Medical Care Advisory Committee
Meeting Minutes
Thursday, August 24, 2023

The Medical Care Advisory Committee (MCAC) met on Thursday, August 24, 2023, from 3 p.m. to 5 p.m. CST at the Willa Cather Branch Library in Omaha, Nebraska. The meeting was held in person and virtually.

MCAC members in attendance: Karma Boll, Dr. Jessica Meeske, Staci Hubert, Amy Nordness, Kenny McMorris, Jason Gieschen, Vietta Swalley, Kelly Weiler

DHHS employees in attendance: Dr. Elsie Verbik, Nate Watson, Jordan Himes, Joe Wright, Matt Ahern, Kevin Bagley, Catherine Kearney, Kris Radke

Members of the public in attendance: Tyler Andersen, Deb Schardt, Ambar Zapata

MCAC members not in attendance: Jason Petik, Melanie Davis, Frank Herzog, Felicia Martin, Shawn Shanahan, Michaela Call

I. Openings and Introductions

The meeting was called to order by Karma at 3:00 p.m. CST.

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

II. Review and Approval of June 15, 2023, Draft Minutes

Karma asks for a motion to approve the minutes because the board does not have any revisions.

- Amy moves to approve the minutes which is seconded by Dr. Meeske. The motion passes.

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

Enrollment Updates:

Jordan: You will find that our enrollment update looks different than what we presented in the past. We were having issues with pulling data, so we had to do a little bit of a workaround to pull the most updated data. I believe this was also an issue in our last meeting, so this is our current and temporary fix to the ongoing issue. The biggest difference we made was that the other and parents and caretaker categories were combined into one category, “Other Adults.” We previously presented those separately. This is the only change we had to make to present this

data to you all, so that's why the numbers may look a little different than what we've presented in the past.

- Dr. Meeske: Is our Unwind well on its way?
    - Nate: Yes, it's on its way. We are one-quarter of the way through the Unwind. The last numbers I have seen are approximately 29% of our members have been disenrolled from coverage. This could be for various reasons, including passing away, moving elsewhere, or voluntarily deciding they do not want Medicaid anymore. It could also be that they are ineligible. It could mean that we have not received specific information from them like paystubs. We can only speculate on the reasons. We talked to our other colleagues from across the country and found that there are a good number of people across the country who believe they no longer qualify for Medicaid, though we do not have data to support this. This could include people with new jobs or people who, despite our outreaches, don't reach back to us. We traditionally have mailed people notices, but seeing as it has been over three years since the previous rules were in effect, we called, we texted, and we tried every way to reach out to people. There is a fallback. If a person is disenrolled for failure to respond and they respond within 90 days of the denial notice, and we find them eligible, then we can reinstate their coverage with no gap. If we need information from a person who was disenrolled for a procedural reason, if they reach out to us and submit the information, we need them could be reinstated. Unfortunately, if it's been longer than 90 days, federal law says they need a new application. Depending on how long it's been, there might be a gap in coverage we can't close. This is why we're trying so hard to ensure people don't have a gap in coverage. Before we started the Unwind, we thought it would be between 10-20%, but it's been higher.
        - Dr. Meeske: Yet the numbers don't reflect that. In January, when you look at total Medicaid enrollment, it's 393,000. Then in June, it jumps up to 396,000. So, I would've expected it to go down.
            - Dr. Bagley: I'll supply updates on the Unwind numbers and provide additional context. The short answer is there have been some updates in the reporting terminology that we've used to try and be more accurate. I'll walk everyone through that later.

Review of Legislative Bills:

- Karma: We are still following Frank's question on LB1014. This bill concerned ARPA funding for nursing staff. He asked if the allotment for the second and third years would be recalled.
    - Dr. Bagley: Seeing that he isn't here, we may have to give another update to him directly. We don't think they will need to be recalled. However, I'm not entirely sure. We will provide additional updates in the next meeting.

COVID-19 Public Health Emergency (PHE):

Dr. Bagley: First, a broad update. I'm sure a lot of you have seen various news articles and discussions of Medicaid Unwind. This has caused Medicaid, specifically the eligibility and enrollment sections, to be in the news more than it typically would be in any other year. This has led to both information and misinformation. The reality is we are moving through and doing those reviews of every single individual enrolled in Medicaid. Doing these annual reviews is something we have been required to do since 1965, so this is not new. However, it may be new for people in our services if they have enrolled in the last three years. We have started doing reviews on

cases we would action on, meaning if a member no longer met Medicaid requirements, then we would remove them from coverage. We have put out two reports, one required by CMS, and the other is our monthly dashboard. The CMS report gives a breakdown on a month-by-month basis of some key metrics.

Through the end of July, since we are updating these numbers monthly, we have completed about 25% of the renewals. This is in line with where we need to be. We are a bit behind compared to if this was evenly distributed. However, we are coming up on three of the busiest months we will have all year. This is about when we would have started to see enrollment in our Medicaid expansion population. We are starting to see this group due for their annual renewals. We will see a huge spike in how many are due. There are a couple of things to note. A lot of states are seeing high rates of procedural denials. Effectively, it means we cannot verify the information we need to see if someone is still eligible or if the member has not responded to our requests to provide the necessary information. For states that have an automated system, a lot of times they will send out the request 15 days later. After 15 days, they will automatically close the case. We are not doing that. After 30 days, since we are giving people longer to respond, our staff will get a notification that they need to review the case. When they pull that up, which could take 31-45 days, they will see if we have or have not received the necessary information to renew the individual's Medicaid. We are not automatically closing cases. There is no threat of us closing cases even if something has been received and not processed. We process enrollment typically on the same day we receive it. You will also see a discussion of the time allocated for individuals. The minimum federal requirement is 15 days to respond. We are providing 30 days to everyone, whether it be a new application or a renewal.

Next is the CMS report. We will first look at renewals and outcomes. This is an area where we've seen a couple of data changes in terms of how we understand the definitions of the following.

The first is the total beneficiaries due for renewal in the reporting period. These are the people for whom a review was due in the month that we are reporting. The most recent month we are reporting for is July. We report about a week and a half to two weeks following the end of the month. We break those down into four different categories. The first is how many were renewed, meaning how many kept coverages. We break that down further, even though CMS doesn't ask us to since this has been a topic of discussion for a lot of people. One is how many people did we renew without having to ask for information, and then how many people did we renew after asking for and receiving the additional information? Those we renewed without having to ask for information are defined as ex parte. The ex parte rate is something that you'll see reported a lot. It's because if there's a notion that we can "automatically" renew someone then there's a lower likelihood that they will lose coverage. If we renew them this way, they don't even have to respond. In the most recent month, we had 18,175 individuals who were renewed, meaning that, in the same month, we approved coverage for 18,175 of the 39,610 individuals due for renewal. There were about 15,500 for whom we were not able to complete a renewal. Generally speaking, these are people who are sent notices that request additional information. Since we give them 30 days to respond, it typically puts us past the same-month view. So, of the 18,000 we renewed, about 2/3rds were renewed ex parte. Another almost 6,000 were renewed after having sent a notice. Our return mail rate is just 3%. We typically get the notice to the right address, but many times there is not a response.

The next important statistic is how many people were determined ineligible. In this case, it means we review the information they send us, and we identify that they don't meet the minimum requirements to receive Medicaid. That's been a little less than 10% every month. The next one is how many of the denials were due to procedural reasons, meaning we didn't get a response for additional information. That number is about 2,800. Are there any additional questions?

- Amy: Over the course of the unwind, for people who have been determined ineligible for procedural, have you had many of these people reach back out?
    - Dr. Bagley: I don't know the percentage off the top of my head. We monitor that. I'd say about 200 people per month. Anecdotally, this is generally because they have gone to seek care and then found out they were not covered. It is certainly not the ideal, but it is often the case.
- Amy: Are most people who receive denial notices getting back to us within 90 days?
    - Dr. Bagley: Some will have to re-apply, but so far, we are just about 90 days from the initial denials. So, at this point, most of the people who have gotten back to us have been within 90 days, but this may change.
- Karma: So, most are still sitting in the grievance process, meaning they still have time to appeal?
    - Dr. Bagley: You can typically appeal within 30 days of that denial, but you don't even need to appeal if it is just a procedural reason. All you have to do is send us the information and we can process it within 90 days.
- Nate: How much are we behind in renewals being completed, apart from the 25% into completion?
    - Dr. Bagley: Great question. Right now, we have 19,646 in our current backlog. These include the items that were not able to be completed in the prior month. This number increases each month. We expect it to get bigger in the coming months. But we will also see a considerable drop in volume at the end of the year. We expect to complete this by the end of the unwinding period. We feel very confident in completing this backlog, but we do recognize that, since we allow people to respond in 30 days, it does put us a little bit behind.

Dr. Bagley: Just as a heads up for everyone, I will apply some radical transparency. Every state recently received a letter from CMS that went through additional metrics they are reviewing in terms of where they see states' compliance in the unwind. They looked at four different areas of compliance, including MAGI application processing timeliness, so what percentage are we processing in the 45 days? For the month that they looked at (May), we are renewing 89%. They think it should be 95%. They also look at call center wait times. However, we are still seeing the same wait times as we did before the unwind period. I will provide a copy of the letter.
The only one where we did not meet or exceed their expectations was the timeliness of MAGI applications. We are typically around 90% but we haven't been over 95%. This is due to the 45-day requirement. I feel good about meeting our requirements and the one we didn't meet was for the right reasons, that is giving people time to respond. Additionally, our average call center wait time is 5 minutes average call abandonment rate is 12%, and 9% of beneficiaries are terminated for procedural reasons. About half of the denials have been for procedural reasons. However, according to the metric CMS computed, it appears as though only 9% of those due were terminated for procedural reasons. We will continue to share information about these statistics. If you have any questions, we are happy to answer. I'm not sure if CMS will continue to publish a letter for every state in the coming months. We will continue to be as transparent as we can.

- Karma: Thank you for sharing. That was a very thorough report for this month. We will keep this on the agenda for the upcoming meetings.

Managed Care Organization (MCO) Contract Update:

Karma: Dr. Meeske had concerns about the dental colleges. Do we have any updates on that status?

- Dr. Meeske: I intervened and tried to intercept with the interim dean of UNMC. I know at least two out of the three MCOs have visited with the college, possibly all three. I think we will be able to work the issue out.
    - Karma: We will keep this on the agenda to see how this is resolved.

MLTC Quality Strategy 2023

Kris: My name is Kris Radke, I am the administrator of Plan Management for Medicaid and Long-term Care. We oversee the managed care contracts. I'm going to introduce you to Catherine Kearney. She is one of our administrators. We're going to discuss some modifications to the quality strategy this year.

Catherine: You all have received the updated quality strategy. It's lengthy so I won't go through it page by page. But I do want to take this opportunity to introduce it so you can be aware of what you're looking at and see our rationale behind the proposed changes. All state Medicaid agencies that provide services via managed care health plans are required by CMS to have a quality strategy. The Nebraska Medicaid managed care quality strategy was last updated by us in 2020 and published in 2021. At a minimum, we do have three years to provide updates. We are at this deadline and some major updates are needed. Since the time of our last update, CMS developed what is called Medicaid and managed care quality strategy toolkit. This toolkit was made to guide states in the drafting of their quality strategy. Due to the release of this guide, we knew significant updates were needed to align with CMS expectations. The updates included do not contain a new approach to our quality strategy. Rather, they focus on elements of existing quality improvement activities that CMS expects states to describe. It also identifies quality measures that we would be using to evaluate the effectiveness of our strategy.

During the last three years, MLTC has experienced an extensive change in membership due to the passing of Medicaid expansion. Additionally, on January 1, 2024, we will be implementing new managed care contracts. Our new quality strategy will allow us to complete a more thorough evaluation and allow us to help our MCO partners align their program enhancements or interventions to further support quality improvement in Medicaid. Some highlights through the document can be seen in the quality and care section on page eight. We describe many of the quality-related contractual requirements of our MCOs alongside descriptions of improvement of improvement of improvement activities that MLTC carries out alongside MCOs. Due to the updated guidance for what CMS wanted us to include, we have added topics like the transition of care and interventions utilized to address health disparities in Medicaid populations. These are topics that are getting a lot of focus from CMS, and they wanted to hear about what we are doing in our state. The next section to focus on is monitoring and compliance. It describes how we monitor MCO activities through various contract requirements which have not undergone any major updates since 2020 and will continue through 2024 with the new contracts. The next section on EQRO describes our contract with the Health Services Advisory Group (HSAG), which is an external quality review organization that now carries out all EQRO activities for our state Medicaid program. Additionally, MLTC now engages with EQRO to evaluate and encounter data for quality assurance. Once this version of the quality strategy is adopted, we are

committed to the regular evaluation of the identified quality metrics to adjust the strategy as needed. We are now better equipped to recognize what aspects of the strategy work and when there should be a shift of focus to a new approach. This allows our program to continue to evolve.

This version of the quality strategy that you've received is soon to be made available for public comment. We have shared this document with the tribes to gather their input. At this point, we request members of this committee send all comments to Kendra Wiebe by September 22 so that they can be taken into consideration before our submission to CMS. At this time, are there any questions about what you've seen or heard?

- Dr. Meeske: I'll submit my comments in writing by the deadline. It was nice to see some of the oral health things worked into the goals. One of my questions revolves around improving the provider experience and streamlining the provider credentialing section. Do we know what the timeframe is for that? I know that is one of the big hang-ups for the dental schools.
    - Kris: The centralized credentialing is set to begin on January 1, 2025.
        - Dr. Meeske: Thank you, that's great news.
- Dr. Meeske: On the second page of the goals and objectives, you state that you will "reduce the number of emergency department visits for substance use disorders." As I said, I'll submit my comments in writing, but could we include reducing the number of non-traumatic dental-related visits? There are codes and measurements for that already. The number of people showing up to the EDs who have oral health-related problems, usually severe dental infections.
    - Kris: We will consider that after we receive your comments. Thank you for speaking up.
- Karma: What is the deadline for submitting comments so we can capture it for the minutes?
    - Catherine: September 22 and they need to be submitted to Kendra Wiebe, who is Director Bagley's administrative assistant. Her email is kendra.wiebe@nebraska.gov

IV. Project Discussion

Karma: As we usually discuss, we want to see if we can move these projects forward to make a difference for Nebraskans on Medicaid.

Dental Student Reimbursement:

Dr. Meeske: A more accurate way to refer to this project is "Dental Loan Repayment for Early Career Dentists based on Medicaid Engagement." It would be a new loan repayment program where, instead of the current system, it would look at a model based on how many Medicaid dental services you provide. I just had a meeting with Governor Pillen this morning and was invited to pitch it. I will be following up with his staff next week. At least it's out there for the administration to consider.

The next step is to meet with Heidi Pierce in the Office of Public Health. If this is something we feel like we will have good stakeholder support for, then the Nebraska Dental Association would need to get organized and look at what a fiscal note would be as well as find someone to champion the bill. I'm looking at it as a pilot program. We would have to analyze the outcomes to

see if when these dentists exited their loan repayment contract, they need to continue to see patients with Medicaid to know if it works. The way I've written the draft is that it's a finite program that would sunset. It's not something a senator would have to sign onto for perpetuity. Let's try it and see how it works. If the return on investment (ROI) is good then we can try to renew it and, if not, then we know that it didn't work.

- Karma: One would hope that we continue to see advancements in this. This is great news.

Nursing Home Staffing:
Karma: Frank is not here so we will table it for the next meeting

Maternal and Newborn Health:
Karma: Staci Hubert has volunteered, Shawn Shanahan has volunteered, and Dr. Verbik has volunteered. Kenny, could you get someone from maternal child health to participate in our workgroup? We have set this meeting for August 29 at 4 p.m. The first meeting will be virtual, but we may have more meetings in person. Dr. Verbik you have some things you'd like to educate us on. Would monthly be a good cadence?

- Dr. Verbik: Monthly would be good to get started, then we can go from there.
    - Karma: This makes sense. The first meeting will be discovery and seeing where we want to go from there. Anyone with questions about this workgroup can either contact me or Jordan.

Other Potential Projects:
Karma: I want to offer this time to see if there is anything you all have thought of that you believe would make a worthwhile project. Does anyone have any suggestions for educational topics? If you do, share them with me or Jordan. Seeing no other suggestions at this time, we will proceed with these three.

V. Future Educational Opportunities

Karma: Are there any topics that everyone is interested in learning about? You can think about it and contact me or Jordan if any ideas come up.

- Nate: If there's something you want to know about Medicaid or even DHHS let us know. There is so much jargon, so let us know if there's ever something you're curious about.

VI. Filling Vacant Positions on the Board

- Karma: We have filled two of the positions. The first is Kelly Weiler, I will have her introduce herself. She helps those who are underserved at the children's hospital. Kelly: I am very grateful for this opportunity. I have been in children's medicine for the last 15 years advocating for pediatric care and the children of Nebraska. I'm thrilled to be part of this group and advocate for these children.

Karma: The other individual who has been selected is Michaela Call from Fairbury. She is a foster parent and has numerous foster children with significant disabilities. This fills a void for our committee. We will have her do a formal introduction next meeting.

- We still have three more vacancies to fill. Staci: Specifically, what are we looking to fill?
    - Jordan: Two provider positions and a member representative. Director Bagley is working with different physicians from across the state to fill these vacancies.

VII. Confirm the Next Meeting Time and Location

Jordan: The next meeting date and time will be October 19 from 3 to 5 p.m. at a library in Lincoln.

- Karma: If anyone has any preferences for a meeting location, please let Jordan know.

VIII. Open Discussion

Karma: Are there any topics that someone would like to bring up for discussion?

- Tyler: I work for Mosaic; we're having a major issue with our dental providers dropping Medicaid. What is this due to?
    - Dr. Meeske: Multiple things are happening to cause this. First, I will describe some of the barriers. One of the problems is the reimbursement rates for dentists, which are 37% of the average Nebraska dentist fee. The overhead average is 75%. It's possible to do dentistry at a break-even point. At 37% it becomes a money loser for every adult Medicaid dental visit, not just special needs. There was a legislative bill, LB358, which would increase the dental fees by 25%. It still wouldn't get us to the break-even point, but it is an increase in the right decision. It got out of the committee but didn't make it to debate so it will be in the next legislative session. I've also been meeting with all the new managed care CEOs as well as their CMOs who are still getting their dental directors into place. We've talked about, from a managed care standpoint, what can be done to improve access. They are in the process of meeting with dentists who have a history of taking care of DD adults as well as other aspects of Medicaid I don't work for a Managed care plan, but I suspect what we'll see happen is if you are a managed care plan and you are in charge of physical, behavioral, and dental health, they will have to invest more on the front end to get these patients and members seen. This is to help clean up their mouths, get them in good health, and so on. Once this happens, a chunk of the population will get into good health. From then on it is the process of keeping these people in good health.

      There are several other reasons for this problem. Another is a labor shortage. Dental hygiene is down quite a bit. We're anticipating that many hygienists will retire in the next five years, and many have already retired due to COVID-19. Dental assistants also decreased and are decreasing across Nebraska. I talked with the governor about workforce issues. Another compacting factor is that dentists are losing operating room time. 2 of my 5 practices have had their operating room time cut in half. For adults with severe DD who need to be seen once or twice a year in a hospital setting, that has been a problem. There's also a shortage of nurses and anesthetists. In terms of the positives, on November 10 we will have a dental Medicaid update in Lincoln. It's a partnership between the Nebraska Dental Association, MLTC, and the managed care plans, and if someone from the developmental disabilities adult community would like to come and represent your organization then I can give you a few minutes and a microphone to talk as a member advocate. It's been a perfect storm and we are trying to work through a lot of it. I plan to ask the governor when he's in town to make a plea from the highest office in the state that everyone must serve in some shape or form. The only people that can take part in this are dental hygienists. Without these people committing and leaning into this problem, the problem

becomes exacerbated. If the dentists hear it from the governor, then they may listen. We have a lot of providers that want to do the right thing, but they need the incentive and the ability to not lose a significant amount of money. I am collecting letters from members and patients. I'm putting together a notebook and visiting senators from across the state. I share personal stories about caregivers and people within their district. When we have beneficiaries tell their story, it goes a long way to make our points.

- Amy: From the standpoint of the OR availability, is it all tied up to finances because of the reimbursement?
    - Dr. Meeske: At a federal level, our professional organizations were able to make a change in the hospital facility code for all things dental. The facilities are now getting a higher rate, it's just hospitals. We are currently waiting on a decision nationally, and we'd like to see a bump. It has certainly been a facility fee issue because places like Hastings and Mary Lanning Hospital get a much higher fee for ophthalmology and orthopedic surgery, but dentistry falls low on the totem pole. Another thing is the shortage of anesthesia providers. As a result of this anesthesia shortage, in-office general anesthesia with anesthesia teams from out of the state gets credentialed and comes into your office.

      The managed care plans are credentialing these dental anesthesia providers to come in, which is helpful. For the DD population Medicaid will cover it. You can always do things faster in your office than in a hospital office. Because of the seriousness of DD populations, sometimes the safest place is the hospital and having the OR for backup in case things go wrong. In the office, you can do ASA, which is a classification that stands for how much risk someone is for undergoing anesthesia. You can do ASA-1 and ASA-2 in the office, sometimes ASA-3 in the surgery center but most will be done in a children's or regular hospital. One of the worst examples is at the medical center. The wait to get a patient who needs to go to the operating room who is an adult is over a year. The dental access for adult Medicaid and adult special needs is becoming dire all over. Surgeries are getting split up. You cannot treat part of the mouth for gum disease and then the other part a year later.

      Recently, I purchased a practice in Kearney, Nebraska. We have over 200 DD patients. It is not appropriate for pediatric dentists to work on them. They do not work on adult root canals and gum disease. I feel your pain because I must try to find a dental home for 200 adult DD patients in the Central Nebraska area. It is always easier to go to a dentist and say what we need to do to make this work than go to a dentist who hasn't provided Medicaid coverage in over 20 years. You won't get those people to jump on board. This is why I think having a robust loan repayment program aimed at young dentists, talking about this, and talking about solutions is a huge part of this. Once the poisonous seed has been planted by some faculty members which states Medicaid isn't worth your time, the negative impact this has on a dental student who is 300k in debt is huge. I will talk with the new dean and be on his doorstep saying it all starts right here.
        - Karma: Thank you for that. Did you get your question answered, Tyler?
            - Tyler: Yes.

- Jordan: We have a question in the chat, any plans to reimburse public health hygienists for the work they are doing in the community?
    - Matt: This is something we are actively working on. There will be more to come.
- Ambar: I'm currently a psychology intern and am a year away from graduating. We must pay attention to other professionals who are also affected. From my past training with certain supervisors, I've encountered supervisors who would not take Medicaid because of the reimbursement situation. Some agencies don't accept Medicaid and it impacts the community in a major way. I want to collect data, but I'm limited. Then it causes me to limit the quality of service to the community. We must advocate for all professionals. Not just dentists but psychologists and more.
    - Dr. Meeske: In one of the pediatric medical and behavioral groups in Hastings, they were struggling with submitting claims. I called Director Bagley, and he got the right people to visit, and they got their problems worked through. If you can find the right staff person at MLTC or in the managed care plan, then you can have your issues resolved if you find the right person. I went straight to the top to Director Bagley, and I sent him an email saying I would love it if he would meet with my pediatricians. Within a week, he and them had it figured out.
    - Matt: We also meet regularly with NABHO. We are putting out policies, engaging with them, and addressing their concerns. They would be a good resource to contact.
    - Jordan: You can also email the MLTC experience box for any MLTC-specific questions. We can help get these questions to the right people.
- Tyler: Is anyone else having issues with VISAs for vision coverage?
    - Nate: Matt do you happen to know if they are a subcontractor for one of the MCOs?
        - Matt: Yes, they are. What I would suggest is to reach out to the MLTC experience email and forward the specific question. Then the question can be forwarded to my team. I'm one of the deputy directors of Medicaid and I help manage all the contracts for the MCOs. We can figure out exactly what is happening, and I can forward this to one of the MCOs.
- Staci: Some of the managed care questions that come up in our meetings are if the billing codes a provider, let's say, for example, a blood pressure monitor that Medicaid patients of ours can't afford, and some of them aren't considered providers, so we have to bill under the medical billing versus the pharmacy. One of the MCOs we were able to give is to go under the pharmacy side of the blood pressure monitors. That way, we knew the Medicaid patients would get an at-home blood pressure monitor. Is it possible to get easier access to this and make a more concerted effort to make sure the pharmacies that are doing clinical services are provided services instead of jumping over all these hoops? I'm in the process of working with pharmacies to make them a part of the medical billing. However, there are still areas of concern.
    - Nate: Would you mind sending an email to our dhhs.mltcexperience@nebraska.gov account? We can get that submitted to the right people.
        - Staci: Sure, thank you.

IX. Adjournment

Amy makes a motion to adjourn which is seconded by Vietta at 4:31 p.m. CST.