Mid-Point Assessment of the Substance Use Disorder Treatment Provision

FOR
WISCONSIN'S BADGERCARE REFORM
CMS 1115 DEMONSTRATION WAIVER FOR 2019–2023

Submitted to the
Wisconsin Department of Health Services
Division of Medicaid Services

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Institute for Research on Poverty
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LIST OF EXHIBITS

LIST OF ACRONYMS

AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
CMS	Center for Medicare and Medicaid Services
DCTS	DHS Division of Care and Treatment Services
DHS	WI Department of Health Services
DMS	DHS Division of Medicaid Services
DQA	DHS Division of Quality Assurance
DSPS	Department of Safety and Professional Services
ED	Emergency Department
IMD	Institutions for Mental Diseases
MAT	Medication Assisted Treatment
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
QTTs	Qualified Treatment Trainees
STC	Standard Terms and Conditions
SU	Substance Use
SUD	Substance Use Disorder

BACKGROUND

Demonstration Waiver Information

The Medicaid program in Wisconsin historically covered an array of treatment options for members with substance use disorders (SUDs) including outpatient counseling, day treatment, psychosocial rehabilitation, medication-assisted treatment (MAT), and inpatient treatment. Yet, some gaps remained in the availability of clinically appropriate, evidence-based SUD treatment which was the motivation behind using Wisconsin's Section 1115 BadgerCare Reform Demonstration Waiver to expand coverage for the continuum of SUD treatment.

While several providers across the state have offered residential substance use treatment, it represented a gap in the Wisconsin Medicaid plan of reimbursable benefits. Wisconsin's 1115 BadgerCare waiver closes the gap by authorizing federal funding for treatment provided to Medicaid members in Institutions for Mental Diseases (IMD). While IMDs include hospitals and other facilities with 16 or more beds that provide mental health treatment, they also include facilities that offered nearly two-thirds of all SU residential treatment capacity throughout Wisconsin prior to the BadgerCare waiver provision. Thus, the federal restriction on the use of Medicaid funds for treatment in IMDs was a significant barrier to access substance use (SU) residential treatment for Medicaid members and to the possible expansion of residential treatment capacity.

Exhibit 1: Overview of Wisconsin's Substance Use Disorder Demonstration Waiver

Demonstration Name:	Wisconsin BadgerCare Reform 1115 Demonstration Waiver
Demonstration Waiver Period:	October 31, 2018–December 31, 2023
Substance Use Disorder Implementation Protocol Approval:	October 22, 2019
Start of Substance Use Residential Treatment Medicaid Coverage:	February 1, 2021 (originally February 1, 2020)
Substance Use Disorder Monitoring Protocol Approval:	June 21, 2021 (updated approval from October 26, 2020)
Critical Monitoring Metrics Measurement Period for Mid-point Assessment:	2021–2022

The approved demonstration waiver period—October 31, 2018, to December 31, 2023 (**Exhibit 1**)—and the COVID pandemic had significant impacts on the implementation timeline for the SU residential treatment benefit. The original implementation start date for Medicaid coverage of the residential benefit was February 1, 2020, but the DMS decided to delay implementation because of a variety of provider concerns. Most prominently, a planned HMO carve-in of the benefit concerned providers, but the planned coverage policy including reimbursement and prior authorization were also concerns. In January 2020, DMS announced a decision to delay the benefit roll-out (ForwardHealth Update 2020-05[1]) to conduct more research and engage in stakeholder outreach. COVID created a further delay for the state implementation team and for residential providers who experienced unique challenges in incorporating COVID precautions into residential models of care.

[1] ForwardHealth Update 2020-05: Implementation of the New ForwardHealth Residential Facility Substance Use Disorder Treatment Benefit Will Be Delayed. https://www.forwardhealth.wi.gov/kw/pdf/2020-05.pdf.

The Medicaid coverage start date was delayed one year to February 1, 2021. The Wisconsin Department of Health Services (DHS) also adjusted the period of measurement for the critical monitoring metrics in the SU Implementation Monitoring Protocol. Despite 2020 being the first year in the pre-implementation period for the residential benefit, the impact of COVID on treatment facilities enrollments and discharges made it an unrepresentative baseline measurement year. Thus, the Wisconsin DHS started reporting on the critical monitoring metrics in 2021 and the comparison years available for this report are 2021 versus 2022.

While the process of implementing a new statewide Medicaid benefit is extensive, two initiatives were particularly critical and are noted throughout this report. First, the Wisconsin DHS updated its Administrative Code § DHS 75 which defines the standards for providing substance use treatment. In addition to updates for residential treatment, standards were updated for the entire continuum of substance use disorder services in Wisconsin through a process that began in 2018. This process culminated in a new administrative code, published in October 2021. Second, the DHS published a ForwardHealth update #2020-42 in December 2020 which was the official Medicaid policy announcement on coverage, prior authorization, claims submission, and reimbursement for the substance use residential treatment benefit.

Wisconsin State Agency Collaboration Needed for Implementation

The state governmental agencies below are collaborating to implement the substance use residential treatment benefit in Wisconsin and are referenced throughout this report.

- The DHS Division of Medicaid Services (DMS)
  - DMS is the state Medicaid agency. The DMS applied for the demonstration waiver and is responsible for the oversight of its implementation.
- The DHS Division of Care and Treatment Services (DCTS)
  - DCTS is the Wisconsin state substance use authority and is responsible for setting provider qualification requirements and practice standards for residential and other types of substance use treatment. The DCTS was the lead agency updating Wisconsin Administrative Code § DHS 75, which sets standards for the delivery of substance use treatment, with the latest evidence-based practices including the American Society of Addiction Medicine (ASAM) placement criteria. The DMS was a consulting partner on the administrative rule revision. The updated treatment standards are a critical component of Wisconsin's Implementation Protocol for the SU residential treatment benefit.
- The DHS Division of Quality Assurance (DQA)
  - DQA is responsible for the review and certification of substance use treatment agencies in Wisconsin.
- The Department of Safety and Professional Services (DSPS)
  - DSPS is a parallel agency to DHS and is responsible for testing and licensing individuals to provide substance use treatment in Wisconsin. DSPS also hosts the Prescription Drug Monitoring Program (PDMP) application for monitoring physicians' prescriptions of opioids and other drugs.

Description of the Demonstration's Policy Goals

In accordance with Standard Terms and Conditions (STC) in Wisconsin's SUD demonstration waiver, the SU Implementation Protocol (or plan) describes the strategic approach and project plan to meet required milestones for SUD treatment reform in Wisconsin. The SU Implementation Protocol is Wisconsin's plan to implement the new Medicaid coverage of the SU residential benefit, but also to continue improving the entire state SU service delivery system beyond just the residential treatment benefit. The federal Center for Medicare and Medicaid Services (CMS) has set six milestones that each demonstration state must use to design and assess its SU Implementation Protocol. The six milestones listed below are used to evaluate Wisconsin's implementation progress in this report:

1. Access to critical levels of care for OUD and other SUDs;

2. Widespread use of evidence-based, SUD-specific patient placement criteria;

3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;

4. Sufficient provider capacity at each level of care, including MAT;

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and

6. Improved care coordination and transitions between levels of care.

Within this framework, Wisconsin Medicaid has also developed more specific goals for SUD treatment reform which include:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs;

2. Increased adherence to and retention in treatment for OUD and other SUDs;

3. Reductions in overdose deaths, particularly those due to opioids;

4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;

5. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUD; and

6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

The required six milestones are associated with CMS-required critical metrics which are designed as indicators of progress for each milestone. The milestones and critical metrics provide the federally required framework for assessing states' progress in this Midpoint Assessment Report.

METHODOLOGY

The evaluation framework for the SU Midpoint Assessment Report is specified in Version 1.0 of the "CMS Mid-Point Assessment Technical Assistance Manual." The following methodological guidelines have been applied to this report.

Data Sources

Critical Metrics – For each demonstration milestone, CMS has identified a subset of critical monitoring metrics that the state must include in its mid-point assessment. Collectively, the critical metrics: (1) have clear directionality and are CMS-required demonstration monitoring metrics, (2) have direct alignment with demonstration milestones, and (3) are most directly responsive to demonstration activities. The definition of the critical metrics is prescribed in Version 4.0 of the "CMS Manual for Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics." The Wisconsin SU Monitoring Protocol is the approved list of these indicators that DMS reports to CMS quarterly and annually which have also been used to inform this Midpoint Assessment Report.

Other Monitoring Metrics – The state may choose to describe performance on other monitoring metrics not included in the critical metrics list, but included in its approved monitoring protocol, to provide additional information about its progress towards each demonstration milestone. These metrics are defined by CMS but are considered optional for state reporting depending on their match with a state's implementation goals. These "other" metrics are also part of Wisconsin's regular reporting to CMS using its SU Monitoring Protocol.

Implementation Plan Action Items – Wisconsin's SU Implementation Protocol outlines multiple action items associated with each milestone. These are the necessary activities to create policy, expand coverage, add benefits, etc., to progress towards the completion of each milestone. Each milestone and associated implementation activities are described in each section of this report and assessed for the status of their progress within the demonstration period.

Qualitative Interviews with Key Stakeholders – Informal qualitative interviews were conducted with key stakeholders from state agencies participating in the demonstration waiver efforts. The qualitative data is used primarily in the assessment of progress on the SU Implementation Protocol goals and activities.

State Policy and Procedural Documentation – Correspondence, formal policy memos, state administrative rules, procedural forms, and other relevant documentation were used to describe demonstration activities and provide context for state progress or challenges in implementation.

Analytic Methods

The critical and other metrics are reported for the baseline and midpoint periods. The periods are typically calendar year 2021 and calendar year 2022 with some exceptions. Each set of time periods is specified under each table of metrics. Percent change from baseline to midpoint is reported for each metric to assess progress. In its SU Monitoring Protocol, the state has set a progress goal for each indicator to be "increased," "decreased," or "consistent" if no change is expected. The percent change calculations are used to assess whether metrics actually "increased," "decreased," or were "consistent" with the baseline metric value. Progress is considered any movement toward the state's overall demonstration target.

The SU Implementation Protocol action items are assessed primarily with qualitative information as “completed,” “open,” or “suspended/delayed.” An open item is an implementation activity that is still in progress.

Assessment of Overall Risk of Not Meeting Milestones

A final assessment of the risk of not meeting a milestone is required using all the combined analyses of progress on metrics and the state’s implementation activities. Risk assessment is only required for each overall milestone rather than the individual metrics or implementation activities within each milestone. The following risk assessment categories and methodology per CMS guidance were used:

Low Risk – For all or nearly all critical metrics (e.g., 75 percent or more), the state is moving in the direction expected according to its annual goals and overall demonstration targets. The state has fully completed most/all associated action items as scheduled to date. Few stakeholders identified risks related to meeting the milestone, and the risks identified can easily be addressed within the planned timeframe. If the state decides to submit availability assessment data, the state is moving in the expected direction for all or nearly all (e.g., 75 percent or more) of the data.

Medium Risk – The state is moving in the expected direction relative to its annual goals and overall demonstration targets for some (e.g., 25-75 percent) of the critical metrics and additional monitoring metrics that the state reported for additional context. The state fully completed some of the associated action items as scheduled. Multiple stakeholders identified risks that could cause challenges in meeting the milestone. If the state decides to submit availability assessment data, the state is moving in the expected direction for some (e.g., 25-75 percent) of the data.

High Risk – The state is moving in the expected direction relative to its annual goals and overall demonstration targets for few (e.g., less than 25 percent) of the critical metrics and additional monitoring metrics that the state reported for additional context. The state fully completed few or none of the associated action items as scheduled. Stakeholders identified significant risks to meeting the milestone. If the state decides to submit availability assessment data, the state is moving in the expected direction for few (e.g., less than 25 percent) of the data.

Limitations

Due to a late start to the SU Midpoint Assessment, time and resources for collecting input from providers and Medicaid members through interviews or surveys was not available. Provider feedback may have been helpful in assessing all of the six milestones, but especially the milestone to assess provider capacity in the state. Member feedback may have also provided helpful input on access to different SU services in the state array.

MILESTONE 1 PROGRESS: ACCESS TO CRITICAL LEVELS OF CARE FOR OUD AND OTHER SUDS

Milestone 1 requires states to improve access to OUD and SUD treatment services for Medicaid beneficiaries. States must offer a range of services at varying levels of intensity across a continuum of care to address the needs of beneficiaries. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient services
- Intensive outpatient services
- Medication assisted treatment (MAT)
- Residential treatment services
- Inpatient services
- Medically supervised withdrawal management.

Wisconsin's demonstration waiver and implementation plan (**Exhibit 2**) primarily focus on filling the gap in Medicaid coverage for SU residential treatment provided in IMD's. The other SU services are already included in the Wisconsin Medicaid State Plan, but Wisconsin is expected to maintain its full array of SU services while filling the residential treatment coverage gap and improve access and coverage to other services whenever possible.

Implementation of Coverage for SU Residential Treatment

The initial goal in Wisconsin's demonstration waiver STCs was to implement the new residential treatment benefit for OUDs and other SUDs within 12-24 months of waiver approval. October 31 of 2020 represented the end of the first 24 months after the waiver was approved. The new Medicaid coverage was initially scheduled to begin February 1, 2020, but was delayed one year to afford residential treatment providers preparation time to implement the new service. Wisconsin's new Medicaid coverage for the SU residential treatment benefit officially began on February 1, 2021.

The Wis. Admin. Code § DHS 75 administrative rule[2] sets standards for the delivery of substance use treatment and was re-written between 2018-2021 to include updated standards of treatment and the latest evidence-based practices. Updates were incorporated for both transitional residential treatment in DHS 75.53 and medically monitored residential treatment established in DHS 75.54 (**Exhibit 3**). Prior to the administrative rule update, the two levels of residential treatment were based on ASAM levels of care, but not explicitly matched to them. Wisconsin's definitions in administrative code for transitional residential and medically

[2]Wisconsin Administrative Code § Chapter DHS 75 for community substance use service standards. https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75/

Exhibit 2: Milestone 1 Implementation Plan Activity Status

Level of Care – Future State Implementation Goal	Actions Needed	Target Completion Date	Status
Outpatient Services – Continued monitoring of services and expenditures.	No immediate action necessary. Will review coverage policies following implementation of residential benefit and update to State regulations.	Not applicable	Completed
Intensive Outpatient Services – Continued monitoring of services and expenditures.	No immediate action. Will review coverage policies following implementation of residential benefit and update to State regulations.	Not applicable	Completed
Medication Assisted Treatment – Continued monitoring of services and expenditures.	No immediate action. Will review coverage policies following implementation of residential benefit and update to State regulations.	Not applicable	Completed
Residential Treatment Services – Implement a new SU residential treatment benefit.	Wisconsin Medicaid will establish coverage and reimbursement policies aligned with ASAM criteria and state regulations, including, but not limited to, eligible provider criteria; medical necessity criteria; claims submission and reimbursement guidelines; and utilization management.	February 2020	Completed
	Wisconsin's new benefit will cover two types of treatment: transitional residential programs and medically monitored treatment services.	February 2020	Completed
Inpatient Services – Expanded coverage to include any previously excluded IMD providers.	Wisconsin Medicaid will provide coverage and reimbursement policy guidance to any facilities previously excluded from providing treatment due to categorization as an IMD.	November 2020	Open
Medically Supervised Withdrawal Management – Expanded coverage to include any previously excluded IMD providers.	Wisconsin Medicaid will provide coverage and reimbursement policy guidance to any facilities previously excluded from providing treatment due to categorization as an IMD.	November 2020	Open

monitored residential are now tied directly to the ASAM (Third Edition[3]) levels of care 3.1 and 3.5, respectively,[4] as listed below:

- ASAM Level of Care 3.1 - Clinically Managed Low-intensity Residential 24-hour structure with available trained personnel; at least 5 hours of clinical service/week

- ASAM Level of Care 3.5 - Clinically Managed High-intensity Residential 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment; able to tolerate and use full active milieu or therapeutic community.

Exhibit 3: Wisconsin Administrative Rule Updates for Residential Treatment

DHS 75.53 - Transitional Residential Treatment Service
In this section, "transitional residential treatment service" means a residential substance use treatment service totaling 6 or more hours of treatment services per patient per week, in which substance use treatment personnel provide assessment and treatment for substance use disorders in a structured and recovery-supportive 24-hour residential setting.

DHS 75.54 - Medically Monitored Residential Treatment Service
In this section, "medically monitored residential treatment service" means a residential substance use treatment service totaling 20 or more hours of treatment services per patient per week, in which substance use and mental health treatment personnel provide assessment and treatment for substance use disorders and co-occurring mental health disorders, under the oversight of a medical director.

The Wisconsin SU Implementation Protocol also calls for the establishment of a full set of benefit policies aligned with ASAM criteria including eligible provider criteria, medical necessity criteria, claims submission and reimbursement, and utilization management. Wisconsin Medicaid policy for the new SU residential treatment benefit on these items was established in a formal policy memo (ForwardHealth Update #2020-42)[5] in December 2020 just before coverage for the residential treatment benefit began in February 2021. At the time the Medicaid residential SUD treatment benefit launched, revisions to DHS 75 were still in progress. Ultimately, the DHS 75 administrative rule was published in October 2021 and took effect in October 2022. Anticipating that DHS 75 would more closely align treatment standards with ASAM, Medicaid coverage policy used ASAM standards to set requirements for treatment hours, assessment criteria for placements, and clinical documentation. While the Wisconsin administrative rule sets standards for providers, the ForwardHealth Update #2020-42 sets firm requirements for providers on the delivery of residential treatment for substance use disorders if Medicaid funds are used.

For example, the DMS policy update explains the IMD waiver by clarifying that members residing in a facility for the sole purpose of SUD treatment are not considered to be residing in a medical institution, even if the benefit is delivered at an IMD. The DMS set new reimbursement rates on a per diem basis and has made them available through their ForwardHealth portal for

[3] The ASAM fourth edition was released October 15, 2023, after Wisconsin's update to its state administrative rule.

[4] Revised Wis. Admin. Code chapter DHS 75 Implementation: Levels of Care (webinar presentation). https://www.dhs.wisconsin.gov/rules/dhs75-session-2.pdf

[5] ForwardHealth Update 2020-42: New Benefit for Residential Substance Use Disorder Treatment. https://www.forwardhealth.wi.gov/kw/pdf/2020-42.pdf.

providers.[6] To submit claims, the update describes the required institutional claim form, the Healthcare Common Procedure Coding System (HCPCS) procedure codes and required modifiers, and optional modifiers that could be used to describe clinical complexity. In addition to these Medicaid policies, policies on assessments and utilization management/prior authorization were established in the ForwardHealth Update 2020-42 and are discussed in the Milestone 2 section of this report.

Expansion and Improvement of Coverage for Other SU Services

The DMS plans to implement policies to expand inpatient and medically supervised withdrawal management services by setting Medicaid coverage and reimbursement policies for IMDs that are providing these services. The formal policies have not yet been established for IMDs, but the DMS is currently working towards this goal. The DHS previously submitted a budget request for State legislative approval to create a new benefit for outpatient withdrawal management services. The request was not approved, but the DMS may submit another request for the next budget cycle. In addition, the DMS is currently preparing an application for a mental health treatment IMD waiver due January 1, 2025. The waiver would allow Medicaid reimbursement for mental health inpatient services and DMS will seek input from CMS on coordinating the SUD waiver with the SMI/SED IMD waiver.

Wisconsin's SU Implementation Protocol includes monitoring the coverage policies for opportunities to expand or improve. DMS has been actively working to align and expand SU services to match the updated DHS 75 administrative code standards, and to enhance parity between mental health and SU treatment. The following Medicaid coverage projects related to the DHS 75 updates have been completed, are in progress, or are in the DMS's queue for implementation plans:

- SU treatment reimbursement rates have been aligned with mental health treatment reimbursement rates to be equitable across similar professional levels.
- Coverage for point-of-care drug testing in outpatient and day treatment levels of care has been implemented.
- Coverage for pregnancy testing for opioid treatment programs has been implemented.
- Currently, the DMS is developing a coverage policy for an integrated intensive outpatient service that will add a missing level of care between current outpatient and day treatment benefits. The service would be for mental health, SU, or co-occurring needs and is planned to be implemented in early 2025.
- Planned future coverage projects will allow concurrent services at more than one level of care, add continuing care services, and add withdrawal management services outside of hospital settings in order to further align these services with the DHS 75 administrative code updates.

[6]Residential SUD Treatment Rate Schedule, ForwardHealth Portal. https://www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/ResidentSUDTreatment/resources_84.htm.spage.

COVID-19 and Other Influences on Progress

Several factors influenced a delay in the start of Medicaid coverage for the SU residential treatment benefit. It was initially scheduled to begin in February 2020, but was delayed due to provider concerns, then further delayed by the COVID-19 pandemic. Residential and other similar treatment facilities were severely impacted by their adaptations to a safe residence and in-person treatment services. The Wisconsin DHS was also severely impacted by adapting to COVID-19 safe work environment and virtual work arrangements. Thus, neither residential treatment providers nor the Wisconsin DHS could prioritize implementing the SU residential treatment. Medicaid coverage was delayed one year to February 2021. A November 2020 initiative to update policy guidance for the provision of medically supervised withdrawal management services in an IMD was also put on hold due to the COVID-19 pandemic.

Critical Metrics Progress

Increases in utilization were seen for all individual types of SU services (Exhibit 4), in line with the state's demonstration target. The overall increase in beneficiaries receiving any type of SUD treatment (Metric # 6) was 7.7% by the mid-point. Given that Wisconsin's demonstration waiver allows Medicaid reimbursement for SU residential treatment in IMD's, monitoring Metric #10 for changes in the utilization of residential and inpatient services is a priority. Medicaid claims data analyses reveal that Wisconsin's goal of increasing SU residential and inpatient utilization for Medicaid beneficiaries is being met at the mid-point assessment with an 11.6% increase. Also notable is an 18% increase in members receiving pharmacotherapy for OUD for at least 180 days of continuous treatment (Metric #22).

Exhibit 4: Milestone 1 Progress on Critical Metrics

		Monitoring Metric Rate or Count				
Metric #	Metric Name	At Baseline[a]	At Mid-Point[b]	Percent Change	State's Demonstration Target	Direction at Mid-Point
6	Any SUD Treatment	25,393	27,357	7.7%	Increase	Increase
7	Early Intervention	17	23	35.3%	Increase	Increase
8	Outpatient Services	18,522	19,935	7.6%	Increase	Increase
9	Intensive Outpatient and Partial Hospitalization Services	479	496	3.5%	Increase	Increase
10	Residential and Inpatient Services	847	945	11.6%	Increase	Increase
11	Withdrawal Management	503	566	12.5%	Increase	Increase
12	Medication-Assisted Treatment	13,406	14,138	5.5%	Increase	Increase
22	Continuity of Pharmacotherapy for Opioid Use Disorder[c]	39.8%	46.9%	18.0%	Increase	Increase

[a]Baseline period = 10/01/2021 - 10/31/2021.
[b]Mid-point period = 03/01/2023 - 03/31/2023.
[c]For Metric #22: Baseline period = 01/01/2021 - 12/31/2021, Mid-point period = 01/01/2022 - 12/31/2022

Risk Assessment and Recommendations

The risk of not meeting Milestone 1 is assessed as low. With utilization of all SU services increasing from baseline to mid-point as projected in Wisconsin's SUD Monitoring Protocol, all the critical metrics indicate that access to Wisconsin's SU service array is increasing for Medicaid beneficiaries. The expansion of Medicaid coverage for SU residential treatment appears to have increased access to SU residential treatment without adversely impacting access to other SU services in the array. Of the seven SU Implementation action items, the two residential treatment action items are complete and the three action items for ongoing monitoring of outpatient and MAT services are assessed as complete. Although ongoing monitoring for policy improvements continues for the three outpatient and MAT services, the action items are assessed as complete given that some Medicaid coverage expansions have been implemented and the DMS has demonstrated an existing system for reviewing coverage policies for improvements.

The expansion of coverage to IMDs for inpatient and withdrawal management services are open action items. However, plans are developing to expand coverage to IMDs for these last two services and it is recommended that the DMS formalize a set of plans. The risk of not meeting this milestone remains low contingent on the continuation of the developing expansion efforts for these services.

MILESTONE 2 PROGRESS: WIDESPREAD USE OF EVIDENCE-BASED, SUD-SPECIFIC PATIENT PLACEMENT CRITERIA

To ensure consumers receive appropriate and effective substance use treatment, the placement decision must be the best fit for the consumer's needs and be informed by evidence-based criteria. The initial placement decision dictates the treatment path and effectiveness of treatment, so it is critical that evidence-based guidelines be used in the baseline assessment to ensure the initial placement is the best fit. If the initial placement is effective and facilitates progress for the client, a less intensive placement may eventually be needed. Thus, a utilization management plan that incorporates ongoing assessments using evidence-based placement criteria are also critical. More specifically, the goals of the SUD demonstration waiver for evidence-based placement decisions (**Exhibit 5**) include:

- Implementation of a requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines, and

- Implementation of a utilization management approach, such that:

    - beneficiaries have access to SUD services at the appropriate level of care,

    - interventions are appropriate for the diagnosis and level of care,

    - there is an independent process for reviewing placement in residential treatment settings.

Exhibit 5: Milestone 2 Implementation Plan Activity Status

Future State Implementation Goal	Actions Needed	Target Completion Date	Status
Milestone 2 Criteria: Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines			
Revise Wisconsin Administrative Code DHS 75 with references to ASAM patient placement criteria.	The revisions to administrative code were authorized by Wisconsin's governor. The new regulations will follow the state's rulemaking process.	July 2018	Completed
	Listening sessions to be held on 5/21/19, 5/23/19, 6/17/19, 6/20/19, 6/27/19, and 7/16/19. The input collected through these sessions will be incorporated in drafting of the revised administrative code. A rule draft will then be shared with an Advisory Committee for discussion and comment.	December 2019	Completed
	Following revisions suggested by the Advisory Committee, the draft rule will be published for public comment and analysis of economic impact.	December 2020	Completed
	Final rule approval by the Wisconsin legislature.	early 2021	Completed
Milestone 2 Criteria: Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care and (b) interventions are appropriate for the diagnosis and level of care there is an independent process for reviewing placement in residential treatment settings			
DQA will continue to survey certified SUD treatment programs for compliance with provider credentialing standards, including requirements for use of patient placement criteria.	Ongoing activity – no new action required	None	Completed
Established Medicaid utilization management policies for SU residential treatment.	Wisconsin Medicaid will establish utilization management policies.	December 2019	Completed
Established Medicaid policies for the authorization guidelines for initial admittance to residential treatment and authorization guidelines for continued stays in residential treatment.	Wisconsin Medicaid will publish authorization requests forms and provide training to residential treatment programs on request submission	December 2019	Completed

SUD-Specific, Multi-Dimensional Assessments

The plan to implement an SUD-specific multi-dimensional assessment tool for local providers was aided by the existing use of ASAM (Third Edition) assessment criteria within the Wisconsin SUD provider community prior to the initiation of the residential treatment benefit. The ASAM criteria have been used in Wisconsin by some providers for many years, but the requirement of the criteria was formalized through two efforts in Wisconsin since the start of the demonstration waiver in 2019.

First, the DHS 75 administrative rule which sets standards for the delivery of substance use treatment was re-written between 2018-2021 to include updated standards of treatment and the latest evidence-based practices. DHS 75.24 (1)(a)1. specifically instructs substance use treatment providers to use a multi-dimensional risk and severity assessment for client screening and DHS 75.24 (11)(d)7. states that a clinical assessment conclude with a level of care recommendation based on the ASAM placement criteria (**Exhibit 6**). The use of the ASAM placement criteria is re-emphasized in DHS 75.23 which sets standards for assignments to service levels of care. The ASAM criteria should be used to determine the appropriate level of care for a client and any other placement criteria must be submitted to the State DHS for review and approval before use.

Exhibit 6: Wisconsin Administrative Rule Updates for Evidence-based Placement Criteria

DHS 75.24 Service Operations

(1) Screening.

(a) A service shall complete an initial screening for an individual that presents for services. The screening shall include all of the following:

1. Sufficient assessment of dimensional risk and severity of need to determine preliminary level of care.

3. An assessment of the patient's suicide risk.

(11) Clinical assessment.

(b) The service shall promote assessments that are trauma−informed.

(d) Information for the assessment shall include the following:

7. Level of care recommendation based on ASAM or other department-approved placement criteria.

(13) Treatment Plan.

(i) The treatment plan review shall include an updated level of care assessment which follows ASAM or other department−approved placement criteria and recommends continued stay, transfer, or discharge.

DHS 75.23 Service Levels of Care

(1) Service Levels of Care.

(a) Services delivered under this chapter shall adhere to standardized levels of care as defined in this chapter. A service shall apply the ASAM criteria or other department−approved placement criteria to determine the appropriate level of care, and services shall be delivered consistent with that level of care.

(b) A service shall not deliver or purport to deliver a service for which they do not possess certification by the department under this chapter.

(2) Use Of ASAM Or Other Department−Approved Placement Criteria.

(a) A service shall utilize ASAM placement criteria or other department−approved placement criteria to determine the level of care that is matched to a patient's needs and risk level.

(b) In order to be approved by the department, other placement criteria must include all of the following:

1. A multi−dimensional assessment tool that captures behavioral health, physical health, readiness for change, social risk levels and directly correlates risk level to service levels of care based on frequency and intensity of the service.

Other evidence-based practices have been incorporated into the DHS 75 administrative rule including the assessment of suicide risk at the time of screening for immediate referral to preliminary care (DHS 75.24 (1)(a)3.). The rule also states that clinical assessments should incorporate a trauma-informed approach (DHS 75.24 (11)(b)).

Second, the Wisconsin Medicaid policy (ForwardHealth Update #2020-42)[7] on the delivery of the new SU residential treatment benefit was established in a formal policy memo in December 2020 just before coverage for the residential treatment benefit began in February 2021. The policy memo explicitly requires providers to complete assessments using the ASAM placement criteria including the following for each ASAM dimension: a brief narrative description, the risk rating to specify severity of needs, and the level of care rating to specify the least restrictive intensity of services needed. To support the implementation of the ASAM requirements, the DMS and DCTS agencies promoted ASAM trainings through a series of provider technical assistance sessions in 2021 after the residential treatment benefit launched.

Utilization Management

Wisconsin's goals for utilization management are to implement policies and practices for a prior authorization process and an assessment update process to ensure that clients are always at the appropriate level of care throughout their treatment episode. For assessment updates, Wisconsin set new standards with its revision of the DHS 75 administrative code. Throughout the client's residential treatment, ongoing re-assessment and treatment plan updates must be completed per DHS 75.24 (13)(i) (**Exhibit 6**) following the ASAM placement criteria.

The DMS also established a Medicaid policy requiring a prior authorization process for the SU residential treatment benefit through ForwardHealth Update #2020-42. The DHS Prior Authorization Form F-02567[8] was developed for providers to complete and submit to the DMS agency for review. Authorization requests for initial admission may result in an automatic approval for the first 10 days of treatment which may be extended up to 30 days through an amended request based on medical necessity. The policy dictates that ASAM placement criteria must be used to determine the initial residential placement as well as any decision to change the residential placement as illustrated on Prior Authorization Form. The prior authorization request must distinguish whether high-intensity or low-intensity residential treatment is appropriate. In Fall 2024, the DMS is planning to expand the length of initial automated prior authorization to 30 days if approval criteria are met which is expected to increase access to treatment for clients with initial long-term needs.

Provider technical assistance sessions offered by the DMS and were instrumental in helping providers adopt the ASAM placement criteria as a standard of care. In addition, individual technical assistance was provided as prior authorizations were submitted. Early provider submissions benefitted from individual technical assistance as some included errors such as non-compliance with ASAM assessment criteria, failing to provide clinical rationale for services, minimal focus on housing plans upon discharge from treatment, and failing to identify discharge criteria. DMS personnel have reported that technical assistance resulted in improved prior authorization requests better aligned with ASAM levels of care and treatment plan quality.

COVID-19 and Other Influences on Progress

As described in Milestone 1, Medicaid coverage for the SU residential treatment benefit was initially scheduled to begin in February 2020, but was delayed to February 2021 by provider concerns and the COVID-19 pandemic. The COVID-19 impact on implementation was

[7]ForwardHealth Update 2020-42: New Benefit for Residential Substance Use Disorder Treatment. https://www.forwardhealth.wi.gov/kw/pdf/2020-42.pdf

[8]ForwardHealth Prior Authorization for Residential Substance Use Disorder Treatment. https://www.dhs.wisconsin.gov/forms/f02567.pdf

experienced both at local treatment facilities and within the DMS. The Milestone 2 assessment and placement goals were also delayed as a result. After the COVID-19 pandemic began, the Wisconsin DHS recognized that the in-person requirements for assessment and treatment in the DHS 75 administrative rule needed to be adapted to allow for virtual service provision and were removed from the rule.

Critical Metrics Progress

With Wisconsin's IMD waiver for SU residential treatment and the implementation activities to improve assessment and placement of individuals in the appropriate level of treatment, Metric #5 for Milestone 2 monitoring Medicaid beneficiaries treated in an IMD is expected to increase (**Exhibit 7**). Medicaid claims data analysis reveals an increase of 271 beneficiaries bringing the total to 3,530 beneficiaries served in the mid-point period of 2022. This 8.6% increase is in the expected direction for Wisconsin's implementation plan.

Exhibit 7: Milestone 2 Progress on Critical Metrics

		Monitoring Metric Rate or Count				
Metric #	Metric Name	At Baseline[a]	At Mid-Point[b]	Percent Change	State's Demonstration Target	Direction at Mid-Point
5	Medicaid Beneficiaries Treated in an IMD for SUD	3,251	3,530	8.6%	Increase	Increase
36	Average Length of Stay in IMDs (days)	17.1	19.9	16.4%	Increase	Increase

[a]Baseline period = 01/01/2021 - 12/31/2021.
[b]Mid-point period = 01/01/2022 - 12/31/2022.

Metric #36 is the average length of stay in IMDs. With increased use of the ASAM placement criteria and improved utilization management practices, placements in IMDs for SU residential treatment should increase placement fit with beneficiaries' needs and minimize length of stay. In the demonstration waiver Special Terms and Conditions (STC), Wisconsin is to "aim for a statewide average length of stay of 30 days in residential treatment settings… to ensure short-term residential treatment stays." The average length of stay at both baseline (17.1 days) and mid-point (19.9 days) is well below the 30-day benchmark (**Exhibit 7**). Wisconsin's implementation plan goal was set to increase the average length of stay and the 16.4% increase matches that expected direction. Although documented rationale was not found for the expected increase, informal interviews with current DMS staff indicate that the expansion of Medicaid coverage was expected to not only increase the number served, but also increase the number served with longer term needs. Before the expansion, some clients' residential stays may have been limited due to coverage limitations, but the elimination of Medicaid coverage limitations may have raised the length of stay in the short term.

Risk Assessment and Recommendations

The risk of not meeting Milestone 2 is currently assessed as low. Both of Wisconsin's critical metrics are trending in the expected direction as planned in the SU Monitoring Protocol. The number of Medicaid beneficiaries using the new SU residential treatment benefit has begun to increase in the first two years of implementation. The increase in the average length of stay in IMDs was expected, but the average is below the 30-day benchmark set in the waiver STCs. In addition, all of the planned activities to implement evidence-based placement criteria and utilization management practices in Wisconsin's SU Implementation Protocol have been

completed. The waiver STCs specified that efforts to improve assessment and placement policy should occur within 24 months of the October 2018 demonstration waiver approval, but the activity was completed with a relatively minor delay. A significant multi-year effort was required to gather stakeholder input and revise the DHS 75 administrative rule for substance use services to formalize the use of ASAM placement criteria and other evidence-based practices. Evidence indicates significant progress was made toward Milestone 2 and the Wisconsin DHS should continue its efforts to maintain progress towards increasing and improving use of its SU residential treatment benefit.

Although the average length of stay in an IMD for SUD is currently stated in Wisconsin's SUD Monitoring Protocol to increase, it is recommended that the target direction of the metric be changed to either "stabilize" or "decrease." The increase may have been expected in the short-term period following implementation of Medicaid coverage as new clients with long-term needs enrolled into care, yet the expectation should be to stabilize or decrease the average length of stay once a new benchmark is set based on the first two years of the SU residential treatment benefit implementation. In addition, to inform DMS options to act on potential future variations, it is recommended that the IMD average length of stay be monitored annually for individual IMD residential treatment facilities. If certain facilities' average length of stay is significantly higher than in other facilities, targeted technical assistance on their plan-of-care management and discharge decisions could help lower their length of stay.

MILESTONE 3 PROGRESS: USE OF EVIDENCE-BASED SUD PROGRAM STANDARDS TO SET RESIDENTIAL TREATMENT PROVIDER QUALIFICATIONS

While Milestone 1 and 2 respectively address the establishment of a complete array of SU services and evidence-based placement practices, Milestone 3 addresses the setting of provider qualifications which adds another necessary component to the implementation process for the SU residential treatment benefit. The following criteria are to be addressed for Milestone 3 and the goals and action items from Wisconsin's SU Implementation Protocol for each criterion are described in **Exhibit 8**:

- Implementation of residential treatment provider qualifications—in licensure requirements, policy manuals, managed care contracts, or other guidance—that meet the ASAM (Third Edition) criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care, and credentials of staff for residential treatment settings;

- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and

- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.

Exhibit 8: Milestone 3 Implementation Plan Activity Status

Future State Implementation Goal	Actions Needed	Target Completion Date	Status
Milestone 3 Criteria: Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards.			
Updated state administrative code to further align provider qualifications with nationally recognized standards.	The revisions to administrative code were authorized by Wisconsin's governor. The new regulations will follow the state's rulemaking process.	July 2018	Completed
	Listening sessions to be held on 5/21/19, 5/23/19, 6/17/19, 6/20/19, 6/27/19, and 7/16/19. The input collected through these sessions will be incorporated in drafting of the revised administrative code. A rule draft will then be shared with an Advisory Committee for discussion and comment.	December 2019	Completed
	Following revisions suggested by the Advisory Committee, the draft rule will be published for public comment and analysis of economic impact.	December 2020	Completed
	Final rule approval by the Wisconsin legislature.	Early 2021	Completed
Milestone 3 Criteria: Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards.			
Continued certification of SUD treatment programs and monitoring of their compliance with state regulations.	No immediate action necessary.	Not applicable	Completed
Milestone 3 Criteria: Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site.			
Published regulatory or policy documents to establish a requirement for residential treatment facilities to offer MAT on-site or facilitate access off site.	DHS staff will implement the requirement.	November 2020	Completed

Implementation of Provider Qualifications in Published Guidance

As the DHS 75 administrative rule was updated for evidence-based assessment and placement standards as described in Milestone 2, the rule was also updated with service and staffing requirements for the SU residential treatment benefits. Wisconsin's SU Implementation Protocol in **Exhibit 8** for provider qualifications replicates the action items for updating the DHS 75 administrative rule in Milestone 2 as the completion of the updated rule served a role in updating provider qualifications as well. DHS 75.48 (2)[9] updates the service requirements for four levels of care within SU residential treatment for professional level of personnel, hours of availability, and types of services. The levels of care were designed to correspond to ASAM levels of care which includes the associated service and personnel requirements. For example, one way that medically monitored residential treatment is distinguished from transitional residential treatment is in the requirement of a medical director to provide medical oversight regarding the clinical operations of the service. In addition to these distinguished provider qualifications by level of

[9]Wisconsin Administrative Code § Chapter DHS 75.48 (2) Service requirements by level of care, residential. https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75/vi/48.

care, DHS 75.33[10] specifies the standard training requirements for residential treatment personnel at all levels of care.

Furthering policy guidance on provider qualifications and the provider enrollment process for the SU residential benefit, DHS published the ForwardHealth 2019-27 Update[11] in November 2019. The policy update outlined how residential facilities must be certified by the Division of Quality Assurance (DQA) before enrolling with Wisconsin Medicaid as a residential SUD treatment provider. The DQA certifies residential providers based on the DHS 75 administrative standards and thus providers are certified based on the ASAM criteria included within the administrative standards. The update further clarifies that providers must revalidate their qualifications every three years to continue participating as a Wisconsin Medicaid provider.

Implementation of a State Process for Reviewing Provider Compliance

The DQA is the agency responsible for reviewing and certifying residential provider facilities for compliance with service provision standards and they updated their certification process to incorporate the updates to the DHS 75 administrative code. Their certifications involve site visits, documentation review, personnel requirement reviews, as well as reviews of physical environment standards for facilities. When Medicaid coverage was added for transitional residential and medically monitored residential treatment, enrollment as a Medicaid provider was made contingent on prior DQA certification for these services.

Implementation of Access to MAT Through Residential Treatment Facilities

Prior to Wisconsin's SUD demonstration waiver, MAT was not required to be available in residential treatment facilities. The SU Implementation Protocol calls for MAT to be provided on-site at SU residential treatment facilities or made available through referral and linkage to off-site MAT services. Wisconsin implemented this as well through the ForwardHealth Update 2020-42 policy memo. The policy requires facilities to admit members who take any type of medications for their substance use needs and not screen members out based on their medication needs.

Implementing the policy required ongoing training and technical assistance. Prior authorization reviewers were trained to search for clinical information about a member's use of medications and seek clarification from the residential facility if the need was not included in the prior authorization request. Not all residential treatment programs fully supported the MAT requirement initially and, thus, the DMS began providing individualized technical assistance to providers answering policy questions and re-emphasizing the requirement. The DMS reports that the technical assistance has resulted in alignment with the MAT requirements for most providers, but ongoing technical assistance is continuing for others.

Critical Metrics Progress

No critical monitoring metrics are required for the assessment of Milestone 3.

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[10] Wisconsin Administrative Code § Chapter DHS 75.33. Residential personnel requirements. https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75/v/33.

[11] ForwardHealth Update 2019-27, Provider Enrollment Information for the New Residential Facility Substance Use Disorder Treatment Benefit. https://www.forwardhealth.wi.gov/kw/pdf/2019-27.pdf.

Risk Assessment and Recommendations

The risk of not meeting Milestone 3 is assessed to be low. All action items in the SU Implementation Protocol have been completed by the Wisconsin DHS. The initiative to update the Wisconsin administrative code DHS 75 has formalized the link between standards for provider qualifications and the ASAM levels of care assigned to residential facilities through certification. Per the SUD demonstration waiver STCs, the goal was to implement changes within 24 months of the waiver approval which was October 2020. While this timeline was delayed, the updates to provider qualifications are complete. The DQA continues to certify providers and has adapted their certification reviews to the updates in DHS 75. Finally, the requirement of access to MAT through residential providers has been formalized through a DMS Medicaid policy memo. No recommendations are deemed necessary for Wisconsin to further its progress in meeting Milestone 3.

MILESTONE 4 PROGRESS: SUFFICIENT PROVIDER CAPACITY AT CRITICAL LEVELS OF CARE

While Milestone 1 emphasizes that states provide a full SU service continuum at six critical levels of care, Milestone 4 emphasizes that these critical levels of care must have sufficient capacity to provide statewide access. To meet Milestone 4, states are asked to complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. The assessments must determine the availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as the availability of MAT throughout the state. Without the provider capacity assessments, gaps in the availability of services cannot be identified and addressed. **Exhibit 9** describes Wisconsin's SU Implementation Protocol which calls for provider capacity assessments at each level of care with a long-term goal of updating the methodology for assigning provider credentials to maximize provider capacity at each level of care.

Exhibit 9: Milestone 4 Implementation Plan Activity Status

Future State Implementation Goal	Actions Needed	Target Completion Date	Status
Milestone 4 Criteria: Completion of assessment of the availability of providers enrolled in Wisconsin Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT: outpatient services, intensive outpatient services, MAT, intensive care in residential and inpatient settings, and medically supervised withdrawal management.			
Updated licensure or certification requirements and updated methodology to assign new provider credentials associated with the appropriate level of care.	Wisconsin will complete baseline measurements for provider capacity at each level of care.	November 2019	Open

Provider Availability Assessments for Critical Levels of Care

In the "Critical Metrics Progress" section for Milestone 4 below, Wisconsin used Medicaid claims data to assess overall statewide capacity for all SU providers and specifically for MAT providers. Minimally, these statewide assessments of the number of providers represent the first essential step in assessing changes in capacity.

Another assessment of SU residential provider capacity that DMS used draws from the roster of all certified providers maintained by the DQA. To measure the impact on provider capacity associated with the implementation of Medicaid coverage for the SU residential treatment benefit, a 2020 provider assessment revealed 57 certified residential SUD treatment facilities in the state prior to the beginning of Medicaid coverage in February 2021. Of the 57 providers, 36 enrolled with Medicaid in 2021 during the first year of Medicaid coverage for the residential benefit and four facilities closed. In 2022, no new agencies enrolled with Medicaid, but SU residential provider Medicaid enrollments increased by six in 2023 and four in 2024 to date. Despite the absence of new provider enrollments in 2022, the assessment illustrates that the increase in capacity of SU residential providers continues steadily.

The DMS's contracted evaluator for Wisconsin's 1115 SU demonstration waiver also found increases in Medicaid-enrolled residential treatment providers after coverage was implemented using the National Survey of Substance Abuse Treatment Services data in the latest annual evaluation report. In 2017, 35% of SU residential treatment facilities in Wisconsin reported accepting Medicaid which increased to 83% in 2021[12]. By comparison, in the 12 states without a Medicaid IMD waiver, the average percentage of facilities that reported accepting Medicaid remained relatively stable from 40–43% over the same period.

In addition, changes in the supply of all SU treatment providers following the implementation of the SU residential treatment benefit were analyzed. A steady supply in the 2017-2019 pre-implementation period averaged 11.84 providers per 1,000 beneficiaries. In 2020, when the COVID-19 pandemic began, a sharp decline occurred in April 2020 to approximately a 9.40 provider rate. The decline was followed by a temporary rebound in 2021 to 10.17 providers per 1,000 beneficiaries before declining again to a 9.17 rate in 2022. A comparison group of diabetes providers revealed a very similar trend in provider supply from 2017-2022. A difference-in-differences analysis indicated very small differences in the change over time between SUD and diabetes provider supplies. Thus, the changes in the supply of Medicaid-enrolled SUD providers do not appear to be changing in response to the SUD demonstration waiver. DMS's partnership with its evaluator for the demonstration waiver for such analyses demonstrate its effort to monitor changes in provider supply related to its implementation of coverage for the SU residential treatment benefit.

The DMS efforts described above to assess and monitor capacity for all SU providers, MAT providers, and residential providers demonstrate significant progress towards the Milestone 4 criterion. DMS was not able to complete the planned coordinated assessment in 2019 of provider capacity for other critical levels of care including outpatient, intensive outpatient, inpatient, and medically supervised withdrawal management services. However, DMS has been engaged in other efforts to monitor and build the supply of SUD providers across these other levels of care.

Related to the publication of DHS 75 rule revisions in October 2021, all SU agencies in the state were required to update their state SU certifications before the rule went into effect in October 2022. The DMS, DQA, and DCTS actively monitored the counts for all agencies for each service across the SU continuum of care to evaluate providers' progress toward updating their certifications and Medicaid enrollment. DMS participated in the monitoring and accounting of SU providers at all levels of care to ensure that none were left behind in the re-certification process and to support agencies that elected to pursue new or additional certifications.

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[12]Wisconsin's Medicaid & BadgerCare Plus Health Coverage Annual Evaluation Report – Project Year 04. University of Wisconsin Institute for Research on Poverty. February 2024.

Similarly, as part of the continuing work to align with DHS 75 and address gaps in the SUD continuum of care, the DMS began in 2022 to scope an effort to implement a new intensive outpatient (IOP) benefit for co-occurring care, including assessing the provider supply in each adjacent level of care – outpatient and day treatment/partial hospitalization. The baseline results (**Exhibit 10**) are based on DQA provider certifications issued as of October 2022.

Currently, Medicaid providers are reimbursed for IOP through the outpatient benefit. In **Exhibit 10**, IOPs are also included in the count of outpatient providers. DMS has used the baseline capacity assessment to analyze service delivery trends for each level of care to identify providers that may add or transition to IOP services from their current level of care when the IOP benefit coverage begins. The DMS intends to re-assess provider capacity at these levels of care near the end of 2024 to measure capacity changes since the baseline.

Exhibit 10: Certified SU Provider Assessment as of October 2022

Service/Level of Care	Wis. Admin. Rule Reference	Number of DQA Certified Providers	Number of Medicaid Enrolled Providers
Outpatient	75.49, 75.50	272	202
IOP	75.51	11	0
Day Treatment/ Partial Hospitalization	75.52	51	42

In addition to the above efforts, interviews with DMS and DCTS staff indicated several provider capacity-building efforts have been completed or are underway including the following:

- Easing Medicaid SUD provider enrollment requirements to align with expanded scopes of practice for various behavioral health professionals, increasing the SUD workforce (see ForwardHealth Update 2020-28[13] and 2022-56[14]);
- Retaining and adding new workforce capacity for all levels of care by aligning SUD and mental health Medicaid reimbursement rates to be more equitable;
- Updating state administrative rules and add Medicaid coverage for peer recovery coaches in 2025, and;
- Expanding the settings in which Qualified Treatment Trainees can be reimbursed for SUD services.

Qualified Treatment Trainees (QTTs) are licensed professional counselors in training, licensed marriage and family therapists in training, and psychologists working towards licensure that work under the supervision of a qualified Medicaid provider. Currently, QTTs can only be reimbursed for SUD services in certified clinics. A September 2024 policy update will expand coverage for QTTs, allowing reimbursement for QTT-rendered SUD services in all settings allowable for fully licensed professionals.

[13] ForwardHealth Update #2020-28. Expanded Scope of Practice for Outpatient Behavioral Health Providers. https://www.forwardhealth.wi.gov/kw/pdf/2020-28.pdf.

[14] ForwardHealth Update #2022-56. Expanded Scope of Practice for Substance Use Disorder Providers. https://www.forwardhealth.wi.gov/kw/pdf/2022-56.pdf.

COVID-19 and Other Influences on Progress

DHS staff anecdotal evidence indicated that the SU provider workforce in residential treatment facilities declined in 2020 due to the risks of contracting COVID and the adaptations required of the physical work environment in facilities. The delay in Medicaid coverage in IMD's until 2021 likely aided the implementation process and may have stemmed the drop in capacity. The new residential treatment facilities that enrolled as Medicaid providers in 2021 included some providers that had prepared for enrollment leading up to the initial implementation date of February 2020. When no new SU residential providers enrolled with Medicaid in 2022, a possible explanation was that no new providers were preparing for certification and enrollment in 2021 due to the COVID pandemic and were not ready in 2022 to become officially enrolled. The DMS staff also indicate that the state agency's own staff capacity was impacted in 2020-21 which hindered its ability to conduct other SU provider capacity assessments.

Critical Metrics Progress

The overall SU provider capacity in Critical Metric #13 measures the count of providers and indicates a 12.3% increase from 2021 to 2022 (**Exhibit 11**). The increase matches the direction projected in Wisconsin's SU Implementation Protocol. The MAT provider capacity was also planned to increase, but Critical Metric #14 reveals a 13.5% decrease from 2021 to 2022. DCTS staff who work with oversight of MAT services reported medication prescribers dropped and some existing prescribers became more reluctant to prescribe MAT for opioid use disorders during the COVID pandemic. However, a rebound in providers is expected in 2023 due to the federal MAT Act[15] which removes the federal requirement for practitioners to have a waiver to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD).

Exhibit 11: Milestone 4 Progress on Critical Metrics

		Monitoring Metric Rate or Count				
Metric #	Metric Name	At Baseline[a]	At Mid-Point[b]	Percent Change	State's Demonstration Target	Direction at Mid-Point
13	SUD Provider Availability	9,008	10,115	12.3%	Increase	Increase
14	SUD Provider Availability – MAT	540	467	-13.5%	Increase	Decrease

[a]Baseline period = 01/01/2021 - 12/31/2021.
[b]Mid-point period = 01/01/2022 - 12/31/2022.

Risk Assessment and Recommendations

The risk of not meeting Milestone 4 is assessed at low. The milestone criterion is to develop a sufficient capacity of providers at all levels of care. Wisconsin's specific implementation plan activity is to complete an assessment of provider capacity at all levels of care to inform further capacity development. Of the two critical metrics, the increase in overall supply of SU providers by 12.3% from 2021 to 2022 clearly indicates Wisconsin has successfully developed provider capacity and has demonstrated a system of measuring capacity to facilitate continued monitoring. Active Medicaid provider capacity for MAT unexpectedly decreased, but the DMS system to assess provider capacity indicates success towards its goal of capacity assessments at all levels of care. The SU Implementation action item remains "open" due to the ongoing efforts to assess provider capacity at other critical levels of care. Efforts to assess capacity for

[15] https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act.

outpatient, IOP, day treatment, MAT, and residential treatment cover the majority of the critical levels of care. The DMS has analyzed both the potential capacity of providers who are certified and the active capacity of Medicaid-enrolled providers for these levels of care. The DMS's demonstrated system to assess capacity through a combination of Medicaid claims, provider enrollments, and DQA-certified provider databases indicates new and follow-up capacity assessments can be completed in the future.

To further lower the risk of not meeting Milestone 4, it is recommended that the DMS direct its capacity assessment capabilities to examine potential needs in the two remaining critical levels of care in the array − inpatient and medically supervised withdrawal management services. As described in the Milestone 1 section, Wisconsin is currently developing plans to add coverage for these two services in IMD's. To assess the impact of these developing efforts, baseline provider capacity assessments will be necessary. As Wisconsin has demonstrated with other efforts, the DMS resources for capacity assessments can be applied for these two remaining services to complete Wisconsin's goal of assessing all levels of care to inform its capacity-building efforts.

MILESTONE 5 PROGRESS: IMPLEMENTATION OF COMPREHENSIVE TREATMENT AND PREVENTION STRATEGIES TO ADDRESS OPIOID ABUSE AND OUD

Milestone 5 prioritizes opioid treatment and prevention services, directing states to address increasing opioid use. Wisconsin's SU Implementation Protocol activities in **Exhibit 12** primarily call for new activity to improve the Wisconsin Prescription Drug Monitoring Program (PDMP). Wisconsin's SU Implementation Protocol contains a large Health Information Technology implementation plan defining the activities required to implement improvements. However, many implementation items only require ongoing monitoring, so the three goals that require action items are combined into the PDMP implementation goal below.

Exhibit 12: Milestone 5 Implementation Plan Activity Status

Future State Implementation Goal	Actions Needed	Target Completion Date	Status
Milestone 5 Criteria: Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse.			
Continued monitoring and evaluation of current opioid prescribing guidelines.	No immediate action necessary.	Not applicable	Completed
Milestone 5 Criteria: Expanded coverage of, and access to, naloxone for overdose reversal.			
Continued monitoring and evaluation of current Medicaid coverage of naloxone for overdoses.	No immediate action necessary.	Not applicable	Completed
Milestone 5 Criteria: Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.			
Increased functionality and ease of use for end user prescribers	Interstate data sharing for end users, Improve ease of use, and the addition of an alert for patients with very little opioid use history	2020	Completed

Implementation of Opioid Prescribing Guidelines and Other Interventions

Although the SU Implementation Protocol calls only for continued monitoring of opioid prescribing guidelines and interventions, many new initiatives have occurred since the approval of the SU demonstration waiver. When the DHS 75 administrative rule was published in October 2021, it included two revised opioid treatment services established under 75.59 and 75.60 distinguishing stand−alone office−based opioid services from more comprehensive opioid treatment programs (OTPs).

Wisconsin has also received opioid settlement funds as a result of national litigation against the pharmaceutical industry that must be used to prevent or treat opioid use disorders. In one initiative, settlement funds have been used to cover room and board costs for members in SU residential treatment facilities which Medicaid policy will not cover.

In addition, some opioid treatment programs have begun employing mobile units as a method of improving member access to MAT. The DMS is also currently exploring policy updates needed to align with the newly released fourth edition of the ASAM criteria which includes an increased focus on MAT at all levels of care.

Expanded Coverage of Naloxone for Overdose Reversal

The Wisconsin Medicaid State Plan already covers Naloxone as a preferred drug and does not require prior authorization for coverage. In 2018, Wisconsin Medicaid expanded reimbursement policy to allow opioid treatment programs to be reimbursed for dispensing naloxone. The DMS implementation activity plan is to continue monitoring and evaluating naloxone coverage policies, but no improvements are currently deemed necessary.

Improvements for the Prescription Drug Monitoring Program

The Wisconsin PDMP technology is hosted by the State Department of Safety and Professional Services (DSPS). The DMS has developed and implemented a platform that enables data linkage with the Wisconsin PDMP for analyses promoting improved safety, health, and quality assurance for providers and members.

One of the implementation goals for Wisconsin is to connect the PDMP to a second interstate data sharing hub and to continue connecting with additional compatible states for interstate data sharing when possible. At the time the SU Implementation Protocol was created, the DMS was attempting to link to another data sharing hub named RxCheck to the PDMP. The agreement was completed at the end of 2019 adding more prescription history from seven more states to the Wisconsin PDMP. Additional work is underway to ensure interstate data can be presented to end users who access PDMP reports from within the workflow of their electronic health records.

A second goal is to enhance the “ease of use” for prescribers within the PDMP by gathering stakeholder feedback. A user-led enhancement grant project through the U.S. Department of Justice, Bureau of Justice Assistance, has allowed Wisconsin to collect and act on this feedback. Some of the major user-led enhancements released since 2019 include: new patient history report design, improved and added service features, and added data fields including naloxone administration information for law enforcement alerts. More recently in 2023,

enhancements to the PDMP user interface were made to allow users to reconfigure their own patient report layout to prioritize information most useful to their treatment decisions.[16]

A third goal is for the PDMP to design an analytics-driven alert identifying patients who are "opioid naïve," or do not have a history of long-term opioid use. The opioid naïve alert was completed and released in 2020 and will help prescribers with educating "naïve" opioid users.

Critical Metrics Progress

The critical metrics for Milestone 5 are all designed to monitor acute events potentially associated with opioid use. Since acute events are measured, the planned direction for each is a decrease at the midpoint. Decreases of 7 to 8% did occur for ED utilization and concurrent use of opioids and benzodiazepines (**Exhibit 13**). However, overdose deaths and opioid use at high dosages for persons without cancer both increased slightly.

Exhibit 13: Milestone 5 Progress on Critical Metrics

		Monitoring Metric Rate or Count				
Metric #	Metric Name	At Baseline[a]	At Mid-Point[b]	Percent Change	State's Demonstration Target	Direction at Mid-Point
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries[c]	3.84	3.51	-8.6%	Decrease	Decrease
27	Overdose Deaths (statewide rate)	0.77	0.82	6.5%	Decrease	Increase
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	22.6%	23.5%	3.9%	Decrease	Increase
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	10.8%	10.0%	-7.2%	Decrease	Decrease

[a]Baseline period = 01/01/2021 - 12/31/2021.
[b]Mid-point period = 01/01/2022 - 12/31/2022.
[c]For Metric #23: Baseline period = 10/01/2021 - 10/31/2021, Mid-point period = 03/01/2023 - 03/31/2023

Risk Assessment and Recommendations

The risk of not meeting Milestone 5 is assessed at low. Two of the critical metrics are decreasing as expected in Wisconsin's SU Monitoring Protocol, but the other two are increasing in 2022 at the mid-point assessment. However, all four metrics have only changed slightly regardless of direction. All three of the activities in the SU Implementation Protocol have been completed or require no new activities. The enhancement of the PDMP is the major activity for Wisconsin in Milestone 5 and significant improvements have been made since the approval of the demonstration waiver. Specific health information technology efforts have increased the useability and functionality of the PDMP system to enhance the information available to prescribers.

[16]"Wisconsin Announces Improvements to Prescription Drug Monitoring Program." DSPS news release. October 12, 2023. https://dsps.wi.gov/Documents/NewsMedia/20231012WIePDMPNewsRelease.pdf.

MILESTONE 6 PROGRESS: IMPROVED CARE COORDINATION AND TRANSITIONS BETWEEN LEVELS OF CARE

To meet Milestone 6, states must implement policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities. The coordination of care between stages of treatment, specifically initiation and engagement, are also assessed in the critical metrics for this milestone. Also emphasized is the coordination of care for co-occurring physical and mental health conditions. Wisconsin's progress towards its two specific goals and action items to improve care coordination are summarized in **Exhibit 14**.

Exhibit 14: Milestone 6 Implementation Plan Activity Status

Future State Implementation Goal	Actions Needed	Target Completion Date	Status
Milestone 6 Criteria: Additional policies to ensure coordination of care for co-occurring physical and mental health conditions.			
A new residential SUD benefit that is carved into acute managed care plans to ensure coordination between physical and behavioral health services.	Wisconsin Medicaid will revise acute managed care contracts and conduct ongoing monitoring through managed care provider network and quality monitoring.	January 2020	Open
Development of more intensive care coordination models for individuals with SUD, including health homes or other intensive care coordination models.	Initial analysis of the health home model for enhanced core coordination for individuals with SUD.	2020	Completed

Policies to Coordinate Care for Co-Occurring Physical and Mental Health Conditions

Standards for both the provision of continuing care during transitions and co-occurring services were prominent features of additional updates to Wisconsin Administrative Code DHS 75. The expansion of the SU service array continued with the creation of two new levels of care for integrated treatment of mental health and substance use disorders (**Exhibit 15**). Definitions and standards for integrated outpatient behavioral health services and integrated residential behavioral health stabilization services have been established in DHS 75.50 and DHS 75.56 respectively. To facilitate discharges and transfers, DHS 75.24 stipulates that clients who are discharged should have a continuing care plan and be allowed to continue contact with their discharge provider for transitional support until no longer necessary.

Exhibit 15: Wisconsin Administrative Rule Updates for Continuing and Co-occurring Care

DHS 75.23 Service Levels of Care

(3) Level of care transfer. A service that offers more than one level of care under this chapter shall identify in the clinical record which level of care the patient is receiving based on the clinical assessment. When a level of care transfer is completed as indicated by assessment or treatment plan review, the service shall document the level of care transfer in the record and shall thereafter meet the service requirements for the indicated level of care.

DHS 75.24 – Service Operations

(22) Discharge.

(d) A discharge summary shall be entered into the patient's case record, including the following:

1. A completed copy of the standardized placement criteria and level of care indicated.

2. Recommendations regarding care after discharge.

(23) Continuing care services.

(b) A patient who has completed services and been discharged may continue contact with the provider at agreed upon intervals without completing a new clinical assessment, intake, or treatment plan.

DHS 75.50 Outpatient Integrated Behavioral Health Treatment Service

(1) Service description. In this section, "outpatient integrated behavioral health treatment service" means a non−residential treatment service totaling less than 9 hours of treatment services per patient per week for adults, and less than 6 hours of treatment services per patient per week for minors, in which substance use and mental health treatment personnel provide screening, assessment and treatment for substance use and mental health disorders. Patients in this setting may receive treatment services for a substance use disorder, a mental health disorder, or both.

DHS 75.56 Adult Residential Integrated Behavioral Health Stabilization Service

(1) Service description. In this section, "adult residential integrated behavioral health stabilization service" means a residential behavioral health treatment service, delivered under the oversight of a medical director, that provides withdrawal management and intoxication monitoring, as well as integrated behavioral health stabilization services, and includes nursing care on−site for medical monitoring available on a 24−hour basis. Patients in this setting may receive treatment services for a substance use disorder, a mental health disorder, or both.

The prior authorization requirements in ForwardHealth Update 2020-42 include the identification of discharge criteria and a continuing care plan to aid the transition from residential treatment. The requirements for the continuing care plan include:

- Documented coordination with the member's care manager for the next level of care, which may include the member's HMO/managed care organization, psychosocial rehabilitation program, Medicaid health home, or other care manager;
- Planning for services upon discharge, such as individual counseling, medication management, support group meetings;
- Confirmation of living arrangements that will encourage recovery and reduce the chances of relapse;
- Emergency and counseling contact information, and;
- Overdose prevention plan, if applicable.

More specifically identified in Wisconsin's SU Implementation Protocol is the need to update managed care contracts with requirements to coordinate care between behavioral health and

physical health care. The DMS initially planned to carve the residential benefit into managed care contracts. However, providers expressed extensive concerns about the draft coverage policy, including both benefit and rate design. Providers also reported a lack of operational capacity to manage processes such as prior authorization, institutional claim billing, and contracting with the multiple managed care entities. This initial feedback led to the DMS collecting additional input through statewide in-person stakeholder input sessions which led into the COVID pandemic. Ultimately, the SU residential benefit was not carved-in to managed care contracts when the benefit coverage was launched in February 2021. The DMS requires residential SUD providers to contact managed care organizations within 48 hours of a member's admission, and managed care entities are contractually required to coordinate the services they provide with services provided on a fee-for-service basis. The DMS has focused on promoting program quality and care coordination through prior authorization requirements, such as continuing care plans, but has not monitored compliance with the policy requirement for providers to notify managed care organizations or the contract requirement for managed care entities to coordinate with fee-for-service providers. While the DMS continues to encourage managed care partnerships with residential providers, no known plan exists to formally evaluate or update requirements for coordination of co-occurring services and thus this implementation item remains open in Wisconsin's plan.

The second action item in Wisconsin's implementation plan includes an analysis and development of an intensive care coordination model of service delivery such as the health home model. The DMS has made significant progress in selecting and implementing a hub and spoke model for members with SU disorders since the demonstration began. Wisconsin's 2019-2021 state budget allocated funds for a hub-and-spoke treatment model to be delivered under the Medicaid health home benefits for persons with substance use disorders. A health home coordinates care for individuals with chronic conditions, and some states have used the Medicaid health home benefit to create SUD health homes. Based on Vermont's Hub and Spoke program, the Wisconsin hub and spoke pilot will expand the range of services available for SUDs to enhance care coordination and supports available. The new benefit coordinates access to mental health treatment, primary care, and other supports that may be needed. This benefit became effective on June 15, 2021, and the pilot program will continue through December 2025.

Under the hub and spoke pilot program, hubs provide access to SU treatment including assessment, medication for opioid use disorder, behavioral health care, and other forms of assistance. Hubs transfer primary care collaboration to or from a spoke when indicated by the needed level of care or by member choice. Spokes are community partners working with the hubs to provide both services and care management. They monitor adherence to treatment and coordinate access to available services. Spokes include professionals who are waivered to prescribe buprenorphine in a clinical setting for patients with opioid use disorder. The coordinated care model is intended to increase the capacity to provide quality care for SU disorders. Wisconsin has four participating sites in 2024, including one tribal agency provider.

COVID-19 and Other Influences on Progress

As described above, carving in SU residential services to managed care contracts caused delayed implementation of the benefit, which was further delayed by the timing of the COVID-19 pandemic. In addition, the administrative complications of adapting managed care contracts with the care coordination requirements seemed even more insurmountable when the pandemic complicated the service delivery system.

Critical Metrics Progress

To examine the coordination of care, differences between the rate of initiation and rate of engagement in services are measured for Milestone 6 as an indicator of the quality of coordination between stages of treatment. The rate of follow-up services after emergency department (ED) visits is also used as an indicator of the coordination of care. The critical metrics for Milestone 6 are defined as follows:

- *Initiation of AOD Treatment* = the percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis.

- *Engagement of AOD Treatment* = the percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

- *Follow-Up After ED Visit* = Percentage of ED visits for substance use for which the beneficiary received a follow-up visit for substance use within 7 or 30 days of the ED visit. The same definition is used with ED visits for mental illness.

- *Readmissions* = The rate of all-cause inpatient readmissions within 30 days among beneficiaries with an initial inpatient stay with a SU diagnosis.

The baseline and midpoint measures are for 2021 and 2022. Any critical metric demonstrating less than 2% change is categorized as a “consistent” direction at the midpoint assessment relative to the baseline.

Of the different alcohol and other drug (AOD) disorders for which service initiation and engagement rates are examined in **Exhibit 16**, the rates for opioid treatment are unique in experiencing projected increases as specified in the SU Implementation Protocol. Initiation and engagement rates increased by 4.0% and 6.1%, respectively. In addition, for opioid treatment, the 57.3% initiation rate and the 29.4% engagement rate at the midpoint were significantly higher than for other treatment services. The rates for other drug treatment (excluding alcohol and opioid treatment) stayed consistent over time as did the overall AOD rates. The initiation and engagement rates for alcohol treatment decreased slightly by the midpoint assessment.

The SU Implementation Protocol projected increases in ED follow-up rates for members with SU disorders, but follow-up rates within 7 and 30 days of an ED visit were at approximately 40% and 50% respectively at baseline and decreased slightly by the midpoint. The 7-day and 30-day follow-up rates for ED visits addressing mental health needs are higher at 75.2% and 81.7% respectively at baseline, but also experienced decreases just over 2%. Finally, inpatient readmission rates were expected to decline, but remained consistent.

Exhibit 16: Milestone 6 Progress on Critical Metrics

Metric #	Metric Name	Monitoring Metric Rate or Count			State's Demonstration Target	Direction at Mid-Point
		At Baseline[a]	At Mid-Point[b]	Percent Change		
15	***Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)***					
	Initiation of AOD Treatment - Total AOD abuse or dependence	41.5%	41.5%	0.0%	Increase	Consistent
	Engagement of AOD Treatment - Total AOD abuse of dependence	14.4%	14.2%	-1.4%	Increase	Consistent
	Initiation of AOD Treatment - Alcohol abuse or dependence	41.7%	40.6%	-2.6%	Increase	Decrease
	Engagement of AOD Treatment - Alcohol abuse or dependence	13.5%	12.2%	-9.6%	Increase	Decrease
	Initiation of AOD Treatment - Opioid abuse or dependence	55.1%	57.3%	4.0%	Increase	Increase
	Engagement of AOD Treatment - Opioid abuse or dependence	27.7%	29.4%	6.1%	Increase	Increase
	Initiation of AOD Treatment - Other drug abuse or dependence	40.4%	40.5%	0.2%	Increase	Consistent
	Engagement of AOD Treatment - Other drug abuse or dependence	11.0%	11.2%	1.8%	Increase	Consistent
17(1)	***Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)***					
	Percentage of ED visits with follow-up within 30 days	39.3%	38.1%	-3.1%	Increase	Decrease
	Percentage of ED visits with follow-up within 7 days	50.3%	48.5%	-3.6%	Increase	Decrease
17(2)	***Follow-up after Emergency Department Visit for Mental Illness (FUM-AD)***					
	Percentage of ED visits for mental illness with follow-up within 30 days	75.2%	73.6%	-2.1%	Increase	Decrease
	Percentage of ED visits for mental illness with follow-up within 7 days	81.1%	79.1%	-2.5%	Increase	Decrease
25	Readmissions Among Beneficiaries with SUD	0.18	0.18	0.0%	Decrease	Consistent

[a]Baseline period = 01/01/2021 - 12/31/2021.
[b]Mid-point period = 01/01/2022 - 12/31/2022.

Risk Assessment and Recommendations

The risk of not meeting Milestone 6 is assessed at medium. Of the 13 critical metrics, the four metrics about the initiation and engagement of treatment for opioid and other drug use have increased in a positive direction. The progress for the other drug use metrics are rated as "consistent" due to small increases, but are headed in a positive direction. Six metrics experienced small decreases despite planned increases in the SU Implementation Protocol. The follow-up rates after ED visits for both SU and mental health needs all decreased at the midpoint. However, at least two other states' SU Midpoint Assessment reports (North

Carolina,[17] New Hampshire[18]) indicate typically lower follow-up rates than Wisconsin's. Thus, while Wisconsin's decreases should continue to be monitored, no further recommendations are offered to address the small decreases.

Of the two primary implementation activities, the creation of policies to require transitional care and coordinated co-occurring care has advanced for all SU services and for Medicaid services specifically. However, residential provider critical feedback on the operational difficulties of implementing the new SU residential treatment benefit within managed care plans has delayed progress. Managed care members can still receive the SU residential treatment benefit through a fee-for-service arrangement, but additional care coordination is needed without the benefit carved into managed care plans. The DMS itself has identified that most members receiving the SU residential treatment benefit are likely to be enrolled in a managed care plan. Although significant progress was made on Milestone 6, it is recommended that Wisconsin could lower the risk of not meeting this milestone by assessing whether conditions have become more favorable for residential providers to participate with managed care organizations on a carved-in SU residential treatment benefit. With the necessary COVID pandemic adaptations to residential facilities in place, providers' operational concerns with carving in the benefit may have diminished.

SUMMARY, RECOMMENDATIONS, AND STATE RESPONSE

A high-level summary of the risk assessments and recommendations for all six milestones are displayed in **Exhibit 17** below. Short individual summaries of each milestone's status are also provided.

For this SU Midpoint Assessment of the 1115 SUD demonstration waiver, the CMS requires an evaluation of a state's specific SU implementation plans as well as a state's progress in improving the entire statewide SU service delivery system. Wisconsin has made significant progress at both levels. Overall, Wisconsin's SU Implementation Protocol has progressed in all areas at the midpoint of its SU demonstration waiver.

Milestones 1 and 4 emphasize the importance of a state system with a broad array of services at six levels within a continuum of intensity. The primary provision of the demonstration waiver for the SU service system is the statewide implementation of Medicaid coverage for the SU residential treatment benefit in IMDs. Coverage for the residential benefit has been added and updated definitions of residential levels of care have been added to the state administrative code. Within the broader system, updated definitions have also been added for opioid and integrated behavioral health services. Wisconsin is developing plans to expand coverage across the broader system including for IOP services addressing co-occurring mental health and SU needs. To make expanded coverage effective, adequate provider capacity (Milestone 4) must exist and Wisconsin has been able to improve its residential treatment provider capacity despite negative impacts of the COVID pandemic. Across the broader system, Wisconsin has used provider capacity assessments to monitor the overall supply of all SU providers and to set a baseline to inform developing plans to expanding coverage for IOP services.

[17] Mid-Point Assessment of North Carolina's Substance Use Disorder 1115 Waiver. The Cecil G. Sheps Center for Health Services Research, University of North Carolina.

[18] New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115 Medicaid Demonstration Mid-Point Assessment Report. The Pacific Health Policy Group. December 2021.

Milestones 2, 3, and 6 emphasize the quality of care through the use of evidence-based standards and the coordination of care. Wisconsin's extensive update of its state administrative code has facilitated the implementation of the SU residential benefit coverage, but the updates improve standards across all levels of care within the broader SU service system. Wisconsin's use of ASAM (Third Edition) standards throughout its administrative code is improving assessment and placement decisions for both residential and other levels of care. Wisconsin's Medicaid policies have gone beyond the minimum standards in the administrative code and made ASAM standards required for their enrolled providers' practices. Milestone 6 emphasizes the importance of the coordination of care between the new residential benefit and other services within the continuum. Although adding coordination requirements into managed care contracts has proven difficult, Wisconsin has again used updated administrative codes and Medicaid policies to set standards and requirements for continuing care plans and integrated services that will have an impact on the broader service system beyond just the residential treatment benefit.

In Milestone 5, the emphasis is on improving strategies to address the opioid use epidemic across the service system. While Wisconsin's primary effort in the SUD demonstration has been the implementation of new coverage for the SU residential benefit, the state has simultaneously been able to increase its opioid programming efforts through the use of new opioid settlement funds and significant improvements to its PDMP system to control over-prescribing.

When recommendations have been offered regarding managed care contracts or expanding provider capacity assessments, Wisconsin either had plans that were delayed or was able to demonstrate its system capabilities that could move these implementation items forward in the future. Overall, the midpoint assessment of Wisconsin's SUD demonstration waiver reveals positive progress in the past and demonstrated capabilities that should drive continued progress in the future.

Exhibit 17: Summary of Risk Assessment and Recommendations

Milestone	Implementation Activities Completed	Critical Metrics with Progress	Risk Level	Recommendations
1. Access	5/7 (71%)	7/7 (100%)	Low	None
2. Placement Criteria	7/7 (100%)	2/2 (100%)	Low	Adjust the planned direction of IMD lengths of stay to "stabilize" or "decrease"
3. Provider Qualifications	6/6 (100%)	—	Low	None
4. Capacity	0/1 (0%)	1/2 (50%)	Low	Assess provider capacity for the remainder of the SU critical levels of care replicating previous successful assessments
5. Prescribing and Overdose	3/3 (100%)	2/4 (50%)	Low	None
6. Coordination of Care	1/2 (50%)	4/13 (31%)	Medium	Re-assess conditions for managed care organizations to carve in the SU residential treatment benefit

- Milestone 1. Access to Critical Levels of Care for OUD and Other SUDs

The risk of not meeting Milestone 1 is assessed as low. The highlight in Milestone 1 is Wisconsin's extensive efforts to successfully implement the new SU residential treatment service and expanding Medicaid coverage to IMDs through revisions to state practice standards and Medicaid policy. Increased access to services is further indicated through increases in utilization across the entire service array from baseline to mid-point for Medicaid beneficiaries. Next steps for Wisconsin are to continue its demonstrated monitoring of coverage policies for ongoing opportunities for expansion, including the possible expansion of Medicaid coverage for inpatient and withdrawal management services in IMDs.

- Milestone 2. Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria

The risk of not meeting Milestone 2 is assessed as low. Wisconsin's efforts to incorporate ASAM placement criteria and levels of care throughout its entire SU service system have been systematic and thorough through revised state administrative codes for all SU services and Medicaid policies for SU residential treatment. Both Implementation plan activities to implement evidence-based placement criteria and utilization management practices have progressed and all critical metrics are progressing in the planned direction. Although the COVID-19 pandemic caused a brief one-year delay, all activities are complete an no recommendations are made except to adjust the planned direction of the IMD length of stay metric to "stabilize" or "decrease."

- Milestone 3. Use of Nationally Recognized, Evidence-Based, SUD Program Standards to Set Residential Treatment Provider Qualifications

The risk of not meeting Milestone 3 is assessed as low. All action items in the SU Implementation Protocol have been completed by the Wisconsin DHS to tie provider qualifications to ASAM criteria, continue regular certification reviews of residential providers, and continue ongoing technical assistance to further the implementation of MAT accessibility through residential providers. No critical metrics are required for Milestone 3 and no recommendations are necessary.

- Milestone 4. Sufficient Provider Capacity at each Level of Care, Including MAT

The risk of not meeting Milestone 4 is assessed as low. Wisconsin's single implementation activity is to perform provider capacity assessments for each level of care which it has successfully done for 4 of 6 levels of care. For the two critical metrics, the active provider capacity for all SU providers has significantly increased by 12.3%. While MAT provider capacity is unexpectedly decreasing, the capacity assessment itself demonstrates the state's ability to monitor capacity which is the primary activity in its SU Implementation Protocol. Further provider capacity assessments for the remaining inpatient and medically supervised withdrawal management services are recommended and will complete this milestone. Current efforts to add coverage for these two services in IMD's will be well-informed by the capacity assessments.

- Milestone 5. Implementation Of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

The risk of not meeting Milestone 5 is assessed as low. Two of the critical metrics are decreasing as expected in Wisconsin's SU Monitoring Protocol, but the other two are increasing. All three of the activities in the SU Implementation Protocol have been completed. Improvements to the PDMP system stand out as access to prescribing data has increased and

the useability of the PDMP interface has improved for users. Also noteworthy are opioid treatment initiatives that were unexpectedly developed due to Wisconsin's award of opioid settlement funds. No recommendations are made.

- Milestone 6. Improved Care Coordination and Transitions Between Levels of Care

The risk of not meeting Milestone 6 is assessed as medium. The coordination of care for co-occurring conditions from the SU Implementation Protocol has been furthered through administrative code and Medicaid policy updates as well as a pilot project to implement coordinated care for four sites using a hub-and-spoke service delivery model. The effort to require care coordination between the SU residential benefit and behavioral and physical health services in managed care contracts has been delayed due to residential providers' operational concerns with implementing a carved-in benefit. In addition, just 4 of the 13 critical metrics are trending in the planned direction at the midpoint and require further monitoring. The recommendation is for DHS to re-assess residential providers' concerns with carving in the SU residential benefit into managed care contracts.

The State DHS Response

In response to the recommendation for Milestone 6, the Wisconsin Department of Health Services will assess compliance with the existing policy requirement for residential SUD providers and contract requirement for HMOs to coordinate care for members they have in common. Technical assistance will be provided as needed to improve care coordination between providers and managed care entities.

APPENDIX A: DESCRIPTION OF INDEPENDENT EVALUATOR

The University of Wisconsin's Institute for Research on Poverty is the independent evaluator of Wisconsin's 1115 SUD demonstration waiver and the SU Midpoint Assessment report.

IRP was established in 1966 at the UW–Madison with funding from the federal government to serve as the nation's center for the study of the nature, causes, and cures of poverty. It is a nonpartisan research institution dedicated to producing and disseminating rigorous evidence to inform policies and programs to combat poverty, inequality, and their effects in the United States.

The IRP's Mission of Applied and Academic Policy Research

The Institute for Research on Poverty's (IRP) mission is to advance the understanding of the causes and consequences of poverty and inequality including a special focus area on health care policy. IRP brings together social scientists from across research disciplines such as economics, sociology, social work, and demography. The result is a well-rounded understanding of poverty and health care issues.

Health research and analysis projects focus on health care access, cost, financing, health system performance, and quality — in short: What works? Who benefits? Who pays?

To support these efforts, and in realization of the Wisconsin Idea, IRP engages in:

- Regular meetings with DHS leadership and program staff to understand policy priorities and create shared research and evaluation agendas
- Partnerships with agencies to pursue funding for pilot, program, and evaluation opportunities
- Translational activities to share research and evaluation results in meaningful ways with policymakers, practitioners, and the public, including the development of fact sheets, policy briefs, podcasts, webinars, and learning exchanges.

The IRP Partnership with the Wisconsin Division of Medicaid Services

The IRP's Medicaid Evaluation Research and Technical Assistance (MERTA) program provides health care research and evaluation services to the Division of Medicaid Services (DMS) through a five-year contract ending June 30, 2025. The current slate of projects includes the evaluation of large-scale CMS demonstration waivers such as for BadgerCare childless adults and SeniorCare, and health care program interventions like the Intensive Care Coordination Program (ICCP) to reduce the use of emergency departments and the Hub and Spoke model to increase access to coordinated substance use and primary care treatment.

Two primary branches of inquiry fall within IRP's MERTA program:

1. Evaluate program and policy changes planned for or occurring in Wisconsin Medicaid, as authorized by the Centers for Medicare and Medicaid Services (CMS) under federally authorized § 1115 research and demonstration waivers. The CMS § 1115 waiver Special Terms and Conditions (STCs) to State Medicaid agencies specify guidelines for rigorous, independent evaluation. An IRP-based team of investigators conducts these evaluations.

2. Provide advanced research and analytical services to advance the purposes of the Medicaid program: effective operation, quality and efficiency of services, reduced costs, and improved outcomes for Medicaid enrollees. Research and evaluation topics may be specified by DHS or may be initiated by UW investigators.

The MERTA and other IRP health policy research activities produce memos, issue briefs, make presentations to State executive branch and elected officials, and publish peer-reviewed publications.

Some examples of MERTA evaluation results that are informing Medicaid policy include:

- From 2012-2021, ***BadgerCare's*** coverage of all childless adults increased 3% and coverage of childless adults under 100% of the federal poverty level increased 29%, with little change in coverage among a comparison group of parents.

- The ***SeniorCare*** demonstration waiver program has greatly increased affordability of specialty drugs with SeniorCare members paying less than 5% of the costs paid by a comparison group of Medicare Part D members in 2019.

- Children's social and emotional functioning improved significantly while receiving ***Birth to 3 Program*** services. Less than 20% of children met age expectations for social and emotional functioning at service entry, but by service exit, more than 40% met age expectations.

Conflict of Interest Statement

The IRP conducted an independent evaluation of the progress of Wisconsin's SU Implementation Protocol without undue influence from the Wisconsin Department of Health Services (DHS). The evaluation was reliant on anecdotal evidence of progress through informal interviews with DHS staff. Wherever possible, documented evidence of activities and progress from DHS was used to substantiate progress. While DHS staffs' input was important to the report, the evaluator's analysis of evidence and determination of risk were not influenced by DHS staff.

The IRP attests to producing the SU Midpoint Assessment Report in an independent manner uninfluenced by financial, contractual, or any other potential conflicts of interest.