OPEN MEETING MINUTES

Name of Governmental Body: Medicaid Advisory Committee (MAC)			Attending: Bobby Peterson, Mandy Stanley, Laura Waldvogel, Marguerite Burns, Jordan Mason, Jessica Stevens, Allison Espeseth, Kelly Carter, Kyle Nondorf, Dipesh Navsaria, Dino Tousis, Randi Espinoza, Lori Fierst, Robin Carufel, Paula Tran, Karen Nelson
Date: 6/3/2025	Time Started: 9:02 a.m.	Time Ended: 11:30 a.m.	
Location: Virtual Zoom Meeting			Presiding Officer: Laura Waldvogel

Minutes

Members absent: David Gunderson, Ariel Robbins, Shalya Olson

Others present: Bill Hanna, Amanda Dreyer, Allie Merfeld, Cheryl Jatczak-Glenn, Gina Anderson, Derrick Mrozinski, Tadeb Shakur Tabira, Chloe Sieman, Noah Walch

Meeting Call to Order, Laura Waldvogel, MAC Chairperson

- Laura welcomed the group; roll was called through introductions. Sixteen members were present, constituting a quorum.
- The agenda was reviewed.
- Minutes from the 12/4/24 and 3/11/25 meeting were approved. Motion to approve by Marguerite Burns and seconded by Kyle Nondorf.

Public Comment: nine members of the public were present.

- A public comment provided by Kelly Lovelace was read aloud by Allie Merfeld: On Friday May 30, 2025, I needed to find an ophthalmologist in the Forward Health portal, to address pressing vision issues. Just after 8 AM, I attempted a search for providers, and according to the online portal, there are none, which I know is wrong. I then tried to search for optometrists, which returned some nearby providers for that specialty, so I picked up the phone. The providers I called told me that they were not participating providers.

  I had been previously told by Forward Health service representatives, on multiple occasions, that it is the provider's responsibility to keep their information and plan participation updated with Forward Health, and that Forward Health has no responsibility to patients if its providers fail to do so.

  At this point, I was very frustrated and even though it harms my health to do so, I placed a call to Forward Health for verbal assistance. The representative I spoke with was unable to assist me either. I discussed the issues I had already encountered, and she put me on hold. She came back with a toll-free number, but with no provider name or info attached to it. I questioned this and was told someone at this number would “find an ophthalmologist for me.” I was skeptical and asked for other numbers, to avoid needing to call back. I was given 4 more blind phone numbers to try. I spent an hour calling around - first, to determine who they were; second, to see if they had an ophthalmologist there; and third, to verify they really did accept my insurance.

  That toll-free number I was given goes to a place called Signify Health. They do NOT have any ophthalmologist there. They also specifically stated that they are NOT a Forward Health provider either. Signify Health appears to be just another subcontractor along the way, hiding an expensive attempt to pull patients away from actual providers, through the guise of Medicaid-covered home health visits. It appears to me that Medicaid funds are being utilized to cover non-Medicaid providers, which is a separate legal issue you must sort out.

We live in an online information age. Communication access for disabled people is a federally protected right in this country, under Titles 2 and 3 of the Americans with Disabilities Act. The current state of Forward Health, their provider portal, and their provider agreements appear to all be falling well below what people of every ability deserve. Forward Health puts unnecessary strain on elderly and disabled patients, to have to jump through multiple hoops, and still not receiving clear, accurate information to access their own health care benefits. It is unreasonable and unrealistic to expect that this below-standard treatment should be allowed to continue.

Being unable to advocate professionally any longer due to disabilities, does not negate my extensive education, professional skills, or personal experiences. I choose to be part of the solution today. I hope that my statement is a wake-up call that opens a path to change within the Wisconsin Medicaid system because, on its current path, Forward Health is failing patients every day and harming long-term patient outcomes.

- Corey comment: I am following up on an issue I spent about a month trying to rectify. I am a dual-eligible. I am having trouble accessing a medication added to the formulary (Sofdra (sofprionium)), replacing an older drug. Neither is covered by Medicare, so expected this would be covered by Medicaid. There were issues with the specialty pharmacy, seemingly not being onboarded. It's difficult to get information about whether things are covered, or why not. I have been unable to get coverage despite it being a covered drug. Not sure if there is further information with regards to this. Similarly with the terrifying prospects passed by the House, I have no idea what to expect as a member – whether I will lose the coverage that keeps me functional. Not sure if there are contingency plans. Hope is that the Senate listens to their constituents.

- Lori Fierst comment: It is a big issue trying to find providers who accept Medicaid. Son is a member and have had this issue – they call the number on the Forward Health card to get a list, and many of the providers on the list no longer accept Medicaid. It is a big source of frustration.

Updates and Discussion

Bill Hanna: There's a lot going on! A few updates on what's happening in WI (related to state budget) and the action in Washington D.C., and what it means for Wisconsin if House Bill is passed.
State:

- Joint Finance Committee held public hearings in four parts of the state. Medicaid and Healthcare were #2 following education. There's confusion between State and Federal level action and the implications of each. There's concern about protecting Medicaid.
    - As a note, provisions being pulled doesn't mean much at this stage, and things staying doesn't mean much.
    - That said, 12-month postpartum coverage was not pulled out of budget
- Discussion about cost-to-continue for Medicaid, $1.75B in next two years

Federal:

- House passed the reconciliation bill.
    - Next step is Senate to take up, pass, amend, or redo that bill. Senate is starting in earnest this week on bill House passed.
    - There is disagreement – some Republicans think the bill spends too much; others think the cuts to Medicaid are too significant.
- Current House Bill version:
    - Work Requirements: for individuals 19-64 without dependent children
        - There is a lot of talk about the expansion population, but this specifically applies to those who have expanded via waiver (which is just Wisconsin).

- These members would need to document that they were working, volunteering, or in an education program for 80 hours per month.
- Estimate is that 63,000 individuals may be impacted in Wisconsin (out of ~195,000).
- Estimated to increase income maintenance workload by another 10 staff in Milwaukee.

- Eligibility redeterminations every 6 months (instead of every 12).
  - Mostly a paperwork hassle, will cause people to lose their insurance.
  - In Wisconsin, eligibility error rate is incredibly low.
  - Increasing the frequency of these checks is unlikely to impact most members' eligibility.
  - This will also double the workload for ~195,000 individuals impacted (twice vs. once per year).
  - There is also a lot of work in helping people understand new requirements.
  - Estimated to cost state ~$3M per year ongoing (about 25 new staff in Milwaukee, new county staff, etc.).
- FoodShare:
  - Wisconsin has fully funded FoodShare employment training – other states have waitlists.
  - Building a similar model in Wisconsin would cost an estimated $2M in FY27.
- There are major concerns among Medicaid directors with the timeframe.
  - Originally planned 2029, then moved up in final amendments to 12/1/2026.
  - CMS still needs to write rules and technical guidance, then implementation – all in 18 months.
- Retroactive Coverage Changes:
  - Today, we can do 90 days of retroactive coverage. This would change to only one month.
  - Likely to lead to increases in uncompensated care, and increased medical debt for impacted individuals.
- Provider Taxes and State Directed Payments (SDP)
  - Provider Taxes: Many states use provider taxes to fund non-federal share, and then increase provider rates.
  - Wisconsin has three: biggest is hospitals. Hospitals pay a tax to states, and then goes back to hospitals in the form of access payments.
  - This bill would grandfather in current taxes as-is.
  - Some states are taxing up to the max of 6% (Wisconsin is taxing 2%).
  - States that were conservative are now sort of being punished for previously being judicious with these taxes – those who maxed out taxes get to continue.
  - Governor's budget included changes to hospital provider tax – there is now a time crunch if Legislature wants to do it, and will have to pass before federal bill is signed into law.
  - State Directed Payments: When a state directs a portion of funding through a managed care organization.
    - We have BadgerCare HMOs and FamilyCare MCOs.
    - These are risk-based contracts: HMO/MCO is at risk for costs.
    - We can do SDPs where we tell the HMO/MCO what and how much to pay to whom.
    - Biggest change is to rate a provider can receive.
      - Currently, max SDP is the average commercial rate (ACR). It's much higher than Medicare or Medicaid rate.
      - This bill grandfathers in SDPs already approved or submitted as of bill passage. So, lots of states are now rushing to submit these. We can't do this without legislation.
    - Bill lowers upper limit for SDPs – new SPDs after this bill is signed are limited to 100% of Medicare rates for expansion states, or 110% for non-expansion states.
      - It's not clear which bucket they count us in. May require court interpretation.

        - If we are grandfathered in at a higher rate and then expand Medicaid, lose grandfathering of our SDPs. Makes a good case for expansion now!
    - Bill also takes away enhanced match.
        - Previously, enhanced match enticed non-expansion states – extra 5% FMAP for 2 years that would generate $1.3B for Wisconsin over next two years.
        - If we don't do it now, we lose out on this option after bill is passed.
        - North Carolina was only state that took advantage of this incentive and they benefitted majorly.
- Other relevant, but non-Medicaid, provisions:
    - FoodShare: Would be a major cost-shift of SNAP costs.
        - This bill would, at a minimum, require each state to pay 5% of benefit cost starting October 2027, which would impact next budget. Historically, benefits loaded onto FoodShare card were 100% federally funded.
            - State costs goes up depending on state error rate:
                - If the error rate goes over 6%, goes up to 15% share. If the error rate goes over 9.9%, goes up to 25% share.
            - We have to calculate exactly how much an individual's benefit should be – there are a lot of deductions, can be complicated by self-employment, etc. These are sampled for errors. Today, if we're off by a few dollars a month, considered minor error and cost to fix is more than cost of error. Under this bill, any error – even $0.50 – is an error.
                - These changes would almost certainly put us over 6%, so a lot of work will be required to maintain our current low error rate.
            - This bill is expected to cost Wisconsin $69M annually to maintain the program as-is.
                - We have one of the lowest error rates in the country as of now.
                - We have low error rates and low costs per case currently, but this bill would require zero tolerance for error.
                - If error rate goes to 6.01%, share goes up $138M to $207M per year.
        - Today, administrative costs of FoodShare are split 50/50 – this would become 75/25 (states cover 75% of costs).
            - This would cost Wisconsin $51M annually to maintain FoodShare.
    - Affordable Care Act:
        - Does not extend premium subsidies for marketplace plans.
            - Estimated premiums could double for people getting insurance through exchange. Many folks would likely not renew coverage and would become uninsured.
            - It's also understood that if someone is eligible for Medicaid but fails to meet work requirement, they lose exchange access.
    - A few references:
        - Congressional Medicaid Cuts: The Impact on Wisconsin
        - Proposed Changes to SNAP Will Drive Wisconsinites into Hunger and Harm Our Local Economy
- Marguerite: Did Wisconsin Medicaid build any tools for the state waiver application that would be helpful here?
    - Bill: Wisconsin applied for a waiver to implement work requirements, but were not implemented.
    - We did do some work that helps with our technology.

        - The question is: Does this align with the final bill? Can we build off what we've started, how much needs to be built brand new?
        - This bill puts the burden on states to have data-matching tools to do as much of an ex-parte renewal as possible. Specifics of CMS guidance matter here – tolerance level if it doesn't match exactly, etc.
    - Jessica: During the last meeting, we talked about people's understanding of the changes occurring and how that impacts their healthcare. Spent time talking to folks about this, and now more shocked than ever. A young lady came in wearing a MAGA hat, and advocated for cuts to Medicaid, and Jessica talked her through: this impacts the patient. She was shocked that "Medicaid" is her insurance.
        - It's our job to help educate clientele: not just for advocacy purposes, but for managing if/when the changes impact them
    - Bobby: One issue that Bill raised is uncompensated care, medical debt increases – this will be a huge problem for clients we work with. Medical debt doesn't just go away, it filters into other expenses. How can we sharpen that message? There's a cost to these cuts. Debt doesn't just go away. We also talked about error rates, and Bobby has concerns about negative error rate, too. We should think about folks who are wrongly excluded. Infrastructure for assistance is bottoming out: ACA navigators, etc. Who is going to help advocate for these folks?
        - Bill: In Medicaid, negative error rate is all or nothing – you're in or you're not. There are other provisions: for higher error rates on eligibility, don't have to pay states back. Puts burden on member to go through a quasi-judicial process (with fewer supports).
            - On SNAP side, it's both over and under-payments. We do have an underpayment error rate, and if an underpayment is found, member is made whole. If they are overpaid (currently), there is a recoupment.
            - On medical debt side: when you think about the enhanced FMAP we're passing up, North Carolina was able to use that funding to wipe out a lot of medical debt.
        - Bobby: Uncompensated care for Wisconsin in 2023 was just under $1.4B.
    - Robin: Wisconsin Tribal Health Directors are discussing the HMO/MCO topic on June 11 looking at contract issues. Will share what they discuss. Andy Miller wanted to also comment (possibly next week) to reaffirm that Medicaid has worked with Tribal leaders about a month ago to confirm that we will continue discussions on SDPs, which may affect Tribes. Tribes have a special federal relationship and want their unique issues to be kept front of mind.
        - Bill: We had Tribal Consultation about a month ago: DHS and Tribal leaders to discuss how to maximize care and reimbursement for Tribal members, especially in long-term care space.
        - For those who aren't aware, states can receive 100% federal reimbursement for Tribal members, which we want to maximize for the benefit of everyone.
- Bill: We're in uncertain times. Trying to lead through this uncertainty, but curious to hear advice on what else we should do as we navigate the next stretch.
    - Allison: Thinking about what Jessica said – we hear this as well. Folks don't know they have Medicaid. Is there anything the Department can do in regular communications to spell out: "this is Medicaid." Not sure if this can be the purpose of comms, or just tucked in – to help underline the point. We as navigators have this challenge helping folks understand their coverage and requirements, so helping draw the connection between federal and state issues to their real lives helps them be better informed.
        - Bill: We are working on this! And this is timely and should happen ASAP.
    - Marguerite: Wondering what the Department is doing (or can do) to engage other affected partners? Like Wisconsin Hospital Association – they are going to take some hits as well. Are they engaged?

        - Bill: Yes, talking to WHA – they have done outreach to Congressional delegation, especially around provider taxes and SDPs. They will feel this impact. American Hospital Association is also carrying this water.
        - We also meet with BPDD, Kids Forward, other advocacy groups on ageing resources to answer questions and provide factual information they can share with members.
        - And we're doing our own Congressional outreach! But it's perhaps more powerful coming from constituents/non-state groups. We try to make it county specific, too.
        - Worth underscoring, we are all healthcare consumers, and this will impact everybody.
    - Bobby: The communications strategy is so important. There's a need to repeat and reinforce. Department should pull all the levers: working with hospitals, health plans, counties, ADRCs. It's all hands-on deck to get the message out. We need to keep improving our efforts, too.
        - Bill: There are a lot of Medicaid employees, and it's easy to get demoralized. We need to stay solution oriented. It feels like moral harm to see these policies pay out, but there is a lot within our control.
    - Jordan: Consider the implications of the minimum fee schedule. From provider perspective, feels like it's been weaponized by MCOs. Seeing lower reimbursement rates than ever – raises a lot of concerns. Since acquisition by Humana of Inclusa, raised red flags, and rates are getting tighter and tighter. As a provider, compensation was based on rates from before these changes. Revenue has been cut now. Clients suffer as a result.
        - Bill: Happy to follow up – we've been having individual conversations with providers to get into the specifics of provider-MCO relationships. We are looking at MCO contract changes going forward. This was not the intention behind minimum fee, and now working through the implementation challenges. The specifics matter here as we look at individual relationships.
    - Robin: Reminds me of when Wisconsin had HMO/managed care expansion. There were provider workgroups convening in person – this might be another opportunity to do something like that. We're faced with a new challenge. We heard from public comments about systems challenges – online systems may not suffice. Maybe we can do more aggressive messaging that a challenge to Medicaid is a challenge to all.

Program Updates: Amanda Dreyer

Medicaid Member Experience Council:

- CMS put out a rule last year requiring states to create a Beneficiary Advisory Council.
- We are looking to stand up a new committee in July.
- Curious to hear ideas to help welcome these individuals – especially since ¼ of MAC membership will need to be these folks!
- Purpose is to center folks with experience: current/former members, or family/caregivers.
- MMEC will have eight ambassadors representing all regions of the state, plus a couple other perspectives.
    - Milwaukee has the highest number of Medicaid members.
    - Menominee county has highest percentage participation per capita.
    - Tribal Nation representative.
- MMEC members can only serve non-consecutive terms, which will be three years.
- Goal is to identify issues, provide insights, and solve problems.
    - Want to help find ways to faster action.
    - Will identify 1-3 initiatives each year that the MMEC collectively decides are priority, and work with CBOs to identify additional members to help us:
        - Discover root causes
        - Identify solutions

    - Continuing to recruit for Menominee County and a Tribal Nation representative.
- Jessica: In working with Ho-Chunk and Menominee tribes, what we've found is that it's hard to ask someone to be the one representative of Tribal Nations. May want to allow more than one, likely a better fit. Send Jessica an email – will be working with Menominee folks June 16th and can share materials to folks who might be a good fit.
    - Amanda: Appreciate the pressure of being a sole voice for a huge diverse group – will not be possible to represent everyone. Could definitely expand this and is also not intended to be exclusive.
    - Jessica: It's not culturally a norm to stand up and say: "you're doing this wrong." Have to welcome feedback and criticism over and over, break down power dynamics.
    - Robin: Could share this information at upcoming meetings – want to see folks step up to participate. Can also pool communities, taking a collective approach to get broader input and share back.
- Dipesh: Name of the group is well-framed. Referring to folks as members implies more ownership than beneficiary. Benefits is a hard framing – it implies something free.
- Bobby: Thinking of a time when convening a group of parents to represent the state. There was a point when they had to recognize – it's a lot of pressure to represent a region, be a voice for lots of folks who rely on them. Cannot discount this pressure. Need to reinforce it's not their responsibility to solve every issue, but just to give voice to the issues. Preparation for Ambassadors will be crucial – handbooks for multiple learning styles, reading levels, etc. And, to support the group: are there ways members of the MAC can support new MMEC ambassadors? Support/contact people? Building relationships is so important with this type of work.
- Amanda: How do we create a structure for this group that represents such a huge, diverse group of Medicaid members? We've been thinking about this a lot and want continued feedback.
    - Bobby: We found that when you're selecting folks who want to share their voice, it's easier to look back at personal stories.
- Allison: I would say only ask/expect members to represent themselves and their own perspectives
- Marguerite: How to engage folks on this group and make them comfortable. Maybe a buddy system – assign MAC buddies to MMEC ambassadors to meet with folks outside of the group, so that at least they see one face they are more comfortable with.

Amanda: We're also thinking about MAC charter. It's old, it's got some wonky language. It may be time for updates. If folks have suggestions, please let us know. Ideally by end of June – we'll bring next draft for review as well.

SPA Updates

The Department of Health Services is getting ready to submit Q2 State Plan Amendments. Allie walked through the State Plan Amendments that DMS will be submitting in Q2: 25-0008-25-0014.

25-0008: 2023 CAA – Pre-Release Services for Incarcerated Youth (CHIP)

Effective January 1, 2025

Provides two types of services for incarcerated youth who are Children's Health Insurance Program (CHIP) members:

- Early and Periodic Screening, Diagnostic and Treatment screenings (EPSDT, also called HealthCheck in Wisconsin) 30 days prior to release and one week (or as soon as practical) after release. Screenings are intended to diagnose and prevent illness early.
- Targeted case management (TCM) services 30 days prior to release and at least 30 days after release. These are services to identify member needs, develop a care plan and clear goals, provide referrals to services, and monitor progress.

25-0009: Suspending Full CHIP Coverage for Incarcerated Youth

Effective January 1, 2025

When a child is incarcerated, their Children's Health Insurance Program (CHIP) benefits will be suspended, rather than terminated. This is the same practice for incarcerated children covered under Medicaid. During incarceration, CHIP coverage is limited to: services received for an inpatient admission at a medical institution and certain screening and targeted case management services before release.

25-0010: Access to Health Insurance as a CHIP Eligibility Condition

Effective February 22, 2025

Allows eligible individuals with access to employer-sponsored insurance to enroll in the Children's Health Insurance Program (CHIP). Having access to employer-sponsored insurance no longer disqualifies individuals from CHIP coverage. The current policy effectively acts as a waiting period because children and pregnant people who are not enrolled in other health insurance are kept from enrolling in BadgerCare Plus. These individuals will be disqualified from CHIP only if they are enrolled in employer sponsored insurance.

CHIP requires states to take reasonable steps to prevent the crowd-out of private health insurance, also known as substitution of coverage. Today, as part of the strategy to prevent crowd-out, people are ineligible for CHIP if they have current access, future access within the next three months, or past access within the previous twelve months to employer-sponsored health insurance.

25-0011: Outpatient Services Related to Inpatient Stays

Effective April 1, 2025

Permits reimbursement of hospital outpatient services provided to a recipient during an inpatient stay at another hospital without restricting reimbursement to the day of admission or discharge. This change allows the outpatient service provider to receive direct reimbursement, improves access to care, and simplifies provider billing processes.

Under previous policy, these outpatient charges would be considered part of the inpatient stay and separate claims would be denied. The hospitals providing the outpatient services would have to work out a separate agreement with the inpatient hospital to receive reimbursement.

25-0012: HMO Exemptions for Sickle Cell and Gene Access Model

Effective April 1, 2025

Members receiving cell and gene therapy and members receiving bone marrow or stem cell transplants will get care through Medicaid fee-for-service, rather than through managed care. May also exclude certain other members from managed care for a short-term basis, as appropriate. These members will receive all Medicaid services on a fee-for-service basis.

No impact to Medicaid eligibility. These members can use any Medicaid-enrolled provider. If a member who is receiving a transplant or sickle cell disease gene therapy is enrolled in an HMO, DHS will disenroll them using existing processes.

Tribal Medicaid members can continue to choose to enroll in an HMO or access Medicaid services through the fee-for-service model. There is no change to the current process for Tribal members.

Wisconsin Medicaid was recently accepted to participate in the new Centers for Medicare and Medicaid Services Cell and Gene Therapy (CGT) Access Model, intended to improve access to therapies for sickle cell disease. Cell and gene therapy is only available as fee-for-service, which is why these members are now excluded from HMOs. The CGT Access Model will provide new resources to members receiving CGT: education, peer-counseling, health-related social needs screening, clinical navigators, and non-emergency medical transportation (NEMT) rides, including same-day rides for vaso-occlusive crises.

25-0013: Child Care Coordination Managed Care Carve-in
Effective July 1, 2025

Provides Child Care Coordination (CCC) through BadgerCare Plus and SSI managed care for members who are enrolled in the HMO and eligible for this service. CCC providers will be required to contract with HMOs, and members will seek care from providers enrolled with their HMO. CCC services are available to members who reside in the City of Racine and in Milwaukee County.
Previously, CCC was available as fee-for-service.

Updates HMO requirements to provide dental services in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties. Makes non-substantive changes to align the list of carved out services with other sources.

25-0014: School-Based Services Expansion
Effective July 1, 2025

Expands reimbursement for medically necessary health care services provided at school to Medicaid-enrolled students:

1. To include additional types of care plans that document medical necessity
2. To allow more school-based service types, including physician services, dental services, and case management services.

Students with Medicaid coverage receive a variety of health care services in school. These health services are considered school-based services when provided by school staff, like a school nurse or counselor. Currently, Medicaid reimburses for a range of school-based services provided only to Medicaid-enrolled students who have an Individualized Education Plan (IEP) that documents the specific service.
Some health care services are provided in a school setting by federally qualified health centers (FQHC). For Tribal FQHCs, services provided in schools are paid through the all-inclusive rate.
Allowed through Centers for Medicaid and Medicaid Services guidance, 2023.

Q1 SPAs have been submitted with the exception of 25-0002 Family Care Partnership. 25-0001 and 25-0007 have been approved. The expectation is that the rest will be approved by the end of June unless for some reason CMS needs to stop the clock for some reason.

- Allison: What is the normal timeline for SPA approval?
    - Allie: Typically, 90 days. If CMS requests additional information formally, this would pause that timeline. We have not received a request for additional information on any of these SPAs.

<u>Interagency Council on Mental Health Overview:</u>
Karen Odegaard and Angela Miller
1 in 4 Wisconsin Adults report anxiety or depression. Nearly 50% have not received treatment. Over 10% of adults with mental illness are uninsured. In 2022 929 Wisconsinites died by suicide. As many as 135 other individuals are affected by every one suicide.

59% of HS students report one mental health challenge in the past year. 1 in 5 students who felt sad, empty, hopeless, angry, or anxious said they received the help they needed most of the time or always. Nearly 9% have attempted suicide. 78% reported that counseling helped.

The Governor directed agencies to collaborate to reduce barriers and address gaps in mental health. Our task is to create a statewide plan that will create healthy communities and connect Wisconsinites to care. We are taking a whole-of-government approach to this work. The issue cuts across nearly all our state agencies. The council has created 2 workgroups.

- Strong Foundation workgroup is focused on how agencies can foster a culture and environment that promotes mental wellness
- Coordinated Response workgroup is focused on how agencies can help ensure that when a person or loved one needs help, they get the care they need no matter their mental health symptoms on which door they come through.

We have a survey open until June that we would love for you to share. www.dhs.wisconsin.gov/icmh/index.htm

Discussion:
Question: What does it mean to you to have a strong foundation for mental wellness? What do you need to attain and maintain mental wellness?

Jessica: Navigating systems can be difficult. Specifically talking about children, legislatively there is not a lot of support. Mental wellness is not protected like healthcare. We do not protect mental health the same way we do healthcare. We as providers are stuck if the caregivers do not agree that treatment is needed. Medication is covered by Medicaid once patients get into see a psychiatry provider. Primary care does the best they can. It takes up to a year for a child to get in to see a psychiatrist.

Bobby: A foundation of this is reflected in our clients. A lot of this is run through the County. The DHS1 ability to pay interview is an important part of this. Reviewing those procedures is important and foundational. Make sure the coverage is identified and looking ahead. We have developed some tools that boil it down to about 15 questions.

Randi: It is a coverage issue on the children's side. You must have some form of Medicaid. We have some who don't qualify, and some can only get access by joining CLTS, when what they really need is CCS but we have no choice but to enroll then in CLTS. We have some parents whose cost share is over $700.00 per month to have home and community-based waivers because things are all being counted as child income. As a result, they can't afford the cost share.

Jessica: Mental Health should be the same conversation as your health care. We need to get to a space where mental health and physical health are all one consideration as well being.

Jessica: As a County, we write off way more than we should need to for psych appts.

Kelly Carter: Access to immediate assistance or emergency services whether its counseling, intervention or respite services is key to maintaining mental wellness.

Question: What have you seen has worked well, what barriers do you see, and how do we ensure access to affordable, accessible, and timely care?

Jessica: Adams Count and Monroe County: Things are completely separate. We have CCS representatives invited to every meeting. Encouraging that and having better reimbursement would help.

Laura: when I did practice, I had a large percentage of Medicaid members come to me and I spent a lot of time doing case management because just trying to navigate the system is so challenging. We need to make it more accessible earlier. Not just when someone is in a mental health crisis. A lot of time private practice won't accept Medicaid for that reason. WI has done a good job at improving reimbursement. If there were access to navigators to help navigate the system and sort through the different benefits, I think that would help. So, we know where to steer someone.

Next Steps: Share any additional thoughts with us by filing out the Interagency Council on Mental Health survey www.dhs.wisconsin.gov/icmh/index.htm . Your insights will inform the recommendations included in the Interagency Council on Mental Health statewide action plan and will be shared with the teams within our department.

Suggested topics for Future meetings: No suggestions were made.

2025 Medicaid Advisory Committee meetings: March 11, June 3, September 9, December 9

Adjourn

- A motion to adjourn was not obtained. The meeting concluded at 11:30 am central time.

Prepared by: Allie Merfeld and Gina Andearson on 6/3/2025.

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