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

Pete Ricketts, Governor

MLTC Tribal Consultation
November 11, 2022
1:00-4:00 p.m. Central Standard Time

Lincoln Health and Wellness Center
1600 Windhoek Drive
Lincoln, NE 68512

1. Welcome / Group Introductions
   i. Celebrations

- **MLTC:** November is National Native American Heritage Month, and we want to take this time to celebrate the rich and diverse cultures, traditions, and heritages of the Tribes in NE, as well as the important contributions you all have made to the Medicaid Program. Thank you all so much for all your hard work and initiatives to improve the program and help advance Tribal Health for the beneficiaries we serve in NE.

   ii. Update of MLTC Tribal contacts / email list

2. SPA/Waiver Discussion – **Jacob Kawamoto**
   i. 2022 Overview and recap

- **State Plan Amendments or Waiver updates Overview**
- **SPAs:**
  - **NE 22-0007:** Tribal Telehealth
    - Allows for the Tribes to bill and be reimbursed at the AIR for services appropriately provided via telehealth. This SPA would make this permanent, and not contingent on the PHE.
      - Submitted to CMS on 11.7.22
  - **NE 22-0013:** Home Health APRN
    - Allows a nurse practitioner, clinical nurse specialist, and nurse midwife to order home health services and certify plan of care

   ii. Encounter Rate Project
      i. Updates on the project and scope
- **Encounter Rate Project**
  - The Policy team recently switched to a different project manager to facilitate not only internal policy changes regarding the encounter rate, but to help with oversight and

implementation of Tribal-related provisions in the new MCO contracts as well. This includes:
    - Identifying and addressing any gaps that might exist within our program and the MCOs related to Tribal Health,
    - Continuing to improve coordination between MLTC and MCO Tribal liaisons to ensure we are providing the best services to Tribal beneficiaries and health care providers.
- Main Goals of the Project:
    - Updating regulations or any policy to clarify reimbursement for the IHS encounter rate
    - Clarifying billing multiple encounters
    - Clarifying services that are incident to an encounter, and physician services
    - Gathering institutional knowledge that has been created by the MCOs around Tribal health, and encouraging the creation of such where it currently does not exist
- The Policy Team is currently still in the research phase of this project and has been looking into surrounding state regulations to create uniformity for all Tribal beneficiaries that Medicaid provides services to. Per suggestions from the last in-person Consultation Meeting in August, MLTC has also been looking into Iowa's regulations around the encounter rate to help ensure this uniformity.
- MLTC leadership is in favor of expanding the scope of the encounter rate where/if possible. But the main intention of this project is to help clarify what services can and can't be reimbursed at the encounter rate. For example, NEMT can't be reimbursed at the encounter rate due to the services not being face-to-face visits with a provider. We are looking into home health services with the encounter rate and each state reimburses these a bit differently. Right now, we are still researching and in the early stages of developing any potential policy updates.

- <u>QUESTION/ANSWER</u>:
    - **QUESTION:** If you do decide to update this policy will it be done through a SPA or regulation update?
        - **ANSWER:** It would likely be done through both a SPA and regulation update if the decision is made to make policy/language updates. There is encounter rate language in both the regulations and SPA that would be updated, and it would likely be the same language in both places.

    - **QUESTION:** Are these updates being applied to fee-for-service or just the encounter rate?
        - **ANSWER:** This update would likely impact all encounter claims, whether FFS or managed care. But claims which are not encounters but are billed at the FFS rate would not be impacted by any policy updates made to the encounter rate language.

3. COVID-19 Public Health Emergency (PHE) – **Chris Morton**
    i. Review of draft PHE unwinding stakeholder communications

- **<u>Background:</u>**

- Review the following four documents for feedback related to COVID-19 unwind communications: FAQ, Flyer, Fact Sheet, & Card.
  - Please provide input on the information. MLTC wants to ensure that the information is accurate and captures all the necessary information and feedback from Tribal partners needed for a successful unwind from the PHE.

- **Review of PHE unwinding stakeholder communications:**
  - **COVID-19 Unwind Presentation:**
    - PHE Emergency Requirements
      - Families First Coronavirus Response Act (2020); provided federal funds and implemented the continuous coverage requirement (members enrolled on or after March 18th can't lose coverage until the month after the month the PHE ends. EX: if it ends in January, no one could lose coverage until February at the earliest.)
        - There has been a considerable amount of membership growth since the PHE began and MLTC wants to ensure eligibility still holds up or that members are able to find coverage through the Marketplace.
    - PHE Termination/Expiration
      - Every 90 days the PHE can be renewed
      - DHHS's priority is to ensure continuity of coverage. If someone is no longer eligible post-PHE we want to get them signed up elsewhere as applicable (e.g. Marketplace coverage).
    - Conducting renewals
      - Due to the "Continuous Coverage" requirement no one lost coverage
      - Once the PHE ends, Medicaid is expecting many individuals to lose coverage for the following reasons:
        - Failure to respond to a verification request or renewal form sent by DHHS
          - This may be additionally impacted by changes to contact information and failure to update info with the Dept.
        - Changes in eligibility information which leads to categorical ineligibility
    - MLTC transition to "normal operations"
      - This will take 12 months and MLTC encourages all members to go through renewal process even if they no longer qualify
        - If they complete their renewal and are found ineligible due to increased income, we'll send their information to the Federal Marketplace, where they can enroll in a subsidized plan at little to no cost.
        - DHHS goal is to help ensure no interruption to coverage
    - Member outreach
      - Since June 2022 – MLTC has been texting/emailing members during annual renewals
      - When PHE ends MLTC will:
        - Send letters, run social media campaigns, run paid media adds, issue press releases and public services announcements, conduct

media interviews, and work with community partners to share informational resources with members.
    - Work with Tribes to help provide useful information to update contact information and help ensure continuity of care for beneficiaries

- How can you Help?
  - Provide feedback on the draft materials that were shared last week
  - Encourage members to update their information
    - Members should let DHHS know on any life changes that impact eligibility
    - Members who have signed up for ACCESSNebraska can use the "Medicaid Renewal" feature
    - → **NOTE:** Any address/contact information updated through the MCO or MCO portal's will ***not*** be transferred to Medicaid eligibility systems. ***Please send any changes or updates to Medicaid via ACCESSNebraska***. ←

- QUESTION & ANSWER:
  - **QUESTION (Ponca):** Will MLTC be conducting renewals based on the renewal date of when the individual applied and NOT the verification month?
    - **ANSWER (MLTC):** There are some cases where renewals might not be based on the application date, but for the majority of cases the renewal date will be the month they individual applied. However, these processes are also subject to change based on forthcoming federal guidance and requirements. Encourage members to check when their renewal is with the annual renewal button on ACCESSNebraska.

  - **QUESTION (Ponca):** Is it the application date or the retro date?
    - **ANSWER (MLTC):** It is from the application date.

  - **QUESTION (Omaha):** Some of our elders have received a letter, and they will not be eligible after the PHE ends. Do they need to complete any other actions?
    - **ANSWER (MLTC):** You can always submit another application to verify any additional information need (proof of income etc.).
      - **QUESTION (Ponca):** They do not have to do this until renewal, correct? They will have Medicaid until that renewal.
        - **ANSWER:** Yes, that is correct. Even if they are categorically ineligible now and received a letter, they will continue to have coverage through the end of the PHE and up until the time of their next renewal.

- **QUESTION (Santee):** Does MLTC believe the PHE will end January 2023?
  - **ANSWER (MLTC):** We are unsure currently.
    UPDATE: Since the time of the November consultation, we have not received the 60-day notice from CMS. As a result, MLTC expects the PHE to be extended past the currently scheduled January end date.

- **QUESTION (Ponca):** Expansion was available in October 2020, in MLTC only going to do a certain percent of the renewals for that month due to the increase in renewal volume?
  - **ANSWER (MLTC):** Renewals will be spaced out over the course of 12 months.
    - **ANSWER (MCO):** We do want to engage providers in this outreach. The best proactive thing we can do is update contact information via ACCESSNebraska.

- ***NOTE*:** See 'Open Agenda' Section Below for discussion around:
  - Address Changes
  - Authorized Representatives
  - Impact of COLA Increases
  - Medically Needy/Share of Cost
  - Other Misc. Q&A

4. Crossover Claims Update – **Jacob Kawamoto**

- **MLTC:** MLTC revised its crossover claims reports to include both the previous Medicare and Medicaid (if any) paid amounts. These were then added up and subtracted from the applicable AIR for the year of the claim to determine the amount owed for the crossover claims for the period of 7/1/17-6/330/19. MLTC resent these updated crossover claims reports to the Tribes on 10.31.22.
  - We understand that some of the claims do not follow up and we will be sure to adjust any issues accordingly. We will be sure to follow up if there are any questions or concerns. We are also working with Tribal liaisons from other States to help us address any issues we have pending. We are hoping for more unified solutions.

- **Santee-Sioux:** We would like to schedule a meeting with MLTC and the finance team to discuss these crossover claims. The latest reports are still not accurate with the records Santee has, and there are even some beneficiaries/claims on the report that Santee's facility does not see.
  - **MLTC:** MLTC will take claims info from Santee back to the MLTC Finance and Claims teams to understand where the discrepancies are originating from, and then set up a meeting with Santee.
- **Omaha:** Omaha also believes that the claims on the latest report are not fully accurate. They have lost some of their EOBs due to flood damage but will send the info they do have access to over to MLTC for review.
  - **MLTC will then set up a follow up meeting.**

- **Santee-Sioux:** One of the main issues is Healthy Blue is not paying up to the all-inclusive rate for any of the supplemental plans (Medicare Advantage Plans). But the beneficiaries are still eligible for Medicare, but the facility is not receiving the all-inclusive rate for individuals enrolled in the MA plans. These individuals have Medicare A and B.
    - **HEALTHY BLUE (HBN):** HBN has sent over a state request regarding this.
        - **MLTC:** MLTC will work with the MCOs and CMS to resolve this issue.

- **MCO:** A Medicare Advantage Plan would be a Part C plan and would likely include Part D (prescription drug) benefits.
    - **Santee-Sioux:** The Plan D we pick is based on their prescriptions. We take care of all the plans and helping them choose for our members. We can also use our dollars to supplement their care, but these supplemental plans are making it difficult to do so. The advantage plans are not clear especially with the pharmacy coverage. Almost every county in Nebraska has an advantage plan.
        - **MCO:** Please connect with Liaisons and liaisons will connect more with benefit coordinators to make sure you are receiving the most accurate information. The MCOs want to provide coordinated education regarding their Medicare Advantage Plan options.

- **Omaha:** Most of our patients are not included in the crossover claims list that you had sent over. There are claims on that report that are not included. We will send you the report we almost have finalized, and it would be best to meet with finance team to discuss this further. These reports should be just for the crossover claims.
    - **MLTC:** First we pulled the fee-for-service (FFS) claims since 7/1/17 for those beneficiaries who are fully dual eligible, and sent out repayments to reimburse these past FFS crossover claims. But everyone else who is managed care would be included in the most recent second reports. We will be sure to follow up and touch base on these updates. We will also take additional information to finance. These are meant to be Managed Care claims. MLTC will set up a meeting with Omaha once we receive the report Omaha has created.

5. Break

6. Personal Assistance Services (PAS): Overview and Discussion – **Chris Morton**

- PAS PowerPoint Presentation:
    - Introduction to PAS:
        - Assistance with activities of daily living; individuals with a chronic medical condition or medical disability
        - Qualification: any age, living at home, receiving Medicaid, necessity to live at home
    - Frequently Asked Questions:
        - ACCESSNebraska and beneficiary work together to determine requirements based on needs
            - The beneficiary might be hesitant to share personal details to the worker. MLTC is considering these obstacles for the beneficiary

        - The beneficiary has the right to choose their own PAS provider and a family member can be a paid PAS provider if they are not a parent/guardian or spouse of the beneficiary
    - Becoming a PAS Provider:
        - It typically takes 6-8 weeks to be approved as a PAS provider
            - One way to expedite these services is as soon as the prospective provider receives information from Maximus the resource developer worker will take note of what means of communication would work best for the provider. If the prospective provider can answer as quickly as possible it will help expedite the enrollment process.
        - MLTC wants to help ensure culturally competent care. We are outlining the process so that individuals are aware of how to apply efficiently.
            - One option would be for Tribal providers to coordinate with and enroll PAS providers to build a roster of enrolled PAS providers that they could then recommend to beneficiaries who need PAS services. The feasibility of this option likely depends on many different variables, but the goal of this presentation is to clearly identify the steps for individuals to become PAS providers and help equip Tribal health facilities to make it easy for these prospective providers to enroll and provide culturally sensitive care.
                - PAS provider can live in the same household as the individual just can't be a spouse, parents, or primary guardian
        - Starting Provider Enrollment Process:
            - ACCESSNebraska worker makes a referral to DHHS resource development
            - Resource Development will contact you (15 business days period)
            - Prospective providers will need to call the resource developer worker listed on the referral letter they receive
                - To streamline the process quickly PAS providers should contact the resource developer immediately
            - Referral will be sent to Maximus for background check; once background check has passed the prospective PAS provider will need to be fingerprinted to continue the enrollment process
        - Billing:
            - Medicaid uses electronic visit verification (EVV) to bill for PA EVV requires the PAS provider to electronically log when they clock in and out.
        - Road-Bumps to Enrolling:
            - EVV
                - EVV requires the provider to at least have intermittent internet access
            - Expense for Background Checks
                - $50 fingerprint (does not include County Sheriffs' fee)
                    - This is legally required to enroll as a PAS provider
            - Consider needs for Medicaid beneficiary
                - Want to ensure the beneficiary is getting their needs met so gaps are filled. Is one PAS provider sufficient to ensure the beneficiary is getting the care they need? Also consider things like what would happen if that PAS provider the beneficiary usually sees is ill, away, or otherwise unavailable

- QUESTION/ANSWER:
  - **QUESTION:** If they are picking their own provider how do you know they will be qualified? What are the qualifications of the DHHS worker to make that type of assessment?
    - **ANSWER (MLTC):** The Eligibility Worker does not do the provider screening. They complete a referral with our resource developer. The resource developer then contacts the prospective provider to get information. But ultimately the prospective provider is referred to Maximus, and they make the determination on whether the individual is qualified. Maximus is qualified to run and screen these qualifications for prospective providers.

  - **QUESTION (Ponca/Santee/Sioux):** Depending on the services that are being provided, how are they qualified to make that decision? For example, some individuals will need assistance with grocery shopping etc., while others will need assistance with insulin. Are these services medical or just daily activities? And who determines what services can be provided?
    - **ANSWER (MLTC):** The background checks go through Maximus who is qualified to do these checks and data screening. The judgement on the extent a provider is qualified to provide services is based on Medicaid rules and regulations (471 NAC 15). These services are typically for activities that the beneficiary would "normally" do for themselves. When it comes to medically specific territory there are some services that can be done by PAS provider, but they would need to get a note from a doctor or licensed provider explaining that the PAS provider has been completely trained to assist with minor medical services. If the beneficiary is looking at a high level of medical care PAS is probably not the correct program for them.
      - **ANSWER (MCO):** Consult the Medicaid regulations for PAS services vs. Home Health Services. The regulations associated with a PAS provider and covered services are outlined in regulations.

  - **QUESTION (Ponca):** Is there a list of questions that the resource developer inquiries about to determine the level of care? Are we able to have access to these questions?
    - **ANSWER (MLTC):** Yes, and a lot of these questions are included in the regulations for PAS, 471 NAC 15. An easy way to give a high-level overview for someone who might qualify for PAS is to refer to "Activities of Daily Living" (ADL), which include things like basic hygiene (shaving, dressing, bathing, etc.), mobility issues (wheelchair/walker), nutrition services (feeding themselves, preparing meals etc.), medication services (don't recall exact times of taking medicine, pills, etc.). An individual will need to require assistance with at least one ADL to qualify for PAS.

  - **QUESTION (Omaha):** Does the PAS provider transfer them to appointments? If they do transfer them to appointment, are they able to qualify for reimbursements for mileage?

        - **ANSWER (MLTC):** PAS does not pay for mileage but will pay for the PAS provider to go with the beneficiary to appointments only if the beneficiary needs their assistance. (EX: Mobility issues). Mileage is paid through NEMT.

    - **QUESTION (Ponca):** Can the adult child be the PAS provider?
        - **ANSWER (MLTC):** In these circumstances more extensive research would be done to ensure that the adult child is not legally responsible for the beneficiary. Everyone is looked at a case by case.

    - **QUESTION (Ponca):** Would we have a representative or Point of Contact that we could communicate with during the assessment?
        - **ANSWER (MLTC):** Marcy and Kathy would be happy to assist with specific information on a case.

    - **QUESTION (Ponca):** Is there any way to expedite the services or process for an individual who needs immediate services?
        - **ANSWER (MLTC):** No, the process from start to finish usually takes 6-8 weeks.

    - **QUESTION (Ponca):** Can authorized representatives see how many hours were approved for the individual's care?
        - **ANSWER (MLTC):** Yes. When the beneficiary talks to the worker on the phone the worker will let the beneficiary know exactly how many hours they will be approved for. Workers will be able to share this information with the authorized rep. per beneficiary's approval.

    - **QUESTION (Ponca):** Is there any way to go straight to Maximus for approval?
        - **ANSWER (MLTC):** No. Once the process with N FOCUS has been completed it will be referred to the resource developer in Maximus. Later next year MLTC plans to develop protocol so individuals can go straight to Maximus and apply. But that is not the current protocol.

7. NEMT – MCO Program Overviews – **MCOs**

- **<u>Potential Solutions to NEMT Barriers Faced by the Tribes (Led by Jeff with UHC):</u>**
    - **Correction from last meeting:** United Healthcare (UHC) no longer does mileage reimbursement for friends and family. At the August 2022 Tribal Consultation Meeting UHC stated that they did so, but this was incorrect information.
        - The MCOs completed an example grid that was passed around during the meeting to gage and compare different services provided by each MCO for transportation services
            - The idea is so the Tribes can have an easy way to identify the best possible services for their beneficiaries, and easily identify what is available to them based on the plan they are enrolled in
    - Discussion around possible solutions for Friends and Family Reimbursement or other current barriers to NEMT services:

        - Option to work on Tribal-Specific NEMT approach with MLTC
            - UHC can provide minimum transportation outside of the traditional Medicaid Services appointment
            - This option would be on the MCO dime, so not reimbursed through any of the state or federal funds United Health Care Receives.
        - Option to establish a workaround with MLTC for peer support drivers for mental health services
            - This has been done before in other states (Kansas)
        - Option of something like a $5,000 Community Contribution for transportation services
            - This would not require a contract, but rather would be a quality and health initiative which has been done in the past
        - Option to offer NEMT as a value-added service
        - Option for the Tribal Health Facilities or existing transportation networks to become a Source Provider – Santee required more information on this
            - Medicaid ID# would be required
            - The Tribe would need to be enrolled as a transportation provider in Maximus
            - Contracting process would be initiated once this provider credentialling has been completed
        - MCOs can assist with this process
            - Arrange specialized claims training
            - Portal training with Tribal liaisons
    - Gas Card Updates:
        - At this time UHC does not have a process for Gas Cards. This will be something that will need to put in place with MLTC and approved by legal team.

- **NEMT Services for Healthy Blue Updates (GELISHA):**
    - If the Tribes are set up as a transportation provider, they would be able to contract with the MCO's 3rd party transportation vendor
    - Value added benefit: $25 gas cards available per quarter
        - Tribal liaison will share contact information to be issued to members
        - Benefit coordinators/beneficiaries can also call the Customer Service

- QUESTION & ANSWER:
    - **QUESTION (Ponca):** Can local facilities like Fred LeRoy Clinic be part of Community Contribution method because in the past we have had these initiatives denied?
        - **ANSWER:** Yes, MCOs would need to discuss with MLTC to ensure they are following the proper policy.

    - **QUESTION (Omaha):** Are there any issues with patients who need to cross state lines?
        - **ANSWER (UHC):** At this time, it is uncertain what a friend and family reimbursement would look like, MCOs will need to circle back with this. A certain amount of mileage does require a certain amount of authorization so for questions on this the Tribes should reach out to the MCO Tribal liaisons. Certain situations could qualify for "out of state" reimbursement, but the Tribes will need to follow up with MCO Tribal liaison to ensure that the mileage requirements are met.

- **QUESTION (Ponca):** Can the MCOs provide information on the NEMT mileage requirements and limit?
  - **ANSWER (NTC):** MCOs will follow up with the Tribes and share more specific information on this mileage topic.

8. Roundtable discussion on how MLTC can support the Tribes' work
   i. Managed Care Discussion
      i. Updates from MCO Liaisons
      ii. CMS Guidance: ensuring timely and accurate payment to IHCPs
      iii. Medicare Advantage Crossover Claims Reimbursement
   ii. Summer Youth Programs – follow up

- Dani has sent follow up emails to Omaha, Santee, and Winnebago to verify participation and hours of summer youth programs so a work around can be developed in MLTC's systems. Please respond to that email at your earliest convivence with some feedback to streamline the process for these programs.

   iii. Planning Site/Facility Visits

- MLTC would still like to schedule follow up visits with Santee and Omaha. Thank you to Ponca, for hosting us at all your facilities. These site visits help give the MLTC team a better understanding of all the work each Tribal facility does and helps increase understanding of how MLTC can partner with the Tribes.

   iv. Open Agenda
      - **<u>ADDRESS CHANGE DISCUSSION</u>**
        - **NTC:** If information is updated with MLTC it will be updated with the MCOs. Sometimes when address updates are received there is a two-step verification process in MCO systems, and the MCOs need to verify changes with the beneficiary. The best way to update information is to have the beneficiary or authorized rep update contact information through ACCESSNebraska.

        - **Ponca:** Tried to do an address change through the MCO, and it was never completed.
          - **NTC:** This was the gap identified before. The MCOs do not control the eligibility systems for Medicaid, and when the MCOs receive information from the state it must be verified by the beneficiary. If it is not verified by the beneficiary, it will <u>*not*</u> be updated in the MCOs' systems.
            - **Ponca:** It would be helpful if it was verified through a form to mitigate some of the barriers.
              - **MLTC:** MLTC will follow up with more information on authorized reps. The Tribes should also always consider contacting field workers
                - **Ponca:** We have tried contacting field workers in the past and information is still not updated. If there is a form that can be filled out and faxed to the ANDIcenter to mitigate some of these obstacles, that would be helpful.

- MLTC will follow up on this.

- **AUTHORIZED REP. DISCUSSION**
  - Authorized Rep. Process (Kathy - MLTC):
    - Address changes from third parties are not accepted unless:
      - a ***signed*** Authorized rep. form is completed by the beneficiary,
      - the authorized rep. box is ***checked*** on electronic application
        - on the paper form they must fill out Appendix C
      - or ***verbal*** verification is provided by the beneficiary to field staff
    - Eligibility Staff will not update any information unless it is from an authorized rep. or the beneficiary
    - The best way an authorized rep. can submit any changes on behalf of the beneficiary is to:
      - Ensure they have completed the authorized rep. process accurately
      - Email the ANDI center (this is the fastest way)
        - Include Master Case Number in the subject line and identify you are authorized rep. within the email
      - Can also do Change Report through ACCESSNebraska
    - **Ponca:** It is difficult to get beneficiaries to correctly fill out the Medicaid applications to have benefit coordinators as their authorized rep.
      - **HealthyBlue (HBN):** Benefit coordinators can receive approval from the beneficiary by having them fill out a separate paper authorized rep. form that is then fax, emailed, or otherwise sent to DHHS
        - ***NOTE:*** Clinics can get a blank copy of the authorized rep. form and have their beneficiaries sign it. Beneficiaries can fill out the form whenever they visit the clinic, even after applying for Medicaid.
  - MLTC will send out more authorized rep. information in order to help streamline authorized rep. processes for benefit coordinators

  - QUESTION/ANSWER:
    - **QUESTION (Ponca):** Which application has the "checked box" for authorized representatives?
      - **ANSWER (MLTC):** On the electronic application there is a "box" for the beneficiary to check to indicate an authorized rep. The online application also requires the applicant to be very specific in designating their authorized rep, and the authorized rep's scope to be able to act on behalf of the applicant in the future. Additionally, the MLTC-35 Form can be used to designate an authorized representative if there is any uncertainty on the online application or if the applicant wants to add an authorized rep after the application was

approved. For paper applications, applicants should be sure to fill out the top half of the Appendix C (last page of the application). This section designates an authorized representative. Please refer to the public forms website for the paper application or any additional forms related to Authorized rep. https://public-dhhs.ne.gov/forms/home.aspx ACCESSNebraska customer services line can also help with additional information.

- **NOTE:** Applicants must be sure to sign the application and/or MLTC-35 Form designating an authorized rep. Failure to do so would lead to an invalid application, and no authorized representative would be designated. Further, the applicant must be the one to sign for the initial application and/or authorized representative approval, not the one being designated as authorized rep.

- **QUESTION (Ponca):** Is the primary insurance that is identified in the portal also included with the MCOs beneficiary profiles?
  - **ANSWER (HBN):** If an EOB is received with other primary insurance, we would create a profile for the individual and add this information to their profile.

- **QUESTION (Omaha):** Do the MCO's talk with the State regarding other insurance?
  - **ANSWER (NTC):** If the member has insurance in the state eligibility systems, this information will get passed along to the MCOs. The MCOs do need to verify other insurances beyond what the states includes if any is reported. The State expects that the MCOs identify other insurances.

- **QUESTION (Santee):** Have there been discussions about possibly having more Medicaid representatives strategically placed throughout the State of Nebraska to help update contact information?
  - **MLTC:** Hopefully with the end of the PHE we can be more mobile. It would be great to have field workers visit Tribal health clinics after the PHE to help with things like updating contact information, but there are some logistics that would need to be figured out first in order to make this effective.

- **COLA INCREASE DISCUSSION:**
  - **Ponca:** With the COLA increase will this change the allowable income for the Age, Blind, and Disabled patients? Many individuals will no longer qualify based on their income if there were a COLA increase. Will these individuals be dropped down to another eligibility category? Will this impact their Medicaid benefits?
    - **MLTC:** For those whose eligibility may be impacted by the COLA increases, MLTC will exclude the amounts of the COLA increase if

it would cause them to change eligibility categories until the new FPLs are released. In other words, these individuals will maintain the current level of benefits until the new FPLs are released and determinations can be made accordingly.

- **MEDICALLY NEEDY/SHARE OF COST DISCUSSION:**
  - Medically Needy Category (Kathy- MLTC):
    - There is no specific form, website, etc. that needs to be completed for individuals to qualify for Medically Needy with a Share of Cost (SOC). However, it is helpful if the beneficiary indicates on the application (using the comment section or writing on to the paper application) that they would like a SOC determination
      - When eligibility workers review the case, they determine if the beneficiary has a significant SOC. If there is no indication that the beneficiary has a high medical need each month then there are instances where the SSW does not approve SOC budgets. Eligibility workers should reach out to the beneficiary to see if they want the SOC.
        - EX: If someone was under chemotherapy treatments and they do not qualify for full Medicaid the Share of Cost would be a great option due to the significant medical expenses they will have.
      - The beneficiary decides themselves if they should be considered for the Medically Needy SOC category to eligibility staff
        - MLTC will evaluate the case to determine if they fit the category
    - A "MOCK" budget will be useful to determine if this category is suitable for beneficiaries
      - Unfortunately, there is no chart/graph to determine eligibility for Medically Needy category

  - QUESTION/ANSWER
    - **QUESTION (Ponca):** How does the Medically Needy criteria work especially for individuals who are on SOC?
      - **ANSWER (MLTC):** There is nothing specific to apply for regarding Medically Needy, but Medicaid does not kick in until they have obligated (or met) the Share of Cost. However, the adult expansion population is not eligible for Medically Needy. This is for children, parent/caretakers, pregnant women, and AABD (477 NAC 25.002.001). This program is best for individuals with high recurring medical costs.

    - **QUESTION (Ponca):** Is there a possibility to do training for employees to have a better understanding of these programs such as Medically Needy?

- **ANSWER (MLTC):** Great idea to do a training, MLTC will be sure to follow up with this information.

9. Closing