BadgerCare Reform 1115 Waiver
Serious Mental Illness / Serious Emotional Disturbance Amendment Application

Wisconsin Medicaid
December 2024

Contents

Section I. Executive Summary

Through this waiver amendment, the Wisconsin Department of Health Services (DHS) seeks to expand the current authority to reimburse for acute inpatient stays in Wisconsin hospital-based institutions for mental diseases (IMDs) to include Medicaid-enrolled adults, age 21-64, diagnosed with serious mental illness (SMI) or serious emotional disturbance (SED).

Wisconsin has historically covered an array of treatment options for members with substance use disorders (SUDs), including outpatient counseling, day treatment, psychosocial rehabilitation, medication-assisted treatment, and inpatient treatment. Wisconsin's BadgerCare Reform waiver was approved by the Centers for Medicare and Medicaid Services (CMS) in 2018 and authorized federal funding for treatment provided to Medicaid members in IMDs, including residential SUD treatment facilities. The BadgerCare Reform waiver equipped Wisconsin to better address the full continuum of treatment needs for members with SUD and co-occurring SUD and mental health needs by allowing Medicaid to reimburse IMDs for Medicaid eligible adults ages 21-64 with SUDs.

However, adults with severe mental illness who are not being treated for SUD continue to have limited access to acute mental health treatment in Wisconsin. Currently, Wisconsin provides coverage in IMDs for members under age 21 and over age 64. Under this waiver, Wisconsin would close this gap in coverage by reimbursing psychiatric services provided in a hospital IMD to members of all ages. Wisconsin would align coverage for all medically necessary inpatient admissions, including elective urgent admissions as well as emergency admissions for this population to match the existing coverage policy for members under age 21 and over 64. Emergency admissions are involuntary civil commitments necessary to prevent death or serious impairment of the member's health. Medicaid routinely covers medically necessary services related to medical emergencies and also intends to cover medically necessary services related to mental health emergencies. Individuals residing in an IMD under operation of criminal law would not be eligible for this benefit. Through this SMI/SED waiver amendment, Wisconsin will provide more equitable access to care for members with mental health conditions.

This SMI/SED waiver will expand access to care for new patient populations and address a critical gap in Wisconsin's continuum of crisis and mental health services. Through this waiver, Wisconsin will strengthen care coordination and transitions to community care for Medicaid-eligible adults with mental illness by implementing CMS requirements for pre-discharge care coordination planning. Care planning assessments will consider the member's social determinants of health and provide warm handoffs to community-based services. These assessments will identify treatment needs, criteria for discharge readiness, access to community resources, treatment plans, and supports. These assessments include healthcare access (insurance status, any already established providers, access to medication/pharmacy), safe housing, transportation, legal issues, and personal safety. Wisconsin's state health information exchange (WISHIN) will facilitate data sharing for care coordination and continuity of care as patients transition from inpatient to community-based treatment settings.

This waiver will build upon Wisconsin's readiness and commitment to improving access to care for individuals with mental illness. The state is actively engaged in improving behavioral health services, including crisis system transformation. After an extensive study of the state's behavioral health system in 2019, Wisconsin is aligning with the best practice "Crisis Now" framework as a comprehensive statewide crisis system. In 2022, Wisconsin began providing free, confidential services to individuals who are in crisis by implementing the 988 Suicide and Crisis Lifeline. In 2023, Wisconsin Medicaid reduced the need

for law enforcement responses by implementing an expanded mobile crisis benefit to reimburse teams of mental health professionals who respond to individuals in crisis. Since 2020, Wisconsin expanded access to treatment by opening three youth crisis stabilization facilities and five regional adult crisis stabilization facilities.

Wisconsin Medicaid provides coverage for a range of treatment options at various levels of intensity to meet the individual needs and preferences of the member. Wisconsin is dedicated to enhancing the availability of non-hospital, non-residential crisis stabilization services by improving local capacity to manage crises effectively within community settings, thereby reducing the need for residential crisis placements and promoting sustained recovery for youth and adults experiencing behavioral health challenges. Wisconsin continues to demonstrate a commitment to strengthening and expanding the continuum of care through recent initiatives to expand coverage and reimbursing for multi-disciplinary mobile crisis teams, adding new billable provider types, and updating billing codes to differentiate services along the continuum of care.

Wisconsin has a number of programs and policies that can be leveraged for earlier identification, engagement, and treatment of serious mental health conditions. This includes leveraging Wisconsin Medicaid's comprehensive coverage of outpatient mental health and substance abuse treatment services in settings as diverse as the member's home (for members under 21 years of age and the parent[s] of the member), provider's office, hospital, nursing home, school, hospital outpatient clinic, and outpatient clinic. With these policies, members receive care through schools, supported education and employment programs, and integrated behavioral health care in primary care settings in Wisconsin's Federally Qualified Health Centers (FQHCs).

Medicaid coverage is essential to the accessibility and sustainability of programs that treat mental health in Wisconsin. While Wisconsin prioritizes the provision of non-institutional, community-based mental health care, we also recognize treating some serious mental illnesses requires short-term inpatient treatment in a specialized psychiatric hospital setting. By pursuing this waiver amendment, Wisconsin seeks to fill a critical gap in the state's continuum of Medicaid-covered crisis and mental health services and improve access to necessary care for individuals with mental health conditions.

Section II. Program Background, Goals, and Strategies

A. Program Background

Through this waiver amendment, DHS seeks to expand the current authority to reimburse for acute inpatient stays in hospital IMDs to include individuals diagnosed with serious mental illness or serious emotional disturbance. This will expand access to care for new populations and address a gap in Wisconsin's continuum of crisis and mental health services.

BadgerCare Reform Waiver

In 2018, the Wisconsin DHS received authority from the Centers for Medicare and Medicaid Services to reimburse institutions for mental diseases for Medicaid eligible individuals ages 21-64 with substance use disorders. Historically, Wisconsin covered an array of treatment options for members with SUDs, including outpatient counseling, day treatment, psychosocial rehabilitation, medication-assisted treatment, and inpatient treatment. Funding for residential levels of SUD treatment was limited because nearly two-thirds of all SUD residential treatment beds in Wisconsin were in IMDs. The BadgerCare

Reform waiver sought to fill a gap in Wisconsin's continuum of reimbursable benefits by authorizing federal funding for treatment provided to Medicaid members in IMDs, including residential SUD treatment facilities.

While the existing BadgerCare Reform 1115 IMD waiver equips Wisconsin to better address the full continuum of treatment needs for individuals with SUD adults with SMI or SED who do not have SUD concerns continue to have limited access to acute mental health treatment in IMD settings. Medicaid managed care members may have some time-limited coverage as an in lieu of service and Medicaid fee-for-service (FFS) members have no coverage for IMD stays. Through this waiver amendment, Wisconsin will provide more equitable access to the full continuum of care for members with mental health conditions.

Crisis System Transformation

Wisconsin has been actively engaged in improving behavioral health services, including crisis system transformation. In 2019, Wisconsin conducted an extensive study of the state's overall behavioral health system, including a comprehensive survey of all county crisis programs, to identify strengths and gaps in existing systems of care. Since then, Wisconsin has worked to align with the best practice "Crisis Now" framework as a comprehensive statewide crisis system. In 2022, Wisconsin implemented the 988 Suicide and Crisis Lifeline to provide free and confidential support for anyone experiencing a suicidal, mental health, and/or substance use crisis. In 2023, Wisconsin Medicaid implemented an expanded mobile crisis benefit to provide reimbursement for teams of mental health professionals responding to individuals in crisis, intended to reduce the need for law enforcement responses. Since 2020, Wisconsin has opened three youth crisis stabilization facilities and five regional adult crisis stabilization facilities to provide home-like settings for individuals who can't safely stay in their community but who don't need to be hospitalized. Today, a project is underway to establish sub-acute regional crisis urgent care observation and receiving facilities. These facilities provide voluntary and involuntary treatment to individuals in crisis with the goal of avoiding unnecessary hospitalizations.

Wisconsin prioritizes the provision of non-institutional, community-based mental health care. At the same time, Wisconsin recognizes that treating some serious mental illnesses requires short-term inpatient treatment in a specialized psychiatric hospital setting. However, the lack of Medicaid funding for IMD settings limits access to care for individuals affected by SMI or SED conditions. This waiver amendment allows Wisconsin to address a gap in the state's continuum of Medicaid-covered crisis and mental health services, providing improved access to needed care for individuals with mental health conditions.

B. Demonstration Goals

Wisconsin's goals are aligned with CMS's goals for this demonstration waiver and are part of broader efforts within the Wisconsin Department of Health Services to ensure a comprehensive continuum of behavioral health services, including:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized setting.
- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.

- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

C. Wisconsin's Strategies for Addressing Waiver Milestones

Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

Wisconsin has a number of mechanisms to ensure members receive high quality care in hospitals and residential settings. These mechanisms establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes.

The Wisconsin Department of Health Services Division of Quality Assurance (DQA) is responsible for the accreditation and oversight of hospitals and residential treatment facilities. Wisconsin hospitals are licensed by DQA for behavioral health treatment as required by Wisconsin Code DHS 124.03 (1) and Wisconsin Statute § 50.36 (1). Although Wisconsin does not require hospitals to be accredited by an outside accreditation entity, nearly all hospitals seek Medicare enrollment. New hospitals have historically obtained outside accreditation within twelve months of Medicaid enrollment. Residential treatment settings are licensed by DQA to provide behavioral health treatment. Hospitals are periodically surveyed and recertified either by the state or an outside accreditation entity like the Joint Commission (every three years on average). DQA surveys hospitals to the Medicare conditions of participation (Medicare CoP). Outside accreditation entities survey hospitals to either the Medicare CoP or a higher standard. Residential treatment settings are recertified approximately every two years.

Wisconsin Medicaid has authorities and tools in place that could be leveraged to ensure members have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary. Wisconsin Code DHS 107.02(3)(a) provides authority to the Wisconsin Medicaid Program to prior authorize services, and the program already uses a certificate of need (CON) form, process, and policy for IMD stays for members under 21. The Medicaid Program's contracted External Quality Review Organization (EQRO) vendor performs reviews of CON documentation for appropriateness. Upon approval of this waiver amendment, Wisconsin will implement prior authorization or extend the CON requirements for the contracted EQRO vendor for services delivered under this waiver amendment. Wisconsin will clarify expectations for coverage and payment of services with Medicaid managed care plans.

The State has a number of mechanisms for ensuring hospitals and residential treatment settings meet federal program integrity requirements. DHS evaluates and assigns providers a risk level at enrollment and revalidation. At enrollment and while enrolled, a provider is checked against the List of Excluded Individuals and Families, Excluded Parties List System, and the Social Security Administration Death Master Report. Providers found to be in violation are end-dated. The Wisconsin Office of the Inspector General provides program integrity oversight such as data analysis, post pay audits, compliance reviews, payment integrity review, and investigation of credible allegations of fraud.

Wisconsin Medicaid requires psychiatric hospitals to meet the screening criteria set forth in Wisconsin Code DHS 105.21 and 42 CFR § 482.61 and to have the capacity to address issues discovered during screening. Upon admission, psychiatric hospitals perform a physical examination and take the patient's

health history. The expectation is the hospital will have capacity to deal with common acute physical issues or transfer the patient to a different hospital for care.

Improving Care Coordination and Transitions to Community-Based Care
Currently, Wisconsin Medicaid does not have a pre-discharge care coordination requirement specific to individuals hospitalized for SMI and SED. However, there are some requirements and resources in place that could be leveraged and expanded to achieve this milestone.

- Approximately 72% of Wisconsin Medicaid members are enrolled in acute and primary care managed care organizations (MCOs), including almost 300,000 members who require care for SMI and SED. Medicaid MCO contracts include requirements for care coordination and case management services for members.
- Wisconsin's contracts for Family Care (long-term care coverage) and Family Care Partnership (long-term care, health care, and prescription drug coverage) also include provisions for pre-discharge care coordination and require a memorandum of understanding with county human services. In Wisconsin, this is critical because county human services coordinate Medicaid member behavioral health benefits, including with IMDs.
- For members in FFS Medicaid, Medicare care coordination requirements apply. Wisconsin hospitals are surveyed to Medicare CoP and Medicare requires providers to meet the discharge planning standards identified in 42 CFR § 482.43, which include coordination with community-based providers. Wisconsin will implement a change to the FFS Medicaid policy to require care coordination before discharge from an IMD.

Addressing housing needs is not required by state or federal regulation for Wisconsin hospitals. However, many hospitals already screen and refer homeless patients to housing resources as a part of discharge planning.

- For members enrolled in SSI Medicaid, MCO contracts require consideration of housing stability as part of a broader social determinants of health assessment when developing member care plans.
- Wisconsin's Family Care and Family Care Partnership Programs conduct a risk assessment of each member's housing stability and finances to sustain housing. If required by the member, the program supplies housing counseling services and relocation services for assistance finding and establishing housing in the community.
- Include, Respect, I Self-Direct (IRIS) is a program for adults with disabilities and elderly people in Wisconsin that provides long-term care services and supports for individuals who prefer to manage their own needs through an FFS arrangement rather than through managed care. Wisconsin's IRIS program provides housing counseling and relocation services if it is an identified need chosen by the member.
- In general, FFS policy does not currently require IMDs to assess housing and referral to resources.

Wisconsin will implement a policy change to require consideration and documentation of social determinants of health, including housing stability, during IMD discharge planning.

Neither Wisconsin hospital regulations nor Wisconsin Medicaid policy require psychiatric hospitals and residential treatment settings to contact patients within 72 hours of discharge. Wisconsin Medicaid will implement a policy change to require facilities to contact each patient within 72 hours of discharge

and to ensure individuals access follow-up care after leaving those facilities and use claims auditing to assure consistent follow-up.

Wisconsin has a number of programs and resources to prevent or decrease the length of stay in emergency departments (EDs) among beneficiaries with SMI or SED, including regional crisis stabilization facilities, crisis urgent care and observation facilities, youth crisis stabilization services, co-responder mobile units and mobile assessments, an intensive ED care coordination pilot project (2017 WI Act 279), integrating peers into crisis responder models, and utilizing telehealth to support law enforcement responding to mental health crises.

In addition to the programs and resources listed above, there are two pieces of recent legislation that will expand Wisconsin's ability to prevent or decrease length of stay in EDs. These include:

- 2019 Wisconsin Act 122: DHS to create new administrative rule DHS 72 for Peer Recovery Coaches along with Medicaid reimbursement policy outside of existing benefit coverage (Spring 2025), and
- 2024 Wisconsin Act 249: DHS to create new administrative rule DHS 31 for Crisis Urgent Care and Observation Facilities (mid-late 2025).

2009 Wisconsin Act 274 established Wisconsin's State Health Information Exchange (WISHIN) and set forth requirements for interoperability and access to health information. After more than ten years of operation, the WISHIN platform can be leveraged to facilitate care coordination and continuity of care as patients transition from inpatient to community-based treatment settings.

In Wisconsin, IMDs are currently required to assess the patient immediately upon admission and periodically during their stay to identify treatment needs, criteria for discharge readiness, access to community resources, treatment, and supports. This assessment also includes access to healthcare (insurance status, any already established providers, access to medication/pharmacy,) safe housing, transportation, legal issues, and personal safety.

Increasing Access to Continuum of Care Including Crisis Stabilization Services
Wisconsin Medicaid provides coverage for a range of treatment options at various levels of intensity to meet the individual needs and preferences of the member.

Wisconsin DHS has the resources to conduct an annual assessment of the availability of mental health providers. Wisconsin is currently creating a publicly available directory of Medicaid-enrolled providers. The project is expected to be complete in July 2025.

The Wisconsin Department of Health Services Division of Care and Treatment Services (DCTS) is dedicated to enhancing the availability of non-hospital, non-residential crisis stabilization services. The DCTS Bureau of Prevention, Treatment, and Recovery improves local capacity to manage crises effectively within community settings, thereby reducing the need for residential crisis placements and promoting sustained recovery for youth and adults experiencing behavioral health challenges. Medicaid covers crisis intervention services including mobile crisis response, crisis stabilization and crisis follow up. Wisconsin continues to demonstrate a commitment to strengthening and expanding the continuum of care through recent initiatives to expand coverage and reimbursing for multi-disciplinary mobile crisis teams, adding new billable provider types, and updating billing codes to differentiate services along the continuum of care. Medicaid coverage is essential to the sustainability of county crisis programs.

The Wisconsin Hospital Association (WHA) administers a psychiatric bed locator tool that allows participating providers to identify available inpatient and crisis stabilization beds. Participation is voluntary. Wisconsin will work with WHA to expand participation in the psychiatric bed locator tool, particularly among state-run hospitals and crisis stabilization providers.

Per Wisconsin Code DHS 51.03(5)(b), Wisconsin requires a comprehensive assessment has been completed to determine a plan of care. There is no specific assessment tool required for IMDs and other behavioral health providers. Many behavioral health providers use LOCUS as a standard assessment tool. Wisconsin will require the use of an evidence-based tool, but not a specific tool, to allow for flexibility to use the appropriate tool in the appropriate situation.

Earlier Identification and Engagement in Treatment, Including Through Increased Integration
Wisconsin has a number of programs and policies that can be leveraged for earlier identification of serious mental health conditions and focus efforts to engage individuals for earlier treatment, including existing programs focused on young adults and adolescents.

Existing Wisconsin Medicaid provides cover services that identify youth in need of SMI or SED treatment. These mechanisms can be adapted to identify adults in need of SMI or SED treatment and include:

- The Coordinated Services Team, Coordinated Specialty Care programs, and the Individual Placement and Support model provide supports for youth in need of SMI and SED treatment. The Wisconsin Department of Health Services Division of Medicaid Services Bureau of Children's Services and Employment Resources Inc. coordinate on Think Possible!, a website that assists parents and youth to build a future toward employment.
- 2017 Wisconsin Act 178 requires the Department of Workforce Development's Division of Vocational Rehabilitation, the Department of Health Services, and the Department of Public Instruction to collaborate, with the input of interested parties, in the development of a joint plan to increase Competitive Integrated Employment in Wisconsin for adults and youth.
- The Wisconsin Department of Health Services Division of Medicaid Services Children's Long-Term Supports Waiver Program benefit includes supports for career planning and community integrated employment for youth.
- Children enrolled in the Wisconsin Department of Health Services Division of Medicaid Services Comprehensive Community Services program receive services for mental or behavioral health needs that, if ignored, could lead to hospitalization during a crisis.

Nearly all schools across the state partner with specialty treatment providers or employ their own school-based mental health providers to offer access to expert resources and consultation, enhancing early intervention. The Wisconsin Intellectual and Developmental Disabilities-Mental Health System Improvement Program (START) aims to improve systems and services for people who have intellectual and developmental disabilities and mental health needs. The next phase of the START project will be the Implementation Phase. In recent years, there has been a movement towards integrating behavioral health care into primary care settings in Wisconsin's FQHCs. Wisconsin Medicaid covers collaborative care and behavioral health integration services in primary care settings, including FQHCs.

Wisconsin has a number of options for specialized settings and services focused on the needs of young people. Wisconsin Medicaid provides comprehensive coverage of outpatient mental health and substance abuse treatment services. Reimbursement is allowed in the home (for members under 21 years of age and the parent[s] of the member), provider's office, hospital, nursing home, school, hospital outpatient clinic, and outpatient clinic. In addition, Wisconsin established Youth Crisis Stabilization

Facilities (Wisconsin Code DHS 50) in 2020. These are an allowable place of service for the Medicaid Crisis Intervention benefit. Regional Crisis Stabilization Facilities are located across the state.

Section III. Demonstration Description

A. Delivery System

All enrollees will continue to receive services through their current delivery system.

B. Eligibility Requirements

All Wisconsin Medicaid enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, except those listed below, and between the ages of 21 and 64, will be eligible for services under the waiver amendment, subject to medical necessity criteria.

Only the following eligibility groups will not be eligible for services under the waiver amendment, as these groups provide limited Medicaid benefits only.

- Emergency Services for Non-Qualifying Aliens (42 CFR § 435.139)
- Qualified Medicare Beneficiary (QMB) Program (1902(a)(10)(E)(i) and 1905(p) of the Social Security Act)
- Specified Low-Income Medicare Beneficiary (SLMB) Program (1902(a)(10)(E)(iii) and 1905(p) of the Social Security Act)
- Qualifying Individual (QI) Program (1902(a)(10)(E)(iv) and 1905(p) of the Social Security Act)
- Qualified Disabled and Working Individual (QDWI) Program (1902(a)(10)(E)(ii) and 1905(s) of the Social Security Act)
- Tuberculosis-Related Medicaid (42 CFR § 435.215)
- Temporary Enrollment for Pregnant Members (42 CFR § 435.1103(a) and 42 CFR § 435.1110)
- BadgerCare Plus Prenatal Program (42 CFR § 457.10)
- SeniorCare Prescription Drug Program (1115(a) of the Social Security Act)
- Family Planning Only Services (42 CFR § 435.214)

C. Benefits Coverage

Currently, Wisconsin Medicaid members have access to a wide array of behavioral health services, including inpatient, residential treatment, partial hospitalization, intensive outpatient program, outpatient behavioral health, crisis stabilization, peer support, Medication-Assisted Treatment, and other services. Over the course of this demonstration, Wisconsin will maintain coverage for these services and seek to enhance these benefits by improving quality, access, and utilization.

In addition to maintaining and enhancing these services, Wisconsin will expand the settings eligible for reimbursement where clinically appropriate short-term stays for acute or residential psychiatric care can be provided through this demonstration, subject to medical necessity. Currently, Wisconsin provides coverage in IMDs for members under age 21 and over age 64. Under this waiver, Wisconsin would close this gap in coverage by reimbursing psychiatric services provided in a hospital IMD to members of all ages. Wisconsin would align coverage for elective urgent admissions as well as emergency admissions for this population to match the existing coverage policy for members under age 21 and over 64. Emergency admissions are involuntary civil commitments necessary to prevent death or serious impairment of the member's health. Medicaid routinely covers medically necessary services related to medical

emergencies and should also cover medically necessary services related to mental health emergencies. Individuals residing in an IMD under operation of criminal law would not be eligible for this benefit. The addition of IMDs to the network of Medicaid behavioral health care providers will help ease some of the current access challenges and expand access to the full continuum of evidence-based care.

D. Cost Sharing

The Waiver amendment does not impose new cost-sharing requirements. Rather, those individuals determined eligible for Medicaid will be subject to the same nominal copayments and cost sharing as authorized under Wisconsin's Medicaid State Plan.

E. Impact on Enrollment

This demonstration is not expected to impact enrollment because the waiver amendment will enable additional services to be provided.

F. Payment Rates

Payment methodologies will be consistent with those approved in the Medicaid State Plan.

Section IV. Impact on Expenditures/Financing and Budget Neutrality

Federal policy requires Section 1115 demonstration waivers are budget neutral to the federal government. This means a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration. Demonstration of federal budget neutrality for a Section 1115 demonstration application must follow a unique process from federal and state budgeting and health plan rate setting. The processes, methods, and calculations required to demonstration federal budget neutrality appropriately are for that express purpose only. Therefore, the budget neutrality model should not be construed as a substitute for budgeting and rate setting or imply any guarantee of any specific payment.

To ensure budget neutrality for each federal fiscal year for this extension, Wisconsin uses a per-member-per month (PMPM) based methodology specific to the applicable Medicaid Eligibility Group (MEG) for this waiver population. The MEG is defined as individuals, ages 21 through 64, diagnosed with serious mental illness or serious emotional disturbance for short term stays for acute care treatment in psychiatric hospitals that qualify as IMDs. The PMPM calculation has been established in the context of current federal and state law, and with the appropriate analytically sound baselines and adjustments. The Department is currently working with CMS on the final Budget Neutrality limits. CMS establishes the trend rates and amounts at approval. The outcome of these calculations will be shared as an appendix with the CMS application and the final budget neutrality limits will be posted at approval.

Section V. Demonstration Hypothesis and Preliminary Evaluation Plan

This demonstration will test whether the expenditure authority granted under this demonstration, in addition to other current behavioral health delivery system enhancements results in increased access to health care services and improved health outcomes for individuals with SMI or SED.

Wisconsin proposes the following preliminary evaluation plan which has been developed in alignment with CMS evaluation design guidance for SMI/SED 1115 waiver demonstrations. Upon approval of this waiver amendment application, the State will contract with an independent evaluator to conduct a rigorous and independent evaluation of the demonstration. Wisconsin will work with CMS and the evaluator to develop the design and methods for the evaluation. Evaluation design and reports will follow CMS guidelines.

The tables below present the preliminary evaluation plan based on CMS guidance. Goals and hypotheses are linked to evaluation questions and evaluation parameters and methodology.

<table>
<tr><th>Objective/Goal</th><th>Hypothesis</th><th>Evaluation Parameters/Methodology</th></tr>
<tr><td colspan="3">Evaluation Questions:
• Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings?
• How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED vary by geographic area or beneficiary characteristics?
• How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings?</td></tr>
<tr><td>GOAL 1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.</td><td>Hypothesis 1. The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.</td><td>Data Sources:
• Claims data
• Medical records or administrative records
• Interviews or focus groups

Analytic Approach:
• Difference-in-differences model
• Subgroup analyses
• Descriptive quantitative analysis
• Qualitative analysis</td></tr>
</table>

<table>
<tr><th>Objective/Goal</th><th>Hypothesis</th><th>Evaluation Parameters/Methodology</th></tr>
<tr><td colspan="3">Evaluation Questions:
• Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings?
• How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics?
• How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings?</td></tr>
</table>

• Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?		
GOAL 2. Reduced preventable readmissions to acute care hospitals and residential settings.	**Hypothesis 2.** The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	**Data Sources:** • Claims data • Medical records • Beneficiary survey **Analytic Approach:** • Difference-in-differences model • Qualitative analysis • Descriptive quantitative analysis

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: • To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state? • To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? • To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?		
GOAL 3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs; psychiatric hospitals; and residential treatment settings throughout the state.	**Hypothesis 3.** The demonstration will result in improved availability of crisis stabilization services throughout the state.	**Data Sources:** • Annual assessments of availability of mental health services • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: • Does the demonstration result in improved access of beneficiaries with SMI or SED to community-based services to address their chronic mental health needs?		

• To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI or SED? • To what extent does the demonstration result in improved access of SMI or SED beneficiaries to specific types of community-based services? • How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics? • Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI or SED improve under the demonstration?		
GOAL 4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care.	**Hypothesis 4.** Access of beneficiaries with SMI or SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	**Data Sources:** • Claims data • Annual assessments of • availability of mental • health services • Administrative data • Medical records **Analytic Approach:** • Descriptive quantitative analysis • Chi squared analysis • Difference-in differences model

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: • Does the demonstration result in improved care coordination for beneficiaries with SMI or SED? • Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? • Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities? • How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?		
GOAL 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Hypothesis 5.** The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Data Sources:** • Claims data • Medical records • Interviews or focus groups • Facility records **Analytic Approach:** • Difference-in-differences model • Descriptive quantitative analysis

		• Qualitative analysis

Section VI. Waiver and Expenditure Authorities

Wisconsin requests expenditure authority under this Section 1115 Waiver amendment for otherwise covered services furnished to otherwise eligible individuals, ages 21 through 64, for short-term stays for acute care in a psychiatric hospital that qualifies as an IMD. No additional waivers of Title XIX or Title XXI are requested through this demonstration application. All other initiatives and proposed program enhancements will be implemented through other authorities outside of this Section 1115 Waiver.

Appendix A. Acronyms

Acronym	Definition
CMS	Center for Medicare and Medicaid Services
CON	Certificate of Need
DHS	Wisconsin Department of Health Services
DMS	Division of Medicaid Services (Wisconsin Department of Health Services)
DQA	Division of Quality Assurance (Wisconsin Department of Health Services)
ED	Emergency Department
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
IMD	Institution for Mental Diseases
IRIS	Include, Respect, I Self-Direct
MCO	Managed Care Organization
Medicare CoP	Medicare Conditions of Participation
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
START	The Wisconsin Intellectual and Developmental Disabilities-Mental Health System Improvement Program
SUD	Substance Use Disorder
WISHIN	Wisconsin State Health Information Network (State-Designated Health Information Exchange)