Medical Care Advisory Committee
Meeting Minutes
Thursday, April 20, 2023

The Medical Care Advisory Committee (MCAC) met on Thursday, April 20, 2023, from 3 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, Frank Herzog, Amy Nordness, Kenny McMorris, Sharon Price, Shawn Shanahan

DHHS employees in attendance: Kevin Bagley, Matt Ahern, Nate Watson, Jason Davis, Chris Morton, Collin Spilinek, Jordan Himes

Members of the public in attendance: Cindy Kadavy, Audrey Nuamah, Jess Sharp

MCAC members not in attendance: Staci Hubert, Jessica Meeske, D.D.S., Jason Petik, Vietta Swalley, Melanie Davis, Jason Gieschen, Felicia Martin

I. Openings and Introductions

The meeting was called to order by Karma at 3:06 p.m. CST.

- The Open Meetings Act was made available for attendees.
- Karma ran through roll call.

II. Review and Approval of February 17, 2023 Draft Minutes

Karma requests one change to be made to the spelling of Molina prior to approval.

- Frank moves to approve the minutes as long as the spelling error is corrected. The motion is seconded by Amy, and the motion passes.

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

Enrollment Updates:

The board received a document with enrollment updates two weeks prior to the meeting.

- Karma: I notice a slight increase in expansion, an increase of about 6,000 people since October.
    - Nate: Yes, that increase was anticipated.

Review of Legislative Bills:

- Kevin: The session is moving rather slow this year. One bill that was not included in the handout you received two weeks ago, but is probably of interest since its amendment, is LB227. About 16 bills that were passed by the Health and Human Services Committee were bundled into LB227. Each bill is considered an amendment. Once the amendments are passed, the bill must be passed in whole or not at all. Though, the bill can continue to be amended on the floor, it is currently on the second reading.
    - LB227 includes bills that are designed to:
        - Relieve stress on hospitals
        - Incentivize nursing homes
            - I noted in my testimony that it is not that nursing homes don't want to take a new patient that is a Medicaid member, but that they physically can't due to special needs or staffing shortages.
- Frank: Is it a financial incentive for nursing homes to take additional patients?
    - Kevin: LB227 and LB512 are both directed toward providing nursing homes with a financial incentive if they take a patient when the hospital is at capacity.
- Frank: Is ARPA money still being used to recruit and train staff for nursing homes?
    - Kevin: Yes, they will continue to receive a series of payments to incentivize the nursing homes. This year's payment recently went out.
- Frank: Is there any way to track how nursing homes are allocating this money?
    - Kevin: I will take that back and figure it out for you. I do know that nursing homes are not having to offset staffing shortages with traveling nurses as much as they had been.
- Frank: Locally, Certified Nursing Assistants (CNAs) are moving towards contracting. In one sense, it is helping offset the need but in another, the residents are upset that the staff caring for them changes every few days. Those nursing homes are employing and training a CNA for a few days, they then have to redo the process over again. I would like to know how the money is actually getting to the residents.
    - Cindy: You may see some variation between facilities but we are looking at the cost reports. There has been approximately a 30% wage increase across all nursing homes. They are also trying to stay away from agency staff because of the concerns you mentioned, they want to use the same staff for consistency. We are seeing a benefit from the ARPA money in raising wages.
    - Kevin: A potential struggle we may see in the future is the sustainability of those increased wages when the ARPA funding goes away.
- Cindy: There is currently a bill in the Legislature that would require staffing agencies to register in the state to see if they are legitimately operating in the state.
    - Karma: So there is currently no way to determine that?
    - Cindy: No, at this time we believe that there are over 800 agencies operating in the state but there is currently no definitive way to know.

COVID-19 Public Health Emergency (PHE):

Nate: The return to normal operations is underway and the normal rules of eligibility have resumed. We are actively working to help prevent an unnecessary loss of coverage. As of May 11, the PHE will end. The national emergency ended when the president signed Congress' bill. During the pandemic, some requirements were allowed to be conducted virtually but there are a

lot of reasons to have those checks in person. For example, re-enrollment and facility checks have resumed for the safety of our members.
Some of those flexibilities kick back in on May 11, May 12, or July 11. Others we have decided to keep because federally there has been a flexibility that allows us to permit virtual use when it makes sense.

- Karma: Will telehealth continue in the state?
    - Kevin: Yes, many of those flexibilities are still mandated federally, and further determinations will be made in the future. Unfortunately, we don't know when that is. We have been updating our rules to reflect those changes. We will let you know when something changes at the federal level. At this time, the reason to keep telehealth is to improve access to healthcare for our members.
    - Chris: We recently published a provider bulletin with the information that we do have. I will send that out to you.

Nebraska Medicaid Unwind:
Kevin: We have resumed regular reviews of member eligibility and have seen a few hundred members lose coverage in April. The vast majority of those individuals requested to disenroll or had passed away during the continuous coverage requirement. We have also seen a loss of coverage for members who were in the refugee resettlement program. As their immigration status changes their coverage can be impacted. Between those groups, there was approximately 200 who lost coverage, and less than 50 people lost coverage because they were no longer eligible.

- Karma: Does that include people who failed to provide information?
    - Kevin: No, you may see some in May who lose coverage for failing to provide information but I anticipate that to be relatively small.
- Karma: Over the course of the unwind, how many people are expected to lose eligibility?
    - Kevin: We are currently estimating 10 to 20%. That follows national estimates and is very broad. We won't know for sure what the statewide trend will be until later on.
- Karma: Is there an appeal process?
    - Kevin: Yes, and for anyone who does lose coverage for failure to respond, they have 90 days to provide their information. If they are found eligible, their coverage will resume without a gap.

April 2023 Listening Tour:
Kevin: The primary message in our listening tour is that we need folks to understand what this change means and people need to know how to provide their information. There have been some meaningful conversations with providers to help them understand how they can help their members. Those conversations included how we can improve their ability to communicate throughout the unwind.

MCO Update on Contracts:
Matt: We are still working through the new contracts and are still on track for the January 1 start date of those services.
Kevin: We will be reviewing all of their information and provider networks to ensure adequacy.

- Frank: You had all of their implementation plans in January?

    - Matt: Yes, we meet every two weeks to discuss their progress to see if there are any barriers or concerns to implementing things in a timely manner. So far, we don't have any significant concerns in that regard.
- Sharon: On the Omaha Therapy Network Facebook page there are some counselors and therapists who are licensed in Nebraska but do not live in Nebraska. One of the MCOs, Healthy Blue, recently decided that all providers have to live in the state to continue to be a provider. I feel that this will hurt the deaf and hard-of-hearing community if they do not have access to providers who know how to sign. Right now, we only have one provider for those services, they live in Maryland. The post says that Starting May 1, 2023, providers who use telehealth must reside in the state of Nebraska and be a member of a credentialed Nebraska-based PB or employed by a licensed or credentialed facility in Nebraska.
    - Matt: There may have been some assessment codes that we did not consider for telehealth. We have enrolled providers who do not live in Nebraska and still cover them. I will look into that and will let you know if something was changed so we can discuss this more in the future.
- Kenny: For behavioral therapy at the moment, you don't have to live in Nebraska to provide that service if you are licensed here, correct?
    - Matt: We will double-check that and confirm it for you.
- Shawn: Where can I find more information about the incentive pay for nursing homes if they take a discharged patient from a hospital? Who is communicating that to nursing homes across the state? When will this take effect? And, does the hospital need to show proof of capacity and if so how is that going to be done to assist in nursing home incentive payment?
    - Kevin: That is a great question. The bill has not passed yet and if it does those are the procedural questions we will be asking.
- Karma: Our group will continue to follow up on that.
- Frank: When you share that information with us is it shared on the website?
    - Kevin: Yes, if there is a publication.
- Frank: I don't want people waiting for a response.
    - Kevin: As we get that information we will figure out what the best way is to communicate the update to the general public.

Medicaid and CHIP Payment and Access Commission (MACPAC):
Kevin: We have recently had some outreach from the folks at MACPAC. They are the advisory committee, similar to this one, at the federal level for Medicaid and CHIP. Their advisor is interested in this committee and wanted to know what it looks like. We had a great chat with them and one of the requests they had was to interview some members of our committee to hear from them about their experience. They want to know what is working well and what isn't. There is no pressure to participate but if you would like to we will let them know.

- Karma: If you are interested in participating please send your information to Collin.
- Audrey: We are DC-based and interested in how states are engaging with their MCAC. If you participate, it would be a casual discussion, no more than 60 minutes. We will pay beneficiaries for their time. We would like to know how this experience is going for you and how your input is being received by MLTC. I would be happy to provide my email and discuss this.
    - Kenny: Is there a timeline you need this completed by?

- Audrey: We would like this done by mid-May so please reach out within the next week or two.

IV. Presentation on Spend Down

Jason: There are two situations where a beneficiary would owe an amount of money each month: spend down, and long-term care (LTC) cases. These are referred to as share of cost cases but there are two distinct situations there.

People under spend down qualify for Medicaid but they have an income above our income limits. Not everyone, but a lot of people can request a spend down budget if they are just above the limit. What happens is they will get sent a share of cost form each month and record their medical expenses from their provider(s). Meeting a share of cost can also be done with medical expenses such as provider or insurance premiums, travel for healthcare, prescription drugs, and medical equipment.

The form provides them with information on the month our employees are looking at and how much money they need to spend. Once they have met that amount, they turn the form into MLTC and the claims team reviews the information. Once they meet their share of cost they are eligible for Medicaid for that month and Medicaid covers the remaining expenses. It is on a month-by-month basis and as they keep qualifying they will continue to receive those forms.

In a share of cost budget, the member needs to spend a high percentage of their income. It is not the best solution for someone who needs ongoing coverage. The program is good at capping what that person's liability would be at any point. Because the share of cost is so high, the long-term solution of being on spend down is probably not the best.

Sometimes, the program is used as a bridge for other coverage. Maybe someone goes into a nursing facility and they don't know how long their stay will be. The program is good to cap their liability during that stay. If they have to stay in the facility for an extended period of time they will be moved to another program.

The spend down population is not a part of managed care so this will not be someone who is enrolled in the managed care unit. Because their eligibility is month-to-month, Medicaid covers them as fee-for-service. These individuals will not have a Medicaid card to show coverage but they will have the form. Someone who has inconsistent costs may not need coverage in May or June but might need it in April and July. That coverage will continue to be there for them the months they do meet their cost requirement.

Our LTC coverage is within the same category of spend down. When a person has excess resources they will get HCBS or a nursing facility. We know that LTC is expensive. People in LTC will meet that share of cost and will be eligible each month. So, they do get enrolled in managed care and they do not have a share of cost form sent out. However, they still have an obligation owed to the provider. Our team lets the provider know what that cost is and we let them collect it from there. If they have other costs not covered by Medicaid they can use those expenses to help meet share of cost. In that case, they will have to let their eligibility staff know so they can adjust for the month.

- Karma: Is it a monthly amount or yearly cost that needs to be met?
    - Jason: In Nebraska it is month-to-month.

- Karma: Is there something we can give people so that they know what they need to spend money on and how this works? Is there a point of contact or information for these people?
    - Jason: There is some information on the website and in the appendix to our regulations. We are working on updating our information now. It can depend on if the person is in a nursing facility or under HCBS. Generally with HCBS, if the person's income is below 100% of the federal poverty level they do not have a share of cost that needs to be met. One of the few deductions is health insurance premiums. We can use those policies so that they can meet that status.
- Karma: If people have questions should they call their eligibility staff?
    - Jason: Yes, some people have an assigned worker or they can call the eligibility office.
    - Kevin: If they have specific questions they should call the eligibility office, if it is a broad question they can email the MLTC Experience inbox so we can help field that information.
- Frank: Is the aging and disability resource center a good place to call too?
    - Kevin: Yes

V. Project Discussion

Karma: Dr. Meeske has the student one and I will meet with her in May so we can speak to that in greater detail in our June meeting. I want to offer you this time to suggest projects to see what you are interested in pursuing.

Frank: We haven't solved the nursing and direct care staffing problem yet. I would like to do what I can to improve that situation.

- Kevin: One thing we've seen a lot is rural nursing homes closing. A lot of that has to do with staffing and how many people are in the facility. Part of what I testified to in the Legislature is the notion that federal infrastructure draws a distinct line and does not let things cross those lines. We want to figure out how to build sustainable health hubs, particularly in rural communities. I would be interested in having you help. You bring a lot of talent and I would like to hear from you.

- Karma: The hard-to-place patients, will that be part of it?
    - Kevin: I think so, but I feel that specific initiatives will come out of it. Going into it, as a baseline we are trying to see what the sustainable future is for not only that but, servicing, and staffing.
- Frank: Are you envisioning the nursing home being the hub?
    - Kevin: We think it could be but there are a lot of question marks and potential barriers to federal regulations.

Jess: I'm a public health dental hygienist, in our area some suggestions for dental care are three hours away for our patients. Are we working to address that? Managed care taking over dental is important but I think we will lose a lot of providers because of credentialing for all of them.

- Kevin: From a credentialing standpoint, we note that is a potential and burden for dental providers. We are working with our health plans to develop a streamline process for providers, our organizations have all agreed to use CAQH for credentialing. If you are seeing those issues, please reach out and make us aware.

- Jess: Is that the same for dental hygenists? If that is how we need to steer them we would like to let them know.
    - Kevin: I'm not fully certain but am happy to look into that and give you, and others, the right information.
- Jess: What about the lack of dentists?
    - Kevin: We spoke with the delegates for the Nebraska Dental Association about the changes we are making. We are asking those who aren't providers to consider becoming one and we want to know the concerns they may have and we are currently collaborating and working together to solve those problems. We need you all to participate in those discussions. If we don't hear that there is a problem then we may falsely think there isn't one. We recognize there is a significant issue with dental access in the state, that's true across the state. We are trying to see what we can do to provide access. We are discussing what investments and support they can provide to the system like mobile dentistry. We are happy to include you on those discussions in the future.

Cindy: I have a question from people in the nursing home. If their provider writes a prescription with a high dose of calcium its not covered. I thought Medicaid used to cover that but apparently, now the MCOs do not. I don't know where to go with that. The resident shouldn't have to cover that with their small personal needs allowance.

- Kevin: Will you send that example to the MLTC Experience email and we will see if we can provide you with a good answer.

Karma: I want to improve maternal and newborn health in Nebraska. We are not doing good. We are scored as a "D" by the March of Dimes. States on the east coast have rates as "A" and states on the west coast have rates as "B." In Nebraska, 10.8% of babies born in 2021 were preterm. We can do better. We have maternal healthcare deserts where women cannot get access to care. I am passionate about this and will throw it out there as a project. We can't keep waiting until the baby is born and in the NICU to get them on Medicaid.

- Staci: I think this is a great idea. Anytime a pharmacy would sell a pregnancy test is there information that can be provided to the person purchasing? This is used in other states. Is this something we can begin putting an effort on? I don't know how to go about that but that is another thing we can look into.
    - Karma: That is excellent, beginning that discussion at the point of engagement. That could be part of the solution. Schools and churches could help. Can we use brochures that are generic to help educate and get them eligible sooner rather than later? I would like to discuss this with other states that are currently doing better.
- Shawn: I would love to share with you. In Fremont, our preterm numbers were really high. We put a social worker in our OBGYN clinic to do assessments and remove those barriers. We are also using that social worker to help remove confusion behind cultural barriers. We are giving members of our community information to help them get access by providing them with incentives to get involved in prenatal care. I'm willing to share that information and further this discussion.
- Kenny: There is also a need for additional support services and community-based doulas. There are churches in Omaha that are just starting to get off the ground. I know there is some work with the MCOs on community-based doulas as well.

- Karma: Another thing I've read about is the reimbursement model. There is a lot we can look at with this. Hopefully, we can get this moving another way and think of what we can do to reduce the mortality rate.

VI. Confirm the Next Meeting Time and Location

Karma: The next meeting date and time will be June 15 from 3 to 5 p.m. Will that work? Shall we go back to Lincoln for the meeting?

- Kevin: Lincoln is fine if the group is okay with it.

VII. Open Discussion

Karma: Last meeting we discussed vacancies. We have four openings, we need three providers and one member representative. We will advertise those vacancies on the website and Kevin is pursuing leads on providers.

- Collin: Are we directing applicants to the MCAC email address?
    - Kevin: Yes, please reach out to that email with applications.

Karma: There was concern with UHC representatives and their consistency in getting back to dentists with answers to their questions. MLTC has had a conversation with them and the issue has been rectified.

- Kevin: All three CEOs have been meeting with the dental association and with MLTC. They are doing a lot of work on credentialing optimization and the dental provider manual. The association will provide feedback on those documents and where they need to be consistent or what issues need to be addressed.

VIII. Adjournment

Frank makes a motion to adjourn which is seconded by Kenny at 4:50 p.m. CST.