolled even though others in the household remained eligible, the entire household is marked as disenrolled even though others were still eligible and remained enrolled in Nebraska Medicaid. This is purely an artifact of the reporting metrics and is not affecting member enrollment for those who are still eligible.











Discussion from MLTC's Enrollment and Unwind Updates:

- **QUESTION:** How many people are enrolled in the Katie Beckett program now that the new levels of care are in place?
    - **ANSWER:** MLTC is just beginning to approve eligibility for this program under the new levels of care. There can be significant lead time due to the need for a disability determination. MLTC is also seeing individuals enrolled in Home and Community-Based Services (HCBS) waiver programs switch to the Katie Beckett program, since they may just need Medicaid coverage but not all of the additional HCBS services and supports.
    - **MLTC will bring enrollment numbers for the Katie Beckett program to the next MAC meeting.**
- **Overview of Recent Medicaid Enrollment History**
    - Approx. 250,000 individuals were enrolled before 2020, which was before both Medicaid Expansion in Nebraska and the COVID-19 pandemic.
    - At the height of the pandemic (before the Medicaid Unwinding began, when individuals were continuously eligible, except for in limited circumstances) enrollment figures were at approx. 400,000.
    - Based on the Medicaid Unwinding and recent trends in applications/enrollment, Nebraska Medicaid anticipates that enrollment will level out around approx. 340,000 enrollees. MLTC anticipates that approx. 60,000 of this increase from pre-2020 numbers is from Medicaid Expansion.
        - Recent months have show that application volume has consistently been significantly higher than ever before. This is potentially due to more news coverage of Medicaid enrollment during the Unwind and Nebraska's recent iServe online application, which has made applying for Nebraska Medicaid more widely available and simpler to navigate.
- **QUESTION:** How is Nebraska Medicaid dealing with approx. 90,000 more enrollees (from pre-2020 figures)? Is there more staff?
    - **ANSWER:** Not necessarily. MLTC has implemented strategic triage and delay of activities to help with work loads and has also made overtime available to workers working on eligibility. MLTC will continue to re-evaluate workload demands and available resources going forward. The Agency is also more fully staffed than in previous years. Some positions were added years ago to assist with the increased workload of Medicaid Expansion.
- **QUESTION:** What about the Executive Order to eliminate state positions that are unfilled?
    - **ANSWER:** There is an exception in the Executive Order for frontline staff.

- **QUESTION:** Does MLTC also have service coordinators (like the Division of Developmental Disabilities (DD) does)?
    - **ANSWER:** Yes, for the Personal Assistance Services (PAS) program. The Managed Care Organizations (MCOs) also have service coordinators.

IV. CMS Final Rule: Medicaid Advisory Committee

The "Access Final Rule" – promulgated by the Centers for Medicare and Medicaid Services (CMS) earlier this year - does affect how this Committee will operate. However, it is up to this Committee to help guide that process and determine how the Committee will be structured and how it will operate in light of the recent Access Rule. The intent behind these changes from CMS is to move stakeholder engagement from being transactional to transformational by incorporating more meaningful engagement.

- **Activities During 2024:**
- Renaming
    - Medical Care Advisory Committee (MCAC) → Medicaid Advisory Committee (MAC)
- Update of Bylaws, Application, and Conflict of Interest Policy
    - Bylaws – MLTC to draft updates for the Committee's review/approval
    - Application – Currently being revised
    - Conflict of Interest Policy – Updated (this available on MLTC's Medicaid Advisory Committee webpage)
- Annual identification of topics the committee will advise on
    - Functionally, these topics will still be chosen the same way that they have been
    - The scope of what the Committee advises Nebraska Medicaid on has expanded under the Access Rule to advise on a broad range of topics (beyond simply the previous scope of "health and medical services") to include:
        - Additions and changes to covered services, coordination of care, quality of services, eligibility, enrollment and renewal processes, enrollee and provider communications, cultural competency, language access, health equity, access to services, and other issues that impact the provision or outcomes of health and medical services.
    - Largely, the Committee has already been advising on many of these topics.
- Develop Beneficiary Advisory Council (BAC)
    - These efforts are currently underway. Any current MAC members interested in serving on the BAC should contact Nebraska Medicaid (Jacob), Amy, or Vietta.

- **Activities During 2025:**
- BAC beings (July 2025)

- MAC/BAC membership overlap: 2 BAC members also serving on the MAC

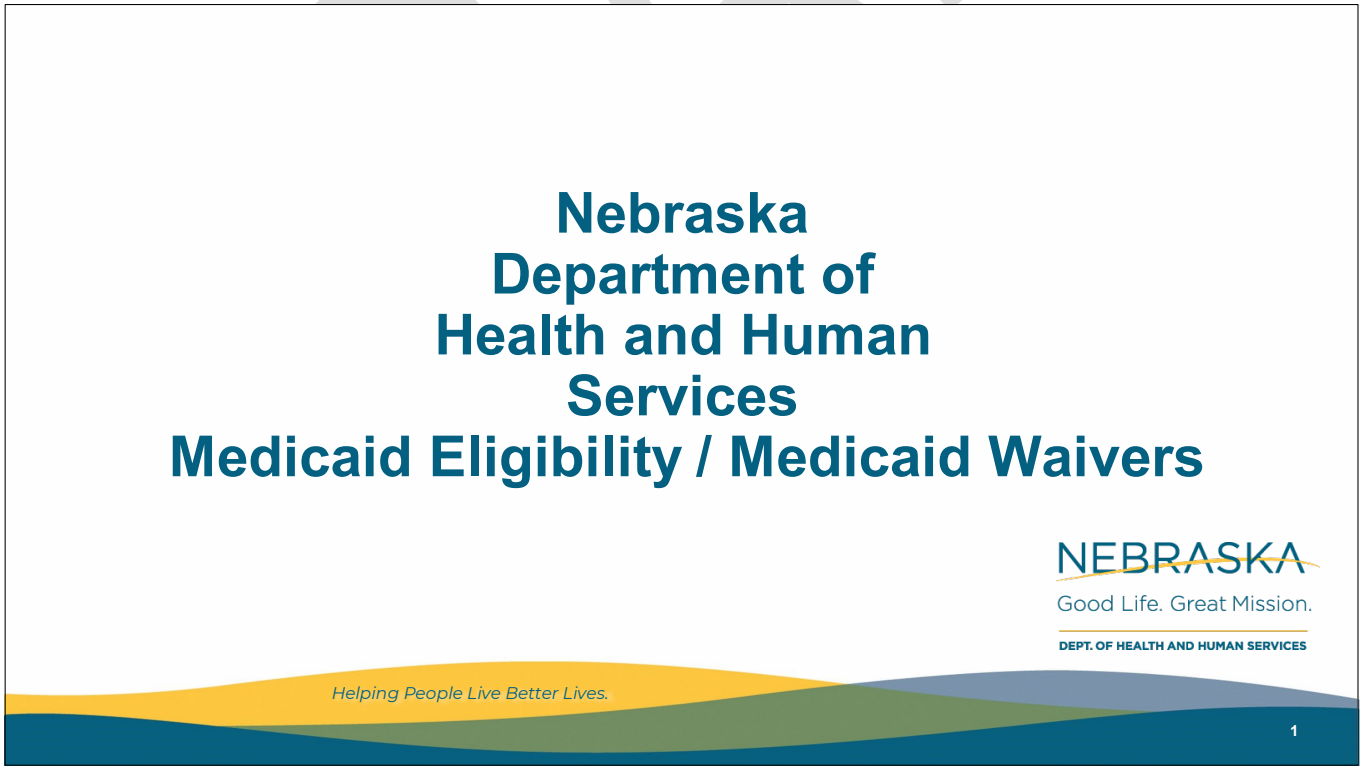
- **Activities During 2026:**
- MAC/BAC membership overlap: 3 BAC members also serving on the MAC
- First Annual Report due (July 2026)

- **Activities During 2027 and Future Years:**
- MAC/BAC membership overlap: 4 BAC members also serving on the MAC
- Annual Report due (July)

- **QUESTION:** Do the MAC bylaws apply to the BAC?
    - **ANSWER:** No, the BAC would have its own bylaws independent of the MAC.
- **NOTE:** Under the new Access Rule, MAC members would not be able to serve multiple consecutive terms, but they could serve multiple non-consecutive terms.
    - **MLTC will post a brief explanation of the changes required under the Access Rule and timeline for implementation to its website.**

V. Educational Discussions

- Information on Medicaid Eligibility and Medicaid Waivers – **Wendy Walgrave**



How to apply

- Submitting an application
  - Over the phone, online, in -person and by mail/fax
- Timeline
  - 45-90 days to determine eligibility

Contact Info

Available Monday through Friday; 8:00 am to 5:00 pm

Phone Number
(402) 473-7000 *Lincoln*
(402) 595-1178 *Omaha*
(402) 471-7256 *TDD*

Toll Free Number
(855) 632-7633

Fax Number
(402) 742-2351

Email Address
DHHS.ANDICenter@nebraska.gov

iServe.Nebraska.gov

Apply for benefits and find the help you need

iServe Nebraska is a convenient new way for Nebraskans to apply to get help with **food**, **utilities**, **healthcare**, **childcare**, and other essential needs.

Nebraskans can apply for a single benefit, or several at the same time.

Explore Benefits | Apply for Benefits | Manage Benefits

Extend Your Benefits | Continue Application

Everything – Medicaid and Waiver eligibility - begins with a Medicaid application. The average time for processing an application is currently less than 20 days.

The 'Explore Benefits' tool can help give people an idea of which benefits they might qualify for before applying. After an application is submitted, MLTC reaches out to the individual if there is any further information needed to make an eligibility determination.

What happens after an application is submitted?

Phone Email Text Mail

Medicaid Eligibility Requirements

- Citizenship/immigration status
- Residency
- Income
- Social Security Number
- Household Composition
- Resources

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Medicaid Categories

- **Children and Families (MAGI)**
  - Children 18 and younger, parent/caretakers, pregnant women
- **MAGI Expansion/Heritage Health Adult (HHA)**
  - Low income adult age 19 -64
- **Aged and Disabled (Non -MAGI)**
  - 65 years of age or older, individual under 65 who has a disability according to Social Security
- **Share of Cost (Medically Needy)**
  - People who are over the income requirements but have a medical need and costly medical expense.
- **599 CHIP**
  - A pregnant woman, who is not otherwise eligible for Medicaid or CHIP, may have her unborn child(rens)'s eligibility
- **Emergency Medical Services Assistance (EMSA)**
  - Emergency medical services may be provided to certain individuals who do not have a qualified non - citizen status for Medicaid.
- **Refugee Resettlement Program**
  - Medical assistance up to twelve months after arrival in the U.S.

Medicaid Income/Resource Levels

MLTC PROGRAM STANDARDS														
INCOME MAXIMUMS										EFFECTIVE 7-1-24				
FPL	-	23%	51%	58%	194%	185%	133%	162%	145%	133%	197%	213%	100%	FPL
HH SIZE	MNIL MA	SAGA	FORMER WARD/ IMD	PARENT/ CARETAKER RELATIVE	PREGNANT WOMEN	TMA	HERITAGE HEALTH ADULT (HHA)	NEWBORN TO AGE 1	CHILDREN AGES 1-5	CHILDREN AGES 6-18	599 CHIP	CHIP	ABD/OMB MSP/QMB	HH SIZE
1	392	289	641	728	2,435	2,322	1,670	2,034	1,820	1,670	2,473	2,674	1,255	1
2	392	392	870	989	3,306	3,153	2,267	2,761	2,470	2,267	3,357	3,630	1,704	2
3	492	495	1,098	1,249	4,175	3,982	2,863	3,487	3,121	2,863	4,240	4,584	2,152	3
4	584	598	1,326	1,508	5,044	4,810	3,458	4,212	3,770	3,458	5,122	5,538	2,600	4
5	675	702	1,555	1,769	5,916	5,641	4,056	4,940	4,422	4,056	6,007	6,495	3,049	5
6	775	805	1,784	2,029	6,785	6,470	4,652	5,666	5,071	4,652	6,890	7,449	3,497	6
7	867	908	2,012	2,289	7,654	7,299	5,247	6,391	5,721	5,247	7,772	8,403	3,945	7
8	967	1,011	2,241	2,549	8,525	8,129	5,845	7,119	6,372	5,845	8,657	9,360	4,394	8
9	1,059	1,114	2,470	2,809	9,394	8,958	6,440	7,845	7,021	6,440	9,539	10,314	4,842	9
10	1,150	1,217	2,698	3,069	10,263	9,787	7,036	8,570	7,671	7,036	10,422	11,268	5,290	10
	+91													

FPL	200%	250%	120%	135%
HH	MIWD	MIWD PREMIUM	SLMB	QI-1
1	2,510	3,138	1,506	1,695
2	3,407	4,260	2,045	2,301

HH SIZE	RESOURCE LIMITS		SSI LEVELS		OTHER LIMITS
	AABD/MA	MSP/QMB SLMB/QI-1	Federal Benefit Rate (FBR)	Referral Level	Shelter Allowance
1	4,000	9,430	943	963	281
2	6,000	14,130	1,415	1,435	349
	Dependent Adult Child (DAC)	Maximum for Burial Trust	Standard Medicare Part B Premium	Standard Medicare Part B Prem. for duals	
	$2,000	$6,346	$174.70	$174.70	

The Federal Poverty Levels used for program eligibility can be found on the Medicaid Eligibility website.

The Katie Beckett program is a Medicaid eligibility category, not a waiver program. As such, it only follows the first 3 steps outlined in the slide below. Note: Nebraska Medicaid cannot review a disability determination that the Social Security Administration (SSA) has already denied or determined.

Waiver Eligibility

To be eligible for waiver services (AD, DDAD, FSW, or CDD)

- Must meet Medicaid financial and non -financial criteria
- Must have a disability determination (either SRT or SSA)
- Must meet appropriate LOC
- Must have appropriate PCP, and consents

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Waiver Eligibility

1. Active in Medicaid
   - SA or SG MED
   - CFS IV-E eligibility
   - MAGI/Non-MAGI or HHA
     - If MAGI or HHA, we will attempt to move to Non -MAGI
   - Financial and Non-Financial eligibility
   - If not active Medicaid, must apply
2. Disability Determination
   - Under the age of 65
   - Social Security/SSI
   - SRT
3. Level of Care
4. PCP/Waiver Consent

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In order to qualify for waiver services, an individual must be eligible for a Medicaid program providing full coverage. Enrollment in a buy-in only program (where Medicaid only helps pay for Medicare costs) does not constitute Medicaid eligibility for Waiver eligibility purposes.

Disability Determination Process

1. Attempt to contact
   - Explain waiver services, or Katie Beckett program
   - Explain SRT Process
2. Verification Request #1
   - Request for records
   - Co-assigned with SSW and SRT Clinical Team
3. SRT Review
   - Same disability criteria as SSA
4. Approval
   - Moves to LOC
5. LOC
   - Based on specific waiver/Katie Beckett applied for
   - Administered by E&E Unit
     - EDN for kids under 4
6. Service Coordination for PCP/Waiver Consent (not required for Katie Beckett)
7. Medicaid processing/Waiver activation
8. Denial
   - Can occur at any step of the process

Medicaid Changes

- Katie Beckett Expanded
  - Effective 7/1/24
  - Nursing Facility and ICF-IID Level of Care added
  - Still requires disability determination or SRT
  - New Cost Effectiveness Form
  - No additional supportive services – Medicaid coverage only
  - Same timelines to process as other HCBS Waiver programs
- Continuous Eligibility
  - Pregnant/Post Partum Women
  - Children

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Pregnant/Post-Partum Women are covered up to the end of their pregnancy, and for 12 months afterward. Children are continuously eligible for 12 months from the time that eligibility is initially determined.

Note: Although reopened cases can take up to 5 days to reflect in the Medicaid and Managed Care system, there is no actual gap in coverage/eligibility.

Ongoing Eligibility

HERITAGE HEALTH ADULT EXPANSION

- Annual renewal
- Medicaid continues as long as eligible.
- Report changes to DHHS within 10 days
- Reopened cases can take up to 5 days to reflect in the Medicaid and Managed Care system

Questions and Discussion regarding Medicaid Eligibility and Medicaid Waivers:

- **QUESTION:** What if someone is currently eligible for Medicaid services, but is considering the MIWD program? Would they need to submit a new application?
    - **ANSWER:** No. If someone is currently eligible for Medicaid, then there is no need for the MIWD program. But if the individual ever does go over income for their current Medicaid program, they will automatically be reviewed for MIWD eligibility.
        - **QUESTION:** Would they also need to apply for share of cost?
    - **ANSWER:** No. Medicaid will automatically review for MIWD before reviewing eligibility for a buy-in or share of cost program.

- **QUESTION:** What happens if someone has a case pending a determination from the Social Security Administration (SSA)?
    - **ANSWER:** If there is immediate medical need, the Nebraska Medicaid State Review Team (SRT) will make a determination. Nebraska Medicaid will then follow the SSA disability determination once that is made.

- **QUESTION:** Families with parents who are over income, but who are applying for their children, are being told not to apply or that they are not eligible. When there is a language barrier for beneficiaries, it can be even harder to navigate this and for parents to know that they can still apply for their children. It is also difficult when the children have disabilities, but the parents don't know how to apply for them (even though the parent may be over income). Are there any questions on the application specifically about applying for Medicaid with a disability?
    - **ANSWER:** On the iServe application, they should be able to note that someone they are applying for has a disability. The Medicaid application doesn't have check boxes for all disability programs, but the application does ask about disability.
        - **COMMENT:** Families are having a hard time understanding how to apply for disability programs. Additionally, they may not see their children's conditions as a disability.
    - **RESPONSE:** Issues with failure to be referred to or reviewed for programs like Katie Beckett might be coming from contracted call centers. Nebraska Medicaid will work with them to ensure they are providing accurate information given recent programmatic changes and updates. Additionally, Medicaid will look into individuals who are over income but not asked about disability, especially when applying for their children. Medicaid is also open to efforts to revise language on the iServe application that screens for disability, but ultimately any updates to the application language would also need approval from federal partner agencies.

        - **QUESTION:** Can Medicaid ask the applicant if they have an individualized education plan (IEP)? The SRT asks for an IEP, but it would be helpful if this was already included on the initial application.
    - **ANSWER:** Nebraska Medicaid will look at whether this can be incorporated with the application questions.
        - **NOTE:** The DD-10 HCBS application is a separate application to apply for home and community based services (HCBS).

- **QUESTION:** Do DD and MLTC share information (like IEPs)?
    - **ANSWER:** The two divisions do share an eligibility system. This would also be a good question for Jenn Clark (from DD) at the next MAC meeting as there are some overlaps in what information is shared for eligibility determinations.

- **QUESTION:** What electronic information is accessed by Medicaid?
    - **ANSWER:** Medicaid has access to various information through the federal Hub including tax information, wages, information from SSA, citizenship status, information from other states, etc.
        - **QUESTION:** Why does Medicaid request an applicant's paystubs for the past 30 days if they have access to electronic information related to income and wages?
    - **ANSWER:** Wage data that Medicaid accesses electronically is typically 3 months behind. Additionally, some employers don't participate with the Hub vendor, and thus the Hub cannot provide wage/income information. A paper request (for things like paystubs) is only sent to applicants as a last option if the eligibility criteria could not be determined with electronic data and records.

- **COMMENT:** Philip shared issues related the SRT's access to medical records. His concern was that the SRT sends paper forms to medical providers to collect medical records, but the providers have medical records available in electronic formats, not paper formats. Thus there is a barrier to providers sharing this information with the SRT.
    - **RESPONSE:** The SRT has an eFax where providers can submit electronic records.
        - Email: DHHS.ANDICenter@Nebraska.gov
        - Fax: 402-742-2351
    - Paper records can be mailed to PO BOX 2992, Omaha, NE 68172-9659 or dropped off in-person at a local DHHS office.

- **QUESTION:** Will the iServe 'Explore Benefits' tool determine if a family is over income for Medicaid?
    - **ANSWER:** The 'Explore Benefits' tool indicates benefits that individuals/families might qualify for. But when in doubt, or if they're

wondering, the individual/family should always submit an application.

- **QUESTION:** Is parental income waived for a disabled child?
  - **ANSWER:** Parental income is not waived automatically. There are steps in determining eligibility. For example: eligibility in a MAGI program is always looked at before something like eligibility for the Katie Beckett program.

- **QUESTION:** So do applicants need a denial for certain programs when parents are over income, but the child might still apply?
  - **ANSWER:** It depends on the circumstances, but in these cases a denial is usually administrative in order to pend a new application for other programmatic eligibility that may apply. But if it is unclear that another application is pending after the denial, then it is likely just a denial because the applicant was not found eligible.
    - **QUESTION:** But what if the applicant doesn't know to ask about other programs they may be eligible for? Does the information about disabilities make it onto the application for workers to review? That seems like the key part missing from the process.
  - **RESPONSE:** Nebraska Medicaid will review to see if there is a gap in identifying children with disabilities based on the current application and eligibility review/determination processes.

- **QUESITON:** Do infants need a Social Security Number (SSN), or can an application be submitted for them while that is pending?
  - **ANSWER:** Newborns don't need a SSN for Medicaid until age 1.

- **QUESTION:** Do applications for those newly eligible for SSI need to ask all of the same questions as a normal Medicaid application?
  - **ANSWER:** Yes. A valid application requires a name, address, and signature, so if it is submitted with only that bare minimum of information it will still be reviewed. But the more information that is included, the easier it is for MLTC to review and accurately determine eligibility.

- **QUESTION:** Does the SRT use the same criteria as the SSA?
  - **ANSWER:** Yes.

- **QUESTION:** If the ICF/NF levels of care have been added to the eligibility criteria for the Katie Becket program, why does Medicaid need to coordinate with DD for the Family Support Waiver (FSW)?
  - **ANSWER:** The Katie Beckett program and FSW are two separate things. If someone is on the FSW then they've already met Medicaid

eligibility (since the FSW is a waiver program). Disability on some level is common to all three levels of care: hospital, nursing facility (NF), and intermediate care facility for individuals with developmental disabilities (ICF/DD). But DD holds the eligibility mechanism to determine level of care, hence why they are also involved in Katie Beckett determinations, since NF and ICF/DD levels of care are part of the eligibility criteria for the program. And level of care determinations are needed for all waiver eligibility determinations (like the FSW). But Katie Beckett program is a Medicaid category, not a waiver program.

- **QUESTION:** How many renewals are done for individuals with SSI determinations?
    - **ANSWER:** Don't have the exact numbers (at the time of the meeting), but it is only a percentage of cases with SSI determinations, which itself is a very small percentage of Medicaid cases. Waiver cases are ~10k – 12k, and cases with SSI determinations are a smaller subset of those numbers.

- Next educational sessions:
    i. Dental Access Across the State
    ii. Medicaid-specific data on Suicide

VI. Sub-Committees

- Maternal and Newborn Health – **Karma**
    i. Karma was unable to attend/present at the September 19th MAC meeting.

VII. Confirm the Next Meeting Time and Location

- November 21, 2024, from 3 to 5 p.m.

VIII. Open Discussion / Public Comment

Edison McDonald from the Arc of Nebraska provided public comment:

- They have seen discrepancies with the SRT process and noted that it has been difficult for individuals to apply for services requiring the SRT's review.
- They have concerns that only 97 are enrolled in the FSW when there are 850 spots. A recent report by the Epiphany group recommended removing constraints, and the Arc of NE's opinion is that communication with and from the SRT and DD has been an issue for members.
- Wanted to discuss the recent Access Rule and MAC/BAC requirements, was glad to hear the Committee discussing this at today's meeting.
- They have concerns with a copy of the recent DHHS budget proposal which appeared to recommend cuts for dental services, supports for families, and provider rates. The Arc of NE views this as especially concerning given the current crisis around access to services in the state.
- They were thankful for the robust conversation around the Katie Beckett program.

QUESTIONS:

- **QUESTION:** How many staff are on the SRT?
    - **ANSWER:** 5. Medicaid also contracts with some physicians and specialists to advise as well.
        - **QUESTION:** Who actually makes the decisions?
    - **ANSWER:** The SRT, which has a mix of clinical and administrative perspectives, reviews based on state regulations and requirements and makes a decision. There is also a physician review process which helps inform the SRT.
- **QUESTION:** What about the DD Council?
    - **ANSWER:** Roughly 480 cases were accepted and are being reviewed. About 500 applied. 97 individuals have been approved and are receiving services.
        - **QUESITON:** Both Medicaid and DD agreed on eligibility?
    - **ANSWER:** If an individual is receiving waiver services, then all eligibility requirements have already been met for Medicaid too.
- **NOTE:** The SRT is currently reviewing 83 cases, and there are still some in the que after that.
    - **QUESTION:** How many cases does the SRT review in a month?
- **ANSWER:** This depends, but the SRT will start with a request for information. The SRT has been finding that they are getting some, but not all of the information needed from initial responses, and so they have to request the needed information again. There is a 30 day timeframe for responses for each request, so these additional requests for information can add to the time it takes to complete a review.

Access to waiver services Medicaid programs for individuals with disabilities has been a big topic of concern and discussion in recent MAC meetings. The MAC voted to create a sub-committee dedicated to looking into this topic and bringing information back to the MAC. Philip Gray and Jennifer Hansen volunteered to lead that committee. DHHS will provide Medicaid and DD staff to support these efforts to the degree that such support is available and needed by the sub-committee.

- **QUESTION:** Is Medicaid planning to keep the ‘cost-effective form’ for the Katie Beckett program? Some families got the form, which asked for an approximate cost of the medical care and requires a physician signature. But physicians are not wanting to sign this, or are uncomfortable doing so, because they don’t know all the details of a patient’s health coverage, nor do they have the time or capacity to calculate those costs.
    - **ANSWER:** Yes, this form is part of meeting a federal requirement to demonstrate cost-effectiveness for the program. Medicaid is working on ways to prove cost-effectiveness that meet federal requirements, but are not burdensome on providers or patients and that don’t prevent access to these services. Medicaid hasn’t heard of physicians refusing to sign the

form prior to this, but is open to revising the form to meet all relevant needs.
    - **QUESTION:** What should families do in the meantime?
- **ANSWER:** Medicaid will have to work with them on a case-by-case basis to ensure appropriate access to services and that all relevant requirements are met.

IX. Adjournment

The meeting was adjourned by the Committee at 5:03 p.m. CST.