**MAC Meeting Notes May 26, 2021**

Quorum achieved.

**Attending**: Ritu Bhatnagar, Allison Espeseth, Rebecca Fox, Dave Gundersen, Veronica Gunn, Lauren Jerzak, Joshua Merskey, Dipesh Navasaria, Bobby Peterson, John Rathman, Randy Samuelson, Mike Wallace, Luisana Waukau, Jennifer Winter

**Members Absent**: Samantha Falk, Laura Waldvogel

**Others Present**: Jim Jones, Curtis Cunningham, Gina Anderson, Emily Loman, Jasmine Bowen, Leah Ramirez, Betsy Gentz

**Meeting Called to Order, Dr. Veronica Gunn, Chairperson**

- Roll was called; 14 members were present, constituting a quorum.
- The agenda was reviewed.
- Minutes from the 2/24/21 meeting were approved. Motion Josh Merskey, Mike Wallace 2nd. No opposed, no abstentions.

**DMS Quality Strategy Input, Curtis Cunningham, Assistant Administrator**

Reviewed four priority areas for feedback – infant mortality, lead poisoning, high blood pressure and ED visits for behavioral health. Committee members were asked to provide thoughts on potential interventions, outcome measures and/or levers to enable improvement. Summaries of comments are below with staff responses and links shared in the chat feature indented.

<u>Infant Mortality</u>

- What is the infant mortality rate for Native Americans?
    - Information on IMR for Native Americans is available at: 2019 DPH Annual Birth and Infant Mortality Report https://www.dhs.wisconsin.gov/publications/p01161-19.pdf
- Would a dental metric be appropriate for birth rate measure? Had a patient with severe periodontal disease who had premature birth. Are you looking for scientific foundations for metrics, systems, policy levers?
- What was the process to arriving at these activities? Fishbone diagram? Infant mortality care coordination is exceedingly different depending on who is doing it. Phone call vs picking up mom, taking her to appt, following up.
    - The process involved peer-reviewed literature review, went to other states to discuss logic models
- What is the experience of the people receiving the service, e.g. (slide 8) *gives birth in a trusted environment*? Hard to measure, but we can ask people about their experience – receiving fragmented care? Strong relational health perspective is important to change behavior. Care delivery and payment model. Make this number move vs improve experience.
- What is the 75th percentile comparator, MA managed care clients to general public or MA recipients?
    - HEDIS measure, compares MA HMO enrollees state to national
- Is the intent to develop smart goals? Any coordination with state public health planning? Information database might be important to get.

    - Yes, iterative process of establishing interventions, SWOT analysis, with intent to plan with public health.
- The process of birth cost recovery. MA child support program to pursue birth parents for cost of birth – stressful for parents to prove, WI has disparate impact on Blacks. Process should be elevated for review. Money maker for child support office so they don't have to use GPR. Governor had put in budget to eliminate. Should be addressed somewhere to acknowledge prenatal stress. Most states don't pursue this, but WI leads the country in recovery.
    - Information on the "birth tax" was provided in the chat: www.safetyweb.org/healthwatchwi/birth-tax.html
- Need to acknowledge the inherent bias of literature that is informing these logic models. Historically, our peer-reviewed literature has reflected biased beliefs/hypotheses on what causes poor birth outcomes. Use our own WI data to understand disparate outcomes to address those modifiable factors.

Lead Poisoning

- Who initiates testing? Can be through public health or PCP office, and there's a system that gathers the lead testing info. Is there a central repository for state? There are also community resources.
    - Link shared in chat: https://tamararubin.com/
- Older kids are less likely to get tested.
- There are a number of children not being tested. Logic model doesn't seem to include that element. Complex interplay – families who are less likely to be tested or present for care often live in areas with higher risk of lead exposure.
- Post-natal doula can follow the birth of child to ensure they meet developmental milestones, and get tested for lead. Families can get support for 6-9 months.
- Is there a metric that can be used to understand where they're getting tested so we know who is providing testing?

High blood pressure

- We are missing the reality of people we're working with. You can educate but if you don't address the issues that are causing the stress, then education is patronizing. Levers: care coordination – people need to get food, getting whole foods, instructions on preparing healthy foods. Response: you don't qualify for all those home care programs. Hard to follow a diet they can't access – leads to distrust of provider. Perhaps there is a role for care coordinators?
    - Community health workers can help members navigate the system.
- This applies to all measures: what is the role of continuous coverage? Is it assumed?
- Can you measure food deserts? Measure access to healthy food options?
- Will we promote local systems? Logic models seem very global. Community-based strategies are important.
    - The Division would be interested in this. We are agnostic to a specific model; want to learn more about models that address social determinants of health (SDoH).

ED visits for behavioral health needs

- MA has levers at statewide level regarding follow-up from hospital discharge. HMOs and hospitals claim they have a wide network of providers, but it can be inaccurate e.g., list outpatient providers as inpatient, or providers who are not taking new patients. We then have to send people far away for services. Make sure list of providers is local and accurate for f/u after hospital.
- Substance Use Disorder is a top reason for readmission because people have nowhere to go. People cannot afford residential services. People fail multiple times before the county will step in. People can die if they cannot get care. The Residential Substance Use Disorder (RSUD) benefit started in March and DMS is closely monitoring the services being provided, including to whom, how many individuals receive the services, etc.
- Is alcohol and other drug abuse (AODA) included in this category of "Behavioral Health?"
    - Yes.
- There is a lack of clarity in health benefits management service. People don't know what their coverage is and get into trouble. There are opportunities to align coverage to reduce stress on members; can do this by building skills of existing benefits personnel.
- Is urgent care for mental health an option? How can we create these options to prevent ED use, de-escalate crisis, have better conversations and avoid the stigma of going to hospital? Especially in communities of color, youth.
- There should be continuity of care between BH and medical health homes. Marketplace coverage from Medicaid. Proactive planning coordinating with family care to prevent crisis programs county. Opportunity for HMOs to coordinate.
- We have an opportunity to prevent the need for crisis care; opportunities to support resilience among children and youth. Validated models. Coordinate amongst ALL governmental models.
- How can we coordinate prevention across public health and, state level planning entities? How can we link efforts across state programs?
- Is polypharmacy overdose considered in these measures, or just opioid related deaths? There is no single substance overdose. Should look beyond just opioids. How long does it take for people to get into services after they call? People lose interest or spiral downward if they can't get in. It would be helpful to track the length of time between intake and receipt of counseling services – it could be weeks and months.
- Note that even with the RSUD benefit, Room and Board is not covered so not affordable for most.
    - There is something in the budget to support room and board.
- Will you work to coordinate efforts with public health?
    - We will re-engage with DPH after pandemic.

**Medicaid Managed Care Quality Strategy Input, Jasmine Bowen, Quality Assurance Program Specialist**

MAC members were invited to share insights and comments on performance measures and continuous quality improvement mechanisms within the Managed Care Quality Strategy. Summaries of comments are below with staff responses indented.

- Are the strategies listed in a prioritized order?
    - No.
- What feedback was received during the public comment period?

    - Received a lot of feedback from providers. Feedback broad in scope. DMS should strengthen partnerships with providers. Some specific measure suggestions.
- This strategy is valuable because it sets managed care's goals for us in the next 2 years.
- Member-centered strategy is a key element for clients who are looking for better engagement. Helps with engagement strategies for low-income people. Noted in the Churn report by DMS staff. Helps people manage their benefits. Access to quality care for kids – health check is still very misunderstood by providers.
- The strategy supports case managers to better engage members and get them better outcomes.
- People want health care not health insurance. Mechanics should not get in the way of health care. Make the mechanics of the health care delivery system invisible.
- Members do not necessarily care about performance measures as they are listed, they care about the experience. Providers don't want to recommend a particular HMO because of real or perceived conflicts of interest, but there are some that are better than others. People don't care about performance measures. Engaging with members and community – make it centered on and meaningful to members and community leaders. Ask people what's important to their health. Access is more important than quality when it comes to Behavioral health.
- Regarding justice/equity, HMOs should get an overall score and then broken down by demographic groups (race, ethnicity, etc).
- Regarding quality, efforts to reduce health disparities will impact every other strategy, i.e., equity and quality are the same.
- How does the managed care plan support the whole health of the person? Beneficiaries should be allowed to state what's important to them.
- What is outward facing to help people engage in a particular plan? This seems much more operational/internal facing.
    - HMO/MCO scorecards with star ratings are more accessible to members.
- Regarding equity, are scorecards reflecting equity as process, or outcome or both?
    - Outcomes. Population stratification to look at disparities to identify evidence-based interventions. We expect to see better outcomes. Raise ALL boats.
- Will the approach include intersection analysis of factors impacting equity at level of measurement?
    - Yes. We want to take out the emotion of the discussion of race and ethnicity. Could be rural/urban, sexual orientation, disability. Setting up data infrastructure to address disparities. JEDI – justice, equity, diversity, and inclusion.
- How do you operationalize all of this? How do you break down silos in care delivery? How do you engage MA members to access the services that are being measured? Take the show on the road to ask community leaders what matters to address SDoH. Prevention, wellness, detection more than heads in bed.
- Who are the community leaders we're trying to engage because every community is unique, e.g., Moms doing support groups, etc.
- Scorecards have a role for things that are not obvious, but they're easy to game, based on how you talk about things. Ultimately, it comes down to the experience.

**Medicaid Housing Initiative**

- Due to the lengthy discussion and feedback from MAC members on the quality strategies, this agenda item was tabled until a subsequent meeting.

**Receive Public Comment on Medicaid Quality Strategy**

- No members of the public joined the meeting to offer comments.

**Biennial budget Update, Jim Jones, Director**

Director Jones highlighted a number of items in the Governor's budget currently under review by the Joint Finance Committee.

- Twelve-month post-partum coverage
- Mid-level psycho social rehabilitation benefit
- Community health workers, community health benefit to allow community programs to address SDoH, and room and board for RSUD.
- Hub and Spoke program aimed at SUD – treats ALL SUDs not just opioid. 3 pilot sites across the state.
- The Tribal Shared Savings initiative proposed by Governor Evers was included in the final biennial budget act. DMS is now working towards implementation.
- .Link to the Governor's budget fact sheet: https://www.dhs.wisconsin.gov/budget/index.htm

**Wrap-up, Dr. Veronica Gunn, Chairperson**

- Next meeting is August 25. Topic is equity. Will follow with an email with links

**Adjourn**

- There was no formal motion to adjourn. The meeting concluded at 11:30 am central time.