State of Wisconsin
Department of Health Services
Scott Walker, Governor
Linda Seemeyer, Secretary

February 16, 2018

Dear Chairman Hatch, Ranking Member Wyden and Members of the US Senate Committee on Finance,

Thank you for your letter requesting feedback to inform policy recommendations to address root causes that lead to or fail to prevent, opioid use disorder (OUD) and other substance abuse disorders (SUD) and to improve access to quality of treatment. Below, please find the Wisconsin Department of Health Services (WI DHS) feedback and recommendations on the eight questions you included in your letter.

1) How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?
    - State Medicaid programs generally use the Medicare fee schedule as a benchmark for rate setting. WI DHS continues to encourage Medicare to ensure rates promote provider willingness to participate in our programs and promote higher rates for cost-effective, evidence-based alternatives to pain management vs. more costly non-evidenced based procedures.

2) What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid?
    - Medicaid covered services definitions and provider types are in a traditional medical model while non-pharmaceutical therapies for chronic pain may not fit this model for obtaining payment from Medicaid.
    - Medicaid programs need authority within Section 1905 to pay for non-traditional treatment by providers who may not be able to meet traditional Medicaid-enrollment and medical models.
    - Additionally, federal incentives/requirements/support to ensure that Medicaid is not the only payer in the market for these non-traditional services would be helpful. Federal movement to encourage adoption across self-insured, commercial, Medicare, Medicaid, QHPs, Marketplace, etc., should be considered.
    - Another way to improve access to quality treatment is finding a way to transition federal grant funded care models into best-practice sustainable models with commercial/Medicaid benefit payments. For example, Wisconsin has a promising model for MAT which focused on highly individualized wraparound supports which doesn't fit into a traditional 1905 payment category when moving to sustainable Medicaid payment model. We need the federal government to allow CMS to take SAMHSA models that are deemed "best practice" and allow states to draw down federal Medicaid dollars to fund without requiring the time intensive and onerous processes of the 1115 waiver for small models. Given the public health crisis, state Medicaid programs should be granted authorize to pay for evaluated SAMSHA grants that are found to be successful by SAMSHA.

3) How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?
    - Allow Medicaid coverage of residential addiction treatment in IMD settings larger than 16 beds for adults between 21 and 65 without a special Medicaid Waiver.
    - Assure continued Medicaid, Medicare and health plan coverage for evidence-based treatment for Opioid Use Disorders (OUD), including Medication-Assisted Treatment and addictions counseling services.
    - Authorize benefits in Medicare and Medicaid to include reimbursement for peer specialist services in outpatient addiction counseling as, well as other treatment settings, to improve client engagement and recovery support for people with OUDs.
    - Increase incentives and remove disincentives for screening for Substance Use Disorders (SUD) in the primary care settings; and otherwise increase incentives in Medicaid and Medicare to offer integrated primary and behavioral health care to follow-up on those individuals who screen positive for the need for an assessment for addiction treatment services.
    - Initiate a Behavioral Health Workforce Task Force to address the nation-wide shortage of key personnel in addictions treatment from physicians with addictions specialty to substance abuse and mental health counselors. This could include recognizing substance use disorder treatment facilities as approved sites for the National Health Service Corps program.
    - Provide guidance to hospitals on treating individuals experiencing an overdose to include best practices for linking and engaging individuals into treatment, as well as providing access to life-saving medication, naloxone, at discharge.

4) Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?
    - Assure that Medicare reimburses for full range of FDA approved Medication-Assisted Treatment medications, including Methadone in outpatient settings. Currently Medicare does not cover methadone for opioid use disorder in the community at opioid treatment programs. This creates a significant barrier to treatment for many older adults.

5) How can Medicare and Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?
    - Provide 90/10 match for state DUR activities to encourage states to invest more resources into existing work efforts in this area. State DURs are doing this work, but many times resources are limited due to staff.
    - Designate a staff team at CMS and clinical advisory team that states could use as a resource for developing algorithms and targeted interventions that are best practices for states and to disseminate best practice letters for states to issue.

6) What can be done to improve data sharing and coordination between Medicaid, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?
    - 42CFR Part II: Use federal and legislative authority to align privacy and confidentiality regulations, addressing legal barriers to information sharing related to substance abuse. Create standard mechanisms for patient consent to share substance use and behavioral health-related information. Alternately, consider allowing Medicaid agencies to waive this rule for sharing SUD-related information, for treatment purposes.

- Create specific federal legal interpretations for information sharing, so individual agencies are not subject to different legal interpretations. In Wisconsin, our PDMP is housed in a different state agency, not WI DHS. There is a need to facilitate streamlined interpretations across federal, state, and organizational policies, to encourage information sharing.

7) What best practices employed by states through innovative Medicaid policies or the private sector can be enhance through federal efforts or incorporated into Medicare?
    - Please refer to our last bullet for question #2.

8) What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?
    - Both WI DHS and Wisconsin Department of Children and Families have supported and funded partners to implement the Strengthening Families curriculum in communities. Strengthening Families is an is an evidence-based program found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance. Parents also strengthen bonds with their children and learn more effective parenting skills.