OPEN MEETING MINUTES

Name of Governmental Body: Medicaid Advisory Committee (MAC)			Attending: Dipesh Navsaria, Laura Waldvogel, Randi Espinosa, Allison Espeseth, Lori Fierst, Marguerite Burns, Jessica Stevens, Bobby Peterson, John Rathman, Dino Tousis, Kyle Nondorf, Paula Tran
Date: 12/4/2024	Time Started: 9:03 a.m.	Time Ended: 11:31 a.m.	
Location: Virtual Zoom Meeting			Presiding Officer: Laura Waldvogel

Minutes

Members absent: David Gunderson, Kelly Carter, Jordan Mason, Shayla Olson, Ariel Robbins

Others present: Bill Hanna, Amanda Dreyer, Cheryl Jatczak-Glenn, Allie Merfeld, Gina Anderson, Autumn Knudtson

Meeting Call to Order, Laura Waldvogel, MAC Chairperson

- Roll was called. Twelve members were present, constituting a quorum.
- The agenda was reviewed.
- Minutes from the 9/4/2024 meeting were reviewed. A motion was made to approve by Marguerite Burns and seconded by Dipesh Navsaria. Minutes were approved. None opposed.

Public Comment: There were members of the public present.
No public comments were made.

Updates and Discussion
Medicaid Director, Bill Hanna

We want to provide some context - what do the election results mean for WI Medicaid?

- At NAMD, members of House and Senate from both parties were in attendance and shared some thoughts.
- There's a lot of speculation.
- As a reminder - Medicaid is a state/federal partnership.
- States have a lot of flexibility in how they design programs.
- There's a lot we get to decide at the state level - and every state looks different.
- A few pieces that seem likely to happen because of congressional interest:
    - 4,000 pages of rules that were released in May - likely to be some changes.
    - Because of the timing of release, new administration cannot wholesale rescind those rules (neither can Congress)
        - Would need to be new rulemaking to rescind.
        - Minimum staffing related to nursing homes - there was a lot of discussion about longevity even before election.
        - 80/20 rule (HCBS payments to direct care workers) - lots of conversation about modifying this rule.
    - There are also parts of the rules with bipartisan support which are likely to remain.
    - We'll be watching to see what changes.
    - We're continuing to move forward on rules with near-term deadlines.
        - Some aren't effective for years.
    - Things like block grants - not a change that would happen quickly and would have drastic impacts to state budgets.
        - Medicaid is a big piece of WI's budget, as in many states.
        - This would require congressional action and we can expect lots of lobbying.

        - Work requirements - several states were in process of getting approval under the last Trump administration, which Biden administration rolled back.
        - In WI, assume budgeting will be similar to previous sessions.
- Any time there's an administration change, things slow down as they fill political appointee slots.
    - 1115 IMD waiver - we were required to submit to CMS by end of year.
    - We don't anticipate any hangups - many states already have this waiver, and ours is modeled after those.
    - May take longer than anticipated.
- Looking ahead - CMS completed several important approvals for us at the end of October.
    - 5-year approval of 1115 BadgerCare Plus waiver
        - This is the waiver that allows us to cover childless adults up to 100% FPL.
        - Allows us to provide residential SUD treatment.
        - We received a 1-year extension at the end of 2023.
    - FamilyCare
        - Another 5-year approval.
        - We briefed MAC last time on these changes.
        - 1915(b) and 1915(c).
    - 1915(i) Housing Benefit SPA
        - 2-year journey to reach approval.
        - Will go into effect in 2025.

Allie Merfeld SPA/Waiver Updates

- Waiver Updates:
    - BadgerCare Plus Approval
        - Coverage for childless adults, people with incomes over 100% of federal poverty level who were previously enrolled in Medicaid, former foster care youth from other states.
        - Timing: 5 yr. approval 10/29/24-12/31/29
    - Family Care Approval
        - Home and Community-based services for adults age 65+ and Adults aged 18-64 with disabilities who need nursing home care.
        - Timing: 5 yr. approval 1/1/25-12/31/29
    - Senior Care Interim Evaluation Report Submission
        - Prescription Drug benefits & optional medication therapy management (MTM) for adults 65+ with incomes at or below 200% of the federal poverty level.
        - Timing: Interim evaluation report submitted 10/2/24. Renewal 12/31/28
- SPA Updates
    - Q4 SPAs to be submitted:
        - Per-diem hospital start up periods
        - Mandatory reporting for core reporting set-Adult & Child measures
        - 1945 HHQM reporting SUD
        - 1945 HHQM reporting HIV/AIDS
        - IOP- Intensive Outpatient
        - Act 182 Complex rehab tech rates
    - Recently Approved SPAs
        - 1915 HCBS housing
        - Personal needs allowance
        - Medicare Advantage supplemental benefits disregard
        - Weight Loss Drug Coverage
    - Pending SPAs and expected Approvals
        - WI ground emergency medical transport Ambulance (WIGEMT)

- WI ambulance service provider fee reimbursement program
- ABP Vaccine SPA
- CHIP Continuous Enrollment

Full list of SPAs is available here https://www.dhs.wisconsin.gov/medicaid/housing-supports.htm, https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html?f%5B0%5D=state%3A941

https://www.dhs.wisconsin.gov/mandatoryreports/mastateplan/index.htm .

The DHS site includes the full state plan, but not specific state plan amendments. This will not include the most recently approved SPAs.

The Medicaid Director noted the 4 parts to the housing benefit: housing consulting services, transition to help make the move, financial support to move from temporary spaces to home such as basic home furnishing and security deposits, then support to keeping them housed. The CLTS benefit and the housing benefit will likely not overlap. CLTS is for the children and the new housing benefit is geared to adults with different requirements.

Child Care Coordination:

- Autumn provided an overview of the benefit.
  - Current CCC benefit - for kids who receive an initial risk assessment in Milwaukee County up to age 7 and City of Racine up to 2.
  - Goals: promoting positive parenting, improving child health outcomes, preventing abuse and neglect
  - Services: assessment, care plan development, ongoing care coordination
  - Today, CCC and PNCC are linked - CCC providers are enrolled as PNCC providers.
- Purpose:
  - Address inequalities in health outcomes.
  - Increased access to quality, coordinated health services promotes successful care and better outcomes.
  - Medicaid members are facing greater system complexities.
  - CCC providers are largely community-based, serve members in home and community, and have local relationships to culturally appropriate resources.
  - Enhance provider enrollment requirements for benefit integrity purposes.
- What's changing?
  - Enhancing provider qualifications
  - Improving covered services policy
  - Distinguishing CCC from other benefits
  - Support requirements to help mitigate fraud, waste, and abuse.
- Questions?
  - Bobby: Geographic scope - still just Milwaukee County and city of Racine?
    - Yes, for CCC.
    - PNCC is available statewide.
  - Bobby: learning resources through UW-Milwaukee: how are these learning opportunities directed towards identifying community resources?
    - We can come back and talk about that - they'll be available for providers at beginning of 2025.
    - It's about a 5-hour professional development course with several modules walking providers through a) being a Medicaid provider and b) being a CCC provider.
    - Bobby: 5 hours feels light - how do they get continued up to date info? Needs to be a good connection point to resources.
    - Autumn: Modules are biggest and newest thing we're doing in this space, but we've previously also enhanced website to consolidate resources for PNCC/CCC providers.
      - Goal is to clarify requirements for these providers as it is noted that these providers are different than providers who are doctors or nurses.
  - Paula: can we share a description of covered services?

- Bill shared. https://www.forwardhealth.wi.gov/WIPortal/cms/public/provider/medicaid/child-care-coordination/resources
- Jessica: if this ever went further beyond geographic locations, would look at name - Child Care means something else (e.g., daycare).
  - Do we anticipate a gap in services from transition of current to future state here with managed care organization networks?
    - Autumn - these transitions are a critical time in any service.
    - Team is working diligently on transition plan.
    - Begins at beginning of the year when we get rule authority - so first step is enrollment.
    - Then, we turn on the benefit when providers are ready - it's about a 6-month period to ensure providers get enrolled, meet requirements, and get into HMO networks.
    - Bill: HMO partners are eager for this benefit, especially as we've raised expectations of them around postpartum and well-child visits.
  - This is not a type of program limited to first child, right?
    - No, not limited - available to children meeting a needs assessment within first 8 weeks of life, or if parent participated in PNCC as well.
- Dipesh:
  - Also confused by name, reiterate this.
  - Found link Bill shared previously - a plain language description might be good.
  - Imagine we need to come back with this, but: would like to see data about how much this benefit is used - how many actually use it? What do we anticipate after this change? What if we scaled to full state?

Coverage for Justice-Involved Youth:

- Autumn provided an overview of the benefit of the Consolidated Appropriations Act of 2023 – CAA.
  - Directs states to meet new requirements for coverage of incarcerated youth.
    - Medicaid eligibility should be suspended, not terminated, when youth enter the justice system.
      - WI Medicaid is already in compliance with this.
    - Required updates for states to provide services to eligible youth with justice involvement 30 days prior to release or within one week or as soon as practicable after release:
      - Required services include:
        - EPSDT
          - A way to ensure children are receiving all early screenings and care to detect/prevent/intervene.
          - HealthCheck is WI terminology.
          - Also known as well-child checks
        - TCM
          - Care management services assisting members and families to gain access to and coordinate a full array of services.
          - Includes referrals to the appropriate care and services available within the geographic region of the eligible juvenile's home or residence (where possible)
    - Timeline:
      - 1/1/2025 allow existing EPSDT/TCM providers to render and bill services in a correctional facility (will be a ForwardHealth update).
      - 1/2025 - begin phase II work. Work with state carceral facilities to allow those facilities to render and bill for services.
      - We think we have about 100 youth being released a year from a correctional facility, and have about 100 total correctional facilities that we will need to work with
    - Next Steps:
      - Continue to work with Department of Corrections, Department of Children and Families, Division of Care and Treatment Services within DHS.
      - ForwardHealth Update for Phase 1 will be sent to providers later this year.
      - Phase II will begin in 2025 with state carceral facilities and jails.
      - Additional communications will be shared with providers as we go.

- Questions?
    - Marguerite: can existing providers go into these facilities, or is there a training first? How does this relate to MCOs that these kids are likely enrolled in? Could you repeat the scale of kids per facility, etc.
        - About 100 youth per year (under 21, under 26 if aged out of foster care).
        - There are about 120 correctional facilities we will need to work with.
        - Entering facilities is one of the biggest challenges - sheriffs have a lot of authority over these facilities and services provided.
            - Have a conversation with members of the sheriff's association next week and expect a range of responses - will need to work with them to build relationships.
            - DOC is interested in enrolling current staff, or using a current vendor, versus brining in new staff.
            - First phase is really DMS opening allowances, and building relationships will be longer term.
    - Bobby: Coordination issue - within HealthCheck, there are baked in case management services, so how do these relate to TCM services?
        - When we look at services like EPSDT - the treatment piece is shoved at the end but is a huge element - the treatment resulting from diagnostics can be really important.
    - Dipesh: Spent a few years providing youth services at a juvenile detention center - have seen many of these challenges. A lot of these youth, because of circumstances leading to justice involvement, have not received care in a long time. Jail population tends to be more transient than prison population.
        - This may be the one opportunity to start addressing issues and needs while they're incarcerated - having Medicaid basically disappear on them was a challenge.
- Jessica: Glad we're doing this. If clients end up in jail, Behavioral Health providers go to the jail to provide care and there's no training. Sheriffs can be challenging, can be really good. Sheriffs are not the ones who know the people in their jail or their needs. Local administrator has reached out to Jessica with new intakes and provides a roster to help them coordinate. County has been a huge facilitator and eats the cost of some of this care.
    - In older adolescent population, discharge planning shouldn't happen at the very beginning of a long term - we see this currently, but plans change (where they'll live, what providers they'll see) change from day one to release. Doing this as part of intake is not helpful.
    - For younger adolescents, this has looked much different. But about 16 and older, having these conversations too soon makes discharge really difficult.
- Bill: thanks for these comments. We've had conversations with sheriffs - some have directed Medicaid to jail administrators, others want to be more involved.
    - To the point of treatment: this benefit is about getting in 30 days before release to do an intentional evaluation and not get lost in the handoff. We should be making connections to providers and following up to ensure engagement with the healthcare system. This is a narrow time-limited benefit, so that transition is crucial.
- Laura: there's such a high prevalence of behavioral health issues among justice involved youth, so even if it's just those 30 days, this handoff can go a long way to break the cycle.
- Allison: Curious if DHS is exploring this federal funding opportunity that could support this initiative and effort care and treatment for the re-entry population: Notice of Funding Opportunity for Planning Grants to Address Continuity of Care for People Who Have Been Incarcerated: https://www.grants.gov/search-results-detail/356168
    - Autumn indicated we are aware and exploring this for first quarter of next year.

Bill: Statewide focus to improve youth BH:

- Working with DCF and DPI to look at cohorts of kids that are in the child welfare system but don't really belong in this system.

- We estimate that about 1/3 of kids in the system aren't in the system because of abuse and neglect, but because of uncontrollable behavior (child is a danger to other kids in the home, parents don't have the skills to care for the kids).
- Don't believe this system, which is trauma-inducing and hard on families, is the right approach for these families.
- Often, means sending the child out of state for treatment.
- We were part of a national learning collaborative - part of this was a data analysis to understand the population.
    - 3 clear cohorts of the population:
        - Youth 13-15:
            - Youth with a developmental disability who often had these behaviors when they were younger and are now too big to be physically restrained when needed.
            - Trauma - a lot more girls.
            - Oppositional Defiance Disorder, 'acting out.'
        - A lot of kids weren't able to access CCS or CLTS prior to entering child welfare.
- This system is complex, operates across 72 counties, and need to find the right point of entry.
- What we are proposing is to develop a statewide system for this most complex population.
    - We think there needs to be some statewide expertise -
        - If this is the first time in a county someone is experiencing this, might struggle without a statewide approach to help identify resources.
    - This is related to Children Come First/Wraparound Milwaukee - these programs weren't sustained, but the benefits of the wraparound produced better outcomes.
- We're also thinking about a holistic approach - can't just remove the child, 'treat them,' and put them back in their original environment.
    - Whole family approach.
    - DCF has more flexible funding and is paying for some things Medicaid couldn’t pay for - they have flexibility to pay for more family supports and enable kids to live at home.
- One model we're looking at: OhioRISE
    - Designed for the same types of populations.
    - Ohio doesn't have the same next step down benefits like we have in CLTS/CCS - and we're not talking about replacing those.
    - We're talking about the kids in multiple systems - Justice involved, school issues, in CLTS/CCS.
        - Can we do better by developing higher fidelity, wraparound services, with more manageable caseloads?
    - We need approval from legislature to pursue a waiver.
    - Long process - designing with many systems who work with these kids.
    - Would be looking for funding in next biennium.
- We think there are 1,000 - 2,000 kids in this range.
    - How do we identify who *will* be these kids - identifying them early and connecting families to resources much earlier to prevent out of home intervention.
    - We don't have psychiatric residential treatment facilities in state - we don't want them to become the easy button and just start housing kids in PRTFs.
    - We need the tool in our toolkit, need oversight to ensure these are utilized appropriately for short term acute care.
- Laura: Did a lot of in-home work early in career - for in-home benefit, have something already in place that you can identify - kids that are at risk.
    - We have some screening tools we want to build off of - youth functional screen - needs to be updated.
    - We should pay more for more intensive treatment through an ACO/PIP model - more flexibility for providers.
- Lori: The school systems could help identify these children and then the families could be given counseling/therapy and training. I know from working as a teacher and substitute teacher in the schools that these children are standing out in the schools. I know my son was not identified by the school he was at 16 years ago. The school didn't offer much help at all.
    - Bill: schools need to know what comes next once a kid is identified - it's complex, and they need the right resources to do that.
- Dipesh: Want to think about far upstream elements - early childhood/parent supports.
    - These are more cost effective and preventive.

    - It's not an either/or. We'll still need the services we're talking about.
    - We have a tendency to segment away kids younger than say, six, and view their mental health as something separate and different.
    - Two resources re: Parenting Support Programs that make differences in early childhood: https://www.pediatricssupportingparents.org/_files/ugd/318c62_0a3a1ae724a74cf9bee1c399d1d7fd04.pdf ; https://www.pediatricssupportingparents.org/_files/ugd/318c62_6a02990830d14c3686d82fe494e50adf.pdf
        - And one more on Title V and MA: https://www.pediatricssupportingparents.org/_files/ugd/318c62_333257b578ce4fcea12b59531bedd724.pdf
- Jessica: These things don't magically appear at age 6 because that's what the DSM says.
    - Often don't see much movement until youth justice gets involved, often after several incidents.
    - This is a generational issue - how do we break that cycle?
    - How can we provide parent supports (e.g., payment for missed work).
    - Don't have requirements for young kids who are survivors of sexual abuse to get BH treatment - there are gaps.
- Bobby: in 30+ years in this space, an area where there are persistent knowledge barriers = coverage management, coverage rules.
    - Need to invest time and resources into helping people understand what is covered, when, and how.
    - Bill: that's an area we're talking about related to eligibility - this isn't a typical Medicaid population.
        - How do we provide for kids who may not qualify for income reasons, but don't have commercial insurance, or have a high deductible commercial plan?
        - How do we use Medicaid to hold commercial insurance accountable AND to provide for kids who aren't eligible for Medicaid?
- Randi: Doing functional screens for kids regularly, and uptick in referrals is intense.
    - Long waitlists - kids who had aged out and never got off the waitlist.
    - Now, we have where we're not supposed to have a waitlist, but counties still have budgets, and need to go through this whole process to get new staff approved.
    - Functional screen determines eligibility for wraparound services - many kids qualify for more than one, but hard to navigate what pays for what.
    - There are often 5 or more case managers telling families what to do and need to cut through that complexity for the most intense cases.
    - There's a change in 2025 that counties no longer need to contract with individual providers, can contract statewide - but the issue becomes when the new rate schedule crosswalk came out for CLTS, some codes are reimbursed 80% of what they're asking for and they won't provide those services, but can't go through CCS because that provider doesn't work with CCS.

Allie - BadgerCare Plus Public Forum:

- About BadgerCare Plus
    - BadgerCare Plus is an 1115 waiver program and one of a few Medicaid programs in WI. Medicaid is a joint state and federal program. WI must get approval from the Federal Centers for Medicare & Medicaid Services (CMS) to make changes to our Medicaid Programs.
    - WI is committed to delivering high-quality health care coverage for our citizens that is affordable, comprehensive, and sustainable.
    - In 1999 WI Badger Care was approved by CMS to cover parents and caregivers**.** In 2013 it was replaced by BadgerCare plus which has been extended twice. It was extended 10/29/24 and will operate until 12/31/29.
- BadgerCare Plus Waiver Overview
    - Eligible groups:
        - Childless adults without children and family incomes up to 100% of federal poverty level.
        - Transitional medical assistance, people with incomes over 100% of federal poverty level who were previously enrolled in BadgerCare Plus or Medicaid.

        - Former foster care youth from other states who were in care in another state or tribe when they turned 18, were enrolled in Medicaid while in foster care, are now applying for WI Medicaid.
    - Benefits and Requirements
        - Substance Use disorder program: The waiver includes an SUD benefit that expands to cover short term residential services in institutions for mental diseases for all Medicaid members.
        - Nonemergency emergency department visit copay: Charges childless adults $8.00 copayment if they go the to the emergency room while not having an emergency.
        - Removed and pending requirements**:** As of Jan 1, 2024, BadgerCare Plus can no longer:
            - Charge monthly premiums.
            - Vary monthly premium payments based on the completion of a health risk assessment.
            - Deny eligibility for not completing a health assessment.
            - Deny eligibility and prohibit enrollment for up to 6 months for failure to pay premiums.
        - WI Medicaid was required by the legislature to request these authorities through 2017 Act 370.
        - In 2020 WI requested to add a health savings account for BadgerCare Plus members. This request is still pending.
- Budget Requirements: Federal policy requires Section 1115 demonstration waivers to be budget neutral to the federal government. This means there is no extra funding for newly eligible groups or new benefits covered by BadgerCare Plus.
- Helpful Materials
    - Waiver materials and annual quarterly monitoring reports: Medicaid: BadgerCare Waiver | Wisconsin Department of Health Services
    - 2023 annual monitoring report https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wi-badgercare-reform-annual-monit-rpt-2023-attachment-a.pdf
- No questions or comments.

Amanda - Medicaid Advisory Committee and Beneficiary Advisory Council:

- New requirement - CMS released rules in April that include the requirement to create MAC and BAC.
- Goal is to engage Medicaid members in decisions that impact them.
- Reviewed requirements and flexibilities.
- Comments:
    - Jessica: When I was a Medicaid recipient, this would have intimidated me - wasn't a professional, had no understanding that people at this level met to discuss the services I was getting. I was struggling with these services - it can be more comfortable to put things in writing than saying it out loud. It's not about anything anyone here is doing, it's just the reality.
        - How do we make a more inviting space?
            - Dressing down - not accentuating the power dynamic.
            - Mentors - professional to community member - assign them one to help the transition and do check ins.
    - Dipesh: Agreed. I'm a university-type physician and occasional policy nerd, and *I* worry about whether I sound clueless in a group like this.
    - Bobby: Onboarding and building comfort and understanding needs to be intentional.
        - Experiential kinship helps.
        - Identifying the right people to do the onboarding - relating to and understanding the population.
    - Paula: acronyms, programs, etc. - plain language is huge and makes it easier to keep up.
        - Occasional joint meetings between MAC and BAC.
        - Annotated agendas with plain language.
        - Pre-reading and post-meeting materials.
    - Randi:
        - Echo dress.
        - Biographies of new members is great but can also be intimidating.
            - Should support people with that if we're doing it.
            - People don't identify with being an expert, necessarily.
            - People echo struggling with bios.
    - Mentorship - should mentors be current/longer term members? DMS staff?

        - A past committee Jessica participated on assigned members who had at least on term under their belt.
            - Met before first meeting, sat together when in person, post-meeting check-ins throughout new members' first terms.
    - Dipesh: Nonprofit boards I've been on have called that "Board Buddies" — an identified person who can guide you through acclimating to the process. Dipesh also noted in chat that plain language materials are key and adds that being able to admit that you don't know something in a group like this is a marker of privilege.
    - Paula: Culturally, some folks are not used to government wanting honest opinions from them. Takes a trusted person to create some comfort and safety around that. Immigration can be a stressor, so need to be clear that this is not related to other agencies/statuses/etc. There are cultural, legal, and other fears of participating in these spaces.
    - Maybe give space to explain members roles. That helps connections.
    - Icebreakers: "If you could dress up as a State Plan Amendment, which one would it be?" :-)
    - Allison: I appreciate the ways in which DHS is really looking to the member perspective to guide admin and programming.
    - Send suggestions regarding the BAC to Amanda or Gina.
    - Jessica also noted that giving space to explain each of the MAC member roles would help make connections.

Wrap-up, Laura Waldvogel, MAC Chairperson

- Future meetings Suggested topics:
    - Medical debt/bills. Families and members deal with this. It's an important to clue to identifying things that went wrong.

- Laura reviewed the 2025 meeting schedule: March 11, June 10, September 9, December 9

Adjourn

- A motion to adjourn was not obtained. The meeting concluded at 11:31 am central time.

Prepared by: Allie Merfeld, Gina Anderson on 12/4/2024.

These minutes were reviewed and approved by the governmental body on: