OKLAHOMA
Health Care Authority

Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness/Substance Use Disorder

DRAFT FOR PUBLIC COMMENT

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I. EXECUTIVE SUMMARY

The Oklahoma Health Care Authority (OHCA), in coordination and collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), seeks authorization for a Section 1115(a) demonstration waiver to support a more robust and coordinated continuum of care for adults with serious mental illness (SMI) and substance use disorder (SUD). Like many states, Oklahoma has been significantly affected by the opioid epidemic, and the state continues to experience high rates of SMI and SUD. The current outpatient behavioral health and addiction recovery delivery system is primed for a new influx of Medicaid-eligible adults resulting from the state's pursuit of Medicaid expansion effective July 1, 2020. However, the state seeks to provide richer coverage for higher-intensity services in recognition that robust support of the full continuum of care will promote better outcomes, support recovery, reduce health care costs, and improves the lives of beneficiaries.

Specifically, Oklahoma requests Medicaid reimbursement for medically necessary residential substance use disorder (SUD) treatment, facility-based crisis stabilization, and inpatient treatment services within settings that qualify as institutions for mental disease (IMDs). The goal of the state is to increase access to evidence-based treatment options for newly eligible, as well as currently eligible, adults ages 21-64 with SMI and/or SUD to appropriately address acute behavioral health needs, improve rates of morbidity and mortality for covered populations, and decrease utilization of less appropriate services, such as emergency room visits. The state also seeks to include residential IMD SUD services for individuals under 21 years of age under this waiver, as well as Qualified Residential Treatment Programs (QRTPs), that are determined by the state to meet the definition of an IMD, when they are implemented.

Oklahoma is dedicated and prepared to ensure access to residential and inpatient treatment settings when medically necessary and when other less restrictive settings and services are not in the best interest of the individual. The state also remains committed to maintaining a robust continuum of community-based outpatient services and supports and will enhance current efforts to support a coordinated system of care to promote more successful outcomes and prevent readmissions. Oklahoma's current service delivery system includes a number of innovative service delivery models. Particularly, within the last several years, the state has demonstrated its commitment to a responsive and coordinated statewide system of care through implementation of models such as Health Homes and Certified Community Behavioral Health Clinics (CCBHCs). The state also has a robust crisis assessment and diversion system to support the placement of individuals in least restrictive settings. Oklahoma's wide array of outpatient services is available to both Medicaid enrollees and other individuals not currently eligible for Medicaid. Medicaid expansion in the state will increase availability of these services for newly eligible adults, which will in turn may reduce the need for inpatient and residential treatment for the new population of Medicaid beneficiaries.

The state requests an effective date for this demonstration waiver of October 1, 2020.

II. PROGRAM BACKGROUND AND DESCRIPTION

Overview of Oklahoma's Behavioral Health Service Delivery System

The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) work collaboratively to provide a wide array of behavioral health services for Oklahomans. Medicaid compensable inpatient services are largely administered by the OHCA,

while Medicaid compensable outpatient behavioral health services and other state-funded supports are largely administered by the ODMHSAS. A combined payer system consolidates eligibility determinations, claims, authorizations, and outcomes data for publicly funded services, including both Medicaid compensable and state-funded services.

Services and supports are available statewide through a network of private and government-operated programs. These programs include 13 Community Mental Health Centers (CMHCs) and approximately 70 contracted substance use disorder treatment providers, including 11 Certified Community Addiction Recovery Centers (CCARCs). There are 21 Health Homes for adults with serious mental illness (SMI) and 20 Health Homes for children with serious emotional disturbance (SED) within the provider network; all CMHCs are certified as Health Homes. Health Homes are required to provide care coordination and care management to ensure integrated behavioral health and health care. In addition, there are two RA1SE NAVIGATE programs to assist individuals who are experiencing first episode of psychosis (FEP), along with one FEP crisis care program, and 13 statewide early serious mental illness (eSMI) outreach programs provided through CMHCs. These programs develop and maintain collaborative partnerships with local higher education institutions and local hospitals to increase exposure to young adults within the age range that is most at risk for eSMI.

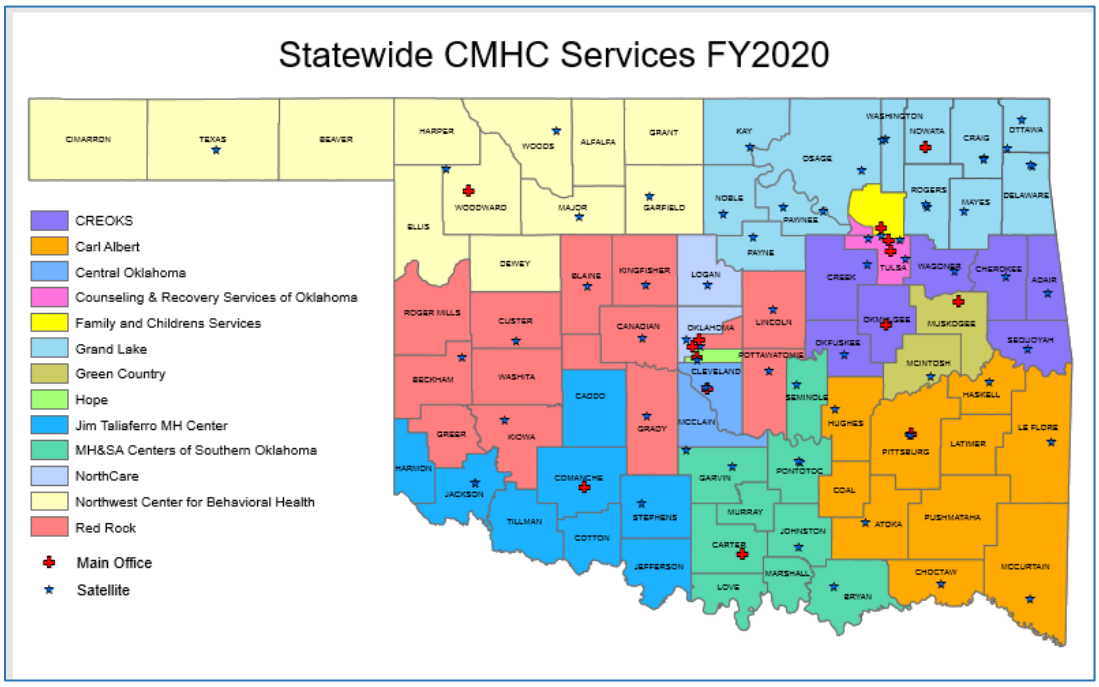
The statewide network of CMHCs is primarily responsible for comprehensive services for adults with SMI. CMHCs served over 82,000 unique individuals in SFY 2019. CMHCs, by regulation, must provide crisis intervention, medication and psychiatric services, case management, evaluation and treatment planning, therapy services, and psychosocial rehabilitation. In addition, clients are provided with job location and placement, housing assistance, educational services, case management services, and other needed supports. All CMHCs also provide co-occurring and SUD treatment services.

The 13 CMHCs also participate in the Oklahoma Systems of Care (SOC) Initiative. Currently, Oklahoma has 80 local SOC sites that cover 72 counties. The SOC sites work in equal partnership with local teams and community organizations to ensure that children with SED and their families have access to the full array of services they need. The SOC initiative includes mobile crisis response and coordinated community response for children across most of the state, as well as community-based assessment to ensure children are placed in appropriate settings and supported in the community whenever possible. Community Based Structured Crisis Centers for children, located in Oklahoma City and Tulsa, address the emergent needs of children and their families.

In the adult system, CMHCs provide emergency assessments to individuals within their communities, largely via telehealth in rural areas. During this process, licensed behavioral health professionals (LBHPs) have the opportunity to stabilize a potential mental health crisis. Seven CMHCs currently serve adults within their mobile crisis teams. There are 11 Programs of Assertive Community Treatment (PACT), all of whom respond to their clients 24/7 (some leveraging technology such as iPads) to de-escalate crisis situations and help individuals maintain independence within their own home, in their own community. ODMHSAS data shows that the average number of inpatient days for CMHC clients has gone from 29.9 in SFY 2015 to 18.7 in SFY 2019.

There are nine crisis centers for adults located in the state. Currently, the state has only one facility-based crisis center with 16 or more beds; however, the state requests authority under this demonstration to include eligibility for Medicaid reimbursement for such facilities that qualify as IMDs. Crisis centers serve

as an important component of the continuum of care, often preventing the need for inpatient admission and allowing for diversion of individuals in behavioral health crisis from emergency departments when clinically appropriate. The state anticipates the potential for increased demand and therefore increased need for access to these Medicaid behavioral health services for newly eligible adults.



Oklahoma's SUD treatment and recovery services network currently provides services across the state and includes CMHCs and other ODMHSAS funded and/or Medicaid enrolled providers. The ODMHSAS funded services are primarily purchased through contracts with private, for-profit and non-profit, certified agencies to provide multiple levels of withdrawal management, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services with substance abuse block grant funds and state appropriations. All SUD treatment organizations must be certified by ODMHSAS. Facilities can be certified as a basic alcohol and drug treatment program providing a specific service set, an opioid treatment program, or as a Certified Comprehensive Addiction Recovery Center (CCARC) providing a full continuum of care, including intensive outpatient services. Currently, 11 CCARCs operate across 11 counties, with 26 site locations. Eighteen opioid treatment program locations cover 10 counties in the state.

The Oklahoma Department of Human Services (DHS) currently operates some congregate care facilities for children in state custody. The state plans to transition these facilities and their care model to serve as Qualified Residential Treatment Programs (QRTPs). The anticipated implementation date is October 1, 2021. As QRTPs are implemented, the state requests authority for Medicaid reimbursement of stays of 60 days or less in facilities that the state determines are IMDs.

Oklahoma's Need and Demand for Services

According to SAMHSA's 2017-2018 National Survey on Drug Use and Health (NSDUH), Oklahoma consistently has among the highest rates nationally for mental illness and substance use disorder. An estimated 20.43% of Oklahomans age 18 or older experience mental illness and 5.23% are estimated to have a serious mental illness. An estimated 8.54% of Oklahoma's population in that age group have a substance use disorder.[1]

Current Medicaid enrollee data and estimates for the newly eligible adult population based on prevalence rates are provided below. Estimated new enrollment in the first year of Medicaid expansion, beginning July 1, 2020, is 128,703. Estimated enrollment of newly eligible adults within the Healthy Adult Opportunity waiver, beginning July 1, 2021, is 144,285 individuals in demonstration year 1, and 151,624 in subsequent demonstration years.

Serious Mental Illness (SMI)

Population	Demonstration Year (DY) 1	DY 2	DY 3	DY 4	DY 5
Current Adult Medicaid Beneficiaries with identified SMI	62,979	62,979	62,979	62,979	62,979
Estimated New Enrollment: Adults with SMI	6,731	7,546	7,930	7,930	7,930
Total	**69,710**	**70,525**	**70,909**	**70,909**	**70,909**

Substance Use Disorder (SUD)

Population	Demonstration Year (DY) 1	DY 2	DY 3	DY 4	DY 5
Current Adult Medicaid Beneficiaries with Identified SUD	6,183	6,183	6,183	6,183	6,183
Current Medicaid Beneficiaries Under Age 18 with Identified SUD	639	639	639	639	639
Estimated New Enrollment: Adults with SUD	10,991	12,322	12,949	12,949	12,949
Total	**17,813**	**19,144**	**19,771**	**19,771**	**19,771**

Notes: DY 1 estimates are based on an estimated 128,703 newly eligible adults as a result of Medicaid expansion. DY 2 estimates are based on an estimated new enrollment of 144,285 within the first year of the Healthy Adult Opportunity, and subsequent years are based on an estimated new enrollment of 151,624. Adults represented in the newly eligible adult group include individuals ages 19-64. Adults represented in the current adult group include individuals ages 18 and over in alignment with the availability assessment.

[1]SAMHSA 2017-2018 National Survey on Drug Use and Health. Accessed from https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates.

A 2016 study by the Commonwealth Fund found that Oklahoma had the eighth highest rate of deaths due to suicide, alcohol poising, or drug overdose. In 2016, methamphetamine became the primary drug of choice cited by those seeking ODMHSAS substance use treatment services. Similar to many states, opioid abuse has become a public health crisis in Oklahoma. Data from the NSDUH 2017-2018 report shows more than 4% of the population ages 12 and older is abusing/misusing painkillers, a rate higher than the national average.[2] A waiver of the IMD exclusion to expand SUD residential services will complement state efforts to combat these high rates.

Oklahomans continue to experience unmet needs for acute treatment of SMI and SUD, including waiting lists for inpatient and residential treatment. For residential treatment of substance abuse alone, recent data from ODMHSAS show that 158 women were on the waiting list (with an average wait time of 29 days to get into treatment) and 415 men were on the list (with an average wait time of 203 days to get into treatment). With additional funds appropriated through the Oklahoma Legislature in 2019, additional residential treatment beds are being added and are estimated to reduce waiting lists by 75%.

Numbers Served

In SFY 2019, 5,353 children under 21 and 2,078 adults ages 21-64 received Medicaid-funded inpatient psychiatric services. In that same year, 196,603 Oklahomans received outpatient and/or state-funded inpatient behavioral health services, of which 55.4% were individuals aged 18 or older. Over 33,000 of those individuals received services for substance abuse disorders; of those, nearly 30,000 were between the ages of 18 and 64. Nearly 18,000 of those adults had a co-occurring mental health and substance abuse diagnosis.

Opioid Epidemic

In 2012, Oklahoma had the fifth highest unintentional poisoning mortality rate in the United States (18.6 deaths per 100,000 population), which paralleled a significant increase in the dispensing of opioid pain relievers for non-cancer pain.[3] Opioid analgesics are involved in more unintentional poisoning deaths in the state than any other medication, representing 69.1% of all unintentional poisoning deaths associated with medications from 2007-2012.[4] Oklahoma is also one of the leading states in painkiller prescriptions per capita.[5] In 2017, Oklahoma providers wrote 88.1 opioid prescriptions for every 100 persons (a 30% decline since 2012, when the rate was 127 opioid prescriptions per 100 persons).[6]

Health Status and Health System Performance

According to the America's Health Rankings 2019 report, Oklahoma ranks 46th for overall health status. The state ranks 42nd in overall health behaviors, with continued high rates of physical inactivity, obesity, and smoking. Oklahoma ranks 32nd in clinical care overall, with a ranking of 44th for preventable

[2] SAMHSA 2017-2018 National Survey on Drug Use and Health. Accessed from https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates

[3] Paulozzi L.J., Butnitz D.S., Xi Y. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiology and Drug Safety 2006;15:618-627.

[4] https://www.ok.gov/health2/documents/UP_Deaths_2007-2012.pdf

[5] Centers for Disease Control and Prevention. Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012. MMWR 2014;63

[6] CDC, US Opioid Prescribing Rate Maps. Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.

hospitalizations. Additionally, the state ranks 47th in cancer deaths, 49th in cardiovascular deaths, 44th in premature death, and 43rd in frequent mental distress.[7]

The 2019 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 50th in overall health system performance, with the state in the bottom quartile on access and affordability, avoidable hospital use and costs, healthy lives, and disparity.[8] Medicaid expansion will significantly increase the number of Oklahomans with health insurance, and subsequently the number of individuals receiving treatment for chronic physical and behavioral health conditions.

Oklahoma's Innovative Strategies

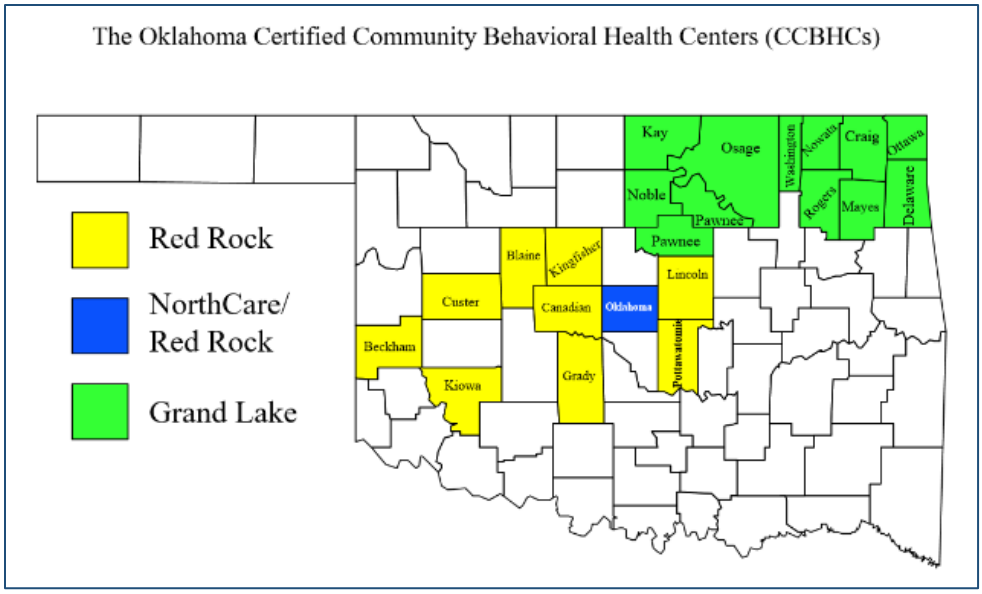
Certified Community Behavioral Health Clinics

In October 2016, Oklahoma was one of only eight states selected by SAMHSA and CMS to pilot Certified Community Behavioral Health Clinics (CCBHCs). The CCBHCs represented an opportunity for states to improve the behavioral health of their citizens by providing community-based mental health and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is an improvement over existing services. Participating CCBHCs must provide a broad array of services and care coordination across settings and providers on a full spectrum of health, including acute, chronic, and behavioral health needs. The CCBHC model also requires integrating mental health, substance use disorder, and physical health services at one location. Quality measures, which include screenings for body mass index, tobacco use, and unhealthy alcohol use and suicide risk assessments, are monitored by ODMHSAS.

There are three behavioral health clinics participating in this program, with site locations covering 22 counties. CCBHCs served over 35,000 unique individuals in SFY 2019. Initial data from the current three CCBHCs shows average inpatient days for CCBHC clients declined from 33.9 in SFY 2017 to 26 in SFY 2019. Further, for clients tracked previous to the launch of CCBHCs, data shows the average number of days inpatient was 43.2 in SFY 2016, demonstrating a significant decrease in the first fiscal year of CCBHC implementation.

[7] America's Health Rankings. (2019). Retrieved from https://www.americashealthrankings.org/learn/reports/2019-annual-report/state-summaries-oklahoma.

[8] Commonwealth Health Fund Score Card 2019 https://scorecard.commonwealthfund.org/state/oklahoma.



Health Homes

Pursuant to a state plan amendment approved on February 10, 2015, Oklahoma implemented a Health Home service delivery model to improve care coordination and service integration, with the goal to improve health outcomes and control future health care costs for individuals with SMI or SED. Unique individuals served in Health Homes has risen from 16,530 in SFY 2016 to 25,544 in SFY 2019, with average inpatient days for Health Home clients decreasing from 42.3 to 22.2 in the same time period. Children with SED and adults with SMI are the most likely of all Oklahoma citizens to need inpatient psychiatric care, and people with SMI in Oklahoma die 25 years younger than the general population on average. Chronic health conditions are a large factor in these populations.

Health Homes focus on the integration of primary care, mental health services, and social services and supports for Medicaid-eligible adults diagnosed with SMI or children diagnosed with SED. The Health Home services model of care utilizes an interdisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals. The Health Home provides opportunities for Medicaid beneficiaries to receive services in their own home or community. Health Home services are designed to help connect people to medically appropriate services, and to help people remove barriers that keep them from effectively engaging with medically necessary services.

Crisis Care and Community-Based Assessments

A tiered support system is currently in place to ensure every effort is made to use inpatient and residential beds when clinically indicated and to support successful outcomes with outpatient services and community supports. ODMHSAS data show that 90% of urgent care clients are diverted from needing a crisis care bed; approximately 93% of individuals receiving crisis care do not move to a hospital bed; and approximately 95% of crisis care recipients are engaged with outpatient service follow-up within seven days of leaving crisis care.

Oklahoma utilizes a system of coordinated community response and mobile crisis response within the Systems of Care network to ensure children in crisis are connected with the appropriate level of care. Community-based assessments (CBAs) are completed by licensed behavioral health professionals (LBHPs) to ensure children in crisis are diverted from more restrictive inpatient settings if other community-based services are available to meet their needs. This system covers the majority of the state outside of the metropolitan areas, and Oklahoma is potentially pursuing expansion of this service to currently unserved areas. The CBA process involves a strong partnership between ODMHSAS and OHCA. CBA providers complete the assessment and work closely with OHCA to locate a proper placement for the child if medically necessary. Once placed in an inpatient setting, requests for extensions of care are provided to the CBA provider from OHCA. A determination from the CBA provider with a clinical rationale for denial or approval, as well as number of days if approved, is then given to OHCA within two hours.

The CMHCs have statewide coverage and are responsible for mental health crises in their service areas. In the adult system, CMHCs provide emergency assessments to their communities, largely via telehealth in rural communities. During this process, LBHPs have the opportunity to stabilize a potential mental health crisis. Seven CMHCs currently serve adults within their mobile crisis teams, with LMHPs connected 24/7 either in person or through telehealth in all but one. There are 11 programs of assertive community treatment (PACT), all of which respond to their clients 24/7 (some via iPads) to de-escalate crisis situations and help individuals maintain in their own home in their own community. All but one is operated within a CMHC. Additionally, one CMHC that covers the northeastern corner of the state provides every client with an iPad that can be used for 24/7 emergent or non-emergent needs. This CMHC also provides iPads to law enforcement in its service area, allowing law enforcement to access a mental health professional without transporting the individual to a facility, reducing police transports and emergency room utilization. In addition, there are nine crisis centers for adults located in the state. Three more are planned for Oklahoma City within the next several years as part of a city improvement ballot initiative passed in December 2019.

Three CMHCs are part of the original CCBHC federal demonstration program, with current funding extended through November 2020. Additionally, a state plan amendment to move forward with new CCBHCs was approved by CMS June 4, 2019. One CMHC is certified to date, with two having active applications and one nearing application. ODMHSAS holds monthly technical assistance meetings to support and promote providers in transitioning to CCBHCs. Within the next two years, the state anticipates CCBHC implementation statewide. This model requires 24/7 mobile crisis response, as well as the ability for crisis response up to 23 hours and 59 minutes to stabilize every crisis possible and divert as many individuals as possible from the necessity of crisis center admissions and/or inpatient admissions.

Discharge Coordination

Efforts to promote successful transitions are integrated within ODMHSAS contractual requirements and administrative rules for providers. CMHCs and substance use disorder providers are contractually required to use the addiction severity index (ASI) or teen addiction severity index (TASI) at admission and discharge. Staff administering the ASI or TASI must be licensed behavioral health professionals and complete ASI training. Providers are also required to use American Society of Addiction Medicine (ASAM) criteria to determine level of care for consumer for admission, continued care, and discharge. Oklahoma also has developed a tool for providers to assess ASAM level of care, the Oklahoma Determination of ASAM Service

Level (ODASL). Outpatient SUD providers are also required to offer case management to consumers discharging from withdrawal management or residential services within one week of discharge.

ODMHSAS operated hospitals serve as providers of short-term acute inpatient stabilization. These providers are required to complete discharge planning for continued treatment for co-occurring disorders and to communicate regularly with CMHCs and addiction recovery programs. CCBHCs are required by administrative rules to have contracts or memoranda of understanding with inpatient, residential, and medical withdrawal management facilities to ensure a formalized structure of transitional care planning. CCBHCs are further required to make reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge.

Inpatient psychiatric providers are required by state administrative rules to have a discharge plan for adults that documents the individual's hospitalization, recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, and a summary of the beneficiary's condition at discharge.

Efforts to Combat Opioid Use Disorder

State Opioid Response

A substantial challenge throughout Oklahoma is the lack of comprehensive access for opioid use disorder (OUD) services. This gap is intensified in the rural areas, in which 34% of the population of Oklahoma reside.[9] However, no county has adequate resources to address the current opioid epidemic. Many individuals with OUD have difficulty keeping and maintaining employment and housing without appropriate treatment, and there are major transportation barriers for rural communities. The cost of medications and other ancillary services that are provided with medication assisted treatment (MAT) can strain the already underfunded system. Additionally, many adults in the state are uninsured. In fact, Oklahoma ranks 49th for its rate of uninsured individuals, with 14.2% of the population without insurance coverage.[10] Those individuals who have private insurance are often unable to afford high deductibles. While Medicaid pays for MAT for women while they are pregnant, this coverage ends 60 days after birth, leaving these women without insurance to maintain services. However, with Medicaid expansion anticipated in the state this year, access to MAT and other outpatient SUD services for newly eligible adults will be significantly increased.

To combat opioid abuse, the ODMHSAS is focused on increasing access to MAT and reducing unmet needs and overdose related deaths through the provision of prevention, treatment, and recovery activities. In addition, the ODMHSAS also distributes naloxone kits and training has been provided to first responders, treatment agencies, and those in need.

Oklahoma has utilized the State Opioid Response (SOR) grant to support and expand efforts related to OUD prevention and treatment. From October 2018, to April 2019, ODMHSAS trained and equipped over

[9] United States Census Bureau. (2010). Decennial census, urban and rural. Retrieved from https://data.census.gov/.

[10] America's Health Rankings. (2019). Retrieved from https://www.americashealthrankings.org/learn/reports/2019-annual-report/state-summaries-oklahoma.

1,500 law enforcement officers in more than 300 agencies statewide with naloxone; another 3,700 individuals were equipped through expanded prevention hubs, of which there are 70 in the state.

Continued partnerships with pharmacies throughout the state have promoted the availability of naloxone for walk-in and purchase. Additionally, community coalitions have directly engaged over 52,000 Oklahomans and made nearly 10,000 referrals to treatment and overdose prevention services, with just under 4,400 Oklahomans receiving direct treatment and recovery services through the grant. ODMHSAS also contracted to make available A-CHESS (Addiction Comprehensive Health Enhancement Support System), a relapse prevention program administered through a smartphone application. This application has multiple uses, including making automatic consented referrals to a referring partnering agency, giving the authority of the agency to contact the individual in need.

Enhancement of provider skills and knowledge is also a part of these efforts. Cognitive behavior therapy (CBT) training has been provided by ODMHSAS and all CMHCs employ clinical staff trained in CBT. ODMHSAS also trains and certifies peer recovery support specialists (PRSS). SOR efforts have included expansion of MAT through telehealth and throughout a statewide network of CMHCs and Comprehensive Community Addiction Centers (CCARCs), as current availability to MAT in residential treatment settings is a challenge for the state. Under this demonstration, the state will require all Medicaid-enrolled residential SUD providers to provide MAT or have a relationship with a MAT provider to ensure access to medication for the individuals they serve.

The ODMHSAS has also increased access to services through telemedicine. Thus far, Oklahoma is recognized as the first state to do induction via telehealth for buprenorphine. The state has several agencies in rural areas that are now providing this service. Due the lack of waivered prescribers that are actively prescribing, it is difficult for some individuals to receive this service without telehealth.

Practice Facilitation

The OHCA has partnered with a third-party vendor (Telligen) to conduct targeted practice facilitation of SoonerCare Patient Centered Medical Home (PCMH) providers. The practice facilitators, who are trained in pain management, work with providers over a six-month period to improve patient care management. The areas addressed include:

- How to conduct initial patient assessments for chronic pain and risk of opioid dependence;
- Methods for monitoring medication use, including conducting urine drug screenings at each visit;
- Alternative pain management techniques that can be offered to patients; and
- Assistance in making patient referrals to physician pain management specialists.

The OHCA has targeted the program to providers with high opioid prescribing patterns. The program began in January 2016. Since that time, approximately 100 practices have undergone the six-month practice facilitation intervention.

The OHCA also recently expanded Telligen's pain management activities under a new contract that took effect in July 2019. Pursuant to the new contract, Telligen will be offering pain management practice facilitation to PCMH sites undergoing broader practice facilitation for management of patients with chronic medical and/or behavioral health conditions. This is in addition to continuing targeted practice facilitation of high prescribers.

The OHCA has also reduced barriers to MAT by eliminating refill limits through a state plan amendment. A planned future state plan amendment this calendar year will provide coverage of methadone for MAT.

Prescription Monitoring Program

The Oklahoma Prescription Monitoring Program (PMP) is authorized under state law to collect controlled drug prescription information from dispensers. The Oklahoma PMP is operated by the Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBN) while working closely with the Governor's Office, ODMHSAS, the Department of Health, the Medical Examiner's Office, and the OHCA to identify issues impacting the health and safety of Oklahomans. The Oklahoma PMP is widely recognized as one of the most respected and advanced systems in the country. As part of OBN, the Oklahoma PMP pioneered electronic PMP databases, real-time reporting, HIE integration, standard PMP best practices, interstate data sharing standards, and advisory committees.

The Oklahoma PMP requires dispensers of controlled substances to submit prescription information within five minutes of dispensing a scheduled narcotic. The PMP can serve a multitude of functions including assisting in patient care, provide early warning of drug abuse epidemics (especially when combined with other data), evaluating interventions, and investigating drug diversion and insurance fraud. In accordance with state law, the ODMHSAS receives PMP data and has utilized data for epidemiological risk assessments, planning overdose prevention and primary care practice improvement programs, and informing state and community-level opioid prevention and treatment efforts. The ODMHSAS has partnered with the OHCA and the State Department of Health on collaborative efforts to strategically utilize PMP data for prescriber, dispenser, and patient education. The agencies convene an ad hoc PMP advisory committee to solve problems, share information, plan partnership projects, and discuss system needs or enhancements

Provider Qualifications and Service Utilization

OHCA and ODMHSAS understand the importance of maintaining quality assurance with providers serving beneficiaries, including mechanisms to support individuals accessing services consistent with level of care needs in a timely manner. As such, the state currently has in place certification requirements aligned with best practices, including utilization of ASAM program criteria across SUD levels of care. Additional behavioral health provider requirements also provide assurances that beneficiaries are being supported during transitions in care, including care coordination and continuity of the treatment plan between acute care and outpatient providers.

Provider Certification

Certification of psychiatric hospitals and psychiatric units of general hospitals will continue to leverage current requirements, which include either a successful state survey to meet requirements for a Medicare psychiatric hospital or a national accreditation recognized by CMS for psychiatric hospitals in accordance with Oklahoma Administrative Code (OAC) 317:30-5-95.

All SUD treatment organizations must currently be state certified by ODMHSAS. Facilities can be certified as a basic alcohol and drug treatment program providing a specific service set or as a Certified Comprehensive Addiction Recovery Center (CCARC). Under this demonstration, all Medicaid-enrolled

residential SUD providers will be required to have accreditation by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). Additionally, the state plans to pursue the implementation of a certificate of need (CON) process, or similar process, for the addition of new residential beds or providers entering the network. A CON process is currently in place for inpatient psychiatric beds under the authority of the Oklahoma State Department of Health.

Community-Based Structured Crisis Centers must be certified by ODMHSAS in accordance with OAC 450:23. While there is currently only one crisis center that qualifies as an IMD in the state, the state seeks authorization under this waiver to include additional facilities in the Medicaid program should they become available in response to the state's needs. It is anticipated that some providers will be willing to increase capacity if there is continued access to Medicaid reimbursement. Particularly with Medicaid expansion adding a new population to the Medicaid program, the state recognizes that expansion of the provider network may be necessary in order to be responsive to the state's changing needs and demands for these services. The state's current system limits crisis facilities to CMHCs, CCARCs, or state-operated facilities, and as such the ODMHSAS will monitor needs for additional beds or providers.

Oklahoma anticipates implementation of QRTPs on October 1, 2021. All QRTPs will be licensed by the Oklahoma DHS. To qualify as a QRTP, in accordance with Title IV-E federal requirements, the program must be licensed and nationally accredited by CARF, the Joint Commission, or COA.

Prior Authorization, Medical Necessity Criteria, and Length of Stay

Prior authorization will be required for all newly eligible inpatient stays for adults authorized within this waiver through a process developed by ODMHSAS in partnership with OHCA. Facility-based crisis services are currently authorized by ODMHSAS through an instant prior authorization process. Residential SUD services are currently authorized, and will continue to be authorized, by ODMHSAS though a streamlined prior authorization process based on the submission of an ASAM level of care assessment tool by an outpatient provider. The state plans to utilize assessment tools such as the Child and Adolescent Needs and Strengths assessment to identify children appropriate for placement in a QRTP.

Oklahoma will aim for a statewide average length of stay for inpatient treatment and residential treatment of 30 days. Length of stay extensions will be authorized on a case by case basis and according to medical necessity and practice guidelines.

III. DEMONSTRATION GOALS AND OBJECTIVES

Through this demonstration, Oklahoma seeks to support the overall health and long-term successful outcomes of individuals with SMI and SUD. The overarching premise this demonstration supports is that, if the full continuum of care is provided, individuals who access the system will receive the least restrictive, most effective provision of services, which is continually evaluated so that individuals' changing needs translate to changing services to meet those needs.

The state's goals as identified below align with CMS guidance given related to demonstration authority for SUD (SMD #17-003) and SMI/SED (SMD #18-011).

SUD Goals

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;

3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for 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 the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
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;
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; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Hypotheses and Evaluation Plan

Based on the goals identified above through CMS guidance, Oklahoma proposes the following evaluation plan. This approach has been developed in alignment with CMS evaluation design guidance for SUD and SMI 1115 demonstrations. The state will contract with an independent evaluator to conduct this review.

Substance Use Disorder

Objective/Goal	**Hypothesis**	**Evaluation Parameters/Methodology**
Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?		
GOAL 1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	**Hypothesis 1.** The demonstration will increase the percentage of beneficiaries who are referred to and engage in treatment for OUD and other SUDs.	**Data Sources:** • Claims data • Provider survey • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 2. Increased adherence to and retention in treatment for OUD and other SUDs.	**Hypothesis 2.** The demonstration will increase the percentage of beneficiaries who adhere to treatment of OUD and other SUDs.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance • T-Test
GOAL 3. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	**Hypothesis 3.** The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.	**Data Sources:** • Claims data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Do enrollees receiving SUD services experience improved health outcomes?		
GOAL 4. Improved access to care for physical health conditions among beneficiaries.	**Hypothesis 4.** The demonstration will increase the percentage of beneficiaries with SUD who experience care for comorbid conditions.	**Data Sources:** • Claims data • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
GOAL 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.	**Hypothesis 5.** Among beneficiaries receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 6. Reduction in overdose death, particularly those due to opioids.	**Hypothesis 6**. The demonstration will decrease the rate of overdose deaths due to opioids.	**Data Sources:** • Claims data • Administrative data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance

Serious Mental Illness

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
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/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/SED while awaiting mental health treatment in specialized settings?		
GOAL 1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.	**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.	**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
Evaluation Question: 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? 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?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
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-difference models • Qualitative analysis • Descriptive quantitative analysis
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 • AHRF data • NMHSS survey • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis
Evaluation Questions: Does the demonstration result in improved access of beneficiaries with SMI/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/SED? To what extent does the demonstration result in improved access of SMI/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/SED improve under the demonstration?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
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/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 • AHRF • NMHSS survey • Administrative data • URS • Medical records **Analytic Approach:** • Descriptive quantitative analysis • Chi squared analysis • Difference-in-differences model
Evaluation Questions: Does the demonstration result in improved care coordination for beneficiaries with SMI/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

IV. IMPACT ON ENROLLMENT, BENEFITS, COST SHARING, AND DELIVERY SYSTEM

Demonstration Eligibility

All enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and between the ages of 21-64, will be eligible for services under the waiver, subject to medical necessity

criteria. Additionally, Medicaid enrollees under the age of 21 may qualify for services under the waiver when receiving residential SUD or QRTP services. Only the eligibility groups outlined in the table below will not be eligible for these services as they receive limited Medicaid benefits only.

Eligibility Group Name	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR § 435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(10)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Soon-to-be-Sooners (STBS/Unborn Child)	2111(b)(4)

Enrollment

SoonerCare currently covers approximately 785,000 total individuals within all programs. Medicaid expansion is anticipated to add approximately 128,703 individuals in its first year, beginning July 1, 2020. Subsequent implementation of the Healthy Adult Opportunity (HAO) waiver starting July 1, 2021 is anticipated to bring enrollment of newly eligible adults to 144,285 in its first year and is expected to rise in subsequent years to 151,624. Because the HAO waiver exempts individuals with SMI receiving treatment and individuals participating in addiction treatment programs from the community engagement and cost sharing requirements, it is not expected that enrollment for those populations will be significantly impacted by those requirements.

This 1115 waiver is not anticipated to impact SoonerCare enrollment over the course of the five-year demonstration, as there are no waiver-specific eligibility criteria included.

Benefits

Current Medicaid beneficiaries have access to a robust behavioral health service system. This demonstration seeks to enhance the continuum of care by adding inpatient, residential substance use disorder, and facility-based crisis stabilization services furnished at an IMD to the Medicaid service system. This enhancement will promote the use of the most effective, appropriate services to support long-term successful outcomes. Specific services in the current and future Medicaid system are provided in Appendix A.

Cost Sharing

This waiver will not impact or add any cost sharing requirements. Currently, the state's Medicaid program includes co-pays for non-exempt individuals covered under Title XIX. Adults are subject to inpatient copays, which are currently $10/day (up to $75 max). Cost sharing has a cap of 5% of the aggregate household income. This cap is based on the household's total gross income and is applied monthly; once the household reaches their 5% cap in a month, no additional cost sharing is assessed in that month. Individuals exempt from copays include pregnant women and individuals who are American Indian/Native American.

Beginning July 1, 2021, the HAO waiver will implement nominal cost sharing through premiums and copays for newly eligible adults. However, individuals with SMI or SUD are excluded from these cost sharing requirements.

Delivery System

This waiver will not change the Medicaid delivery system. The State of Oklahoma is seeking to establish delivery system reforms through the HAO waiver, including a unique managed care delivery system that builds upon the current primary care case management system. This new delivery system will focus on care coordination, behavioral health integration, and value-based payment methodologies for providers. The additional benefits this SMI/SUD waiver seeks authorization to add to the service array will be included in this unique managed care delivery system.

Payment Rates for Services

Payment methodologies will be consistent with those approved in the Medicaid State Plan, where applicable. Inpatient and residential IMD services will be reimbursed via a per diem methodology, with crisis stabilization reimbursed through an hourly payment structure. Under the authority of this waiver, the state seeks to promote the outcomes and goals of the demonstration through the implementation of a value-based payment structure for all Medicaid-enrolled residential SUD providers. The state plans to implement a system whereby these providers must meet certain quality benchmarks in order to receive a 10% bonus to their per diem rate.

The state seeks flexibility to modify the parameters of this payment structure throughout the demonstration period in order make improvements as experience is gained and outcomes data is collected.

V. WAIVER IMPLEMENTATION

This waiver will be implemented statewide, with a requested effective date of October 1, 2020. The state requests a five-year waiver approval for this demonstration.

VI. LIST OF PROPOSED WAIVERS AND WAIVER ELIGIBILITY

Oklahoma seeks expenditure authority under Section 1115(a) for services provided to otherwise eligible individuals under age 21 in QRTPs and for residential substance use disorder stays. Additionally, the state seeks expenditure authority for enrollees ages 21-64 for short-term acute psychiatric stays, residential substance use disorder stays, and facility-based crisis stabilization stays in facilities that qualify as IMDs. Additional services listed in Appendix A will be added through future state plan amendments.

This demonstration will include all eligible individuals ages 21-64 (and under 21 where applicable) who are eligible for Medicaid and does not impose any additional eligibility criteria. Oklahoma is seeking to expand Medicaid eligibility through a submitted state plan amendment, with an effective date of July 1, 2020.

VII. FINANCING AND BUDGET NEUTRALITY

Budget Neutrality Overview

Oklahoma is seeking Section 1115 demonstration authority to offer a full continuum of services for adults requiring treatment for a serious mental illness (SMI), adults in need of substance use disorder (SUD) treatment and adolescents in need of SUD treatment.

Oklahoma prepared its budget neutrality model in accordance with CMS guidelines. The CMS IMD Budget Neutrality Template provides states with two scenarios for establishing "costs not otherwise matchable" or CNOM limits. The State developed per capita limits based on Scenario 1, which is limited to expenditures for otherwise covered services to otherwise eligible members who primarily are receiving treatment for SMI or SUD in an IMD. The completed CMS template for IMD waivers is included as Appendix B.

Oklahoma proposes three Medicaid eligibility groups (MEGs) for the demonstration, as follows:

- MEG 1: Adult SMI, Ages 18 to 64
- MEG 2: Adult SUD, Ages 18 to 64
- MEG 3: Adolescent SUD, Ages 17 and Under

Data Source

Data was extracted from the Oklahoma Medicaid Management Information System, including Department of Mental Health and Substance Abuse Services (DMHSAS) utilization data (funded by State-only dollars), member demographic information, Medicaid eligibility data and Medicaid expenditure data. Oklahoma established Calendar Year 2019 as its base year.

Development of Base Year Utilization and Expenditure Data

Identification of Medicaid Eligibles and MEG Assignment

Utilization data was used to identify inpatient and residential services for the treatment of SMI and SUD diagnoses. Inpatient and residential stays for the treatment of SMI that were over 60 days were removed. Individuals receiving the identified inpatient and residential services then were aligned with Medicaid eligibility data to identify members who were enrolled with Medicaid at the time of their stays. Individuals' ages were determined as of the admission date.

Development of IMD Expenditure Estimates

Total IMD expenditures are equal to the product of IMD utilization (days) and established payment rates. The reimbursement rates to do not include compensation for room and board.

As part of the demonstration, the State intends to offer performance-based bonus payments to promote the goals and outcomes of the demonstration. The State will make bonus payments available to SUD residential providers, up to a maximum of 10 percent of fee-for-service per diem payments. For purposes of estimating total IMD expenditures, the State estimates that 80 percent of bonus payments will be distributed. The established rates for SUD services were adjusted upward by eight percent (10 percent of FFS payment rates x 80 percent of available bonus payments).

Calculation of Medicaid Member Months

Member months were determined based on the whole month where Medicaid members were IMD patients for at least one day during the month. For example, if a member received treatment in an IMD from May 24 through June 2, two member months were included in the historical caseload totals.

Medicaid Expenditure Data

The State identified all Medicaid expenditures for the whole months in which individuals were patients for at least one day in an IMD.

Development of Base Year Per Member Per Month (PMPM) Costs

The table below presents a summary of base year (Calendar Year 2019) PMPM costs for each of the proposed MEGs.

	IMD Services MEG 1: SMI Adults, Ages 18 to 64	IMD Services MEG 2: SUD Adults, Ages 18 to 64	IMD Services MEG 3: SUD Adolescents, Ages 17 and Under
Expenditures	$6,628,831	$13,706,377	$928,996
Member Months	720	3,292	241
Base Year Per Member Per Month (PMPM) Costs	$9,207	$4,164	$3,855

Development of Enrollment and Expenditure Projections

Enrollment Estimates

The base year PMPMs are derived solely from data for members who were enrolled with Medicaid for qualifying IMD stays within the base year (Calendar Year 2019).

The State of Oklahoma has requested CMS authority to expand Medicaid eligibility for adults with incomes up to 133 percent (plus five percent income disregard) of the Federal Poverty Level (FPL).

For purposes of estimating future Medicaid caseload, the State analyzed utilization data for non-Medicaid individuals who received qualifying IMD services. State program coverage for individuals requiring services for the treatment of SMI and SUD currently is offered for individuals with incomes up to 185 percent of the FPL. Utilization data was analyzed to calculate member months for individuals who were not Medicaid eligible but received qualifying inpatient and residential services. The State estimates that 80 percent of non-Medicaid individuals who received qualifying services in Calendar Year 2019 will enroll with Medicaid under Oklahoma's proposed eligibility expansion.

The table below presents a summary of the baseline caseload under the demonstration.

	IMD Services MEG 1: SMI Adults, Ages 18 to 64	IMD Services MEG 2: SUD Adults, Ages 18 to 64	IMD Services MEG 3: SUD Adolescents, Ages 17 and Under
Non-Medicaid Member Months	5,368	7,053	N/A: Oklahoma's proposed eligibility expansion limited to adults
Percentage Eligible for Medicaid Expansion	80%	80%	
Estimated New Medicaid Members Months	4,294	5,642	
Current Medicaid Member Months	720	3,292	241
Baseline Demonstration Member Months	5,014	8,934	241

For purposes of projecting future caseload, Oklahoma established an annual caseload trend rate of six percent. This trend rate reflects the State's estimate of projected annual growth in participation under the IMD demonstration, considering economic factors and their impact on Medicaid eligibility, enhanced access to services for SMI and SUD treatment and population health needs.

Per Member Per Month (PMPM) Trend Rate

Oklahoma applied an annual trend rate to the Calendar Year 2019 base year PMPM equal to 4.8 percent. This trend rate represents the President's Budget trend rate for the Medicaid expansion population.

Budget Neutrality Summary

Oklahoma's proposed IMD demonstration will be budget neutral in accordance with Section 1115 requirements. The table below provides a summary of program expenditures without and with the Demonstration, over the five-year waiver period.

Without-Waiver Total Expenditures

	DEMONSTRTION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1: SMI Adults, Ages 18 to 64	$55,488,928	$61,641,545	$68,476,390	$76,069,073	$84,503,637	$346,179,572
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$44,712,238	$49,669,948	$55,177,335	$61,295,347	$68,091,765	$278,946,631
IMD Services MEG 3: SUD Adults, Ages 17 and Under	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
TOTAL	$101,317,852	$112,551,998	$125,031,776	$138,895,269	$154,295,991	$632,092,887

With-Waiver Total Expenditures

	DEMONSTRTION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1: SMI Adults, Ages 18 to 64	$55,488,928	$61,641,545	$68,476,390	$76,069,073	$84,503,637	$346,179,572
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$44,712,238	$49,669,948	$55,177,335	$61,295,347	$68,091,765	$278,946,631
IMD Services MEG 3: SUD Adults, Ages 17 and Under	$1,116,687	$1,240,505	$1,378,052	$1,530,850	$1,700,590	$6,966,683
TOTAL	$101,317,852	$112,551,998	$125,031,776	$138,895,269	$154,295,991	$632,092,887

Net Overspend	$0	$0	$0	$0	$0	$0

CMS Budget Neutrality Template for IMD Demonstrations

The completed CMS Budget Neutrality template is provided in Appendix B and includes the following tables:

- IMD Overview
- IMD Historical
- IMD Without Waiver
- IMD With Waiver
- IMD Summary
- IMD Caseloads

Maintenance of Effort

In accordance with the November 13, 2018, CMS State Medicaid Director Letter, the state understands this waiver request is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of outpatient treatment for these conditions.

The following table details the SFY 2019 outpatient community-based behavioral health expenditures.

Expenditures on Outpatient Community-Based Behavioral Health Services (in Millions)

Medicaid Program	Total Dollars	Federal Dollars	State Dollars
Regular Title XIX	$157.0	$96.5	$60.5
CHIP	$35.5	$34.1	$1.4
Health Home	$34.3	$21.0	$13.3
CCBHC	$57.1	$41.8	$15.3
Total	**$283.9**	**$193.4**	**$90.5**

Oklahoma is dedicated to maintaining access to community-based services and intends for services authorized within this waiver to complement but not replace these outpatient services. However, we offer

the following caveats as considerations for measuring maintenance of effort based strictly on total expenditures:

- Unpredictable state budgets, particularly in consideration of the COVID-19 emergency, may impact the amount of state funding available for services.
- The state is currently pursuing a number of programmatic changes to the Medicaid program, including a Medicaid expansion state plan amendment, a Healthy Adult Opportunity waiver, and a waiver amendment to include newly eligible individuals in the Patient Centered Medical Home (PCMH). Programmatic changes such as these may impact the number of covered lives and increase health system efficiencies, which will impact expenditures.

VIII. STAKEHOLDER ENGAGEMENT AND PUBLIC NOTICE

Public Notice

The state is conducting public notice in accordance with 42 CFR §431.408. OHCA will be holding virtual public hearings on this proposal as follows:

Virtual Public Hearing
May 6, 2020, at 3 p.m.
Register for Zoom Meeting:
https://okhca.zoom.us/webinar/register/WN_KHdFenQIS6GEeBZNwLfXHg

Virtual Public Hearing
May 8, 2020, at 3 p.m.
Register for Zoom Meeting:
https://okhca.zoom.us/webinar/register/WN_g22DISEpRN2pJw-ZsZHOPQ

Interested persons may visit www.okhca.org/PolicyBlog to view a copy of the proposed waiver, public notice(s), location and times of public hearings, a link to provide public comments on the proposal, supplemental information, and updates. Due to the current public health emergency and the associated social distancing guidelines, persons wishing to present their views in writing or obtain copies of the proposed waiver may do so via mail by writing to: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written comments or requests for copies of the proposed waiver will be accepted by contacting OHCA as indicated. Comments submitted will be available for review online at www.okhca.org/PolicyBlog. Comments will be accepted May 1-31, 2020.

Tribal Consultation

Due to continued social distancing as result of the spread of COVID-19, tribal consultation was held April 1, 2020, by the Oklahoma Health Care Authority (OHCA) via Zoom teleconference. Twelve tribal representatives and 18 OHCA staff were on the call. There was one comment received during the teleconferenced consultation in reference to the IMD waiver. During consultation, a tribal partner expressed interest in further discussion on assessing residential treatment services, as they have two residential facilities. OHCA agreed to further discussion.

APPENDIX A

Current and Proposed Future SoonerCare Behavioral Health Benefits

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	Future 1115
ASAM Level 0.5: Prevention					
Alcohol/Drug Screening	Other Lic. Pract.	3a-1a	QBHT; CPSP		
Primary Care Screening (SBIRT)	Physician		Physician		
OP SA Preventive Counseling	EPSDT	1a-6.6	BHP; QBHT		
Evaluation and Management (Tobacco Cessation)	Physician	2a-2	Physician		
SMI/SED Outpatient & ASAM Level 1: Outpatient					
Alcohol/Drug Assessment.	Other Lic. Pract.; Rehab	3a-1a; 6a-1.2; 1a-6.5	Level 2 BHP		
Medication Management	Physician	2a-2	Physician		
Psychiatric DX Assessment	Physician	2a-2	Psychiatrist		
Psychological Testing	Rehab; EPSDT	6a-1.3	Psychologist BHP		
Licensed Behavioral Health Practitioner Services	EPSDT	1a-6.1	Clinical Psychologist or BHP elig. to practice independently		
Treatment Planning	Rehab; EPSDT	6a-1.2; 6a-1.6 (PACT); 6a-1.14 (CCBH); 1a-6.5	Level 1 or Level 2 BHP		
Psychotherapy: Individual, Family, Group	Rehab; EPSDT	6a.1.2; 6a-1.6a (PACT); 6a-1.14 (CCBH)	Level 1 or Level 2 BHP		
Medication Training & Support	Rehab	6a-1.3; 6a-1.6 (PACT); 6a-1.15 (CCBH)	RN		
Psychosocial Rehab (PSR); Ind., Group	Rehab	6a-1.3; 6a-1.6a; 1a-6.5a	QBHT under supervision of BHP		
PSR, Children	EPSDT	1a-6.5a-5b	QBHT under supervision of BHP		

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	Future 1115
ASAM Level 1: Outpatient (Con't)					
Intensive Family Intervention	EPSDT	1a -6.5a	BHP		
Intensive in-home Services	EPSDT	1a -6.5a	QBHT under supervision of BHP		
Therapeutic Day Treatment	EPSDT	1a -6.5c	QBHT under supervision of BHP		
Therapeutic Behavioral Services	EPSDT	1a -6.5b	QBHA under supervision of BHP		
Multi Systemic Therapy	EPSDT	1a -6.5c	BHP, QBHT (Team)		
Peer/Family Support	Rehab; EPSDT	6a-1.2a; 6a-1.6a (PACT); 6a-1.16 (CCBH); 1a- 6.5b	CPSP		
Co-Occurring Treatment for SA	Rehab (PACT)	6a-1.6a	Appropriately licensed, registered or certified provider		
Psychoeducation and Counseling	Rehab	6a-1.15 (CCBH)	Nurse or Dietitian		
Health Promotion/Wellness	Rehab (PACT)	6a-1.6	Any Qualified Team member		
Case Management, (Incl. drug court) Targeted Case Management Transitional CM	Case Management TCM	Supp to Att. 3.1-A, Pages 1b-1g	QBHT		
Care Coordination	Rehab (CCBH); (PACT)	6a-1.6; 6a-1.14	Team BHP, RN, LPN, QBHT, CPSP		
Health Home	Health Home SPA		Health Home Team		
CCBH Services	Rehab	6a-1.10	CCBH Team		
SMI/SED & ASAM Level 2: Intensive Outpatient/ Partial Hospitalization					
Intensive Outpatient/SA, Adolescent (ASAM 2.1)	EPSDT	1a -6.5c	BHP or CADC		
Intensive Outpatient, Adult (ASAM 2.1)	Rehab, TCM	See Notes	BHP or CADC		
Partial Hospitalization, Adolescent (ASAM 2.5)	EPSDT OP Hosp	1a-6.5e 1a-2	Clinical Team BHP, RN, QBHT		
Partial Hospitalization, Adult (ASAM 2.5)			Clinical Team BHP, RN, QBHT	X	

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	Future 1115
Medication Assisted Treatment					
Suboxone® (buprenorphine/ naloxone SL films), Vivitrol	Prescription Drugs	5a-1	Pharmacy	Adding Methadone	
SMI/SED & ASAM Level: 3.1, 3.3, 3.5, 3.7 Residential / Inpatient					
Clinically Managed Low Intensity Residential (ASAM Level 3.1) for Adults and Adolescents in RTF					X
Clinically Managed Population-Specific, High Intensity Svcs. (ASAM Level 3.3) for Adults in RTF					X
Clinically Managed Medium Intensity for Adolescents and Clinically Managed High Intensity for Adults (ASAM Level 3.5)					X
Medically Monitored High Intensity Inpatient Withdrawal Management (ASAM Level 3.7) for Adults and Adolescents in RTF					X
Qualified Residential Treatment Programs (QRTP)					X
Psychiatric Residential Treatment Facility (PRTF)	IP Psych Services	7a-2	Accredited PRTF		
SMI/SED Crisis Services					
Crisis Intervention Services	Rehab; EPSDT	6a-1.3; 6a-1.6a (PACT); 6a 1.14 (CCBH); 1a-6.5	BHP		
Crisis Psychotherapy, Mobile	Rehab; EPSDT	6a-1.6a (PACT); 6A-1.14 (CCBH) 1a-6.5	Team BHP & QBHT or CPSP		
Facility Based Crisis Stabilization (<16 beds)	Rehab; EPSDT	6a-1.3 1a-6.5	BHP		
Urgent Recovery Center Services	Clinic	4a-1.4	Level 1 or Level 2 BHP		

	Benefit Category	Att. 3.1 Page (s)	Qualified Provider	Future SPA	Future 1115
Crisis Stabilization, >16 beds					X
	Benefit Category	**Att. 3.1 Page (s)**	**Qualified Provider**	**Future SPA**	**Future 1115**
Acute Psychiatric and ASAM Level 4: Inpatient					
Clinically Managed Intensive Inpatient (ASAM Level 4)/Acute Psychiatric for Adolescents in Lic. General Hospital or Lic. Psychiatric Hospital; Adults in Lic. General Hospital	IP Hospital Svcs.; IP Psych Svcs.; EPSDT	1a-1; 7a-2; 1a-6.6			
Clinically Managed Intensive Inpatient (ASAM Level 4)/Acute Psychiatric for Adults in Lic. Psychiatric Hospital/IMD					X

Notes: Ambulatory detox services are not covered as a discrete service model for adults but are routinely provided concurrently with other addiction services, by the same clinical staff, and in the same treatment setting.

Intensive outpatient services are not covered as a discrete service model for adults but can be reimbursed through the provision of a combination of services, including psychotherapy, targeted case management, and psychosocial rehabilitation.

Outpatient coverage includes delivery of telemedicine for applicable services.