DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Christina Foss
Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

Dear Director Foss:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Institutions for Mental Diseases Waiver for SMI/SUD (Project Number 11-W00363/6) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is updating the cadence for this demonstration to annual monitoring reporting (see also section

1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The Institutions for Mental Disease Waiver for SMI/SUD demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on June 29, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 35, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

Some of the metrics currently required for Substance Use Disorder (SUD) and Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) demonstrations will no longer be required.

CMS is also removing the requirement for a Monitoring Protocol deliverable, which has been required under certain types of section 1115 demonstration, including but not limited to the SUD, SMI/SED, Health-Related Social Needs (HRSN), and reentry demonstrations. Removal of the

Monitoring Protocol requirement simplifies and streamlines demonstration monitoring activities for states and CMS.

Demonstration Monitoring Calls

As STC 39 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Institutions for Mental Disease Waiver for SMI/SUD section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

Enclosure
cc: Stacey Steiner, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00363/6

TITLE: Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder

AWARDEE: Oklahoma Health Care Authority

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Oklahoma for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from December 22, 2020 through December 31, 2025, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder demonstration, including the granting of the expenditure authority described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Oklahoma to operate the above-identified section 1115(a) demonstration.

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD), Serious Mental Illness (SMI), or Severe Emotional Disturbance (SED).** Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) or a serious mental illness (SMI) or severe emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00363/6

TITLE: Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder

AWARDEE: Oklahoma Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STC) for the "Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Oklahoma Health Care Authority (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authority authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on the expenditure authority, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. The demonstration will be statewide and is approved for a five-year period, from December 22, 2020 through December 31, 2025.

The STCs have been arranged into the following subject areas:

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment D: SUD Implementation Plan
Attachment E: Reserved for SMI/SED/SUD Monitoring Protocol
Attachment F: Reserved for SMI/SED/SUD Evaluation Design

II. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration will provide the state with authority to provide medically necessary residential treatment, facility-based crisis stabilization, and inpatient treatment services within qualified Institutions for Mental Diseases (IMD), for Medicaid beneficiaries with serious mental illness (SMI), serious emotional disturbance (SED) and/or substance use disorder (SUD) diagnoses. It will also include Qualified Residential Treatment Programs (QRTPs) that meet the definition of an IMD for beneficiaries under age 21. The demonstration will test whether this authority will increase access to evidence-based treatment services and improve overall health and long-term outcomes for those with SMI, SED and SUD when a full continuum of care is provided. The SUD treatment continuum of care shall be based on the American Society of Addiction Medicine (ASAM) criteria and/or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

During the demonstration period, the state seeks to achieve the following goals:

SUD Goals:

1. Increased rates of identification, initiation, and engagement in treatment for SUD;
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 with SUD.

SMI/SED Goals:

1. Reduced utilization and lengths of stay in EDs among beneficiaries with SMI or SED 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 or 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.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is

affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
    a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
    b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
    c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
    d. An up-to-date CHIP allotment worksheet, if necessary;
    e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in

accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the thirty 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
    b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
    c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
    d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination, as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. Adequacy of Infrastructure. The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility. Standards and methodologies for eligibility remain set forth under the state plan.

V. SUD PROGRAM AND BENEFITS

17. **SUD Program Benefits.** Effective upon CMS' approval of the SUD Implementation Plan, the demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Plan. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 19, to ensure short-term residential stays.

    Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging

from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

18. SUD Implementation Plan and Health IT Plan.

a. The state must submit the SUD Implementation Plan within 90 calendar days after approval of this demonstration. The state must submit the revised SUD Implementation Plan within sixty (60) days after receipt of CMS's comments. The state may not claim FFP for services provided in IMDs to beneficiaries who are primarily receiving SUD treatment and withdrawal management services until CMS has approved the SUD Implementation Plan. Once approved, the SUD Implementation Plan will be incorporated into the STCs as Attachment D and, once incorporated, may be altered only with CMS approval. After approval of the applicable implementation plans required by these STCs, FFP will be available prospectively, not retrospectively.

b. Failure to submit a SUD Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 33.

c. At a minimum, the SUD Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

    i. Access to Critical Levels of Care for OUD and other SUDs. Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management, within 12-24 months of demonstration approval.

    ii. Use of Evidence-based SUD-specific Patient Placement Criteria. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;

    iii. Patient Placement. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

    iv. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other

requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

v. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

vi. Standards of Care. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

vii. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD. An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;\

viii. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. Improved Care Coordination and Transitions between levels of care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

x. SUD Health IT Plan. Implementation of the milestones and metrics as detailed in Attachment D

d. SUD Health Information Technology Plan ("Health IT Plan"). The SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 18(a) and 18(c)), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment D), and must be aligned with the state's broader State Medicaid

Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan

i. The state must include in its Monitoring Protocol (see STC 19(a)) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

ii. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 36).

iii. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iv. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

v. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

vi. Components of the Health IT Plan include:

    1) The Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program (PDMP).[1]

    2) The Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

    3) The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the Health IT Plan must describe

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid*.

current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

4) The Health IT Plan will describe how the activities described in (i), (ii) and (iii) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]
5) The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
6) In developing the Health IT Plan, states should use the following resources:
    1. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
    2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
    3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

19. SUD Monitoring Protocol. The state must submit a Monitoring Protocol for the SUD programs authorized by this demonstration within 150 calendar days after approval of the demonstration. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment E. Progress on the

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 18(a) and (c) and reporting relevant information to the state's Health IT plan described in STC 18(d);
b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration; and
c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

20. Evaluation. The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections VIII (General Reporting Requirements) and XI (Evaluation of the Demonstration) of these STCs.

21. Unallowable Expenditures Under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

VI. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

22. SMI Program Benefits. Under this demonstration, beneficiaries will have access to, the full range of otherwise covered Medicaid services, including SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration's SMI Program, to be monitored pursuant to the SMI Monitoring Plan as outlined in STCs 24-27 below.

23. SMI Implementation Plan.

a. The state must submit the SMI Implementation Plan within ninety (90) calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under this expenditure authority until CMS has approved the SMI implementation plan and the SMI financing plan described in STC 23. After approval of the required implementation plan and financing plan, FFP will be available prospectively, but not retrospectively.
b. Once approved, the SMI Implementation Plan will be incorporated into the STCs as Attachment C, and once incorporated, may be altered only with CMS approval. Failure

to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 33.

c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

1. **Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.**
   A. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
   B. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
   C. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
   D. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries 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 and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
   E. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part

455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

F. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

2. **Improving Care Coordination and Transitions to Community-Based Care.**
   A. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
   B. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available;
   C. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;
   D. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
   E. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

3. **Increasing Access to Continuum of Care Including Crisis Stabilization Services.**
   A. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;
   B. Commitment to implementation of the SMI/SED financing plan described in STC 23;

C. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
D. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

4. **Earlier Identification and Engagement in Treatment and Increased Integration**
   A. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;
   B. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;
   C. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.
5. **SMI/SED Health Information Technology (Health IT) Plan.** The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/ "ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 18(b) and 18(c)), to develop the infrastructure/capabilities of the state's health IT infrastructure.

   The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment C), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

   The state will include in its Monitoring Plans (see STC 19)an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.

   The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 23).

   As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation

Specifications' (ISA) in developing and implementing the state's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

Components of the Health IT Plan include:

A. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of *SED/SMI* care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
    i. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
    ii. In developing the Health IT Plan, states should use the following resources:
        1. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and *"Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/)*.
        2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
        3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6. **SMI Financing Plan.** As part of the SMI implementation plan referred to in STC 23the state must submit, within 90 calendar days after approval of the demonstration,

a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment C and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

A. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and
B. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;
C. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

24. SMI Monitoring Protocol(s). The state must submit a Monitoring Protocol for the SMI program authorized by this demonstration within 150 calendar days after approval of the implementation plan. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS' comments, if any. Once approved, the SMI Monitoring Protocol will be incorporated into the STCs, as Attachment E. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports (as required by STC 36). Components of the Monitoring Protocol must include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 24(c) , information relevant to the state's SMI financing plan described in Attachment C, and information relevant to the state's Health IT plans described in STC 18(d);
b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration; and
c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

25. Monitoring, Reporting, and Evaluation. The SMI Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections IX (Monitoring and Reporting Requirements) and XII (Evaluation of the Demonstration) of these STCs. The

state will follow CMS guidelines to ensure the evaluation design is amended to provide a rigorous evaluation of the SMI component of the demonstration.

26. Availability of FFP for the SMI Services Under Expenditure Authority #11. Federal Financial Participation is only available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days—or 45 days, as relevant.

27. Unallowable Expenditures Under the SMI Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
d. Costs for services provided in treatment facilities for beneficiaries under age 21 unless the facility meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G or the definition of a qualified residential treatment program in STC 28.

28. Qualified Residential Treatment Programs. The state may receive FFP for treatment provided to beneficiaries residing in Qualified Residential Treatment Programs (QRTP) that qualify as an IMD if the QRTPs meet the following requirements:

a. The QRTP meets all of the requirements of the Family First Prevention Services Act (FFPSA) that was signed into law on February 9, 2018, as part of the Bipartisan Budget Act of 2018.
b. The state performs a needs assessment for the beneficiary to assure the appropriateness of placement in the QRTP as specified in the FFPSA.
c. QRTP meets any guidance or regulations that may be issued by the Administration for Children and Families in these settings.
d. The billing provider is enrolled in Medicaid.
e. The practitioner who furnishes a service meets federal and state qualifications to provide the service.
f. QRTP complies with CMS regulations regarding seclusion and restraint found in 42 CFR Part 483 Subpart G.
g. FFP is not available for room and board costs in QRTPs.

VII. COST SHARING

29. Cost Sharing. Cost sharing imposed upon beneficiaries enrolled in the demonstration is consistent with the provisions of the approved Medicaid state plan.

VII. DELIVERY SYSTEM

30. Delivery System. All demonstration beneficiaries will continue to receive services through the same delivery system arrangements as currently authorized in the state.

VIII. GENERAL REPORTING REQUIREMENTS

31. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement. The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.
c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits

the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

32. Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plans and the required performance measures in the Monitoring Plan agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The state is expected to meet the milestones by the end of the first two years of the SMI demonstration.

33. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

34. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

X. MONITORING

35. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the

demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; updates on the state's financing plan and maintenance of effort described in STC 23; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements Section XI of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
e. SMI/SED Health IT and/or SUD Health IT. The state will include a summary of progress made in regards to SMI/SED and/or SUD Health IT requirements outlined in STC 18(d).

36. SMI/SED and/or SUD Mid-Point Assessment. The state must conduct an independent mid-point assessment by June 15, 2023. In the design, planning and conduction of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, SMI/SED and/or SUD treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than sixty (60) days after June 15, 2023. This timeline will

allow for the assessment report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. The state must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SMI/SED Implementation Plan and/or the SUD Implementation Plan, the SMI Financing Plan, and the SMI/SED Monitoring Protocol and/or SUD Monitoring Plan for ameliorating these risks. Modifications to the applicable Implementation, Financing, and Monitoring Protocol are subject to CMS approval. Elements of the mid-point assessment include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED and/or the SUD Implementation Plans, the SMI/SED Financing Plan, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol and/or SUD Monitoring Protocol;
b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED or SUD Implementation Plans or SMI/SED Financing Plan or to pertinent factors that the state can influence that will support improvement; and
e. An assessment of whether the state is on track to meet the budget neutrality requirements.

37. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10.

38. Close-Out Report. Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

a. The draft close-out report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the close-out report.
c. The state must take into consideration CMS' comments for incorporation into the final close-out report.
d. The final close-out report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 23.

39. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the

demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

40. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XI. EVALUATION OF THE DEMONSTRATION

41. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 31.

42. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

43. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable Evaluation Design guidance, including guidance about SUD/SMI/SED. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs).
b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

44. Evaluation Budget. A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

45. Evaluation Design Approval and Updates. The state must submit the revised draft Evaluation Designs within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design*s*, the documents will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation designs and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation designs, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

46. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

47. Interim Evaluation Report. The state must submit an Interim Evaluation Report for each evaluation design, as applicable, and for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Reports should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting a renewal for the demonstration, the Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The state must submit the final Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment B of these STCs.

48. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

49. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10

50. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

51. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, the approved Evaluation Design, Interim Evaluation Reports, and Summative Evaluation Reports) on the state's website within thirty (30) calendar days of approval by CMS.

52. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XII.GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

53. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[4]

54. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 (Quarterly Medicaid Expenditure Report), showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

[4] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

55. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XI:

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

56. Sources of Non-Federal Share. The state certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

57. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal

matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain one hundred (100) percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

58. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

59. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
FFS-SMI/SED	Hypo 1	X		X	Medicaid beneficiaries diagnosed with a SMI/SED in fee-for-service
FFS- SUD	Hypo 2	X		X	Medicaid beneficiaries diagnosed with a SUD in fee-for-service
FFS- SUD; 17 and Under	Hypo 3	X		X	Medicaid beneficiaries diagnosed with a SUD in fee-for-service

60. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00339/10). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two

individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
FFS-SMI/SED	Medicaid beneficiaries diagnosed with an SMI/SED in fee-for-service	See STC 59	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	12/15/2020	12/31/2025
FFS- SUD	Medicaid beneficiaries diagnosed with a SUD in fee-for-service	See STC 59	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	12/15/2020	12/31/2025
FFS-SUD, 17 and Under	Medicaid beneficiaries diagnosed with a SUD in fee-for-service	See STC 59	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	12/15/2020	12/31/2025

61. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 4: Demonstration Years

Demonstration Year 1	December 22, 2020 to December 31, 2021	12+months
Demonstration Year 2	January 1, 2022 to December 31, 2022	12 months

Demonstration Year 3	January 1, 2023 to December 31 2023	12 months
Demonstration Year 4	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 5	January 1, 2025 to December 31, 2025	12 months

62. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XI. CMS will provide technical assistance, upon request.[5]

63. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

64. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the

[5] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

65. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

66. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

67. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

68. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

69. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to refund the FFP to CMS.

70. Hypothetical Budget Neutrality Test 1: SMI/SED and/or SUD Services (see Expenditure Authority #1). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5: Hypothetical Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR 2019	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
FFS-SMI/SED Aged 18-64	PC	Both	$9,373	5.6%	$10,452	$11,037	$11,655	$12,308	$12,997
FFS-SUD Aged 18-64	PC	Both	$4,164	5.6%	$4,643	$4,903	$5,177	$5,467	$5,774

FFS-SUD Aged 17 and under	PC	Both	$3,855	5.6%	$4,299	$4,539	$4,794	$5,062	$5,345

71. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

72. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from December 22, 2020 to December 31, 2025. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

73. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 6: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

XIV. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 7: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
30 calendar days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after approval date	SUD and SMI Implementation Plans (including Health IT Plan)	STC 18(a)
60 calendar days after receipt of CMS comments	Revised SUD and SMI Implementation Plans (including Health IT Plan)	STC 18(a)
150 calendar days after Implementation Plan Completeness	Monitoring Protocol	STC 19
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 19
180 calendar days after approval date	Draft Evaluation Design	STC 43
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STC 45
No later than 60 calendar days after July 1, 2023	SUD Mid-Point Assessment	STC 36
June 30, 2024, or with renewal application	Draft Interim Evaluation Report	STC 47(c)
60 calendar days after receipt of CMS comments	Final Interim Evaluation Report	STC 47(d)
Within 18 months after June 30, 2025	Draft Summative Evaluation Report	STC 48
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 48(b)
Monthly Deliverables	Monitoring Calls	STC 39
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Progress Reports, including implementation updates	STC 35
	Quarterly Expenditure Reports	STC 35(c)
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Reports	STC 35

ATTACHMENT A
Developing the Evaluation Design

Introduction

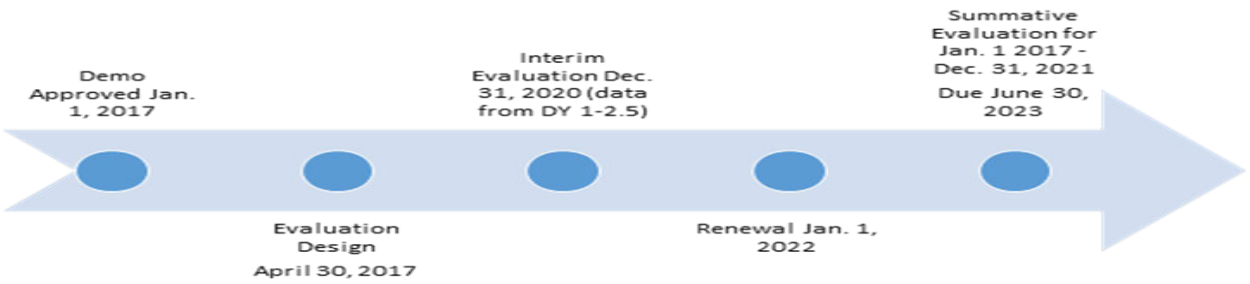
For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:

4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

    b. Qualitative analysis methods may be used, and must be described in detail.

    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

    f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
2) When the demonstration is also considered successful without issues or concerns that

would require more regular reporting, such as:

a. Operating smoothly without administrative changes; and
b. No or minimal appeals and grievances; and
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

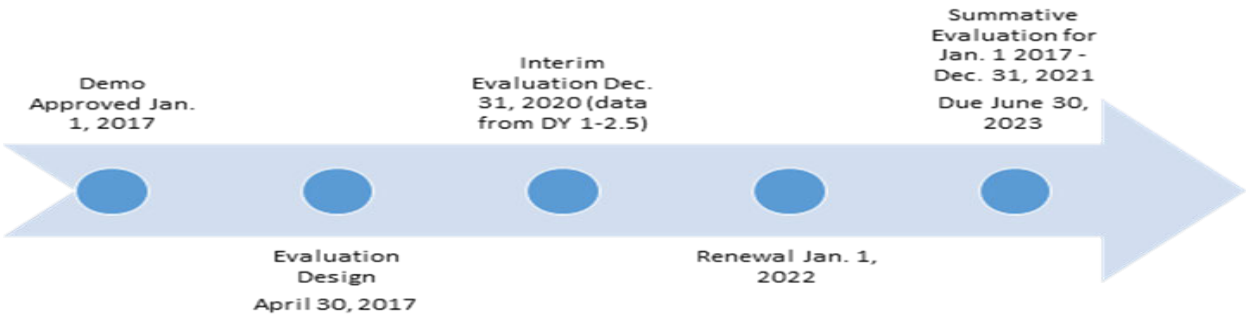
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected
4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

   A. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

B. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

C. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment - Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C
SMI/SED Implementation Plan and Financing Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

State Point of Contact:
Name and Title: Traylor Rains, Deputy State Medicaid Director
Telephone Number: (405) 522-9564
Email Address: Traylor.Rains@okhca.org

Name and Title: Sandra Puebla, Senior Director of Federal & State Authorities
Telephone Number: (405) 522-7270
Email Address: Sandra.Puebla@okhca.org

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

State	*Oklahoma*
Demonstration name	*Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder*
Approval date	*12/15/2020*
Approval period	*12/15/2020 through 12/31/2025*
Implementation date	*12/15/2020*

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status:* The Medical Facilities Division of the Oklahoma State Department of Health licenses and certifies health care facilities in accordance with State and Federal laws. This division has responsibility for inspection, licensure and Medicare re-certification of all non-long-term care medical facilities in Oklahoma. Oklahoma Administrative Code 317:30-5-95 requires: Psychiatric hospitals and psychiatric units of general hospitals. To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that: (1) is a psychiatric hospital that: (A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or (B) is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or (2) is a general hospital with a psychiatric unit that: (A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or (B) is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and (3) meets all applicable federal regulations, including, but not limited to: (A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. §§ 482.60-.62); (B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C); (C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or (D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and (4) is contracted with the OHCA

Prompts	Summary
	The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities. Facility-based crisis units must have certification from ODMHSAS as a Community-Based Structured Crisis Center (CBSCC) and be contracted with ODMHSAS. Provider qualifications are established in OAC 450:23 and providers are limited to CMHCs, CCARCs (Certified Comprehensive Addiction Recovery Centers), or state operated entities by state law. All CBSCCs currently in the state are also CMHCs. CBSCCs must provide 24/7 crisis triage services, 24/7 physician supervision, and 24/7 emergency examination, evaluation, and observation.
	Future Status: Continuation of current requirements. QRTPs will be required to have licensure from the Oklahoma Department of Human Services in accordance with current state requirements for child care facilities. QRTPs will also be required to obtain national accreditation with either CAO, CARF, or JCAHO and to meet CMS standards to become a Medicaid enrolled provider, including compliance with 42 CFR Part 483 Subpart G and QRTP staffing requirements. In addition, participating QRTPs will meet all relevant federal requirements, including requirements regarding needs assessments and assurance of appropriateness of placement in those settings as well as any guidance or regulations that may be issued by the Administration for Children and Families for these settings. In addition, the State will ensure all participating IMD crisis units are nationally accredited by CARF, the Joint Commission, or the Council on Accreditation through the Medicaid enrollment process to ensure compliance with this milestone.
	Summary of Actions Needed: Implement national accreditation enrollment requirement for IMD crisis units by 01.01.2022. Develop administrative rules, contract provisions, and enrollment processes for QRTPs by 12.01.2021. Develop compliance protocols and hire necessary compliance staff by 12.01.2021. Provide outreach/education to potential QRTP providers regarding qualifications by 10.01.2021. Provide technical assistance to current providers transitioning to QRTPs starting 10.01.21.

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* The OHCA conducts onsite service quality reviews (SQR) of facilities providing behavioral health services to SoonerCare members. The audited facilities include acute free-standing psychiatric facilities, psychiatric units within acute general care hospitals, psychiatric residential treatment facilities (PRTFs), community-based treatment (CBT) units and therapeutic foster care (TFC) agencies. The reviews are conducted pursuant to federal regulations requiring the periodic inspection of institutions for mental diseases and Oklahoma regulations requiring these facilities to "maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities." The overarching purpose of these periodic reviews is to verify that facilities are safe for residents, as verified through physical inspections, and that they provide medically necessary care, as documented through patient records. Safety issues and other areas of non-compliance are subject to corrective action plans or, in extreme cases, termination; services not shown to be medically necessary are subject to recoupment. ODMHSAS conducts regular certification site visits for CBSCCs to ensure compliance with all requirements in OAC 450:23 and correction of any previously identified deficiencies. Failure to meet requirements results in suspension or revocation of certification. Unannounced site visits are conducted when necessary to investigate complaints and when initial certification/recertification results in compliance below a minimal threshold.
	Future Status: Continuation of current oversight activities for hospitals and CBSCCs. Development of oversight procedures and rules for QRTPs. Specifically, OHCA plans to implement audit and oversight procedures in collaboration with Oklahoma Department of Human Services (DHS) similar to those currently in place for therapeutic foster care, including unannounced visits and SQRs. DHS will require evidence-based needs assessments, primarily the CANS, to ensure appropriate placement. OHCA will implement rules and STCs to ensure all QRTPs meet federal standards and DHS will provide ongoing oversight to ensure these standards are maintained. DHS will ensure QRTPs implement trauma-informed treatment models, have necessary nursing staff, facilitate family participation in the child's treatment, and provide discharge planning and family based aftercare support for at least 6 months post discharge in alignment with federal guidelines.
	Summary of Actions Needed: Develop administrative rules, contract provisions, and enrollment processes for QRTPs by 12.01.2021. Develop compliance protocols for ongoing monitoring of provider qualifications, staffing, treatment planning and discharge planning by 02.01.2022.
1.c Utilization review process to ensure beneficiaries have access	*Current Status:* Medical necessity criteria and prior authorization requirements for acute psychiatric admissions are stated in Oklahoma Administrative Code 317:30-5-95.1. Facility-based crisis services are currently authorized by

Prompts	Summary
to the appropriate levels and types of care and to provide oversight on lengths of stay	ODMHSAS through an instant prior authorization process. OHCA currently provides utilization review for enrolled adults aged 21-64 receiving inpatient services. ODMHSAS requires providers to complete a Client Assessment Record (CAR) for each member to assist in identifying the level of care need. This standardized tool captures information across multiple domains including cognition, mood, substance use, and self-care.
	Future Status: Prior authorization will be required for all newly eligible inpatient stays for adults and residential stays for adolescents authorized within the waiver through a process developed by OHCA in partnership with ODMHSAS (for adult inpatient) and DHS (for QRTPs). OHCA will incorporate QRTPs into current prior authorization processes/review and develop QRTP-specific medical necessity criteria and prior authorization requirements. Within 60 days of the start of each placement in a QRTP, a family or juvenile court of jurisdiction must consider the CANS assessment, determination and documentation made by the qualified individual in approving the placement.
	Summary of Actions Needed: OHCA will update Administrative Code 317:30-5-41.1 and 317:30-5-95 to reflect reimbursement for acute psychiatric services in IMDs under this demonstration. OHCA will create a reporting structure for purposes of monitoring the ALOS in IMDs. Actions will be completed by October 1, 2021. In partnership with DHS, OHCA will develop QRTP prior authorization processes/requirements, medical necessity criteria, and administrative rules by 12.01.2021.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* In order to receive reimbursement under Medicaid, participating psychiatric hospitals and facility-based crisis units must be enrolled to participate in Oklahoma Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. The OHCA Program Integrity (PI) division spearheads an agency wide effort to identify, recover and prevent inappropriate provider billings and payments. This effort includes the full continuum of behavioral health services. OHCA ensures proper payment to providers and recovers misspent funds leveraging staff in three PI units to perform or assist in provider record review audits. These PI units are Clinical Provider Audits, Behavioral Health Audits, and Data Analytics and Payment Accuracy.
	Future Status: Continued operation of current requirements for psychiatric hospital and crisis units. QRTPs will be required to enroll as a Medicaid provider and comply with DHS licensing provisions set forth in OAC 340:110-3, as well as all national standards for QRTPs. QRTPs will also be included providers under oversight of the OHCA PI division as well as DHS Program Assessment.
	Summary of Actions Needed: Develop and/or integrate procedures and promulgate necessary administrative rules for compliance monitoring of QRTPs by 12.01.2021.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and	*Current Status:* OAC 317:30-5-95.4 requires an individual plan of care for adults aged twenty-one (21) to sixty-four (64) based on a thorough assessment immediately before or upon admission. This plan of care is reviewed every seven (7) days. The plan must incorporate information from required medical, psychiatric, and social evaluations that review physical health, substance use disorders, and suicide ideation. Discharge plans are required to include recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, to include the specific appointment information (time, date, and name, address, and telephone

Prompts	Summary
facilitate access to treatment for those conditions	number of provider and related community services); and a summary of the member's condition at discharge (317:30-5-95.10). OAC 450:23-3-3 requires emergency triage, screening for co-occurring disorders, and integrated mental health and SUD examination for facility based crisis stabilization providers.
	Future Status: Continued operation of current requirements for hospitals. For QRTPs, DHS via a contracted qualified individual will assess any child placed in a QRTP within 30 days of the start of each placement in a QRTP utilizing the CANS, and in conjunction with the family of, and permanency team for, the child. This assessment will include screening for cormorbid physical conditions, SUD and suicide ideation, and will include concrete plans to address these conditions, including the place of service, the type of service, required goals, objectives, evaluative criteria, implementers, and time lines. .
	Summary of Actions Needed: Develop and/or integrate procedures and compliance monitoring of discharge planning by 12.01.2021. Provide technical assistance and outreach to providers by 10.01.2021.
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* Quality of care issues are also identified through client satisfaction surveys. For example, Griffin Memorial Hospital and Tulsa Center for Behavioral Health use a mutual client satisfaction survey which is administered at discharge to everyone leaving the facility. Many of the items were taken from the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey. Other inpatient facilities use similar surveys. CBSCCs have developed a survey for discharging clients as well.
	Future Status: Continued administration of client satisfaction surveys. For QRTPs, a contract will be developed for the qualified individual completing the CANS assessment with similar contractual monitoring and review procedures as to the compliance and quality of assessment being completed. DHS through any authorized representatives will have the right at reasonable times, to inspect, investigate, or otherwise evaluate the services performed at QRTPs. Interventions may include a 1) Plan for Immediate Safety (PFIS) to immediately control any significant and clearly observable condition that is present and endangering or threatening to endanger a resident; 2) Corrective Action Plan (CAP) with steps, actions, or strategies taken to correct or address behaviors or conditions associated with an individual employee related to abuse, neglect, misconduct, or areas of concerns; or 3) Facility Action Step (FAS) to address actions or strategies needed to correct areas of concern identified within the broader agency's culture, services, or contract compliance.
	Summary of Actions Needed: Develop and/or integrate procedures for monitoring and oversight of good quality of care in QRTPs by 12.1.2021. Develop contract by 01.01.2021 with award by 07.01.2021 for qualified individuals completing the CANS assessments.

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SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status:* Oklahoma administrative code requires that each adult member aged twenty-one (21) to sixty-four (64) must have a discharge plan that includes a recapitulation of the member's hospitalization; recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, to include the specific appointment information (time, date, and name, address, and telephone number of provider and related community services); and a summary of the member's condition at discharge. All discharge and aftercare plans must be documented in the member's medical records. Individual plan of care for members under the age of twenty-one (21) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community. State operated inpatient hospitals providing acute short term stabilization must provide a written discharge plan to address the basic needs of the consumer including but not limited to housing, income maintenance and social support as well as specific provisions for ongoing community based mental health or substance abuse treatment needs. When treatment for co-occurring substance abuse and mental health disorders is indicated, discharge planning includes arrangements to continue treatment for the co-occurring disorders. In addition, regular communication including meetings with all community mental health centers and alcohol or drug programs within the state-operated psychiatric inpatient unit service area pursuant to appropriately signed releases by the consumer to support the continuation of care on behalf of the consumer in post- inpatient settings. OAC 450:23-5-8 requires all CBSCCS to complete an aftercare plan upon discharge at the earliest possible point in the discharge process, as well as referral and linkage procedures to ensure transition to the least restrictive setting. OAC 450:23-3-8 also requires specific referrals and linkages for homeless individuals, including housing authorities, shelters, and food banks. Further, since all CBSCCs are also CMHCs, they provide direct access and linkage to outpatient and community-based providers.
	Future Status: Continued operation of current requirements and implementation of QRTP requirements. Each QRTP resident's treatment plan will, at minimum, address plans for the provision of services on discharge planning and post-discharge goal and supports. QRTPs must engage the caretaker and coordinate with the CW Specialist. Within thirty

Prompts	Summary
	(30) calendar days after discharge, a written discharge summary will be provided to the CW specialist and added to the case record. The summary will include a synopsis of treatment and educational services, progress toward treatment goals, reason for discharge, and recommendations toward future treatment, educational and placement needs. QRTPs also must have documented evidence of a relationship with foster care and therapeutic foster care (TFC) agencies under DHS contract to develop transition and discharge options for residents meeting TFC criteria and continuing to need out-of-home placement. QRTPs will also provide discharge planning and family-based aftercare support with the involvement of community-based providers for at least 6 months post-discharge.
	Summary of Actions Needed: Develop and/or integrate procedures and promulgate necessary administrative rules for QRTPs to provide discharge planning and family-based aftercare support by 12.01.2021.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status*: State Hospitals providing acute inpatient services are required under OAC 450:30-9-8 to provide continued treatment planning which begins with the consumer and, pursuant to releases signed by the consumer, the family and the local community mental health center as soon as the consumer is admitted to the state-operated psychiatric inpatient unit. Discharge planning must also include a written discharge plan to address the basic needs of the consumer including but not limited to housing, income maintenance and social support as well as specific provisions for ongoing community based mental health or substance abuse treatment needs. CMHCs who partner in the discharge planning are also required to provide services to individuals with housing insecurity, including linkage and contacts with local housing authorities to assist with accessing income benefit programs and housing programs, among other services *(OAC 450:17-3-161).* OAC 450:23-3-8 requires CBSCCs to make specific referrals and linkages for homeless individuals, including housing authorities, shelters, and food banks. See response in 2.a for information regarding QRTPs.
	Future Status: Continue policy with monitoring by ongoing review of documentation of linkage activities and agreements; clinical records; PICIS reporting data; and CMHC policy and procedures. See response in 2.a for information regarding QRTPs.
	Summary of Actions Needed: N/A –milestone requirements already met. See response in 2.a for information regarding QRTPs.
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* ODMHSAS administrative code 450:17-3-103 requires CMHC case management services for consumers admitted to higher levels of care including: (a) Case managers shall maintain contact with existing CMHC consumers, and establish contact with newly referred persons who are receiving services in inpatient psychiatric settings, Community Based Structured Crisis Centers, (CBSCC), or 24-hour settings providing substance use disorder treatment; and (b) Each CMHC shall assign at least one (1) staff member who is responsible for linkage between psychiatric inpatient units, CBSCCs, and/or the substance use disorder treatment facility and the CMHC. In addition, CMHCs are required to maintain regular visits or communication with the psychiatric inpatient unit,

Prompts	Summary
	CBSCC, and/or substance use disorder treatment facility to monitor progress of those consumers hospitalized and/or in facility-based substance use disorder treatment from the CMHC's service area. CMHCs must also provide knowledge and communication to other CMHC staff regarding psychiatric inpatient unit admission, CBSCC and/or substance use disorder treatment facility and discharge procedures. For admissions, case managers from the CMHC to which the consumer will be discharged must assist the consumer and psychiatric inpatient unit, CBSCC, and/or substance use disorder treatment facility with discharge planning for consumers returning to the community. Individuals discharging from an inpatient psychiatric unit setting, CBSCC, and/or substance use disorder treatment facility, who have not already been engaged, shall be offered case management and other supportive services by CMHCs. This must occur as soon as possible but shall be offered no later than one (1) week post-discharge. CMHCs, which are statewide, are also required to assign designated staff and provide ongoing visits and communication with inpatient psychiatric units, CBSCCs, and substance use disorder treatment facilities. CCBHCs must make and document reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge. The CCBHC is also required to collaborate with all parties involved including the discharging/admitting facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s). Compliance is monitored by a review of the following: clinical records; staff interviews; information from ODMHSAS operated psychiatric inpatient units; CBSCC facilities, substance use disorder treatment facilities; meetings minutes (CMHC or state-operated psychiatric inpatient unit); and a review of a minimum of ten (10) clinical records of consumers who received services at an inpatient unit, CBSCC, and/or 24-hour setting providing substance use disorder treatment within the past twelve (12) months.
	Future Status: Continuation of existing requirements for CMHCs. . Statewide expansion of CCBHCs. The State is aiming for this to be achieved by Year 3 of the demonstration. Steps will include ongoing technical assistance to CMHCs, including continuation of regular meetings with these providers. QRTPs will be required to provide a follow up contact within 72 hours of discharge from the QRTP. See response in 2.a for other information regarding QRTPs.
	Summary of Actions Needed: N/A - Milestone criteria is met. Develop requirements and procedures for required post-discharge follow up by 10.01.2021. See response in 2.a for information regarding QRTPs.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* Oklahoma implemented a Behavioral Health Home (BHH) program. Oklahoma's BHH service delivery model is designed to improve care coordination and service integration, with the goal to improve health outcomes and control future health care costs for individuals with serious mental illness (SMI) or serious emotional disturbance (SED). Care is delivered using an integrated team that comprehensively addresses physical, mental health and substance use disorder treatment needs to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote the use of Health Information Technology (HIT), and

Prompts	Summary
	avoid unnecessary care. There are 21 Health Homes for adults with SMI and 20 Health Homes for children with SED within the provider network; all CMHCs are certified as Health Homes. These Health Homes are required to provide care coordination and care management to ensure integrated behavioral health and health care.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A-milestone met
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* In addition to CMHCs, Oklahoma currently certifies Certified Community Behavioral Health Centers (CCBHC), with four CCBHCs serving a significant portion of the state and two additional CCBHCs in the process of being certified. CCBHCs must develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Emergency Departments, Psychiatric Residential Treatment Facilities (PRTF), ambulatory and medical withdrawal management facilities or other system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of BHH participants. Transitional care will be provided by the CCBHC for consumers who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities. The CCBHC will make and document reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge. The CCBHC is also required to collaborate with all parties involved including the discharging/admitting facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s). Transitional care is not limited to institutional transitions but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services. The CCBHC must document transitional care provided in the clinical records. Oklahoma implemented a Behavioral Health Home (BHH) program. BHHs must develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Psychiatric Residential Treatment Facilities (PRTF) or other system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of BHH participants. May 2017 outcomes measures for Health Homes indicate that follow up rates after hospitalization for Mental Illness within 7 days after discharge have gone from 33.8% in June 2016 to 84.2% in March 2017.
	Future Status: Expansion of CCBHCs throughout the demonstration through support and certification of additional facilities.
	Summary of Actions Needed: Expansion of CCBHCs statewide throughout the course of the demonstration. The State is aiming for this to be achieved by Year 3 of the demonstration. Steps will include ongoing technical assistance to CMHCs, including continuation of regular meetings with these providers.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help	

Prompts	Summary
beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment	*Current Status:* Oklahoma provides a comprehensive statewide service array as described in the availability assessment.
	Future Status: OHCA, in partnership with ODMHSAS, will annually monitor the provider network through completion of the CMS-designated Mental Health Availability Assessment. Where geographic shortage areas are identified, targeted outreach to non-Medicaid enrolled providers in those areas will be conducted. In addition, the state will add the capability to assess the number of providers accepting new patients with implementation of managed care (anticipated 10.01.2021).
	Summary of Actions Needed: Annual completion of the CMS-designated Mental Health Availability Assessment and provider outreach, as applicable. Review of managed care RFP responses to ensure entities can provide data on providers accepting new patients, as required in the RFP, by 03.01.2021. Monitor to ensure this data is captured within overall data required to be submitted by managed care entities on an ongoing basis, beginning 04.01.2022.
a. 3.b Financing plan – See additional guidance in Attachment A	*Current Status:* Please refer to Financing Plan below.
	Future Status: Please refer to Financing Plan below.
	Summary of Actions Needed: Please refer to Financing Plan below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization	*Current Status:* ODMHSAS tracks, in real-time, state operated acute psychiatric and crisis stabilization bed availability.
	Future Status: The current functionality will be expanded to track all Medicaid-contracted inpatient facilities.
	Summary of Actions Needed: ODMHSAS, in partnership with OHCA, will implement these system changes by July

Prompts	Summary
beds	2021.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* ODMHSAS requires providers to complete a Client Assessment Record (CAR) for each member to assist in identifying the level of care need. This standardized tool captures information across multiple domains including cognition, mood, substance use, and self-care. DHS will require age-appropriate, evidence-based, validated, functional assessment to ensure appropriate placement.
	Future Status: Continue required use of CAR including submission with inpatient PA requests. DHS, via a contracted qualified individual will assess any child placed in a QRTP within 30 days of the start of each placement in a QRTP utilizing the CANS, and in conjunction with the family of, and permanency team for, the child. This assessment will entail determining the appropriateness of a placement in a QRTP for the purpose of approving the case plan and the case system review procedures for the child; assessing the strengths and needs of a child and determining the appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child. This assessment may be conducted prior to the placement in the QRTP, but must be completed no later than the end of the 30-day period.
	Summary of Actions Needed: N/A Milestone is met. Develop and/or integrate procedures and promulgate necessary administrative rules for compliance of the federal regulation of an assessment for placement in a QRTP by 12.01.2021.
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* A tiered support system is currently in place to ensure every effort is made to use inpatient and residential beds only 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. 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, 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 need for inpatient admission and allowing for diversion of individuals in behavioral health crisis from emergency departments when clinically appropriate. The 13 CMHCs also participate in the Oklahoma Systems of Care (SOC) Initiative. Currently, Oklahoma has 80 local

Prompts	Summary
	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 and want. 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.
	Future Status: Expanded access to facility-based crisis centers through increased beds within existing facilities as well as new facilities.
	Summary of Actions Needed: Waiver approval and implementation.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
b. 4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment	*Current Status:* OHCA reimburses for behavioral health services provided within a school setting, including screening, psychological evaluation and testing, psychotherapy, and therapeutic behavioral services. These school-based services are available statewide. In addition, the 13 CMHCs 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 and want. 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 addition, there are 2 RA1SE NAVIGATE programs to assist individuals who are experiencing First Episode of Psychosis (FEP), along with 1 early Serious Mental Illness (eSMI) 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. **Special Education.** Under the provision of the Individuals with Disabilities Education Act, children who are placed in a special education program because of a SED must have an Individual Education Plan (IEP). Many CMHC staff and programs particularly affiliated with local Systems of Care are actively involved in supporting families and children for whom an IEP is needed.

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	Supported Education: Adult basic education, like GED classes, is offered on site at two clubhouse programs, and at some CMHCs. CMHCs and other providers also offer advocacy and support services to assist consumers with accessing GED classes within the community, as well as, other community based educational opportunities (i.e., technology centers, trade schools, colleges, universities) and promoting ongoing educational success. Through the ODMHSAS Individual Placement Services (IPS) program, training on "How to Get a GED" is offered for providers and other community stakeholders. **Employment Services.** CMHC case managers assist adults age 18 and older with job location and placement. These activities are funded by the ODMHSAS and specific service codes provide claims and reimbursement data for this. In addition, HOPE Community Services offers a supported employment program. Transitional employment programs are provided by Thunderbird Clubhouse and Crossroads Clubhouse. Both clubhouses are accredited by Clubhouse International (formerly the International Center for Clubhouse Development). The ODMHSAS and the Oklahoma Department of Rehabilitation Services (OKDRS) assist with funding various activities within this array of employment services and utilize a memorandum of understanding to coordinate and monitor related activities. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has adopted Individual Placement and Supports (IPS) as their standard evidence-based supported employment and education model. The ODMHSAS believes that the best way to support self-sufficiency for those assisted with employment is to reinforce rapid entry into the competitive labor market integrated with supportive services as soon as the person feels ready. This focus on the participant's choice and strengths aligns closely with other evidence-based practices models followed by the ODMHSAS and affiliated providers and has allowed for better service provision for Oklahoma's most vulnerable. IPS has expanded to twelve teams serving 23 counties across the state of Oklahoma funded through various different grants, including the Mental Health Block Grant; State Opioid Response grant, Oklahoma Now is the Time grant, and the Assisted Outpatient Treatment grant. On July 1, 2018, the ODMHSAS activated IPS specific billing codes, and the IPS credential process for IPS employment specialists and supervisors. This allows for providers to submit payment claims for delivery of IPS services to ODMHSAS. **Housing Supports:** Assuring satisfactory access to safe, sanitary, and affordable housing for adults with mental illness continues to be a challenge to the state. Specific housing services for people with mental illness are available in urban and rural settings and are funded through the ODMHSAS, the U.S. Department of Housing and Urban Development (HUD), public housing authorities and private sources. Housing models include transitional housing and permanent supported housing (both congregate and scattered site). Although some housing continues to be developed in settings specifically for persons with mental illness (i.e., HUD funded Section 811 and HUD SHP projects), the ODMHSAS continues to place an emphasis on creating opportunities for more integrated housing, including permanent scattered site housing with available support services. Some stakeholders continue to encourage the development of transitional housing services to meet the needs of consumers whose current level of recovery would make it difficult to have

Prompts	Summary
	success in a supported housing model. The state currently has multiple Housing First programs that support individuals with SMI. These programs are the result of multiagency partnerships at the local level between behavioral health providers and housing authorities. OHCA and ODMHSAS support these programs through reimbursement for medical and case management services, including screening and referral to needed behavioral health treatment. Additional housing related service and supports embedded in the system for adults with SMI include flexible funds available to each CMHC that can be used to augment a variety of housing supports, including rental and utility deposits; a Discharge Planning Housing Subsidy specifically for adults discharging from psychiatric inpatient care, Department of Corrections, or aging out of the foster care system; a Transition Youth Housing Subsidy program to assist very low-income young adults ages 17 – 24; a smaller subsidy program for transition youth living in rural areas (added through grant funding in FY 2014); and Residential Care Facilities can receive a higher rate for services if they successfully meet criteria for designation as a Recovery Home. DHS is partnering with the Building Bridges Initiative (BBI) to support QRTP programs in engagement with families and quality discharge planning. Discharge planning will include any identified services and supports for the child to maintain the gains that were made while in treatment (See comments in 2.a). Efforts to improve Oklahoma's continuum of care have resulted in the development of the Enhanced Foster Care (EFC) program to support the identification of children and youth who have complex needs and get them engaged in treatment sooner to ensure that children and families have access to evidence-based treatments and specialized supports. DHS has partnered with Oklahoma's CMHC providers in the coordination of EFC services, which includes Oklahoma Systems of Care, mobile crisis response, and evidence-based treatment. Currently, there are around 120 children in the Enhanced Foster Care Program. Additionally, DHS is collaborating with ODMHSAS and other private providers to address the service gaps within rural areas of the state through quality service mapping.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A - Milestone criteria is met.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* A basic package of primary and preventive behavioral services, such as screenings for depression, anxiety and substance abuse is available to every SoonerCare member without prior authorization for services delivered by a Patient-Centered Medical Homes, Indian/Tribal/Urban (I/T/U) Clinics, and Federally Qualified Health Centers. Part of the responsibilities of SoonerCare Choice medical homes is to conduct behavioral health screenings for members age 5 and older for all tiers. OHCA has put together a Behavioral Health Screening Toolkit of available resources to help providers accomplish this task. OHCA has identified validated public domain screening tools that are available to assist physicians and behavioral health professional with screening and assessing mental health issues. OHCA has also created a behavioral health referral guide and well as a web-based Behavioral Health Provider

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	Directory for use by non-specialty providers. The SoonerCare Psychiatric Consultation Program provides primary care physicians with access to free informal telephonic consultation with board certified psychiatrists. Consultation is available to assist with psychotropic medication management for children, adolescents and adults. ODMHSAS is building an early childhood SOC network statewide. The goal of this network is to work with local partners from the early childhood community to expand the expertise of the OKSOC providers to better serve children ages 0-5 and their families. Training in the following EBPs has been, and will continue to be, provided: Infant Massage, Circle of Security and Child Parent Psychotherapy.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A - Milestone criteria is met.
c. 4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* 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.
	Future Status: Continued operation of current programming. Potential pursuit of expansion of CBA to metropolitan areas.
	Summary of Actions Needed: Implement expansion of CBA, pending analysis of how the implementation of managed care in 2021 will integrate/affect this process. If pursued, the state aims to achieve this by Year 2 of the demonstration. Steps include the development and award of an RFP and coordination with providers.
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* Oklahoma has twenty (20) Health Homes for children with Serious Emotional Disturbance (SED) within the provider network. In addition, there are 2 RA1SE NAVIGATE programs to assist individuals who are experiencing First Episode of Psychosis (FEP), along with 1 early Serious Mental Illness (eSMI) 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

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	exposure to young adults within the age range that is most at risk for eSMI. The Now Is The Time – Healthy Transitions (NITT-HT) grant, referred to in Oklahoma as the Oklahoma Now Is The Time (ONIT) grant, focuses on integrated services and supports for youth and young adults ages 16 through 25 with serious mental health conditions and their families. ONIT's developmentally appropriate and effective youth-guided local Systems of Care have been designed to improve outcomes in education, employment, housing, mental health and co-occurring disorders, and decrease contact with the juvenile and criminal justice systems. ONIT programs focus on a blended model of Wraparound and Transition to Independence Process (TIP). Currently ONIT has five lab sites; three in Oklahoma County, one in Okmulgee County and one in Washington County. During FY17, 693 youth and young adults were outreached; 948 were screening for behavioral health needs; and 320 were referred to services. Drawing on best practices from our Now is the Time Initiative, SOC2 has implemented successful outreach approaches to identify youth and young adults with early signs and symptoms of SED, SMI, or first episode psychosis (FEP). The goal is to engage youth into effective services and connect them with all needed supports early, thereby greatly increasing their chances of full recovery and a life of their choice.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A - Milestone criteria is met.
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status:* CMHCs and CCBHCs are required to provide crisis intervention services, including mobile crisis response as part of their certification requirements. 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 whom 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 (including two for mental health and one for SUD) are planned for Oklahoma City within the next several years as part of a city improvement ballot initiative passed in December 2019.

Prompts	Summary
	A tiered support system is currently in place to ensure every effort is made to use inpatient and residential beds only 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. 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 and want. 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. As noted in milestone 4.x, Oklahoma utilizes a system of coordinated community response and mobile crisis response within the SOC 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. Crisis Intervention Training (CIT) is a community effort partnering both law enforcement officers and the community together for common goals of safety, understanding, and service to individuals with mental illness and their families. Officers participate in a 5-day, 40-hour CIT program hosted by ODMHSAS. The training program consists of sections taught by mental health and substance abuse treatment experts, specially trained officers, local Community Mental Health Centers, and representatives from the National Alliance on Mental Illness (NAMI). The training prepares officers to safely de-escalate a crisis, determine the need for emergency treatment, and get the individual to professional treatment as quickly as possible. Since 2002, ODMHSAS and all supporting CIT partners, have trained around 1,200 law enforcement officers throughout the state. In Oklahoma County alone, CIT-trained officers have saved nearly $1,000,000 in jail costs and over $500,000 in hospital costs through deescalating mental health crisis and diverting individuals to crisis centers.
	Future Status With approval of the waiver crisis stabilization units will be able to expand capacity by adding additional beds while maintaining eligibility for Medicaid reimbursement. Additionally, the State has plans to continue building upon the crisis system that has been developing over the past several years. This includes an expanded, statewide system of: crisis call centers, mobile crisis teams, and urgent care centers strategically placed in each region.
	Summary of Actions Needed: Expansion of non-residential crisis services is anticipated by January 1, 2023. Necessary

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	steps include identification of funding sources, identification of strategic locations/providers, and provision of technical assistance to current and/or new providers.
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status*: 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 well as ability for crisis response up to 23 hours 59 minutes to stabilize every crisis possible and divert as many individuals are possible from the necessity of crisis center admissions and/or inpatient admissions. The State has implemented several community-based initiatives aimed at reducing inpatient admissions and readmissions such as Health Homes for Children with Serious Emotional Disturbance and Adults with Serious Mental Illness, reimbursement for transitional case management and mobile response and stabilization. The State believes that at least a portion of the decreases in the utilization of freestanding psychiatric hospital services post implementation can be attributed to these initiatives. 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 whom 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.
	Future Status: Continued operation of current programming. Promote and implement statewide expansion of CCBHCs, expand CBA to unserved areas, and explore additional opportunities for supported employment and housing.
	Summary of Actions Needed:. Implement additional supports by Year 3. Necessary steps include the provision of ongoing technical assistance to support new CCBHCs, identification of funding sources for expanded supported employment and housing supports, and obtaining necessary federal approvals if Medicaid funding is pursued for supported employment and/or housing supports.
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT	

Prompts	Summary
interoperability in support of the demonstration's goals."[6] *The HIT Plan should also describe, among other items, the:* • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	OHCA made great strides in the adoption of electronic health records (EHRs) through the Electronic Health Record Incentive Program. Unfortunately, behavioral health provider facilities were not eligible for the incentive payments. To bolster interoperability for behavioral health providers, the ODMHSAS applied for and received a grant through SAMHSA's Center for Integrated Health Solutions. Through a voucher program, behavioral health providers work with a certified health information organization (HIO) to connect via a secure, electronic means to communicate, share medical records, perform referrals, obtain lab and pharmacy data electronically, submit reportable data to the Oklahoma State Department of Health (OSDH), and establish interconnectivity to facilitate care coordination. The voucher funding offsets the initial cost of signing up with a certified HIO to electronically exchange health information. Because of the wide variation in the degree of health information technology and the confidentiality regulations around sharing substance use disorder data, the behavioral health voucher program was two tiered. The first tier allowed the providers to see the HIE data through a web portal and share information via DIRECT Secure Messaging to other providers using the messaging system. The second tier allowed them to share data from their EHR or other systems of records. Prior to the award there were 21 behavioral health providers linked to an HIE in the State. These providers were associated with primary care hospitals or large health centers. There were no safety net behavioral health providers who serve individuals with no resources to pay for treatment. Through this project, funding was made available to 27 behavioral health agencies for 365 clinical connections with HIEs. This is a 34% penetration rate of eligible providers. Tier 1 vouchers were used to connect 23 individual clinicians to an HIE through DIRECT and a web portal at seven agencies, and Tier 2 vouchers provided full interfaces to 20 agencies, with 342 individuals clinicians having connections. All of the providers participating in the voucher program serve individuals through Medicaid, state or federal block grant funding. Due to the lack of a statewide HIE, providers experienced barriers in identifying data for their clients. As described further below, this barrier should be remedied with the OHCA's RFP for a statewide HIE. The Office of Management and Enterprise Services, on behalf of the Oklahoma Health Care Authority (OHCA), issued an RFP in October 2019 to solicit proposals for a Supplier to provide a statewide health information exchange (HIE) to be called the Oklahoma Statewide Health Information Network and Exchange (OKSHINE). Oklahoma is looking to

[6] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

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	achieve statewide health information exchange to allow health information to flow seamlessly to and from authorized organizations and individuals in Oklahoma. OKSHINE is intended to meet the needs of end users, allowing providers and their patients, hospitals and health systems, purchasers and payers, state health agencies and local health departments, health information business associates, and an increasingly inclusive ecosystem of human service organizations to have secure, accurate data available at the right time and place, for the right purposes. All CMHCs are health homes and therefore are required to have a meaningful use certified EHR, utilize HIE and a population care management system. The State of Oklahoma has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	The OKSHINE solution will include an organization, with Oklahoma State oversight, to manage and operate the processes and technology to enable Oklahoma healthcare providers to meet the CMS Meaningful Use, Promoting Interoperability Program (PIP) requirements and Medicaid Information Technology Architecture (MITA) 3.0 and Seven Standards and Conditions. OKSHINE will include interoperability with existing state systems including the state agency interoperability system (Health-e Oklahoma), Medicaid, behavioral health and public health to support state initiatives and surveillance, Public Health Reporting including Immunizations, Electronic Laboratory Reports (ELR), Cancer Case Reports, and electronic case reports for reportable diseases. The system will also include a centralized data repository with integration of clinical and claims data to support value-based care initiatives and population health management including tracking trends and preventative care, identify health disparities, and help with management of chronic medical conditions; state use database for analytics and research. The state's SED/SPMI Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, as applicable, the state's Behavioral Health IT Plan.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[7] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the	Oklahoma does not currently have Medicaid managed care contracts. The state plans to work with the OKSHINE vendor to create a sustainability plan for ongoing operations in Oklahoma; and have or obtain full Electronic Healthcare Network Accreditation Commission (EHNAC) Health Information Exchange Accreditation Program (HIEAP) accreditation. The OKSHINE contract will require the supplier to work within the parameters of: • All relevant HITECH State Medicaid Director letters. • CMS Final Rule, Medicare and Medicaid Programs; Electronic Health Record Incentive Program, released by CMS on July 28, 2010 (42 CFR Parts 412, 413, 422, & 495) and any subsequent amendments or updates.

[7] Available at https://www.healthit.gov/isa/.

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state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	• Health Insurance Portability and Accountability Act (HIPAA) of 1996 and any subsequent amendments or updates. • 42 CFR Part 2 and any subsequent amendments or updates • The Trusted Exchange Framework and Common Agreement (TEFCA). • CMS Medicaid Information Technology Architecture (MITA) 3.0 and Seven Standards and Conditions. • Requirements of the 21st Century Cures Act related to interoperability and information blocking. • Federal Information Security Management Act (FISMA)- National Institute of Technology Standards. The state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[1] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in relevant State procurements. [1] Available at https://www.healthit.gov/isa/.
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [8] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[9]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* The State of Oklahoma currently has two private sector regional HIEs which have closed loop referrals/e-referral systems to varying degrees. However, the regional HIEs are not interoperable and therefore cannot share e-referrals between providers outside their respective HIEs. All CMHCs are health homes and therefore are required to have a meaningful use certified EHR, utilize HIE and a population care management system.
	Future State: The RFP for the OKSHINE Contract included a requirement that the vendor have experience in bidirectional exchange of clinical and behavioral health data in the latest standardized HL7 message formats in at least one (1) state for a minimum of five (5) years. OKSHINE will include a provider onboarding program including a

[8] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[9] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

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	website and processes for registration, document exchange and management, outreach, testing and implementing transport connections, and testing secure data exchange of clinical data in standard Health L7 formats; integration with existing state systems including the master person index and provider directory; admission, discharge, transfer (ADT) notifications to physicians and care management teams; care coordination through exchange of patient clinical records quickly, securely, and electronically across participating Oklahoma healthcare providers and other state and national health information exchanges; production and analytics of electronic clinical quality measures (eCQMs). The State will evaluate closed loop referrals and e-Referrals once a vendor for the OKSHINE contract is awarded. The State plans to pursue this functionality and will collaborate with the OKSHINE HIE vendor to assess and determine the necessary resources needed to implement a closed loop e-referral system.
	Summary of Actions Needed: Award and implementation of OKSHINE contract. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* The State of Oklahoma currently has two private sector regional HIEs which have closed loop referrals/e-referral systems to varying degrees. However, the regional HIEs are not interoperable and therefore cannot share e-referrals between providers outside their respective HIEs. Patient-Centered Medical Homes (PCMH) currently have electronic referral capabilities with specialty health care providers.
	Future State: The OKSHINE system will promote care coordination through the exchange of patient clinical records quickly, securely, and electronically across participating Oklahoma healthcare providers and other state and national health information exchanges. Supplier will implement an Oklahoma statewide clinical health information exchange of patient clinical summaries and continuity of care documents in compliance with current ONC-endorsed interoperability standards. This includes the ability to provide a patient-level clinical summary document that is transferred between healthcare providers when a patient is, at a minimum, referred to a specialist, admitted or discharged from a hospital, or transitioned to a long term care or acute care facility. Healthcare providers can view a clinical document architecture (CDA), or other accepted formats, from other healthcare providers through the statewide HIE via portal, EHR interface or browser-based secure messaging and make a CDA from their patients available to other healthcare providers. OKSHINE award is anticipated in February 2021, with implementation anticipated to be complete within 6-8 months.
	Summary of Actions Needed: Award and implementation of OKSHINE contract. Onboarding of Community Mental Health Programs, Certified Community Behavioral Health Centers, Certified Addiction and Recovery Centers, Opioid Treatment Programs, Behavioral Health Homes, Assertive Community Treatment teams, mobile crisis teams, and other state-licensed behavioral health organizations along with Medicaid providers who participate in Patient-Centered Medical Homes (PCMH), Federally Qualified Health Centers (FQHC), Rural Health Centers, IHS, tribal and urban health clinics, and community health centers will occur within the second year of the contract. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***

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1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State:* The State of Oklahoma currently has two private sector regional HIEs which have closed loop referrals/e-referral systems to varying degrees. However, the regional HIEs are not interoperable and therefore cannot share e-referrals between providers outside their respective HIEs. Referrals from physicians and mental health providers to community-based supports are currently conducted via non-electronic processes. Enrollees are connected telephonically and/or through informal case management strategies to community-based supports.
	Future State: OHCA anticipates incorporating the tracking of electronic referrals to community-based supports once the OKSHINE HIE vendor is selected.
	Summary of Actions Needed: The timeline for development of this new programming and functionality is currently under development. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* Health homes utilize HIT to create, document, execute and update the comprehensive, person-centered service plan for every member that is accessible to the interdisciplinary team of providers when external partners have the capability to receive structured, electronic records. The State of Oklahoma has participated in the Promoting Interoperability Program (formally the EHR Incentive Program) January 3, 2011, being one of the first in the nation to launch. To date, Oklahoma has had 3,969 Eligible Professionals (EP) and 138 Eligible Hospitals (EH) participate in the PIP. The purpose of the incentive is to provide a financial incentive to assist eligible providers (both EP& EH) to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology. All current participants **must** use the 2015 Edition of certified electronic health record technology (CEHRT). The more up-to-date standards and functions in 2015 Edition CEHRT better support interoperable exchange of health information and improve clinical workflows. Benefits to using 2015 CEHRT are: • Improves interoperability by adopting new and updated vocabulary and content standards for the structured capture and exchange of health information, including a Common Clinical Data Set (CCDS) composed primarily of data expressed using adopted standards; and rigorously tested and identified content exchange standard (Consolidated Clinical Document Architecture (C-CDA)). Standards-based electronic exchange supports patient care by ensuring that health care data is consistently available to the right person, at the right place, and at the right time. • Includes "application access" certification criteria that requires health IT to demonstrate it can provide application access to the CCDS via an application programming interface (API). • Supports patient electronic access to health information through new functionalities and a range of potential technologies including the use of APIs. These technologies allow patients greater flexibility and choice in how they access and share their health information. • Includes a revised View, Download, and Transmit criterion that continues to support patient access to their

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	health information, including via email transmission to any third party the patient chooses (including to any email address, so long as the patient is properly advised of the risks of doing so) and through a second encrypted method of transmission.
	Future State: Continue to expand uptake of the Promoting Interoperability Program.
	Summary of Actions Needed: See response for 1.1 and 1.2. Continue promotion/outreach; integrate functionality into OKSHINE project.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* Health Homes utilize HIT to communicate with health facilities and other systems and to facilitate interdisciplinary collaboration among all providers, the member, family, caregivers and local supports when external partners have the capability to send and receive electronic, structured records. Health Homes are required to join a certified health information exchange and make a commitment to share information with all providers.
	Future State: Transition CMHC health homes into CCBHCs and continue to support Health Home/CCBHC HIT functionality with state HIE.
	Summary of Actions Needed: Continue promotion/outreach; integrate functionality into OKSHINE project.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The Child's Passport is a web application that allows Bridge families and other resource providers access to SoonerCare (Oklahoma's Medicaid) and education information for all children who enter care, children placed for adoption and for youth exiting care. SoonerCare records are maintained by the OHCA and education records are maintained by the OSDE; in turn these records are made available through the Child's Passport. These records include, but are not limited to: • Health care providers; • Early periodic, screening, diagnosis and treatment recommendations; • Diagnosis; • Immunizations; and • Previous and current prescription medications. The Child's Passport was specifically designed to help providers for children in the custody of OKDHS and the tribes gain current and updated information regarding the child in their care. The child's health history is based on SoonerCare claims, educational information and other pertinent information and is available 24 hours a day, seven days a week through a web-based platform. Guardians can print information and provide to a primary care physician, emergency room provider or therapist.
	Future State: See response for 1.1 and 1.2
	Summary of Actions Needed: See response for 1.1 and 1.2

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2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* See response for 2.3
	Future State: See response for 1.1 and 1.2
	Summary of Actions Needed: See response for 1.1 and 1.2
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* All CMHCs have electronic health records and provide services to both youth and adults. As an individual transitions to adult programs within these agencies, records remain available to staff who meet the applicable HIPPA criteria. Health homes are encouraged to use wireless technology as available to improve coordination and management of care and member adherence to recommendations made by their provider. This may include the use of telemedicine, cell phones, peripheral monitoring devices, and access member care management records, as feasible.
	Future State: See response for 1.1 and 1.2; During the OKSHINE implementation, the State of Oklahoma will collaborate with the OKSHINE vendor and pursue statewide integration of community supports .
	Summary of Actions Needed: See response for 1.1 and 1.2 See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* All CMHCs have electronic health records. These EHR systems maintain electronic consent information for use within the organization and prior to releasing information to external stakeholders.
	Future State: OKSHINE may have a consent registry repository capable of storing and managing the consent directives issued or withdrawn by health care clients regarding the collection, use, or disclosure of their PHI, with an accompanying policy store/rules engine to enable enforcement based on roles and access rules. This repository will be compliant with 42 CFR Part 2 consent requirements.
	Summary of Actions Needed: Award and implementation of OKSHINE contract. During the OKSHINE implementation, the State of Oklahoma will collaborate with the OKSHINE vendor and pursue a secure, private patient portal as well as ensuing a patient consent registry is utilized. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* ODMHSAS has maximized technology and increased the capacity to deliver services by developing an online screening tool. The On-line Assessment Tool System (OATS) allows a provider to make a screening tool available through an email link or on a tablet within the practice. Through the use of this screening tool the client is receives a series of screening tools that look for alcohol abuse, drug abuse, depression and suicidality. Once the client completes the screening tool the provider is able to use the OATS system to pull client screening results into a report for review with the client and to be used to determine possible referral needs. This information is also then available to be kept in the client record as a part of the client's permanent record. The OATS tool is free for providers to use and the ODMHSAS provides all Technical Assistance to the practices using this tool at no cost.

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	All CMHCs/Health Homes/CCBHCs have EHRs that capture screening and assessment data.
	Future State: See response for 1.1 and 1.2 During the OKSHINE implementation, the State of Oklahoma will pursue resourcing and integrating the OATS with OKSHINE infrastructure to promote a statewide solution for intake, assessment and screening. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
	Summary of Actions Needed: See response for 1.1 and 1.2
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* The SoonerCare Psychiatric Consultation Program provides primary care physicians with access to free informal telephonic consultation with board certified psychiatrists. Consultation is available to assist with psychotropic medication management for children, adolescents and adults. In addition, OHCA reimburses for an extensive list of behavioral health services provided via telemedicine. Additionally, ODMHSAS maintains a statewide telemedicine network using Polycom Real Presence. Units are placed in CMHCs and satellite locations covering the entire state. These units increase access to services and information including, medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. In CY2019 (pre COVID-19), 526,289 telehealth behavioral health services were provided to 108,288 unique clients and paid for through Medicaid or state funding. Since the beginning of the COVID-19 pandemic, the State has been working with providers at all levels of care, including inpatient and residential, to promote and expand the use of telehealth as appropriate.
	Future State: Continued operation of current programming and continued promotion of telehealth services for IMD and other providers.
	Summary of Actions Needed: Evaluate long-term flexibility for the provision of services by telehealth. Utilize emergency and other funding mechanisms to support needed infrastructure for providers to offer services by telehealth, particularly in rural areas of the state.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note:	*Current State:* As documented in the State's current Health Homes State Plan, for children with SED, the SOC Wraparound teams are required to access data from the MMIS to monitor use of psychotropic medications. Health homes providers are also encouraged to utilize HIT to monitor member outcomes, initiate changes in care and follow up on member testing, treatments, services and referrals.
	Future State: Continued operation of Health Homes program and CCBHCs.
	Summary of Actions Needed: Expansion of CCBHCs statewide throughout the course of the demonstration. The State is aiming for this to be achieved by Year 3 of the demonstration. The State is also developing its Medicaid managed care RFP to include provisions for care coordination, member engagement during transitions between levels of care,

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research shows that 50% of patients stop engaging after 6 months of treatment[10])	and identification of individuals accessing behavioral health services who are at risk for hospitalization. The State aims to complete the RFP by October 2020 and implement managed care by October 2021.
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* As documented in the State's current Health Homes State Plan, for children with SED, the SOC Wraparound teams are required to access data from the MMIS to monitor use of psychotropic medications. Health homes providers are also encouraged to utilize HIT to monitor member outcomes, initiate changes in care and follow up on member testing, treatments, services and referrals.
	Future State: Continued operation of Health Homes program and transition of CMHC health homes to CCBHCs.
	Summary of Actions Needed: Expansion of CCBHCs statewide throughout the course of the demonstration. The State is aiming for this to be achieved by Year 3 of the demonstration. Specific steps include: 1) continued technical assistance provided to potential CCBHCs, 2) identification of new entities for transition to CCBHC functionality, and 3) continued analysis of provider performance and expenditures.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* The State's eligibility and enrollment system can link children and parents on the same case. All CMHCs have EMRs. As comprehensive providers, multiple family members may be receiving services within the same agency. It is assumed that these records are linked based on demographic information.
	Future State: Continue with current programming.
	Summary of Actions Needed: N/A Milestone is met.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* EMRs assign case numbers to individual patients. Patients are registered and linked to this number with each service.
	Future State: Continue with current programming.
	Summary of Actions Needed: N/A - Milestone is met.

[10] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

ATTACHMENT 1
Schedule of Activities for State HIE (OKSHINE) Procurement

Task Name	Responsible	% Complete	Start	Finish
HITECH 10.0 APD w/HIE APP D		**55%**	**10/1/19**	**11/10/21**
HITECH 9.2 Approval	CMS	100%	10/1/19	10/1/19
Concept Development Phase	OHCA, OSDH	50%	10/21/19	1/24/20
RFP & Contract Approval		**45%**	**10/22/19**	**2/10/21**
Modify current draft & obtain Req #	OHCA Contracts	100%	10/22/19	10/23/19
Coordinate changes with OMES	OHCA Contracts	100%	10/24/19	10/24/19
OMES approval to release	OMES	100%	10/25/19	10/28/19
Release of RFP	OMES	100%	10/28/19	10/29/19
Field and answer bidder questions	OMES/OHCA	100%	10/30/19	11/27/19
HIE RFP out for bids	OMES	100%	10/29/19	12/31/19
Bidding Closed	OMES	100%	12/31/19	12/31/19
Evaluate Bid for Responsivness	OMES	100%	1/1/20	1/13/20
Proposals submitted to Evaluation Committee	Eval Team	100%	1/14/20	1/14/20
Evaluators submit questions to contracts for bidders	Eval Team	100%	1/14/20	1/24/20
Bidders respond to Evaluators questions	OMES	100%	1/15/20	1/24/20
Clarification Items Due to OMES	OHCA Contracts	100%	1/27/20	1/27/20
Evaluators	Eval Team	100%	2/7/20	2/14/20

calculate initial bid scores				
Evaluators send scores to OHCA	Evaluators	100%	2/14/20	2/14/20
OHCA verifies initial scores	Susan Geyer	100%	2/14/20	2/14/20
Evaluators collaborate on discrepancies	Evaluators	100%	2/17/20	2/24/20
OMES validate evaluator initial scores	OMES	100%	2/25/20	3/3/20
Top bidders selected for Demonstrations	OHCA	100%	3/3/20	3/3/20
Bidders notified of Demonstration	OHCA	100%	3/4/20	3/18/20
Coordination of Demonstration w/ vendors and evaluators	OHCA	100%	3/4/20	3/18/20
Bidder Demonstration	Bidders + Eval Team + select others	100%	4/1/20	4/1/20
Pause	All	100%	4/2/20	5/29/20
Vendor clarifications	OMES	100%	6/1/20	6/12/20
Clarifications requested, received & Evaluators review clarifications	Eval Team	100%	6/15/20	7/24/20
decision for second group of demos & Coordinate second set of demos		100%	7/27/20	9/11/20
Second set of demos	Vendors, Eval Tm	100%	9/11/20	9/11/20
Evaluators recommend vendor for award	Eval Team	0%	9/14/20	10/1/20
Final scores entered	OHCA Contracts	0%	10/2/20	10/5/20
Selection of vendor		0%	10/6/20	10/19/20
Security review for	OMES, OHCA	0%	10/20/20	11/16/20

Selected Vendor				
Legal review for Selected Vendor	OMES, OHCA	0%	10/20/20	11/16/20
Vendor Registration with SOS and OMES	OMES, OHCA, SOS	0%	10/20/20	11/9/20
OK Tax permit/exemption obtained	OMES	0%	10/20/20	10/26/20
Vendor BAFO	OMES/OHCA	0%	11/17/20	11/23/20
Vendor registration in PeopleSoft if Necessary	OMES	0%	11/17/20	11/17/20
HIE Contract template development	OHCA	0%	10/20/20	11/23/20
Final Draft Contract developed	OMES/OHCA	0%	11/24/20	11/30/20
Final Draft Contract Complete	OMES/OHCA	0%	12/1/20	12/1/20
Final Draft Contract sent to CMS for approval	OHCA HIE staff	0%	12/1/20	1/30/21
Contract finalized/signed	OHCA	0%	2/1/21	2/3/21
Signed contract sent to CMS	OHCA HIE staff	0%	2/3/21	2/3/21
Start of Contract Implementation	OHCA HIE staff, HIE	0%	2/10/21	2/10/21

ATTACHMENT D:
SUD Implementation Plan

CMS' Opioid and Other SUDs 1115 Demonstration Initiative:

Goals and Milestones to be Addressed in State Implementation Plan Protocols

CMS is committed to working with states to provide a full continuum of care for people with opioid use disorder (OUD) and other SUDs and in supporting state-proposed solutions for expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Section I – Milestone Completion

Milestones

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

Specifications:
To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Current state

Oklahoma's SUD treatment and recovery network currently provides services across the state and includes Community Mental Health Centers (CMHCs) and other Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) funded and/or Medicaid enrolled providers. Under the Medicaid State Plan, the Oklahoma Health Care Authority (OHCA) provides an array of SUD services that include: Screening, Brief Intervention, and Referral to Treatment (SBIRT); crisis intervention; mobile crisis; assessment; service plan development; individual, group and family counseling; peer support; case management; ambulatory detox; medically monitored withdrawal management (ASAM level 4.0); and telemedicine for applicable services. Intensive outpatient level of care is provided through the delivery of an array of SUD services that meet intensive outpatient level of care.

ODMHSAS funded services are primarily purchased through contracts with private, for-profit and non-profit, certified agencies to provide multiple levels of care. These agencies include SUD treatment facilities, community mental health centers, community action agencies, youth and family services agencies, and schools.

All CMHCs are also certified as substance use disorder service providers and receive both mental health and substance use disorder funding for persons with SMI and co-occurring substance use disorders. Specialty substance use disorder treatment providers also collaborate with CMHCs for mental health assessment and other CMHC services as needed. Individualized, gender and culturally specific substance use disorder treatment is required of all providers.

ODMHSAS currently has 18 specific outpatient contracts for adolescent substance use. All outpatient contractors are eligible to provide early intervention, outpatient, and intensive outpatient as well as other ancillary services such as outreach, peer recovery for individuals ages 16 and up. All contracted treatment agencies, whether a community mental health center or a substance use

disorder treatment agency, provide integrated co-occurring services for children and adolescents.

Residential services (ASAM levels 3.1, 3.3, 3.5, and 3.7) are available through ODMHSAS certified residential providers, many of which are contracted with ODMHSAS. ODMHSAS directly operates three SUD residential treatment facilities staffed with state employees.

A strength of the system is the manner by which services are delivered to target populations including persons who inject drugs, adolescents, underserved persons from minority and LGBT communities, pregnant and/or parenting women, and persons who are at risk of communicable diseases.

Currently, Oklahoma's Medicaid program provides coverage for two MAT medications – buprenorphine/naloxone and naltrexone. 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.

ODMHSAS, through its provider certification division, provides certification for SUD providers across the state, with the exception of tribal entities located on land not subject to state jurisdiction. Oklahoma's substance use disorder treatment and recovery services network currently provides services within all 77 Oklahoma counties. 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) providing a full continuum of care, including intensive outpatient services. There are currently 16 opioid treatment programs (OTPs) in the state.

Future state

As part of this waiver, the State will add residential SUD services for Medicaid reimbursement. This will include ASAM levels 3.1, 3.3, 3.5, and 3.7; as well as adolescent residential SUD services. Additionally, the State will be requesting a waiver to provide these services and ASAM levels 3.7 medically monitored withdrawal management services and 4.0 medically managed withdrawal management services in IMDs. OHCA intends to add 2.5 Partial Hospitalization to the state plan through a SPA.

A SPA will be submitted adding Medicaid coverage of methadone for MAT. Under this demonstration, the state will require all Medicaid-enrolled residential substance abuse providers to provide MAT or have a relationship with a MAT provider to ensure access to medication for their residents. ODMHSAS has made recent improvements to the residential SUD waiting list in response to the addition of residential beds made possible through a legislative appropriation in 2019. These additional beds were added within the last year and have essentially eliminated the waiting list. ODMHSAS has transitioned the waiting list system to an online bed availability list, which requires residential providers to update their bed availability every 24-48 hours and lists the types of services available/populations served from each provider. This allows outpatient providers to access the list and make the most appropriate and timely referral to residential services if a client is assessed to meet ASAM residential/Level 3 criteria.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	ASAM Level 1 Outpatient services currently covered under the OHCA state plan include: SBIRT; crisis intervention; mobile crisis; assessment; service plan development; individual, group and family counseling; peer support; case management; ambulatory detox; includes delivery through telemedicine for applicable services.	No changes	No action needed
Coverage of intensive outpatient services	ASAM Level 2.5 services currently are not covered under the OHCA state plan for adults. Intensive outpatient (2.1) is not covered as a discrete service model for adults but can be reimbursed through provision of a combination of services, including psychotherapy, targeted case management, and psychosocial rehabilitation.	OHCA intends to add 2.5 Partial Hospitalization for adults to the state plan through a SPA No change	The State will draft and engage in applicable public notice requirements for SPA submission between 03.01.2022 – 07.30.2022; The State will submit a SPA with a requested effective date of October 2022; the submission will take place no later than the quarter of the requested effective date.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	Current coverage of Buprenorphine, Naloxone, and Vivitrol	Adding coverage of Methadone for MAT	The State will submit a SPA with a requested effective date of 10/1/2020; the SPA will be submitted no later than the end of the quarter of the requested effective date or 12/31/2020. Support OTPs to enroll as Medicaid providers starting 10/1/2020.
Coverage of intensive levels of care in residential and inpatient settings	Residential treatment (Levels 3.1, 3.3, 3.5) are currently not covered in the State Plan but they are certified and funded through ODMHSAS; Level 3.7 Medically Monitored detox within residential settings is also covered by ODMHSAS.	Adding Medicaid coverage of 3.1, 3.3 and 3.5 and 3.7 and adolescent residential SUD services through the state plan and 1115 waiver demonstration	Approval of 1115 waiver application for implementation; Approval of residential SUD SPA with effective date of 10/1/2020

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of medically supervised withdrawal management	Level 3.7 Medically Monitored withdrawal management within residential settings is also covered by ODMHSAS. ASAM Level 4 Medically Managed Withdrawal inpatient services are currently covered in the State Plan	Level 3.7 Medically Monitored withdrawal management and ASAM level 4 Medically Managed withdrawal services provided in an IMD will be covered by the waiver Adding Medicaid coverage of ASAM Level 3.7 through the state plan	Approval of 1115 Waiver application for 10/1/2020 implementation; Approval of residential SUD SPA with effective date of 10/1/2020

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Specifications:

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Current state

ODMHSAS contractually requires SUD treatment providers to address both substance use and mental health needs of consumers for state funded services. To aid providers in screening clients for co-occurring disorders, screening tools are recommended but treatment providers may use the co-occurring instruments of their choice. Oklahoma currently uses an evidence-based SUD patient placement level process as well as utilization management to ensure placement in the appropriate level of care. Each consumer presenting for SUD treatment level of care is assessed according to ASAM criteria. To determine level of care and to guide treatment planning, all ODMHSAS contracted and certified SUD providers are required to complete the Addiction Severity Index (ASI). In addition, residential and SUD inpatient providers complete an ASAM-based level of service tool to support placement. Prior authorization (PA) for SUD residential services is provided by ODMHSAS. To ensure ongoing appropriate placement, ODMHSAS applies ASAM guidelines as part of the placement decision-making process.

Future state

To ensure clinically driven treatment placement across the SUD service array, OHCA/ODMHSAS will require completion of an ASAM-based level of service tool for all level of care determinations. The OHCA will work in partnership with the ODMHSAS to administer PAs for SUD services across the continuum.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	OHCA/ODMHSAS currently requires provider use of the Addiction Severity Index (ASI) to inform level of care and treatment planning. Residential and SUD inpatient providers are also required to determine ASAM level of care. The ASI informs the ASAM level of care determination, though the ASAM level of care determination can be completed independently without an ASI.	OHCA/ODMHSAS will require ASAM level of care determination for all level of care decision making. The State is developing an online, streamlined ASAM level of care determination tool that will automatically calculate the level of care based upon the ASAM criteria met and integrate with the PA process. This tool can either: 1) be completed using ASI information already completed or 2) be completed through a more lengthy process that gathers the needed information if an ASI has not been previously completed.	Development/ modification of tool for use in all level of care decision making (January 1, 2021); updates to prior authorization manual by 1/1/2021

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care	ODMHSAS currently administers PA for SUD residential services. OHCA currently administers PAs for inpatient services. OHCA has removed prior authorization requirements for MAT medications.	OHCA will adopt ODMHSAS residential PA requirements and applicable practice guidelines. ODMHSAS will work collaboratively with the OHCA to administer PAs for all Medicaid beneficiaries. OHCA will continue to administer PAs for inpatient services.	Updates to state rules no later than November 1, 2021. Develop provider education materials outlining PA requirements for applicable services. Updates to provider manual by 01/01/2021
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care	ODMHSAS applies ASAM guidelines as part of the decision-making process	OHCA will work collaboratively with the ODMHSAS to administer PAs for Medicaid beneficiaries.	ODMHSAS will streamline PA process and integrate with ASAM LOC tool by 1/1/2021; updates to PA manual will be completed by 1/1/2021. OHCA will develop additional PA oversight process by 1/1/2021.

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Specifications:

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Current state

Under current administrative rules, ODMHSAS is responsible for certifying SUD residential providers and maintains SUD residential provider manuals. ODMHSAS may accept accreditation granted by The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children as compliance with certain standards; however, national accreditation is not required and may not be substituted for certification by ODMHSAS. The certification standards include requirements for staff qualifications, types of services, hours of clinical care, and discharge that align with the ASAM criteria . Rules provide requirements for staff qualifications, types of services, hours of clinical care, and discharge requirements. Ongoing compliance with state certification standards is monitored through announced and unannounced site reviews conducted by ODMHSAS certification staff.

Future state

For all residential SUD service providers, OHCA will require ODMHSAS certification as a component of Medicaid provider enrollment (with the exception of certain tribal facilities; these entities are exempt from ODMHSAS certification). If exempt from ODMHSAS certification, tribal or other entities will still be required to meet all other requirements within Milestone 3, including MAT access. Medicaid-enrolled residential SUD service providers will be required to have accreditation by a national body. Current residential treatment providers will have an opportunity to obtain accreditation and new residential treatment providers enrolling as Medicaid providers will be required to be accredited upon their initial enrollment. OHCA and ODMHSAS will develop a timeline for current residential providers to achieve national accreditation and communicate this new requirement to all current providers.

Provision of medication assisted treatment for opioid use disorder is not a current requirement for residential treatment providers. ODMHSAS and OHCA will add MAT requirements for Medicaid enrolled SUD residential providers.

ODMHSAS will develop a CON or similar process for the addition of new SUD residential service providers entering the network. Agency rules will be updated to reflect this requirement.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings.	ODMHSAS currently certifies SUD residential providers (administrative rule 450:18-13) as well as maintains SUD residential provider manuals. The ODMHSAS may accept accreditation granted by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation of Services for Families and Children, Inc. as compliance with certain specific ODMHSAS standards, but such accreditation does not supplant ODMHSAS certification. Accredited entities must also be OMDHSAS certified, with the exception of certain tribal facilities. Oklahoma has a Certificate of Need (CON) process for any new psychiatric or chemical	Medicaid-enrolled residential SUD service providers will be required to have accreditation by a national body. ODMHSAS will develop a CON or similar process for the addition of new SUD residential service providers entering the network.	• Addition of SUD residential service to OHCA provider manual by 01/01/2021. • Develop timeline for national accreditation by 10/1/2020. • Communicate new accreditation requirement. • Develop CON or similar process for SUD residential providers by 12/1/2020. • Update agency rules to reflect need for CON by 01/01/2021.

	dependency beds in the state.		
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	Continued certification through current process. ODMHSAS may conduct a site review or visit, or an investigation, which may or may not be unannounced. The OHCA conducts onsite service quality reviews of facilities providing behavioral health services to members. The reviews are conducted pursuant to federal regulations requiring the periodic inspection of IMDs.	OHCA will adopt the current service quality reviews for SUD residential providers.	Begin Medicaid provider enrollment by 1/1/2021 & contract monitoring for SUD residential providers by 10/01/2021.
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site.	Effective 11.16.2020 ODMHSAS provider certification rules require access to MAT for ASAM Level 3 providers.	ODMHSAS and/or OHCA will add MAT requirement to rules and/or contractual requirements.	Amend OHCA rules by January 2021. System changes for contractual purposes are currently underway. Communicate new requirement to providers as well as timeline for compliance starting October 2020.

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Specifications:

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for

beneficiaries in the critical levels of care.

Current state

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. 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 and ambulatory withdrawal management. 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. Currently, 11 CCARCs operate across 11 counties, with 26 site locations. Eighteen Opioid Treatment Program locations cover 10 counties in the state.

Residential programs are contractually required to report their capacity and waiting list information to the ODMHSAS daily. Residential programs utilize an on-line capacity reporting system to provide ODMHSAS with a daily accounting of bed availability.

Future state

Oklahoma will add expanded service coverage to the Medicaid service array through a state plan amendment. These services include ASAM 2.5 adult partial hospitalization, and methadone dispensed for opioid use disorder at an OTP. Through the waiver the state will add ASAM levels 3.1, 3.3, 3.5, and 3.7 residential services; as well as adolescent residential SUD services. Oklahoma is requesting waiver authority for Medicaid reimbursement for residential treatment as well as short-term medically monitored withdrawal management services delivered in an IMD.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	144 certified outpatient providers/94 enrolled in Medicaid. 20 intensive outpatient providers/20 enrolled in Medicaid. 16 OTPs and 280 DATA waivered practitioners. Residential/inpatient services: 3.1 – 27 providers 3.3 – 2 providers 3.5 – 7 providers 3.7 – 1 provider 4.0 - 1 provider with 10 beds; Medicaid-enrolled psychiatric units.	Expanded Medicaid services to include Intensive ASAM Level 2.5 Partial Hospitalization; and ASAM Levels 3.1, 3.3, 3.5, and 3.7 Residential Services. Add adolescent residential SUD services to Medicaid array. Add ASAM Level 4 coverage in IMDs. Enrollment of providers and mid-level clinicians currently not serving Medicaid beneficiaries.	Medicaid waiver and expenditure authority requested with an effective date of 10.01.2020. State plan amendment to add ASAM Levels 3.1, 3.3, 3.5, and 3.7 Residential Services effective 10.01.2020. State plan amendment to add partial hospitalization for adults effective 10.01.2022. Education and engagement of new Medicaid providers begins upon waiver approval beginning no later than 01.01.2021.

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Specifications:

To meet this milestone, states must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Current state

Oklahoma's public health approach for substance abuse prevention services utilizes the Strategic Prevention Framework and focuses on decreasing risk and causal factors, such as the availability of alcohol and drugs, community norms regarding the acceptability of high-risk behaviors, the promotion of alcohol products, reducing family conflict, and youth impulsiveness. ODMHSAS contracts with organizations to plan and implement a public health-based prevention strategy in multiple high-need communities and sectors on data-driven alcohol and other drug priorities.

Oklahoma has implemented strategies for the prevention of OUD as well as improving treatment access. The State has established opioid prescribing and dispensing guidelines, and the ODMHSAS offers continuing education courses for healthcare practitioners. The OHCA has published a pain management tool kit that contains treatment protocols, guidelines for prescriptions, practice tools, and protocols for substance abuse screening and referral for treatment. The ODMHSAS and OHCA have provided practitioner education of evidence-based guidelines that have improved pain management and prescribing practices. The ODMHSAS and OHCA provide pain management practice facilitation to primary care practices across the state, including medical home sites. The ODMHSAS implements Screening, Brief Intervention, and Referral to Treatment (SBIRT) practice dissemination services in healthcare settings across the state.

Oklahoma leveraged a portion of their State Opioid Response (SOR) grant to support and expand efforts related to OUD prevention and treatment, including overdose education and naloxone distribution. From April 2019 to March 2020, ODMHSAS trained and provided naloxone to over 335 law enforcement officers in more than 100 agencies statewide and provided more than 3,000 replacement kits to agencies previously trained in naloxone administration; another 8,400 individuals were equipped through expanded prevention hubs, of which there are 70 in the state. More than 1,400 kits were distributed to schools, youth-serving organizations, and individuals specifically to protect youth 19 and under through a partnership with the OHCA and through Title XXI Health Service Initiative funding. Continued partnerships with pharmacies and community-based agencies throughout the state have promoted the availability of naloxone for general public access to naloxone medication and overdose prevention education. Naloxone is available without a prescription.

By Oklahoma law, it is mandatory that providers check the Oklahoma Prescription Monitoring Program (PMP) prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. Dispensers of

controlled substances are required to submit prescription information within 5 minutes of dispensing a scheduled medication. An ongoing statewide integration project allows providers to access PMP information through their electronic health records. OHCA, ODMHSAS, and the Department of Health continue to partner on collaborative efforts to strategically use PMP data for continuous system improvement, provider education, and public health intervention design.

Future state

Milestone met. The state will continue to support wide availability of naloxone as well as robust provider use of the PMP.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse.	Prescribing guidelines are posted at: https://www.ok.gov/health2/documents/Oklahoma_Opioid_Prescribing_Guidelines_2017.pdf In partnership with University of Oklahoma, the state has improved pain management and prescribing practices through re-education of evidence-based guidelines and practice dissemination efforts; State provides pain management practice facilitation to PCMH sites. Oklahoma Medicaid has implemented step edits and prior authorization criteria which can be found here: http://www.okhca.org/providers.aspx?id=12090#34. In addition, quantity limits and an MME limit of 90 per day have also been put in place. SB 1446 (effective 11/1/2018) mandates an initial supply for a new patient of no more than 7 days and the lowest effective dose.	Milestone met.	No action needed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Expanded coverage of, and access to, naloxone for overdose reversal	The state has operated an overdose education and naloxone distribution program since 2014 with thousands of Naloxone kits distributed. ODMHSAS has partnered with medical licensure boards and associations to provide CME courses to Oklahoma prescribers on controlled substance prescribing, patient safety and behavioral health. Ongoing work with pharmacies to make naloxone available statewide.	Milestone met.	No action needed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.	The Oklahoma PMP requires dispensers of controlled substances to submit prescription information within five minutes of dispensing a scheduled narcotic. 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 OHCA, ODMHSAS, and the State Department of Health have partnered on collaborative efforts to strategically utilize PMP data for prescriber, dispenser, and patient education. Continuing statewide integration efforts allows providers immediate access to the PMP through their EHR.	The OHCA, ODMHSAS, and the State Department of Health will continue to convene an ad hoc PMP advisory committee to solve problems, share information, plan partnership projects, and discuss system needs or enhancements. A current RFP is underway to provide a statewide HIE. The new system will establish interoperability with existing state systems including state agency interoperability system (Health-e Oklahoma) and the Oklahoma Prescription Drug Monitoring Program (PDMP) to support Medicaid and behavioral health initiatives and increase capability to integrate PDMP data into Provider EHRs.	Following award of HIE contract on or about ~~January~~ February 1, 2021 with implementation of it occurring approximately 1-2 weeks after contract is signed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Other	Through the federal grant programs prevention and treatment providers were trained in SUD EBPs, including MAT and other best practices.	Continue to support provider education and skill development.	N/A

6. Improved Care Coordination and Transitions between Levels of Care

Specifications:

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Current state

Oklahoma has policies and practices to ensure care coordination and linkage to resources throughout their SUD care continuum. Through provider contracts and administrative rules, care coordination and transition across levels of care are required. Requirements for SUD providers include screening and referral as well as case management to connect persons with the right level of care and community supports. Case management is offered to all persons to ensure access to needed services.

In addition, policies exist that address care coordination for co-occurring physical and mental health conditions. CMHCs have contractual requirements to engage with discharged patients within 7 days and are eligible for a supplemental payment based on outcome measures including patient follow up within 7 days of discharge. Four Certified Community Behavioral Health Centers (CCBHCs) operate in the state and provide transitional care for hospitalized persons. CCBHCs document attempts to contact persons 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.

Future state

Milestone met. Oklahoma will continue to provide linkage and care coordination as persons transition across levels of care.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.	Care coordination services and transition across levels of care are integrated within ODMHSAS contracts and administrative rules for providers. The Addiction Severity Index (ASI) and ASAM criteria are used to determine level of care including discharge decisions. Community based SUD providers are required to offer case management within one week of discharge.	Milestone met.	N/A
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions.	State protocols – have discharge planning requirements on inpatient providers & CMHCs have to engage within 7 days (CMHC contractual requirement). CMHC supplemental payment program based on outcome measures; one measure is 7-day follow up.	Milestone met.	N/A

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	State rules require certified SUD providers discharge planning and continuing care plans with referrals as needed. Targeted case management is available for individuals at risk for SUD or SMI hospitalizations. Four CCBHCs operating in OK provide integrated care, including SBIRT and care management (covers NE region of state, OK city metro area, Tulsa metro area). Transitional care is provided by the CCBHC for persons who have been hospitalized or placed in other non-community settings. The CCBHC will make and document reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge.		

Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the Implementation plan.

Name and Title: Traylor Rains, Deputy State Medicaid Director
Telephone Number: (405) 522-9564
Email Address: Traylor.Rains@okhca.org

Name and Title: Sandra Puebla, Senior Director of Federal & State Authorities
Telephone Number: (405) 522-7270
Email Address: Sandra.Puebla@okhca.org

Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment A – Template for SUD Health Information Technology (IT) Plan

Section I.

Specifications

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state's PDMP.

Enhancing the Health IT Functionality to Support PDMP Interoperability

Oklahoma began efforts to achieve statewide interoperability with funds appropriated through the State Health Information Exchange Cooperative Agreement Program (SHIECAP) beginning in 2011. There are currently two private HIEs exchanging data with Oklahoma healthcare providers; three large healthcare systems using EPIC; and an unknown number of health information service providers (HISPs).

OHCA made great strides in the adoption of EHRs through the Electronic Health Record Incentive Program. Unfortunately, behavioral health provider facilities were not eligible for the incentive payments. To bolster interoperability for behavioral health providers, the ODMHSAS applied for and received a grant through SAMHSA's Center for Integrated Health Solutions. Through a voucher program, behavioral health providers work with a certified health information organization (HIO) to connect via a secure, electronic means to communicate, share medical records, perform referrals, obtain lab and pharmacy data electronically, submit reportable data to the Oklahoma State Department of Health (OSDH), and establish interconnectivity to facilitate care coordination. The voucher funding offsets the initial cost of signing up with a certified HIO to electronically exchange health information. Because of the wide variation in the degree of health information technology and the confidentiality regulations around sharing substance use disorder data, the behavioral health voucher program was two tiered. The first tier allowed the providers to see the HIE data through a web portal and share information via DIRECT Secure Messaging to other providers using the messaging system. The second tier allowed them to share data from their EHR or other systems of records.

Prior to the award there were 21 behavioral health providers linked to an HIE in the State. These providers were associated with primary care hospitals or large health centers. There were no safety net behavioral health providers who serve individuals with no resources to pay for treatment. Through this project, funding was made available to 27 behavioral health agencies for 365 clinical connections with HIEs. This is a 34% penetration rate of

eligible providers. Tier 1 vouchers were used to connect 23 individual clinicians to an HIE through DIRECT and a web portal at seven agencies, and Tier 2 vouchers provided full interfaces to 20 agencies, with 342 individuals clinicians having connections. All of the providers participating in the voucher program serve individuals through Medicaid, state or federal block grant funding. Due to the lack of a statewide HIE and the two existing HIEs being regional, many providers who had the ability to connect to an HIE, found data of only a few of their clients and eventually stopped looking. This barrier should be remedied with the OHCA's RFP for a statewide HIE.

In 2014, the Oklahoma Health and Human Services cabinet, comprised of top agency officials, chartered the Deliver Interoperable Components Utilizing Shared Services (DISCUSS) committee to collaboratively share resources among the Oklahoma Health and Human Services agencies for the development and implementation of shared information technology products, services, and technology frameworks. Members of DISCUSS include the Department of Health, Department of Human Services, Department of Mental Health and Substance Abuse Services, Department of Rehabilitation Services, and the Health Care Authority. Members agreed to create a shared-services state agency interoperability system that would facilitate the sharing of the state's data across agencies, connect the disparate state systems together for increased efficiencies of reporting by providers and health systems, increase the effectiveness of program operations across the health and social service agencies that are serving needy Oklahomans, and protect public health interests in the state. The state agency solution strategy protects the privacy of individuals in Oklahoma by protecting sensitive state health data that can't be shared outside of explicit purpose-of-use under state program rules through tight protocols that allow access only to authorized state agency staff with appropriate public health and program management purposes.

Enhancing and/or Supporting Clinicians in their Usage of the State's PDMP

In October 2019 OHCA and the Office of Management and Enterprise Services solicited for proposals for a statewide health information exchange called the Oklahoma Statewide Health Information Network and Exchange (OKSHINE). Oklahoma is looking to achieve statewide health information exchange to allow health information to flow seamlessly to and from authorized organizations and individuals in Oklahoma.

The overall scope of work (SOW) for this engagement encompasses the a provider onboarding program; integration with existing state systems including the master person index and provider directory; admission, discharge, transfer (ADT) notifications to physicians and care management teams; care coordination through exchange of patient clinical records; production and analytics of electronic clinical quality measures (eCQMs); interoperability with existing state systems including state agency interoperability system (Health-e Oklahoma), Medicaid, behavioral health and public health to support state initiatives and surveillance.

Major components of this project include:

- Develop a provider onboarding program to establish a connection for bi-directional exchange with Medicaid and other non-Medicaid provider EHRs
- Provide integration with existing state systems including the master person index and provider directory
- Establish an ADT-based notification system to provide physicians and care management teams with necessary clinical information to improve transitions of care
- Promote care coordination through the exchange of patient clinical records quickly, securely, and electronically across participating Oklahoma healthcare providers and other state and national health information exchanges
- Provide production and analytics of electronic clinical quality measures (eCQMs)
- Establish interoperability with existing state systems including state agency interoperability system (Health-e Oklahoma) and the Oklahoma Prescription Drug Monitoring Program (PDMP) to support Medicaid and behavioral health initiatives and care
- Develop capability to integrate PDMP data into Provider EHRs
- Connect current eligible professionals registered in the SoonerCare EHR Program and additional providers in the following categories:
    - Critical physical health: Medicaid providers who participate in: Patient-Centered Medical Homes (PCMH), Federally Qualified Health Centers (FQHC), Rural Health Centers, IHS, tribal and urban health clinics, and community health centers.
    - Major Trading Partners: Major trading Partners include hospitals, health systems, multispecialty clinics, laboratories and radiology, especially those that affect the value of HIE for smaller and rural/frontier providers.
    - Oral health: Clinics and providers serving Medicaid members.
    - Behavioral health: Community Mental Health Programs, Certified Community Behavioral Health Centers, Certified Addiction and Recovery Centers, Opioid Treatment Programs, Behavioral Health Homes, Assertive Community Treatment teams, mobile crisis teams, and other state licensed behavioral health organizations.

Table 1. State's HIT PDMP Assessment & Plan

Statements of Assurance:

Assurance 1: The State has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.

Assurance 2: The State's SED/SPMI Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, as applicable, the state's Behavioral Health IT Plan

Assurance 3: The State intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in relevant State procurements.

Prescription Drug Monitoring Program (PDMP) Functionalities			
Milestone Criteria	Current State	Future State	Summary of Actions Needed
Enhanced interstate data sharing in order to better track patient specific prescription data.	State law allows for the sharing of PMP information with other states' PMP when a reciprocal data-sharing agreement is in place. Partnerships are in place with the VA and IHS.	Milestone met.	N/A
Enhanced "ease of use" for prescribers and other state and federal stakeholders.	Statewide integration allows provider immediate access to the PMP through their electronic health records.	Continue to support PMP integration with provider EHRs. In accordance with the State HIE RFP and subsequent contract, the OKSHINE vendor is required to, "... establish Interoperability with existing state systems including state agency interoperability system (Health-e Oklahoma) and the Oklahoma Prescription Drug Monitoring Program (PDMP) to support Medicaid and behavioral health initiatives and care coordination, and public health surveillance. Activities will include, at a minimum: Develop an execution plan with scope definition; objectives and activities; quality and technical specifications	Ongoing provider training and access to web-based manuals ; award, implementation, and monitoring of State HIE contract. See also Attachment 1, Schedule of Activities for State HIE (OKSHINE) Procurement

		including a technical architectural diagram, resources/staffing, timeline, risks and mitigation strategy, and organizational considerations; Implement the exchange of information with the state agency interoperability system (Health-e Oklahoma) for state use. Develop capability to integrate PDMP data into Provider EHRs."	
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.	On a regional basis the PMP has real-time reporting and HIE integration. 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	New statewide HIE will enhance the PDMP integration with provider networks and EHRs. Also see previous "future state" text.	Following award of HIE contract on or about February 2021 with implementation of it occurring approximately 1-2 weeks after contract is signed. See also Attachment 1, Schedule of Activities for State HIE (OKSHINE) Procurement
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[3] (see also "Use of PDMP" #2 below).	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.	Continued partnerships for data sharing and strategic use.	N/A
Current and Future PDMP Query Capabilities			

Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query).	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. Also see Master Patient Index / Identity Management section below.	New statewide HIE will provide integration with existing state systems including the master person index and provider directory. Also see Master Patient Index / Identity Management section below.	Following award of HIE contract on or about February 2021 with implementation of it occurring approximately 1-2 weeks after contract is signed. See also Attachment 1, Schedule of Activities for State HIE (OKSHINE) Procurement
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.	Statewide integration initiative allows provider immediate access to the PMP through their electronic health records.	New statewide HIE will connect additional providers in the following categories: Physical health Oral health Health systems Behavioral health.	Following award of HIE contract on or about February 2021 with implementation of it occurring approximately 1-2 weeks after contract is signed. See also Attachment 1, Schedule of Activities for State HIE (OKSHINE) Procurement
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.	Statewide integration allows provider immediate access to the PMP through their electronic health records.	New statewide HIE will connect additional providers in the following categories: Physical health Oral health Health systems Behavioral health.	Following award of HIE contract on or about February 2021 with implementation of it occurring approximately 1-2 weeks after contract is signed. See also Attachment 1, Schedule of Activities for State HIE (OKSHINE) Procurement

Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The State currently utilizes a platform called OKDHSLive! (https://www.okdhslive.org/); however, efforts are underway to connect with the Oklahoma State Department of Health's (OSDH) NextGate eMPI. Refer to next column.	It is the state's intent to utilize the OSDH's Nextgate enterprise Master Person Index (eMPI). The Nextgate eMPI will interface with all existing identification systems in order to retrieve data from all other state data sources. The NextGate eMPI is already operational at the OSDH and is in the midst of connecting to other state agencies.	Following award of HIE contract on or about February 2021 with implementation of it occurring approximately 1-2 weeks after contract is signed. State HIE vendor will perform configuration and system mapping when taking over the eMPI. See also Attachment 1, Schedule of Activities for State HIE (OKSHINE) Procurement
Overall Objective for Enhancing PDMP Functionality & Interoperability			
Leverage the above functionalities / capabilities/supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.	On a regional basis the PMP has real-time reporting and HIE integration. Statewide integration allows provider immediate access to the PMP through their electronic health records. ODMHSAS has partnered with the OHCA and the State Department of Health on collaborative efforts to strategically utilize PMP data for prescriber, dispenser,	New statewide HIE will include a centralized data repository with integrated clinical and claims data to support value-based care initiatives and population health management including tracking trends and preventative care, identifying health disparities, and helping patients manage chronic medical conditions. Integrated clinical and claims data will provide an integrated, longitudinal health record used to	Following award of HIE contract on or about February 2021 with implementation of it occurring approximately 1-2 weeks after contract is signed. See also Attachment 1, Schedule of Activities for State HIE (OKSHINE) Procurement

	and patient education.	identify gaps in clinical data and identify additional services (dental, optical, etc.) and filled prescriptions to support Medicaid providers in meeting Meaningful Use requirements beyond HITECH funding. It is the State's long-term goal to have the statewide HIE acting as the main data source to support SUD monitoring and evaluation activities. However, as it will take time for the statewide HIE to connect to all relevant data sources, MMIS, OKPDMP and other supporting data sources will be used initially to meet this criteria.	

Attachment A, Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

Name and Title: Traylor Rains, Deputy State Medicaid Director
Telephone Number: (405) 522-9564
Email Address: Traylor.Rains@okhca.org

Attachment A, Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

ATTACHMENT 1

Schedule of Activities for State HIE (OKSHINE) Procurement

Task Name	Responsible	% Complete	Start	Finish
HITECH 10.0 APD w/HIE APP D		**55%**	**10/1/19**	**11/10/21**
HITECH 9.2 Approval	CMS	100%	10/1/19	10/1/19
Concept Development Phase	OHCA, OSDH	50%	10/21/19	1/24/20
RFP & Contract Approval		**45%**	**10/22/19**	**2/10/21**
Modify current draft & obtain Req #	OHCA Contracts	100%	10/22/19	10/23/19
Coordinate changes with OMES	OHCA Contracts	100%	10/24/19	10/24/19
OMES approval to release	OMES	100%	10/25/19	10/28/19
Release of RFP	OMES	100%	10/28/19	10/29/19
Field and answer bidder questions	OMES/OHCA	100%	10/30/19	11/27/19
HIE RFP out for bids	OMES	100%	10/29/19	12/31/19
Bidding Closed	OMES	100%	12/31/19	12/31/19
Evaluate Bid for Responsivness	OMES	100%	1/1/20	1/13/20
Proposals submitted to Evaluation Committee	Eval Team	100%	1/14/20	1/14/20
Evaluators submit questions to contracts for bidders	Eval Team	100%	1/14/20	1/24/20
Bidders respond to Evaluators questions	OMES	100%	1/15/20	1/24/20
Clarification Items Due to	OHCA Contracts	100%	1/27/20	1/27/20

OMES				
Evaluators calculate initial bid scores	Eval Team	100%	2/7/20	2/14/20
Evaluators send scores to OHCA	Evaluators	100%	2/14/20	2/14/20
OHCA verifies initial scores	Susan Geyer	100%	2/14/20	2/14/20
Evaluators collaborate on discrepancies	Evaluators	100%	2/17/20	2/24/20
OMES validate evaluator initial scores	OMES	100%	2/25/20	3/3/20
Top bidders selected for Demonstrations	OHCA	100%	3/3/20	3/3/20
Bidders notified of Demonstration	OHCA	100%	3/4/20	3/18/20
Coordination of Demonstration w/ vendors and evaluators	OHCA	100%	3/4/20	3/18/20
Bidder Demonstration	Bidders + Eval Team + select others	100%	4/1/20	4/1/20
Pause	All	100%	4/2/20	5/29/20
Vendor clarifications	OMES	100%	6/1/20	6/12/20
Clarifications requested, received & Evaluators review clarifications	Eval Team	100%	6/15/20	7/24/20
decision for second group of demos & Coordinate second set of demos		100%	7/27/20	9/11/20
Second set of demos	Vendors, Eval Tm	100%	9/11/20	9/11/20
Evaluators recommend vendor for award	Eval Team	0%	9/14/20	10/1/20
Final scores entered	OHCA Contracts	0%	10/2/20	10/5/20
Selection of		0%	10/6/20	10/19/20

vendor				
Security review for Selected Vendor	OMES, OHCA	0%	10/20/20	11/16/20
Legal review for Selected Vendor	OMES, OHCA	0%	10/20/20	11/16/20
Vendor Registration with SOS and OMES	OMES, OHCA, SOS	0%	10/20/20	11/9/20
OK Tax permit/exemption obtained	OMES	0%	10/20/20	10/26/20
Vendor BAFO	OMES/OHCA	0%	11/17/20	11/23/20
Vendor registration in PeopleSoft if Necessary	OMES	0%	11/17/20	11/17/20
HIE Contract template development	OHCA	0%	10/20/20	11/23/20
Final Draft Contract developed	OMES/OHCA	0%	11/24/20	11/30/20
Final Draft Contract Complete	OMES/OHCA	0%	12/1/20	12/1/20
Final Draft Contract sent to CMS for approval	OHCA HIE staff	0%	12/1/20	1/30/21
Contract finalized/signed	OHCA	0%	2/1/21	2/3/21
Signed contract sent to CMS	OHCA HIE staff	0%	2/3/21	2/3/21
Start of Contract Implementation	OHCA HIE staff, HIE	0%	2/10/21	2/10/21

Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

The state should complete this title page as part of its SMI/SED monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	*Oklahoma*
Demonstration name	*Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder*
Approval period for section 1115 demonstration	*12/22/2020-12/31/2025*
SMI/SED demonstration start date[a]	*12/22/2020*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	*12/22/2020*
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	*Reduced utilization of emergency departments; Reduced preventable readmissions to acute care hospitals and residential settings; Improved availability of crisis stabilization services; Improved access to community-based services; Improved care coordination*

[a] **SMI/SED demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions of mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Annual Assessment of the Availability of Mental Health Services reporting

☒ The state will use data as of the following month and day of each calendar year to conduct its Annual Assessment of the Availability of Mental Health Services: *February 28*

4. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

5. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters of the section 1115 SMI/SED demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective report for a state with a first SMI/SED DY of less than 12 months should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocol (see Appendix B of the instructions for further guidance determining baseline periods for first SMI/SED DYs that are less than 12 months). If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its SMI/SED demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Section 3. Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for the state to provide context for its

retrospective metrics data, to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the utilization of telehealth services for mental health (Metric #15) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its monitoring report (under Milestone 3) by briefly summarizing the trend and providing context that during this period, the state implemented a grant to improve access to mental health treatment in rural areas through the use of telemedicine.

For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed changes to retrospective reporting. The state should provide justification for its proposed alternative plan.*

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The state should complete this title page as part of its monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	*Oklahoma*
Demonstration name	*Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder*
Approval period for section 1115 demonstration	*12/22/2020-12/31/2025*
SUD demonstration start date[a]	*12/22/2020*
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*01/18/2021*
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	*Increased rates of identification, initiation and engagement in treatment for SUD/OUD; Increased adherence to and retention in treatment for SUD/OUD; Reduced utilization of emergency department and inpatient hospital settings where utilization is preventable or medically inappropriate; Improved access to care for physical health conditions; Fewer preventable/medically inappropriate readmissions to the same or higher level of care; Reduction in overdose death, particularly those due to opioids.*

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters of the section 1115 SUD demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective report for a state with a first SUD DY of less than 12 months, should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocols (see Appendix B of the instruction for further guidance determining baseline periods for first SUD DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other

monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its report (under Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. The state should provide justification for its proposed alternative plan.*

What follows are the planned metrics tabs from the SMI and SUD monitoring protocol workbook (part A). The full workbook is available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned metrics (Version 2.0, revised)
State: *Oklahoma*
Demonstration Name: *Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Metrics

	Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY–MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SMI/SED DYQ; Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 24 (Do not delete or edit this row)	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.*	*EXAMPLE: Milestone 4*	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020–12/31/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes / list specific codes / to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY2Q3*	*EXAMPLE: We are transitioning to a new tool to screen for depression in adults (i.e., we are transitioning from the Duke Anxiety-Depression Scale (DADS) to the Patient Health Questionnaire (PHQ-2 & PHQ-9)). We anticipate that this transition will be complete across sites by mid to late 2021 (DY2).*
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	Two rates will be reported for this measure: 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. 2. SUB-2a: Patients who received the brief intervention during the hospital stay.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	N								
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	Number of all-cause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria of beneficiaries with SMI.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Decrease	Consistent	Y		N		
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Decrease	Decrease	Y		N		
5	Medication Reconciliation Upon Admission	Percentage of patients for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Electronic/paper medical records	Year	Annually	Recommended	N								
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020–12/31/2021	Increase	Increase	Y		N		
7	Follow-up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the child received follow-up within 30 days after discharge • Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
8	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2021–12/31/2021	Increase	Consistent	Y		N		It is anticipated the number of beneficiaries going inpatient will increase due to Medicaid expansion occurring 7/1/2021; however, the rate should decrease.
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2021–12/31/2021	Increase	Increase	N	CMHCs use a variety of POSs so all CMHC services eligible for the meas	N		
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health durine the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2021–12/31/2021	Increase	Increase	N	CMHCs use a variety of POSs so all CMHC services eligible for the meas	N		
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2021–12/31/2021	Increase	Consistent	N	CMHCs use a variety of POSs so all CMHC services eligible for the measure were used. Additional mental health professionals meeting the definition were added to the MH Practitioner value set (101YA0400X-LMFT, 101YS0000X-LPC, 101YM0800X-LBP, LADC/MH, 363LD0000X-certified nurse practitioner/MH). Mental health telephone crisis service was added to the Telephone Visit value set.	N		It is anticipated the number of beneficiaries using emergency department services will increase due to Medicaid expansion occurring 7/1/2021; however, the rate should decrease.
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2021–12/31/2021	Decrease	Consistent	N	Additional mental health professionals meeting the definition were added to the MH Practitioner value set (101YA0400X-LMFT, 101YS0000X-LPC, 101YM0800X-LBP, LADC/MH, 363LD0000X-certified nurse practitioner/MH). Mental health telephone crisis service was added to the Telephone Visit value set.	N		Due to the substantial increase in telehealth services during COVID, it is anticipated the number of telehealth services will decrease.
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2021–12/31/2021	Increase	Increase	N	CMHCs use a variety of POSs so all CMHC services eligible for the measure were used. Additional mental health professionals meeting the definition were added to the MH Practitioner value set (101YA0400X-LMFT, 101YS0000X-LPC, 101YM0800X-LBP, LADC/MH, 363LD0000X-certified nurse practitioner/MH). Mental health telephone crisis service was added to the Telephone Visit value set.	N		
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2021–12/31/2021	Stabilize	No more than 30 days	Y		N		
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2021–12/31/2021	Stabilize	No more than 30 days	Y		N		
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year.	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Consistent	Y		N		It is anticipated the number of beneficiaries going inpatient or residential treatment will increase due to Medicaid expansion occurring 7/1/2021; however, the rate should decrease.
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period.	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period.	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is >9.0%.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2022–12/31/2022	Increase	Increase	N	Based on the data currently available, the State will use the state-specific measure (#61) as a deviation: SSD-AD (Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications).	Y	DY2Q4	The State will continue exploring methods and outreach that encourages providers to bill the codes necessary to calculate the required measure at metric #23: (HPCMI: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)). The State will conduct outreach with providers and depending on the data received and mad available, will calculate the measure by December 2022 or December 2023. Any data limitations that still exist will be documented.
24	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	N								
25	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N								
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
27	Tobacco Use Screening and Follow-up for People with SMI or Alcohol or Other Drug Dependence	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported: • Percentage of adults with SMI who received a screening for tobacco use and follow-up for those identified as a current tobacco user • Percentage of adults with AOD who received a screening for tobacco use and follow-up for those identified as a current tobacco user	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								
28	Alcohol Screening and Follow-up for People with SMI	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol use	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY–MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SMI/SED DYQ; Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 24 (Do not delete or edit this row)	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.*	*EXAMPLE: Milestone 4*	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020–12/31/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY3Q1*	*EXAMPLE: We are transitioning to a new tool to screen for depression in adults (i.e., we are transitioning from the Duke Anxiety-Depression Scale (DADS) to the Patient Health Questionnaire (PHQ-2 & PHQ-9)). We anticipate that this transition will be complete across sites by mid to late 2021 (DY2).*
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: •Percentage of children and adolescents on antipsychotics who received blood glucose testing •Percentage of children and adolescents on antipsychotics who received cholesterol testing •Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	N	CMHCs use a variety of POS so all CMHC services eligible for the measur	N		
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Consistent	Y		N		
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Consistent	Consistent	Y		N		
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Consistent	Consistent	Y		N		
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2021–12/31/2021	Consistent	Consistent	Y		N		
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2021–12/31/2021	Consistent	Consistent	Y		N		
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2021–12/31/2021	Consistent	Consistent	Y		N		
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	Y		N		
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reportine year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2021–12/31/2021	Consistent	Consistent	Y		N		
Q1	Connecting behavioral and mental health providers to health information exchanee (HIE)	Number of mental health providers connected to HIE	Health IT	State-specific	Other annual metrics	HIE	Year	Annually	Required	Y	01/01/2021–12/31/2021	Consistent	Consistent			N		
Q2	Access to additional services using provider directory - connecting primary care to mental health service offerings.	Number of mental health providers managed in provider directory	Health IT	State-specific	Other annual metrics	HIE	Year	Annually	Required	Y	10/01/2021-9/30/2022	Increase	Increase		The state will not retroactively report on this measure. The state will not retroactively report on this measure.	Y	DY2Q1	We are implementing a statewide HIE which will go live in the fall of 2021 (DY1).
Q3	Creation of statewide functionalities for possible use by care team members	Number of ADT (admission, discharge, transfer) electronic messages	Health IT	State-specific	Other annual metrics	HIE	Year	Annually	Required	Y	10/01/2021-9/30/2022	Increase	Increase		The State will utilize the ADT (admission, discharge, transfer) feature as the data point. The ADT is an electronic message sent from a hospital to the HIE; the HIE then pushes out a notification to behavioral health providers that have subscribed to this service on the status of their member. It also provides other information that allows for increased care coordination opportunities. The ADT data point will measure the State's request to report "functionalities for the possible use by care team members" and as a means for better care coordination.	Y	DY2Q1	We are implementing a statewide HIE which will go live in the fall of 2021 (DY1).
State-specific metrics																		
Add rows for any additional state-specific metrics																		
S1	SSD-AD (Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)	Alternative data collection point for Metric #23 due to data limitations; approved by CMS.	Milestone 4	State-specific	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2021–12/31/2021	Increase	Increase	N	Based on the data currently available, the State will use this measure as a deviation from Metric #23 - Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AO).	Y	DY2Q4	

Substance Use Disorder (SUD) Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting goal*	Metric type	Reporting frequency	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration goal	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SUD DY(Q): e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 1 (Do not delete or edit this row)	*EXAMPLE: Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE: Assessment of need and qualification for SUD treatment services*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other monthly and quarterly metric*	*EXAMPLE: Medical record review or claims*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 07/1/2018-06/30/2019*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY2Q1*	*EXAMPLE: This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go-live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Recommended	N					The state will not retroactively report on the metrics.			
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2022	Increase	Increase	Y	The state will not retroactively report on the metrics.	N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
7	Early Intervention	Number of beneficiaries who used early interventions services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Increase	Stabilize	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
14	SUD Provider Availability – MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Medical record review or claims	Year	Annually	Recommended	N								
17(i)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3400; Medicaid Adult Core Set; Adjusted HEDIS measure][8]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #0576; Medicaid Adult Core Set; Adjusted HEDIS measure][7]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA; NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (OMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) [PQA; NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA; NQF #2389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020-12/31/2021	Increase	Increase	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	01/01/2021-12/31/2021	Consistent	Consistent	Y		N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Stabilize	Y		N	It is anticipated the number of overdose deaths among beneficiaries will increase due to Medicaid expansion; however, the rate should decrease.	
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metric	Claims; State-specific IMD database		Annually	Required	Y	01/01/2021-12/31/2021	Stabilize	No more than 30 days	Y		N		
Q1	*E-prescribing of controlled substances*	Number of patients with overlapping opioid prescriptions,e.g., the number of patients who get a p	Health IT	State-specific	Other annual metric	PDMP	Year	Annually	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease			N		
Q2	*Access to additional services provider directory*	Number of behavioral and mental health providers managed in provider directory	Health IT	State-specific	Other annual metric	HIE	Year	Annually	Required	Y	10/01/2021-9/30/2022	Increase	Increase			Y	DY5Q1	We are implementing a statewide HIE which will go live in the fall of 2021 (DY1). The state will not retroactively report on this measure.

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic[a]	Metric type	Reporting rationale	Data source	Measurement method	Reporting frequency	Reporting subunits	State still owns? (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target specification, etc.)	State plans to phase in (Y/N)	Report in which metric will be phased in (Format SUD DY(); Ex: DY(1)(3))	Explanation of any plans to phase in sooner over time
Q3	*Care management/recovery - shared care plan accessibility across care teams*	Number of direct secure messaging for sharing behavioral health treatment data sent by a behavioral health provider.	Health IT	State-specific	Other annual metric	HIE	Year	Annually	Required	Y	10/01/2021-9/30/2022	Increase	Increase			Y	DY3O1	We are implementing a statewide HIE which will go live in the fall of 2021 (DY1). The state will not retroactively report on this measure.
State-Specific Metrics																		
Add rows for any additional state-specific metrics																		

[a] There are no CMS-provided metrics related to milestone 3

[b] Rates 1 and 2 reported for Metric #17(1) correspond to rates 2 and 3 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[c] Rates 1 and 2 reported for Metric #17(2) correspond to rates 1 and 2 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

OKLAHOMA
Health Care Authority

Evaluation Design for the Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Abuse Disorder §1115(a) Demonstration 11-W-00363/6

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A. GENERAL BACKGROUND INFORMATION

The Oklahoma Institutions for Mental Diseases (IMD) Waiver for Serious Mental Illness and Substance Use Disorder Section 1115(a) Demonstration was approved on December 22, 2020, effective December 22, 2020, through December 31, 2025. The Centers for Medicare and Medicaid Services (CMS) CMS concurrently approved Oklahoma's Substance Use Disorder (SUD) and Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Implementation Plans, as well as the Health IT Plan for each initiative.

The Oklahoma Health Care Authority (OHCA) is Oklahoma's Single-State Agency for Medicaid. Medicaid is the largest health care provider in the State of Oklahoma. The 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 inpatient services are largely administered by the OHCA, while Medicaid 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 all publicly funded services.

Based on the Substance Abuse and Mental Health Services Administration (SAMHSA) 2018-2019 National Survey on Drug Use and Health, Oklahoma had among the highest rates nationally for mental illness and SUD. An estimated 22.54 percent of Oklahomans age 18 and older experience mental illness and 5.43 percent are estimated to have a serious mental illness. An estimated 8.01 percent of Oklahomans in that age group had a SUD and 7.40 percent needed but did not receive SUD treatment at a specialized facility.[1]

At the time of its request for an IMD Demonstration, Oklahoma had a waiting list for SUD residential treatment of 158 women, with an average wait time of 29 days, and 415 men, with an average wait time of 208 days. In State Fiscal Year (SFY) 2019, over 5,300 children under 21 and 2,078 adults 21-64 received inpatient psychiatric treatment.

Medicaid expansion is also underway in Oklahoma, with new enrollments starting July 1, 2021. A recent literature review by Kaiser Family Foundation shows that states with Medicaid expansion populations have seen increased access to medications and services for the treatment of mental health and SUD conditions.[2]

In 2019, the State Legislature appropriated additional funds to support residential treatment. This IMD Demonstration was sought to expand residential treatment services and complement the State's efforts to increase access.

[1] SAMHSA 2018-2019 National Survey on Drug Use and Health retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf

[2] Kaiser Family Foundation. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review; M. Guth, R. Garfield, and R. Rudowitz. Published: Mar 17, 2020, retrieved from https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/

The Demonstration provides the State with authority to provide high-quality, clinically appropriate treatment for beneficiaries with a SUD or SMI/SED while they are short-term residents in residential and inpatient treatment settings that qualify as IMDs. This Evaluation Design will assess the Demonstration's association with improvements in access to care, treatment engagement, integration of primary and behavioral health care, and health outcomes.

1. Description of the Demonstration

The IMD Demonstration was implemented to ensure that beneficiaries have access to a full array of SUD and SMI/SED treatment services, including inpatient and residential treatment services provided by facilities that classify as IMDs.

The Demonstration provides the State with authority to provide medically necessary residential treatment, facility-based crisis stabilization, and inpatient treatment services within qualified IMDs, for Medicaid beneficiaries with SMI, SED, and/or SUD diagnoses. The Medicaid authority also includes coverage for Qualified Residential Treatment Programs (QRTPs) that meet the definition of an IMD for beneficiaries under age 21. The State must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving psychiatric coverage.

The SUD treatment continuum of care is based on the American Society of Addiction Medicine (ASAM) criteria and/or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. For SUD treatment services, the State will aim for a statewide average length of stay of 30 days or less in residential treatment settings.

The Demonstration will test whether this authority will increase access to evidence-based treatment services and improve overall health and long-term outcomes for those with SMI, SED, and SUD when a full continuum of care is provided. The State will work to improve care coordination and care for co-occurring physical and behavioral health conditions.

Populations Impacted by the Demonstration

All enrollees eligible under the State Plan for full Medicaid coverage, and between the ages of 21-64, are eligible for services under the Demonstration. Additionally, Medicaid enrollees under the age of 21 may qualify for services under the Demonstration when receiving residential SUD treatment or QRTP services.

Substance Abuse Disorder Treatment Benefits

Members have access to the full range of otherwise covered Medicaid services, including SUD treatment services. This includes high-quality, evidence-based Opioid Use Disorder (OUD)/SUD treatment and recovery services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing treatment in community-based settings. Benefits include short-term stays in residential and inpatient SUD treatment settings that qualify as an IMD.

Serious Mental Illness and Emotional Disturbance Treatment Benefits

Members have access to the full range of otherwise covered Medicaid services, including SMI/SED treatment services. These SMI/SED services range in intensity from early intervention, short-term crisis stabilization, and acute care in an inpatient or residential setting to ongoing treatment in community-based settings. Benefits include short-term stays in residential and inpatient SMI/SED treatment settings that qualify as an IMD.

2. Demonstration Goals

The State seeks to support the overall health and long-term success of individuals with SMI/SED and SUD. Through its partnership with ODMHSAS, the OHCA ensures access to a full continuum of services such that individuals receive the least restrictive, most effective array of services, to meet their clinical needs. The Demonstration goals for each SUD and SMI/SED IMD authorities are outlined below.

Substance Use Disorder Demonstration Goals

1. Increased rates of identification, initiation, and engagement in treatment for SUD;
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.

Serious Mental Illness/Serious Emotional Disturbance Demonstration Goals

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED 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.

3. Delivery System

Behavioral health services and supports are available statewide through a network of private and government-operated programs. This includes 13 Community Mental Health Centers (CMHCs) and approximately 70 contracted SUD treatment providers, including 11 Certified Community Addiction Recovery Centers (CCARCs). ODMHSAS supports 14 Community Based Structured Crisis Centers (CBSCCs) located throughout the State, including three operated by the State (two serving adults and one serving children and adolescents). CBSCC facilities in Ardmore, Oklahoma City, Sapulpa, and Tulsa also operate behavioral health urgent care centers that provide 23-hour respite and observation to help prevent psychiatric emergency and admission to inpatient or crisis beds. These facilities also address substance abuse emergencies.

Mental Health Services

The statewide network of CMHCs provides a wide variety of services, including case management for adults and children, crisis intervention, psychiatric rehabilitation, medication services, and other outpatient mental health services. Additionally, community-based programs include assistance with such services as housing, employment, peer advocacy, and drop-in centers.

There are 21 Behavioral 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 Behavioral Health Homes. Health Homes are required to provide care coordination and care management to ensure integrated behavioral health and health care. The Behavioral Health Homes will sunset September 30, 2021, as CMHC programs transition to meet Certified Behavioral Health Clinic (CCBHC) requirements (see below).

In addition, there are two RA1SE NAVIGATE programs to assist individuals who are experiencing their first episode of psychosis (FEP), along with one early serious mental illness (eSMI) crisis care program, and 13 statewide 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.

Substance Use Disorder Services

Oklahoma supports the delivery of residential and outpatient substance abuse services such as medically supervised withdrawal management, residential treatment, sober living, DUI school, Drug Court, criminal justice diversion treatment services, and other outpatient services.

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, except for tribal entities located on land not subject to State jurisdiction. 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.

Certified Community Behavioral Health Clinics

In October 2016, Oklahoma was one of eight states selected by SAMHSA and CMS to pilot Certified Community Behavioral Health Clinics (CCBHCs). The CCBHC model presented an opportunity for improving community-based mental health and SUD services by:

- 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 underpins all aspects of behavioral health care in the CCBHC model. CCBHCs are expected to 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. Three CMHCs participated in the pilot.

Since the pilot project, Oklahoma has adopted the CCBHC model for statewide expansion. Currently, six of the 13 CMHCs in Oklahoma have achieved CCBHC designation. Under the Demonstration's SMI/SED Implementation Plan, the remaining CMHCs are expected to achieve CCBHC designation by Demonstration year three.

Qualified Residential Treatment Programs

The Oklahoma Department of Human Services (DHS) currently operates 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). As QRTPs are implemented, the Demonstration provides the State with the authority for Medicaid reimbursement of stays of 60 days or less in facilities that the State determines are IMDs.

B. EVALUATION QUESTIONS AND HYPOTHESES

The Demonstration evaluation will consider:

- Nine primary evaluation questions, with eight subsidiary questions related to SUD services.
- Ten primary evaluation questions, with twelve subsidiary questions related to SMI/SED services.

Evaluation questions align with each CMS goal area. Exhibits B-1 and B-2 illustrate the alignment between Demonstration goals and evaluation questions. Exhibit B-1 offers a crosswalk of SUD Demonstration Goals to evaluation questions and Exhibit B-2 offers the same for SMI/SED Demonstration Goals.

Exhibit B-1. SUD Demonstration Goals and Evaluation Questions

CMS Demonstration Goal	OHCA Evaluation Question
1. Increased rates of identification, initiation, and engagement in treatment for SUD	1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? a. How does service utilization vary by member characteristics (e.g., age, aid category code)? b. How does service utilization vary by geographic area (e.g., urban versus rural)?
2. Increased adherence to and retention in treatment	2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?
3. Reductions in overdose deaths, particularly those due to opioids	3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD? 4. Does the Demonstration contain or reduce overdose deaths
4. 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	5. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD? a. How does utilization vary by age and aid category code? b. How does utilization vary by geographic area (e.g., urban versus rural)?
5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate	6. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?

CMS Demonstration Goal	OHCA Evaluation Question
6. Improved access to care for physical health conditions among beneficiaries with SUD	7. Does the Demonstration maintain or improve access to care for physical health conditions?
Expenditure Analysis: Total Cost of Care	8. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?
Expenditure Analysis: Cost Drivers	9. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?

Exhibit B-2. SMI/SED Demonstration Goals and Evaluation Questions

CMS Demonstration Goal	OHCA Evaluation Question
1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings	1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI? a. How does utilization vary by age and aid category code? b. How does utilization vary by geographic area (e.g., urban versus rural)?
2. Reduced preventable readmissions to acute care hospitals and residential settings	2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?
	3. Does the Demonstration result in increased treatment for comorbid SUD and physical health conditions after IMD discharge?
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. Does the Demonstration result in improved availability of crisis outreach and response services?
	5. Does the Demonstration result in improved availability of non-residential, non-hospital crisis outreach and response services?

CMS Demonstration Goal	OHCA Evaluation Question
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	6. 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? a. How does access differ for members receiving CCBHC services? b. How does access differ following the provider's CCBHC designation?
	7. Does the Demonstration improve the integration of primary and behavioral health care to address the chronic mental health care needs of members with SMI/SED? a. How does integration differ for members receiving CCBHC services? b. How does access differ following the provider's CCBHC designation?
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities	8. Does the Demonstration result in improved care coordination for members with SMI/SED? a. How does care coordination differ for members receiving CCBHC services? b. How does care coordination differ following the provider's CCBHC designation? c. Has the CCBHC model of care contributed to decreased length of stay in the ED among members awaiting mental health treatment in specialized settings? d. How does the CCBHC model of care contribute to reductions in utilization and lengths of stays in ED? e. What CCBHC components or characteristics are most effective in reducing utilization and lengths of stays in EDs? f. Are there any obstacles that hinder the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs?
Expenditure Analysis: Total Cost	9. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?
Expenditure Analysis: Cost Drivers	10. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?

1. Logic Model and Quantifiable Targets

The State's SUD and SMI/SED Implementation Plans include quality enhancements and additions to the Medicaid service array. A summary of activities, their impact on Demonstration goals, and a visual depiction of each logic model (SUD and SMI/SED) are presented below.

SUD Logic Model

Prior to the Demonstration, ODMHSAS supported members who required Medication-Assisted Treatment (MAT) and/or treatment under the following ASAM levels of care:

- 3.1 Clinically Managed Low-Intensity Residential Services;
- 3.3. Clinically Managed Population- Specific High-Intensity Residential Programs;
- 3.5 Clinically Managed Residential Services; and
- 3.7 Medically Monitored Inpatient Programs.

These treatment services were reimbursed through State general funds and/or the use of other non-Medicaid federal funds. This coverage included crisis stabilization, residential treatment, and inpatient hospital services provided in facilities classified as an IMD.

Under the Demonstration, the Medicaid State Plan was amended in early 2021 to include coverage for MAT and ASAM level 3.1, 3.3, 3.5, 3.7, and adolescent residential care services. Residential treatment providers are also required to offer (or arrange for) MAT services. It is expected that authorization of Federal Financial Participation (FFP) for IMD services may serve as an incentive for some providers to expand program capacity. These State Plan enhancements are expected to increase access to care, including MAT services; increase SUD provider availability; and increase follow-up after discharge from ED, inpatient, and residential settings.

The Demonstration includes quality enhancements to support alignment of Utilization Management (UM) processes with ASAM levels of care. This includes uses of ASAM assessment protocols and tools and the creation of an automated level of care assessment for providers to use, at their discretion. These enhancements are expected to increase identification, initiation, and engagement in treatment (Goal 1) and increase adherence to and retention in treatment (Goal 2).

ODMHSAS-contracted providers must adhere to comprehensive standards are care, including attention to the holistic needs of members receiving treatment. The OHCA will adopt these standards for all residential providers enrolled in the Medicaid program. Residential provider requirements will also include accreditation by a nationally recognized accreditation entity. These enhancements are expected to improve the comprehensiveness of assessments and result in increased access to physical health care for enrollees (Goal 6).

Lastly, the State will continue its support for Electronic Health Record (EHR) integration with the Prescription Drug Monitoring Program (PDMP) and support providers in adopting workflows that include PDMP inquires. These activities are expected to support the containment and reduction of opioid prescribing at high doses.

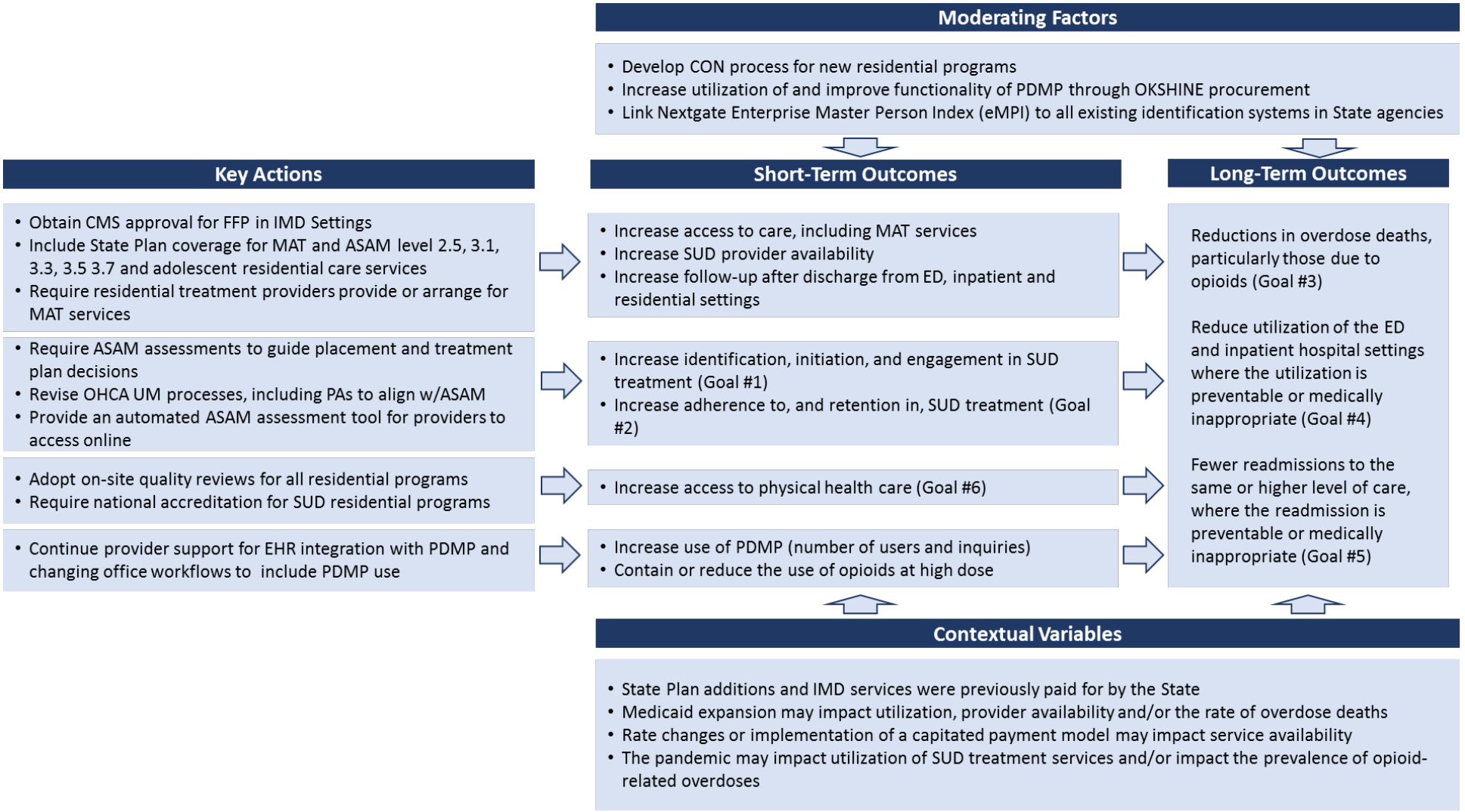
Expanded access, increased initiation, and adherence to treatment, integration of physical health care, and improved opioid prescribing are expected to reduce overdose deaths (Goal 3), reduce utilization of the ED and hospital settings where preventable (Goal 4), and reduce readmissions to the same or higher levels of care (Goal 5.)

Moderating factors contributing to the success of the planned SUD activities include: developing a Certification of Need (CON) process for residential treatment providers; updating and improving the State's Health Information Exchange; offering provider support for modifying office workflows to include PDMP inquires; and linking the Nextgate Enterprise Master Person Index (eMPI) across State agencies.

The evaluation design will consider several contextual factors, including recognition that services added to the Medicaid State Plan were previously funded through non-Medicaid sources; the potential impact of the novel coronavirus pandemic; and the impact of Medicaid eligibility expansion planned for July 1, 2021. The procurement of managed care organizations to begin operation in the fall of 2021 has been placed on hold. Should implementation restart during the Demonstration period, the managed care environment will be considered a contextual factor in the design.

A visual depiction of the Demonstration impact is provided in Exhibit B-3, on the following page.

Exhibit B-3. SUD Demonstration Logic Model



SMI/SED Logic Model

Under the Demonstration, the State will expand non-residential crisis services, including mobile outreach, enhance the tracking of crisis and inpatient psychiatric beds, annually assess the availability of mental health services, and take steps to expand capacity as needed. These activities are expected to increase the availability of crisis stabilization services, including call centers, mobile crisis outreach, Intensive Outpatient, residential, and psychiatric inpatient services (Goal 3).

The Demonstration will also support the expansion of entities designated as CCBHCs. The State expects to have CCBHC coverage statewide by Demonstration year three. CCBHC designation requires entities to support integrated primary and behavioral health services and to ensure seamless transitions of care across settings. This includes maintaining contracts or MOUs with regional hospitals, Psychiatric Rehabilitation and Treatment Facilities and other systems to ensure formal care delivery structures are in place for coordination and timely transitions of care, including discharges from the ED. The State will assess and address the need for additional employment supports and crisis outreach services during the Demonstration.

Quality enhancements are also planned for CBSCC providers; all centers classified as an IMD will be required to have accreditation from a nationally recognized entity. National accreditation requires facilities to have demonstrated comprehensive treatment planning and a holistic focus on member's needs. These quality enhancements are expected to:

- Increase access to community-based services, including through increased integration of primary and behavioral health care (Goal #4);
- Improve metabolic monitoring for children and adolescents on antipsychotic medication;
- Increase medication continuation following inpatient psychiatric discharge; and
- Increase follow-up within 7 and 30 days after discharge from an ED for mental illness.

In total the activities outlined in the SMI/SED implementation plan are expected to:

- Reduce ED utilization among Medicaid members with SMI/SED (Goal 1);
- Reduce preventable readmissions to acute care hospitals and residential settings (Goal 2); and
- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities (Goal 5) and maintain or reduce length of stay in the ED while awaiting mental health treatment in specialized settings (Goal 1).

Under the Demonstration, the State also has the authority for Medicaid reimbursement of QRTP stays of 60 days or less in facilities that the State determines are IMDs. Currently, the State does not expect any QRTP facility to be classified as an IMD. In addition, the

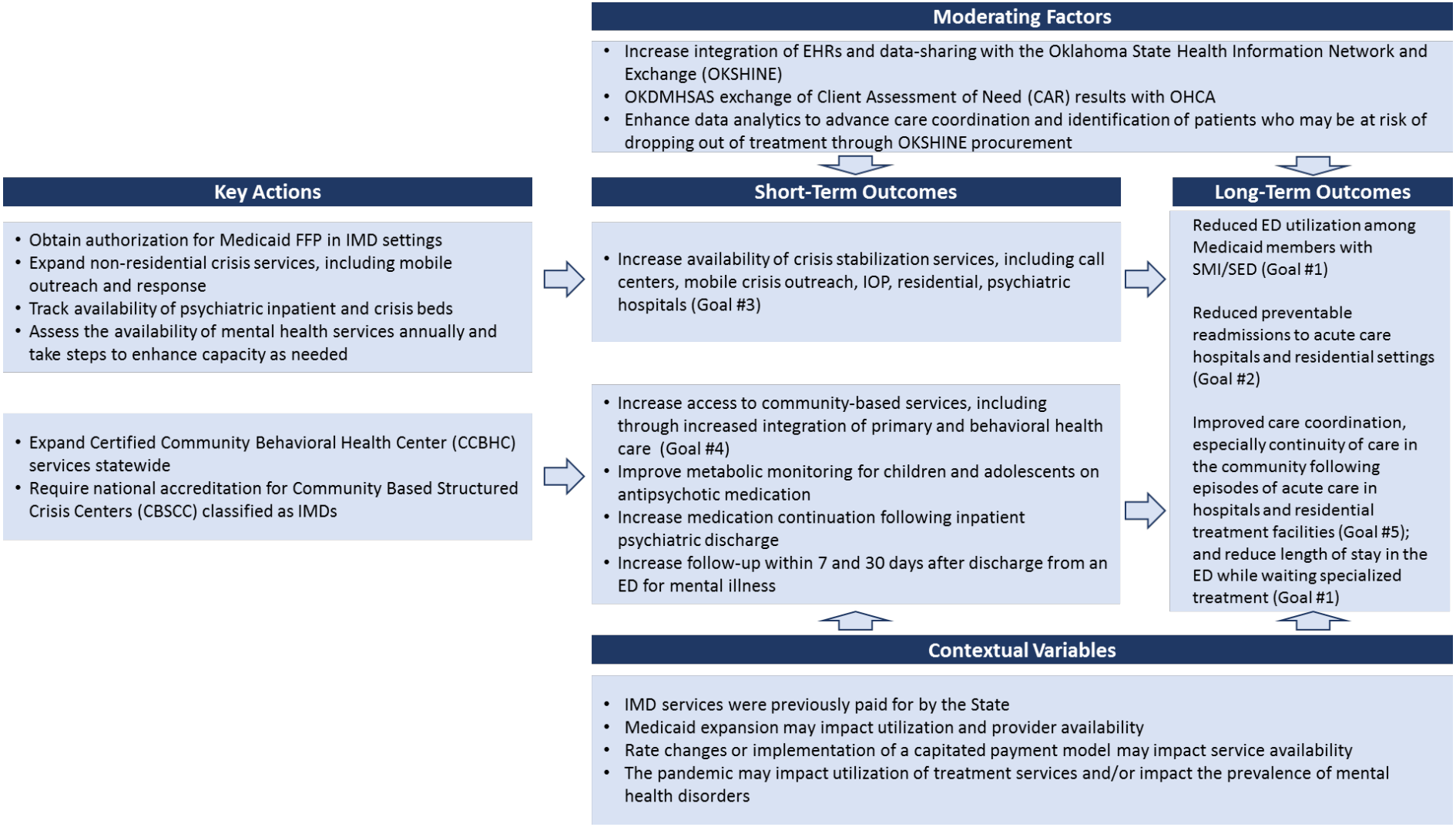
timeline and plan to transition facilities and their care model to serve as QRTPs is being reexamined. QRTP models have not been included in this evaluation design.

Moderating factors contributing to the success of the planned SMI/SED activities include the further integration of EHRs with the State's Health Information Exchange; the exchange of Client Assessment Record information between ODMHSAS and OHCA; and enhanced data analytics to support care coordination and identify clients at risk of dropping out of treatment.

The evaluation design will consider several contextual factors, including services added to the Medicaid State Plan that were previously funded through non-Medicaid sources; the potential impact of the novel coronavirus pandemic; and the impact of Medicaid eligibility expansion planned for July 1, 2021. The procurement of managed care organizations to begin operation in the fall of 2021 has been placed on hold. Should implementation restart during the Demonstration period, the managed care environment will be considered a contextual factor in the design.

A visual depiction of the Demonstration impact is provided in Exhibit B-4, on the following page.

Exhibit B-4. SMI/SED Demonstration Logic Model



2. Evaluation Questions and Hypotheses

The Evaluation Design will consider eight SUD-related evaluation questions, with eight subsidiary questions and ten SMI/SED-related evaluation questions, with twelve subsidiary questions. The evaluation questions will be evaluated through testing of hypotheses related to each IMD authority (SUD and SMI/SED) and goal. The hypotheses associated with each question are presented in Exhibits B-5, for SUD-related questions, and Exhibit B-6 on the second following page, for SMI/SED-related questions.

Exhibit B-5. SUD-Related Evaluation Questions and Hypotheses

Evaluation Question	Hypothesis
1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? a. How does service utilization vary by member characteristics (e.g., age, aid category code)? b. How does service utilization vary by geographic area (e.g., urban versus rural)?	1. The Demonstration will maintain or increase utilization of SUD treatment services.
	2. The Demonstration will maintain or increase SUD provider availability.
	3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.
	4. The Demonstration will maintain or increase initiation and engagement in treatment.
2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD.
3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	1. The Demonstration will contain or reduce the use of opioids at a high dosage.
4. Does the Demonstration contain or reduce overdose deaths	1. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.
5. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD? a. How does utilization vary by age and aid category code? b. How does utilization vary by geographic area (e.g., urban versus rural)?	1. The Demonstration will contain or reduce the rate of ED visits for SUD.
	2. The Demonstration will contain or reduce inpatient admissions for SUD.

Evaluation Question	Hypothesis
6. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?	1. The Demonstration will contain or reduce readmissions to the same or higher levels of care for enrollees with a SUD.
7. Does the Demonstration maintain or improve access to care for physical health conditions?	1. The Demonstration will maintain or increase access to care for physical health conditions for enrollees with a SUD.
8. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?	N/A Exploratory
9. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?	N/A Exploratory

Exhibit B-6. SMI/SED-Related Evaluation Questions and Hypotheses

Evaluation Question	Hypothesis
1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI? a. How does utilization vary by age and aid category code? b. How does utilization vary by geographic area (e.g., urban versus rural)?	1. The Demonstration will contain or reduce mental health-related ED use for adults with an SMI.
2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?	1. The Demonstration will contain or reduce readmissions to acute care hospitals or residential settings for adults with an SMI.
3. Does the Demonstration result in increased treatment for comorbid SUD and physical health conditions after IMD discharge?	1. The Demonstration will maintain or increase access to physical health and/or SUD treatment post-discharge for adults with an SMI.
4. Does the Demonstration result in improved availability of crisis outreach and response services?	1. The Demonstration will maintain or improve the availability of crisis outreach and response services throughout the State.
5. Does the Demonstration result in improved availability of non-residential, non-hospital crisis outreach and response services?	1. The Demonstration will maintain or improve the availability of non-residential, non-hospital crisis outreach and response services.
6. 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? a. How does access differ for members receiving CCBHC services? b. How does access differ following the provider's CCBHC designation?	1. The Demonstration will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED. 2. Expanding CCBHCs statewide will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.
7. Does the Demonstration improve the integration of primary and behavioral health care to address the chronic mental health care needs of members with SMI/SED? a. How does integration differ for members receiving CCBHC services? b. How does integration differ following the provider's CCBHC designation?	1. Expanding CCBHCs statewide will maintain or improve the integration of primary and behavioral health care to address the chronic mental health of members with SMI/SED.

Evaluation Question	Hypothesis
8. Does the Demonstration result in improved care coordination for members with SMI/SED? a. How does care coordination differ for members receiving CCBHC services? b. How does care coordination differ following the provider's CCBHC designation? c. Has the CCBHC model of care contributed to decreased length of stay in the ED while awaiting specialized treatment? d. How does the CCBHC model of care contribute to reductions in utilization and lengths of stays in ED? e. What CCBHC components or characteristics are most effective in reducing utilization and lengths of stays in EDs? f. Are there any obstacles that hinder the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs?	1. Expanding CCBHCs statewide will maintain or improve care coordination for members with an SMI/SED. 2. Expanding CCBHCs statewide will contribute to maintaining or reducing length of stay in the ED among members awaiting mental health treatment in specialized settings.
9. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?	N/A Exploratory
10. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?	N/A Exploratory

3. Promotion of Title XIX Objectives

At least one objective of Title XIX is to enable states to "furnish… medical assistance" to certain vulnerable populations (i.e., payment for certain healthcare services defined in section 1905 of the Act, the services themselves, or both). CMS has determined that the Oklahoma Demonstration promotes Medicaid's objective by expanding coverage to health care services that would otherwise not be available.

In addition, the provision of this coverage may lower program costs through improved beneficiary health, making it possible for the State to expand services with the dollars saved. This further promotes the coverage objective of the Medicaid statute.

CMS has determined that approval of the Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder Demonstration is likely to promote the objectives of the Medicaid program by:

- Increasing the identification, initiation, and engagement of Medicaid beneficiaries diagnosed with SUD and SMI/SED;
- Increasing adherence to, and retention in, SUD and SMI/SED treatment programs; and
- Reducing inappropriate or preventable utilization of emergency departments and inpatient hospital settings through improved access to a continuum of care services.

The evaluation methodology presented in the next section is designed to measure the Demonstration's performance in achieving these and other Demonstration goals.

C. METHODOLOGY

The SUD and SMI/SED-related Demonstration activities include expanded access to services and quality enhancements. Quality enhancements include further alignment of SUD assessments and treatment planning with ASAM guidelines, the promotion of integrated physical and behavioral health care, and improving transitions of care.

This evaluation is designed to measure the Demonstration's performance in achieving SUD and SMI/SED program goals, while also providing actionable information for improving the program in the future. The proposed methodology is outlined in detail below.

1. Evaluation Design

The evaluation will rely on quasi-experimental techniques to measure change over time and differential statistics to describe the population and findings. The evaluation will employ a mixed-methods design using time series and comparison group approaches. The evaluator will employ a combination of analytical techniques, based on the evaluation question and hypothesis.

All SUD-related and four SMI/SED-related hypotheses will rely on an interrupted time series (ITS) analysis to evaluate the impact of Demonstration enhancements. Three SMI/SED-related hypotheses will be evaluated longitudinally using descriptive statistics to examine statewide and regional change over time. The remaining hypotheses will be evaluated using a within-subjects time series and/or a propensity score matching (PSM) comparison strategy. The final use of a comparison strategy will be determined by the best available data and the presence or absence of a valid comparison group after a propensity score matching analysis has been completed.

An overview of each question, hypothesis, and analytic approach is provided on the following pages in Exhibit C-1 for SUD design elements and Exhibit C-2 for SMI/SED design elements. Measures and analytic techniques are described in detail in Sections C-4 and C-6.

Exhibit C-1. SUD Design Approach

Evaluation Question	Hypothesis	Approach
1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? a. How does service utilization vary by member characteristics (e.g., age, race, aid category code)? b. How does service utilization vary by geographic areas (e.g., urban versus rural)?	1. The Demonstration will maintain or increase utilization of SUD treatment services. a. Utilization will maintain or improve by sub-population (e.g., age, race, aid categories) b. Utilization will maintain or improve in both urban and rural areas	ITS; t-test
	2. The Demonstration will maintain or increase SUD provider availability.	
	3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.	
	4. The Demonstration will maintain or increase initiation and engagement in treatment.	
2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD.	ITS; t-test
3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	1. The Demonstration will contain or reduce the use of opioids at a high dosage.	ITS; t-test
4. Does the Demonstration contain or reduce overdose deaths?	1. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.	
5. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD? a. How does utilization vary by age, race and aid category code? b. How does utilization vary by geographic area (e.g., urban versus rural)?	1. The Demonstration will contain or reduce the rate of ED visits. a. ED utilization will maintain or improve by sub-population (e.g., age, race, aid categories) b. ED utilization will maintain or improve in both urban and rural areas	ITS; t-test
	2. The Demonstration will contain or reduce inpatient admissions. a. Inpatient utilization will maintain or improve by sub-	

Evaluation Question	Hypothesis	Approach
	population (e.g., age, aid categories) b. Inpatient utilization will maintain or improve in both urban and rural areas	
6. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?	1. The Demonstration will contain or reduce readmissions to the same or higher levels of care for enrollees with a SUD.	ITS; t-test
7. Does the Demonstration maintain or improve access to care for physical health conditions?	1. The Demonstration will maintain or increase access to care for physical health conditions for enrollees with a SUD.	ITS; t-test
8. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?	N/A Exploratory	ITS; t-test Descriptive
9. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?	N/A Exploratory	

Exhibit C-2. SMI/SED Design Approach

Evaluation Question	Hypothesis	Approach
1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI? a. How does utilization vary by age, race and aid category code? b. How does utilization vary by geographic area (e.g., urban versus rural)?	1. The Demonstration will contain or reduce mental health-related ED use for adults with an SMI. a. ED utilization will maintain or improve by sub-population (e.g., age, race, aid categories) b. ED utilization will maintain or improve in both urban and rural areas	ITS; t-test
2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?	1. The Demonstration will contain or reduce readmissions to acute care hospitals or residential settings for adults with an SMI.	ITS; t-test
3. Does the Demonstration result in increased treatment for comorbid SUD and physical health conditions after IMD discharge?	1. The Demonstration will maintain or increase access to physical health and/or SUD treatment post-discharge for adults with an SMI.	ITS; t-test
4. Does the Demonstration result in improved availability of crisis outreach and response services?	1. The Demonstration will maintain or improve the availability of crisis outreach and response services throughout the State.	Longitudinal (Descriptive)
5. Does the Demonstration result in improved availability of non-residential, non-hospital crisis outreach and response services?	1. The Demonstration will maintain or improve the availability of non-residential, non-hospital crisis outreach and response services.	Longitudinal (Descriptive)
6. 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? a. How does access differ for members receiving CCBHC services? b. How does access differ following the provider's CCBHC designation?	1. The Demonstration will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.	Longitudinal (Descriptive)
	2. Expanding CCBHCs statewide will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.	a. PSM w/t-test b. Within-Subjects Time Series

Evaluation Question	Hypothesis	Approach
7. Does the Demonstration improve the integration of primary and behavioral health care to address the chronic mental health care needs of members with SMI/SED? a. How does integration differ for members receiving CCBHC services? b. How does integration differ following the provider's CCBHC designation?	1. Expanding CCBHCs statewide will maintain or improve the integration of primary and behavioral health care to address the chronic mental health of members with SMI/SED.	a. PSM w/t-test b. Within-Subjects Time Series
8. Does the Demonstration result in improved care coordination for members with SMI/SED? a. How does care coordination differ for members receiving CCBHC services? b. How does care coordination differ following the provider's CCBHC designation? c. Has the CCBHC model of care contributed to decreased length of stay in the ED among members awaiting mental health treatment in specialized settings?	1. Expanding CCBHCs statewide will maintain or improve care coordination for members with an SMI/SED.	a. PSM w/t-test b. Within-Subjects Time Series
d. How does the CCBHC model of care contribute to reductions in utilization and lengths of stays in ED? e. What CCBHC components or characteristics are most effective in reducing utilization and lengths of stays in EDs? f. Are there any obstacles that hinder the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs?	2. Expanding CCBHCs statewide will contribute to maintaining or reducing length of stay in the ED among members awaiting mental health treatment in specialized settings.	c-f. Qualitative; ITS; t-test
9. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?	N/A Exploratory	ITS; t-test; Descriptive

Evaluation Question	Hypothesis	Approach
10. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?	N/A Exploratory	

2. Target and Comparison Populations

All members with an SUD, SMI, or SED will be included in the Demonstration evaluation. The community-based mental health and psychiatric service system in Oklahoma is transforming. CMHCs are enhancing their delivery system and clinical models to meet the requirements for CCBHC certification. This includes an enhanced emphasis on primary care, the integration of physical and behavioral health in treatment planning, and a renewed focus on social determinants of health.

Substance Use Disorder

All full benefit Medicaid enrollees with an SUD are eligible for the Demonstration. Enrollees will be defined as having an SUD if they have one or more of the diagnoses listed in any of the following HEDIS® value sets:

- Alcohol Abuse and Dependence
- Opioid Abuse and Dependence
- Other Drug Abuse and Dependence

All Demonstration enrollees who meet the criteria for the hypothesis and measure under study will be included. The evaluation will not employ random, representative, or other sampling methods. Evaluation measures will be developed based on CMS-defined and HEDIS® specifications that include Medicaid enrollees with an SUD. Inclusion criteria will be specific to each measure.

Residential SUD treatment programs, including IMD treatment facilities, serve residents from across the State. In addition, residential placement decisions for SUD and SMI treatment are made based on nationally recognized placement criteria, including ASAM level of care guidelines for SUD populations. Thus, individuals admitted to residential IMD programs have a clinically different profile and level of care need than those who are not admitted. The statewide nature of the delivery system and clinical differences in service recipients eliminate the possibility of a matched sample of enrollees who receive residential IMD services versus those who did not. The State is not proposing a comparison strategy for SUD-related hypotheses.

Serious Mental Illness

CMHC providers are responsible for comprehensive assessment and designation of members as SMI. Oklahoma defines SMI as:

A condition experienced by persons age 18 and over that demonstrates:

(1) The condition has persisted for six months and is expected to persist for a year or longer;

AND

(2) The condition or serious mental illness is defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded unless they co-occur with another diagnosable serious mental illness;

AND

(3) The adult must exhibit either (A) or (B) below:

(A) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions);

OR

(B) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. This is defined as a functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
(ii) Impairment in community function is manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment, and value systems which result in potential involvement or involvement with the criminal justice system.
(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.
(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations.
(v) Impairment in functioning at school or work is manifested by the inability to pursue educational or career goals.

Serious Emotional Disturbance

CMHC providers are responsible for comprehensive assessment and designation of members as SED. Oklahoma defines SED as:

Children and Adolescents (Under 18 years of age) “Serious Emotional Disturbance” (SED) means a condition experienced by persons from birth to 18 that show evidence of each of the following criteria:

(1) The disability must have persisted for six months and be expected to persist for a year or longer;

AND

(3) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance;

AND

(4) The child must exhibit one of the following:

(A) Psychotic symptoms of a serious mental illness (e.g., schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions);

OR

(B) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
(ii) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment, and value systems which result in potential involvement or involvement with the juvenile justice system.
(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).
(v) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

Comparison Group

An in-state comparison group of members with an SMI or SED not receiving services from a CCBHC will be used for evaluating certain utilization and health outcomes, as identified in Exhibit 9 below. Members are assessed and designated SMI or SED, using the State's criteria, by CMHC and CCBHC providers.

The identification of individuals will be augmented to identify members with an SMI who do not receive CMHC services. Members will be identified using the NCQA definition, as endorsed by CMS in the Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics (version 2.0, August 2020).

NCQA defines individuals with SMI as those who meet at least one of the following criteria within the measurement period:

(1) at least one acute inpatient claim/encounter with any diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depression;

OR

(2) at least two visits in an outpatient, IOP, community mental health center visit, electroconvulsive therapy, observation, ED, nonacute inpatient, or telehealth setting, on different dates of service with a diagnosis of schizophrenia or schizoaffective disorder;

OR

(3) at least two visits in an outpatient, IOP, community mental health center visit, electroconvulsive therapy, observation, ED, nonacute inpatient, or telehealth setting on different dates of service with a diagnosis of bipolar disorder.

3. Evaluation Period

The Demonstration approval period is December 22, 2020, through December 31, 2025. The evaluation will assess CY2017-2020 before the effective date of the Demonstration as the pre-intervention period. Pre-intervention results will be evaluated against the Demonstration period CY2021-2025 (post-intervention timeframe). A claim run out of six months post Demonstration will be applied and a final report produced during the second half of CY2026.

4. Evaluation Measures

The proposed evaluation measures are listed in Exhibits C-3 and C-4 on the following pages, by evaluation question and hypothesis. Where measures are generated based on specifications in the SUD or SMI/SED Monitoring Protocol (MP), the CMS Technical Specifications Manual metric number is included. The evaluation will rely on the most

recent technical manual version published by CMS at the time of measure production and any adjustments needed to align with State-specific claims reporting, as approved by CMS in Oklahoma's final approved SUD and SMI/SED Monitoring Protocols.

Cost measures associated with the Demonstration will be explored using specifications outlined in CMS guidance for SMI/SUD IMD Demonstration Evaluation Design (Appendix C) issued in March of 2019.

One measure, ED length of stay, associated with SMI/SED Evaluation Question 8, Hypothesis C, is currently under development. The evaluators will work with the OHCA and the Health Information Exchange (HIE) staff to refine the metric, as needed, once data extracts are available.

Exhibit C-3. SMI/SED Evaluation Measures

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
Evaluation Question 1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI? a. How does utilization vary by age, race and aid category code? b. How does utilization vary by geographic area (e.g., urban versus rural)?				
Hypothesis 1. The Demonstration will contain or reduce mental health-related ED use for adults with an SMI a. ED utilization will maintain or improve by sub-population (e.g., age, race, aid categories) b. ED utilization will maintain or improve in both urban and rural areas				
Percent of members using the ED for mental health (SMI MP #16 modified)	Number of members with SMI who used the ED for mental health	Number of members with an SMI	Claims	ITS; t-test; Controlled for member demographics and geography
Evaluation Question 2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?				
Hypothesis 1. The Demonstration will contain or reduce readmissions to acute care hospitals or residential settings for adults with an SMI.				
Rate of 30-day all-cause unplanned readmissions following psychiatric hospitalization (SMI MP #4)	The count of 30-day readmission to an inpatient psychiatric facility that occurs within 30-days after discharge	The count of all inpatient psychiatric hospitalizations	Claims	ITS; t-test; Controlled for member demographics and geography
Evaluation Question 3. Does the Demonstration result in increased treatment for comorbid SUD and physical health conditions after IMD discharge?				
Hypothesis 1. The Demonstration will maintain or increase access to physical health and/or SUD treatment post-discharge for adults with an SMI.				
Percentage of members who receive outpatient treatment for a SUD and/or physical health conditions within 30-days of IMD discharge (HEDIS® TRC-modified)	Number of members with an outpatient visit (e.g., office, home-visit, telehealth) for SUD or physical health care within 30-days of discharge	The number of members discharged from SUD residential or inpatient treatment	Claims	ITS; t-test
Evaluation Question 4. Does the Demonstration result in improved availability of crisis outreach and response services?				
Hypothesis 1. The Demonstration will maintain or improve the availability of crisis outreach and response services throughout the state.				
The annual ratio of crisis outreach and response services to Medicaid members who have an SMI/SED	Number of members with an SMI and SED statewide, reported by OHCA annually	The number of crisis outreach and response providers statewide, reported by OHCA annually	Assessment of the Availability of Mental Health Services	Longitudinal (Descriptive)
Evaluation Question 5. Does the Demonstration result in improved availability of non-residential, non-hospital crisis outreach and response services?				
Hypothesis 1. The Demonstration will maintain or improve the availability of non-residential, non-hospital crisis outreach and response services.				
The annual ratio of non-residential and non-hospital crisis outreach and	Number of members with an SMI and SED statewide, reported by OHCA annually	The number of non-residential and non-hospital crisis outreach providers statewide, reported by OHCA annually	Assessment of the Availability	Longitudinal (Descriptive)

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
response services to Medicaid members who have an SMI/SED			of Mental Health Services	
Evaluation Question 6. 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? a. How does access differ for members receiving CCBHC services? b. How does access differ following the provider's CCBHC designation?				
Hypothesis 1. The Demonstration will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED				
The annual ratio of Medicaid enrolled Psychiatrist and licensed Mental Health practitioners to Medicaid members who have an SMI/SED	Number of members with an SMI and SED statewide, reported by OHCA annually	The number of psychiatrists and licensed mental health providers statewide, reported by OHCA annually	Assessment of the Availability of Mental Health Services	Longitudinal (Descriptive)
Hypothesis 2. Expanding CCBHCs statewide will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.				
Use of first-line psychosocial care for youth on antipsychotics (SMI MP #2)	Number of members who received psychosocial care in the 121-day period from 90 days prior to the prescription start date through 30 days after the prescription start	Number of members ages 1 to 17 who had a new prescription for an antipsychotic medication	Claims	(a) PSM w/t-test; (b) Within-Subject Time Series
Medication Continuation Following Inpatient Psychiatric Discharge (SMI MP #6)	Number of members who were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge	Number of members aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder	Claims	
Evaluation Question 7. Does the Demonstration improve the integration of primary and behavioral health care to address the chronic mental health care needs of members with SMI/SED? a. How does integration differ for members receiving CCBHC services? b. How does integration differ following the provider's CCBHC designation?				
Hypothesis 1. Expanding CCBHCs statewide will maintain or improve the integration of primary and behavioral health care to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.				
Access to Preventive/Ambulatory Health Services for members who have an SMI (SMI MP #26)	Number of members who had one or more ambulatory or preventive care visits	Number of members with an SMI diagnosis	Claims	(a) PSM w/t-test; (b) Within-Subject Time Series
Metabolic monitoring for youth on antipsychotics (SMI MP #29)	Number of members who had metabolic testing (at least one test for blood glucose, HbA1c, or Cholesterol)	Number of members age 1-17 who had at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service	Claims	

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
Evaluation Question 8. Does the Demonstration result in improved care coordination for members with SMI/SED? a. How does care coordination differ for members receiving CCBHC services? b. How does care coordination differ following the provider's CCBHC designation? c. Has the CCBHC model of care contributed to decreased length of stay in the ED among members awaiting mental health treatment in specialized settings? d. How does the CCBHC model of care contribute to reductions in utilization and lengths of stays in ED? e. What CCBHC components or characteristics are most effective in reducing utilization and lengths of stays in EDs? f. Are there any obstacles that hinder the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs?				
Hypothesis 1. Expanding CCBHCs statewide will maintain or improve care coordination for members with an SMI/SED.				
Follow-up within 7 days after hospitalization for MH (SMI MP #7)	Number of members who had a follow-up visit with a mental health practitioner within 7-days of discharge	Number of members age 6-17 who had an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm	Claims	(a) PSM w/t-test; (b) Within-Subject Time Series
Follow-up within 30-days after hospitalization for MH (SMI MP #7)	Number of members who had a follow-up visit with a mental health practitioner within 30-days of discharge	Number of members age 6-17 who had an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm	Claims	
Follow-up within 7-days after ED visit for MH (SMI MP #10)	Number of ED visits for which the member received a follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder within 7-days after the ED visit	Number of ED visits for a mental health disorder where the member is age 18 and older on the date of the visit	Claims	
Follow-up within 30-days after ED visit for MH (SMI MP #10)	Number of ED visits for which the member received a follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder within 30-days after the ED visit	Number of ED visits for a mental health disorder where the member is age 18 and older on the date of the visit	Claims	
Hypothesis 2. Expanding CCBHCs statewide will contribute to maintaining or reducing length of stay in the ED among members awaiting mental health treatment in specialized settings.				
Has the CCBHC model of care contributed to decreased length of stay in the ED?	N/A	N/A	Structured interviews or focus groups with hospital, CCBHC, and specialized treatment providers	Qualitative analysis to identify themes associated with the effectiveness of demonstration activities in maintaining or reducing length of stays in EDs
ED Length of Stay	N/A	The median time from ED admission to time of discharge from the ED, calculated quarterly, for members who are admitted or transferred from an ED to inpatient psychiatric treatment	HIE data extract	t-test

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
How does the CCBHC model of care contribute to reductions in utilization and lengths of stays in ED?	N/A	N/A	Structured interviews or focus groups with hospital, CCBHC, and specialized treatment providers	Qualitative analysis to identify themes associated with the effectiveness of demonstration activities in maintaining or reducing length of stays in EDs
What CCBHC components or characteristics are most effective in reducing utilization and lengths of stays in EDs?	N/A	N/A		
Are there any obstacles that hinder the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs?	N/A	N/A		
Evaluation Question 9. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?				
Hypothesis N/A Exploratory				
Per member per month (PMPM) Medicaid cost for individuals who have an SMI/SED	Sum of all Medicaid payments made for physical health and MH-related services	Total member months	Claims	ITS; t-test; Descriptive; Controlled for member demographics and geography
Per member per month (PMPM) cost of MH-Related treatment for individuals who have an SMI/SED	Sum of all Medicaid payments made for MH-related cost, with breakouts for MH-IMD, MH-other treatment	Total member months	Claims	
Per member per month (PMPM) cost of physical health care for individuals who have an SMI/SED	Sum of all Medicaid payments made for physical health care	Total member months	Claims	
Evaluation Question 10. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?				
Hypothesis N/A Exploratory				
Per member per month (PMPM) cost of outpatient (non-ED) for individuals who have an SMI/SED	Sum of all Medicaid payments made for outpatient (non-ED) care	Total member months	Claims	ITS; t-test; Descriptive; Controlled for member demographics and geography
Per member per month (PMPM) cost of pharmacy for individuals who have an SMI/SED	Sum of all Medicaid payments made for pharmacy services	Total member months	Claims	
Per member per month (PMPM) cost of outpatient ED for individuals who have an SMI/SED	Sum of all Medicaid payments made for outpatient-ED services	Total member months	Claims	

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
Per member per month (PMPM) cost of inpatient care for individuals who have an SMI/SED	Sum of all Medicaid payments made for inpatient care	Total member months	Claims	
Per member per month (PMPM) cost of Long-term care for individuals who have an SMI/SED	Sum of all Medicaid payments made for Long-Term Care services	Total member months	Claims	

Exhibit C-4. SUD Evaluation Measures

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
Evaluation Question 1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? a. How does service utilization vary by age, race, aid category code? b. How does service utilization vary by geographic areas (e.g., urban v rural)?				
Hypothesis 1. The Demonstration will maintain or increase utilization of SUD treatment services. a. Utilization will maintain or improve by sub-population (e.g., age, race, aid categories) b. Inpatient utilization will maintain or improve in both urban and rural areas				
Percentage of members receiving any SUD treatment service (SUD MP #6 modified)	Number of members receiving any SUD treatment service	Number of members with a SUD diagnosis	Claims	ITS; t-test; Controlled for member demographics and geography
Percentage of members receiving SUD outpatient treatment services (SUD MP #8 modified)	Number of members receiving outpatient treatment	Number of members with a SUD diagnosis	Claims	
Percentage of members receiving intensive outpatient (IOP) treatment and partial hospitalization (PH) services (SUD MP #9 modified)	Number of members receiving IOP or PH treatment	Number of members with a SUD diagnosis	Claims	
Percentage of members receiving residential and inpatient treatment services (SUD MP #10 modified)	Number of members receiving residential or inpatient treatment	Number of members with a SUD diagnosis	Claims	
Percentage of members receiving withdrawal management services (SUD MP #11 modified)	Number of members receiving withdrawal management services	Number of members with a SUD diagnosis	Claims	
Percentage of members receiving medication-assisted treatment (MAT) (SUD MP #12 modified)	Number of members receiving MAT	Number of members with a SUD diagnosis	Claims	
Hypothesis 2. The Demonstration will maintain or increase SUD provider availability.				
Percentage of providers enrolled in Medicaid and qualified to deliver SUD services (SUD MP #13 modified)	Number of SUD providers enrolled in Medicaid	Number of licensed SUD providers in the State	Licensing Records; Enrollment Files	ITS; t-test
Percentage of providers enrolled in Medicaid and qualified to deliver MAT services (SUD MP #14 modified)	Number of SUD providers who are qualified to deliver MAT services	Number of SUD providers enrolled in Medicaid	Enrollment Files	

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
Hypothesis 3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.				
Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 7-days of discharge (SUD MP #17(1))	Number of members with ED visit for AOD abuse or dependence with a follow-up within 7-days	Number of ED visits with a principal diagnosis of AOD abuse or dependence	Claims	ITS; t-test Controlled for member demographics and geography
Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 30-days of discharge (SUD MP #17(1))	Number of members with ED visit for AOD abuse or dependence with a follow-up within 30-days of ED visit	Number of ED visits with a principal diagnosis of AOD abuse or dependence	Claims	
Hypothesis 4. The Demonstration will maintain or increase initiation and engagement in treatment.				
Percentage of members age 18 and older with a new episode of AOD abuse or dependence who initiate in SUD treatment (SUD MP #15a)	Number of members who initiate treatment within 14 days of diagnosis	Number of members with at least one AOD abuse or dependence diagnoses	Claims	ITS; t-test; Controlled for member demographics and geography
Percentage of members with a new episode of alcohol and other drug abuse or dependence who engage in SUD treatment (SUD MP #15b)	Number of members who received two or more services for AOD abuse or dependence within 34 days of the initiation visit	Number of members who initiate treatment within 14 days of diagnosis	Claims	
Evaluation Question 2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?				
Hypothesis 1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD.				
Percentage of members age 18 and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment (SUD MP #22)	Number of members with an OUD who had at least 180 days of continuous pharmacotherapy	Number of members with an OUD who and at least one claim for an OUD medication	Claims	ITS; t-test
Evaluation Question 3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?				
Hypothesis 1. The Demonstration will contain or reduce the use of opioids at a high dosage.				
Percentage of members age 18 and older who receive prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more (SUD MP #18)	Number of members with an average daily dosage greater than or equal to 90 MME	Number of members with two or more claims for opioid medications on different dates with a cumulative supply of 15 or more days	Claims	ITS; t-test

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
Evaluation Question 4. Does the Demonstration contain or reduce overdose deaths?				
Hypothesis 1. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.				
The rate of opioid overdose deaths per 1,000 Medicaid members (SUD MP #27 OUD subgroup)	The number of opioid-related overdose deaths	Members enrolled in Medicaid for at least one month during the measurement period or 30-days prior to the beginning of the measurement period	Eligibility files; Vital Statistics	ITS; t-test
Evaluation Question 5. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD? a. How does utilization vary by age, race and aid category code? b. How does utilization vary by geographic areas (e.g., urban versus rural)?				
Hypothesis 1. The Demonstration will contain or reduce the rate of ED visits. a. ED utilization will maintain or improve by sub-population (e.g., age, race, aid categories) b. ED utilization will maintain or improve in both urban and rural areas				
Total number of ED visits per 1,000 members	Number of ED visits	Members enrolled in Medicaid for at least one month	Claims	ITS; t-test; Controlled by member demographics and geography
Hypothesis 2. The Demonstration will contain or reduce inpatient admissions.				
Total number of inpatient stays per 1,000 members	Number of inpatient discharges	Members enrolled in Medicaid for at least one month	Claims	ITS; t-test; Controlled for member demographics and geography
Evaluation Question 6. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?				
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care for enrollees with a SUD.				
Percentage of readmission to the same or higher level of residential care (SUD #25 modified)	Members who were readmitted to SUD residential or inpatient within 30-days of discharge	Members who were discharged from residential or inpatient treatment for SUD	Claims	ITS; t-test
Evaluation Question 7. Does the Demonstration maintain or improve access to care for physical health conditions?				
Hypothesis 1. The Demonstration will maintain or increase access to care for physical health conditions for enrollees with a SUD.				
Percentage of members with a SUD who had an ambulatory or preventive health care visit (SUD MP #32)	Members who had one or more ambulatory or preventive care visits	Number of members with a SUD diagnosis	Claims	ITS; t-test; Controlled for member demographics and geography

Measure/Steward	Numerator	Denominator	Data Source	Analytic Methods
Evaluation Question 8. How does the cost of care change over time? a. How does the Medicaid eligibility expansion impact cost over time? b. Does increased federal share for IMD services have an association with increased State investments in behavioral health services?				
Hypothesis N/A Exploratory				
Per member per month (PMPM) Medicaid cost for individuals who have an SUD	Sum of all Medicaid payments made for physical health and SUD-related services	Total member months	Claims	ITS; t-test; Descriptive; Controlled for member demographics and geography
Per member per month (PMPM) cost of SUD-Related treatment for individuals who have an SUD	Sum of all Medicaid payments made for SUD-related cost, with breakouts for SUD-IMD, SUD-other treatment	Total member months	Claims	
Per member per month (PMPM) cost of physical health care for individuals who have an SUD	Sum of all Medicaid payments made for physical health care	Total member months	Claims	
Evaluation Question 9. What are the cost drivers? a. Does increased community-based service utilization have an association with lower ED costs? b. Does increased community-based service utilization have an association with lower inpatient costs?				
Hypothesis N/A Exploratory				
Per member per month (PMPM) cost of outpatient (non-ED) for individuals who have an SUD	Sum of all Medicaid payments made for outpatient (non-ED) care	Total member months	Claims	ITS; t-test; Descriptive; Controlled for member demographics and geography
Per member per month (PMPM) cost of pharmacy for individuals who have an SUD	Sum of all Medicaid payments made for pharmacy services	Total member months	Claims	
Per member per month (PMPM) cost of outpatient ED for individuals who have an SUD	Sum of all Medicaid payments made for outpatient-ED services	Total member months	Claims	
Per member per month (PMPM) cost of inpatient care for individuals who have an SUD	Sum of all Medicaid payments made for inpatient care	Total member months	Claims	
Per member per month (PMPM) cost of Long-term care for individuals who have an SUD	Sum of all Medicaid payments made for Long-Term Care services	Total member months	Claims	

5. Data Sources

The evaluation will rely on administrative data collected by OHCA and ODMHSAS. The primary sources of data will be the Medicaid Management Information System (MMIS), including Medicaid Eligibility and Enrollment files. Data will be augmented by information from the State of Oklahoma Public Health Vital Statistics database and information provided to CMS annually on the availability of mental health service providers. Each quantitative data source is described in brief in Exhibit C-5 below. Qualitative data will be derived from provider interviews described separately in Section 7.

Exhibit C-5. Evaluation Design Data Sources

Data Source/Years Used	Description
Medicaid Management Information System (MMIS) Data for CY2017 – CY2025	Claims data submitted to the State by providers used to support HEDIS® and HEDIS-like performance, Medication-Assisted Treatment, service utilization, and cost metrics for all enrollees.
	Eligibility and enrollment detail for Medicaid beneficiaries used to determine the enrollee's aid category and stratify data into sub-groups, when applicable.
	Non-Medicaid claims for SUD and psychiatric treatment services paid for by the State (CY2017-CY2020).
CMS Workbook: Assessment of the Availability of Mental Health Services Data for CY2020-CY2025	Designed by CMS this workbook provides detail on the number and type of mental health providers operating in the state, those enrolled in Medicaid and those accepting new patients. The workbook includes the ratio of providers to members (regionally and statewide) and represents point-in-time data updated annually during the demonstration period. The OHCA completed the baseline assessment February 2020.
Vital Statistics Data Data for CY2017 – CY2025	Public health birth, death, and other vital records are used to track overdose deaths attributed to Oklahoma residents.
Health Information Exchange Under Development - Expected October 2022	The Health Information Exchange (HIE) is the state-designated organization that facilitates the exchange of health information to and from authorized individuals and health care organizations in the state, including interoperability with existing state systems (e.g., Medicaid, behavioral health, and public health). Member detail regarding ED admission and departure times will be included in the architecture of the HIE. OHCA staff will retrieve the detail necessary to track length of stay in the ED for members with an SMI/SED who are admitted or transferred to inpatient psychiatric care.

6. Data Cleaning and Validation

The IMD evaluation team schedules ad hoc meetings with State subject matter experts if anomalies are found in the data. For example, results or sample size that represent a significant departure from the prior year without clear explanation will prompt individual meetings with data and program experts. In addition, the evaluation team inventories change in the measure specifications, if any, and changes in program operations or policy that may have occurred since the last data submission. Processes will be developed for the HIE data extract when the system is operational, and data is available to the evaluation team. Each existing data set is described below.

Medicaid Management Information System Data

The measures identified for the evaluation rely predominately on the MMIS data. This includes Medicaid claims (paid, suspended, and denied); non-Medicaid claims paid through the MMIS (e.g., treatment services paid for by general fund); and member Medicaid eligibility information. PHPG currently serves as the State's independent evaluator. PHPG receives raw claims extracts annually. PHPG then performs a data audit processes to identify problems and inconsistencies with the data received. This includes direct comparisons to previous raw claims extracts to sample trends, as well as doing independent data extracts on random samples to validate consistency. PHPG works with the State to answer questions and provide feedback to resolve discrepancies in output.

Vital Statistics Data

This Public Health Department data base serves as the authority for birth, death, and other vital records in Oklahoma. Death records are recorded with the cause of death and are used to track overdose deaths attributed to Oklahoma residents. The OHCA links with the Vital Statistics database as part of its program integrity process to ensure Medicaid members who have died are removed from the eligibility system. Deaths attributed to opioid and other drug overdose are matched to Medicaid members to calculate the number and rate of overdose deaths among Medicaid beneficiaries. Case of death data may lag up to one year. To ensure the most accurate data possible, the rate of opioid deaths will be refreshed 12 months following the calculation of preliminary results for each year.

7. Analytic Methods

The evaluation data analysis will consist of both exploratory and descriptive strategies and incorporate univariate, bi-variate, and multi-variate techniques. The analysis will be performed to systematically apply statistical and/or logical techniques to describe, summarize, and compare data within the State and across time.

Descriptive statistics will be used to describe the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. They also will

be used to provide summaries about the participants and their outcomes. An exploratory data analysis will be employed to compare many variables in the search for organized patterns. Data will be analyzed as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode), and/or qualitatively analyzed for themes. Where appropriate, results will be compared to national benchmarks.

Most of the evaluation questions and hypotheses will use member level data to draw program level conclusions. This is illustrated in Exbibit C-6 below and C-7 on the following page.

Exhibit C-6. SUD level of analysis and conclusions drawn by evaluation question and hypothesis

Evaluation Question	Hypothesis	Level of Analysis	Level of Conclusion
1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?	1. The Demonstration will maintain or increase utilization of SUD treatment services.	Member	Program
	2. The Demonstration will maintain or increase SUD provider availability.	Provider	Program
	3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.	Member	Program
	4. The Demonstration will maintain or increase initiation and engagement in treatment.		
2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD.		
3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	1. The Demonstration will contain or reduce the use of opioids at a high dosage.		
4. Does the Demonstration contain or reduce overdose deaths?	1. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.		
5. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD?	1. The Demonstration will contain or reduce the rate of ED visits.		
	1. The Demonstration will contain or reduce inpatient admissions.		

Evaluation Question	Hypothesis	Level of Analysis	Level of Conclusion
10. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?	1. The Demonstration will contain or reduce readmissions to the same or higher levels of care for enrollees with a SUD.		
11. Does the Demonstration maintain or improve access to care for physical health conditions?	1. The Demonstration will maintain or increase access to care for physical health conditions for enrollees with a SUD.		
12. How does the total cost of care change over time?	N/A Exploratory	Program	Program
13. What are the cost drivers?	N/A Exploratory		

Exhibit C-7. SMI/SED level of analysis and conclusions drawn by evaluation question and hypothesis

Evaluation Question	Hypothesis	Level of Analysis	Level of Conclusion
1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI?	1. The Demonstration will contain or reduce mental health-related ED use for adults with an SMI.	Member	Program
2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?	1. The Demonstration will contain or reduce readmissions to acute care hospitals or residential settings for adults with an SMI.		
3. Does the Demonstration result in increased treatment for comorbid SUD and physical health conditions after IMD discharge?	1. The Demonstration will maintain or increase access to physical health and/or SUD treatment post-discharge for adults with an SMI.		
4. Does the Demonstration result in improved availability of crisis outreach and response services?	1. The Demonstration will maintain or improve the availability of crisis outreach and response services throughout the State.	Provider	Program
5. Does the Demonstration result in improved availability of non-	1. The Demonstration will maintain or improve the availability of non-residential, non-hospital		

Evaluation Question	Hypothesis	Level of Analysis	Level of Conclusion
residential, non-hospital crisis outreach and response services?	crisis outreach and response services.		
6. 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?	1. The Demonstration will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.		
	2. Expanding CCBHCs statewide will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.		
7. Does the Demonstration improve the integration of primary and behavioral health care to address the chronic mental health care needs of members with SMI/SED?	1. Expanding CCBHCs statewide will maintain or improve the integration of primary and behavioral health care to address the chronic mental health of members with SMI/SED.	Member	Program
8. Does the Demonstration result in improved care coordination for members with SMI/SED?	1. Expanding CCBHCs statewide will maintain or improve care coordination for members with an SMI/SED.		
9. How does the total cost of care change over time?	N/A Exploratory	Program	Program
10. What are the cost drivers?	N/A Exploratory		

As appropriate, analysis methods will include Logistic Regression, t-test, ANOVA, and propensity score matching with t-test. These tests are used for comparing sample and population means against each other; this can be the same population across time or within the same time but for populations receiving different treatments, or one group does not receive treatment while others do.

t-tests and ANOVA are appropriate when granular (patient-level) data is not available, but population-level means and standard deviations are, the outcome variable is continuous, and the objective is to determine whether the mean of a certain outcome variable of interest

is significantly different between two or more groups. t-tests allow for comparison of means between two groups whereas ANOVA allows this to be done for more than two groups.

The analysis will be stratified into urban and rural subgroups, subject to sample size limitations. The urban subgroup will consist of the counties comprising the greater Oklahoma City, Tulsa, and Lawton metropolitan areas; the rural subgroup will consist of the remainder of the State.

Where feasible, based on sample size and availability of data, the analysis will be stratified by racial and ethnic sub-populations.

The traditionally accepted significance level ($p \leq 0.05$) will be used for all comparisons.

Interrupted Time Series

The time series will include four years of data preceding the program expansion. The four-year baseline period will include CY2017-2020. Evaluation measures being studied using an interrupted time design will be examined quarterly. However, the underlying technical specifications for many measures are designed for the annual calculation of results.

Except for the opioid prescribing and overdose measures, each of the remaining measures selected is event-driven (i.e., action is measured within 31 days after an event has occurred), suggesting that quarterly measurement is viable. To ensure that quarterly measurement is an appropriate interval, for what are otherwise annual measures, the evaluator will assure that quarterly data preserves sufficient variation for comparison study.

Specifically, the evaluator will compare annual results to the baseline period using a t-test. An ANOVA will be used when trends for two or more years are compared. The evaluator then will perform an interrupted time series analysis with quarterly data for the same metrics to confirm that any statistically significant differences seen on an annual level, are also present in the quarterly data.

If the evaluator detects a significant difference in a comparison of means between the annualized measures but not the quarterly measures, it suggests more frequent measurement does not provide sufficient variation for the analysis. If the evaluator detects statistically significant differences in the quarterly data but not on the annual data, the quarterly analysis may be creating an artificial variation (e.g., measuring too frequently).

If either of the phenomena is found, the evaluator will not proceed with the interrupted time series method and will instead conduct annual comparisons of means using a t-test or ANOVA, based on the number of annual means being compared. Logistic regression to the baseline year also may be considered.

Absent any problems with quarterly measurement, the results of the interrupted times series analysis will be reported. The analysis will determine whether any of the following inferences can be made: (1) there was no effect; (2) there was only an immediate effect; (3) there was only a sustained long-term effect; or (4) there was both an immediate and a sustained long-term effect. To model the time series, the evaluator will estimate the following equation:

$$Y = \beta_0 + \beta_1 Time + \beta_2 D + \beta_3 P + \varepsilon$$

where Y is the outcome variable or metric of interest, Time indicates the quarter since the beginning of the observational period (i.e., 1, 2, …), D is an indicator variable (takes on either value 0 or 1) that indicates whether this period is before or after the Demonstration, and P denotes the period or quarter since the Demonstration started (i.e., 0's until the Demonstration effective date then 1, 2, …).

Prior to Medicaid reimbursement, ASAM-aligned treatment services were supported by ODMHSAS through State general funds and other non-Medicaid funds. It is expected that encounter data will be available for Medicaid members who received state-supported services.

If data is not available or sufficient to assess the three years prior to the Demonstration, the evaluator will use logistic regression to measure change over time. If this secondary assessment method is employed, the first year of the Demonstration (2021) will be used as the baseline year.

Controlling for Member Characteristics

The design relies on measures that by nature include participants with attributes that are highly correlated. For example, many measures focus on specific diagnosis, medications, age bands or treatment conditions. The inclusion and exclusion criteria for each measure limits the variability of beneficiary characteristics that are observe in the data. In addition, as measure specificity increases (e.g., youth under 17 on antipsychotic meds), sample size decreases, limiting the conclusions that may be drawn from the analysis.

However, several evaluation questions focus on broader population trends. As part of the interrupted time series analysis and based on the viability of the sample size, the evaluator will control for the following member demographic characteristics: age, race, gender, and aid category code using the following equation:

$$\begin{aligned} Y_t = \beta_0 &+ \beta_1 T_t + \beta_2 X_t + \beta_3 X_t T_t + \beta_4 D_{AGE} + \beta_5 D_{AGE} T_t + \beta_6 D_{AGE} X_t + \beta_7 D_{AGE} X_t T_t \\ &+ \beta_8 D_{GENDER} + \beta_9 D_{GENDER} T_t + \beta_{10} D_{GENDER} X_t + \beta_{11} D_{GENDER} X_t T_t \\ &+ \beta_{12} D_{URBANRURAL} + \beta_{13} D_{URBANRURAL} T_t + \beta_{14} D_{URBANRURAL} X_t \\ &+ \beta_{15} D_{URBANRURAL} X_t T_t + \beta_{16} D_{AIDCAT} + \beta_{17} D_{AIDCAT} T_t + \beta_{18} D_{AIDCAT} X_t \\ &+ \beta_{19} D_{AIDCAT} X_t T_t + \varepsilon \end{aligned}$$

These variables are defined as:

- T_t (time since beginning of data collection)
- X_t (a dummy variable indicating if the current time period is pre-intervention (X_t =0) or post-intervention (X_t =1))
- D_{AGE}, D_{GENDER}, $D_{URBANRURAL}$ (demographic + geography variables)
- X_t T_t, $D_{GENDER}T_t$, $D_{GENDER}X_t$, $D_{GENDER}X_tT_t$, $D_{AGE}X_t$, $D_{AGE}T_t$, $D_{AGE}X_tT_t$, $D_{URBANRURAL}T_t$, $D_{URBANRURAL}X_t$, $D_{URBANRURAL}X_tT_t$, $D_{AIDCAT}T_t$, $D_{AIDCAT}X_t$ and $D_{AIDCAT}X_tT_t$ (interaction variables)

Research questions and outcome measures for the controlled time series analysis are outlined in Exhibit C-8 below and C-9 on the following page.

Exhibit C-8. SMI/SED Cohort - Controlling for Member Characteristics

Evaluation Question	Outcome Measure
1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI?	Percent of members using the ED for mental health
2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?	Rate of 30-day all-cause unplanned readmissions following psychiatric hospitalization
9. How does the cost of care change over time?	Per member per month (PMPM) Medicaid cost for individuals who have an SMI/SED
	Per member per month (PMPM) cost of MH-Related treatment for individuals who have an SMI/SED
	Per member per month (PMPM) cost of physical health care for individuals who have an SMI/SED
10. What are the cost drivers?	Per member per month (PMPM) cost of outpatient (non-ED) for individuals who have an SMI/SED
	Per member per month (PMPM) cost of pharmacy for individuals who have an SMI/SED
	Per member per month (PMPM) cost of outpatient ED for individuals who have an SMI/SED
	Per member per month (PMPM) cost of inpatient care for individuals who have an SMI/SED
	Per member per month (PMPM) cost of Long-term care for individuals who have an SMI/SED

Exhibit C-9. SUD Cohort - Controlling for Member Characteristics

Evaluation Question	Outcome Measure
1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?	Percentage of members receiving any SUD treatment
	Percentage of members receiving SUD outpatient treatment
	Percentage of members receiving intensive outpatient (IOP) treatment and partial hospitalization (PH)
	Percentage of members receiving residential and inpatient treatment services

Evaluation Question	Outcome Measure
	Percentage of members receiving withdrawal management services
	Percentage of members receiving medication-assisted treatment (MAT)
	Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 7-days of discharge
	Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 30-days of discharge
	Percentage of members age 18 and older with a new episode of AOD abuse or dependence who initiate in SUD treatment
	Percentage of members with a new episode of alcohol and other drug abuse or dependence who engage in SUD treatment
5. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD?	Total number of ED visits per 1,000 members
	Total number of inpatient stays per 1,000 members
7. Does the Demonstration maintain or improve access to care for physical health conditions?	Percentage of members with a SUD who had an ambulatory or preventive health care visit
8. How does the cost of care change over time?	Per member per month (PMPM) Medicaid cost for individuals who have an SUD
	Per member per month (PMPM) cost of SUD-Related treatment for individuals who have an SUD
	Per member per month (PMPM) cost of physical health care for individuals who have an SUD
9. What are the cost drivers?	Per member per month (PMPM) cost of outpatient (non-ED) for individuals who have an SUD
	Per member per month (PMPM) cost of pharmacy for individuals who have an SUD
	Per member per month (PMPM) cost of outpatient ED for individuals who have an SUD

Evaluation Question	Outcome Measure
	Per member per month (PMPM) cost of inpatient care for individuals who have an SUD
	Per member per month (PMPM) cost of Long-term care for individuals who have an SUD

Propensity Score Matching

Propensity score Matching with t-test will be used for evaluating CCBHC and non-CCBHC comparison groups. Propensity score matching is intended to reduce confounding variables associated with the observational data. Variables examined for the analysis will include age, geography (recipient county of residence), aid category code, and gender. Geography is characterized as "Urban" and "Rural". The urban subgroup will consist of the counties comprising the greater Oklahoma City, Tulsa, and Lawton metropolitan areas; the rural subgroup will consist of the remainder of the State.

The analysis will account for these variables by selecting similar-looking comparison and treatment groups from the larger population such that the groups look comparable across the demographic factors. A logit regression will be used to estimate propensity scores and to match using the propensity score. After the matching, sample means will be compared between the treatment and control groups to verify that they are indeed comparable before regressing the outcome of interest. This allows for an estimate of the effect of the treatment on the outcome.

The evaluator will use propensity score matching in alignment with Rosenbaum and Rubin (1983)[3] where the propensity score collapses many observable demographic factors that could contribute to the outcome metric of interest to a one-dimensional score that can be used to compare member characteristics and create a comparison group comparable to the treatment group. This allows the evaluator to attribute more of the differences in the metrics of interest across these two groups to their treatment (or lack thereof in the case of the comparison group) and not to one of the demographic factors which could also explain some or all the differences between the groups' outcomes.

The observed baseline covariates include gender, age, geography, and Medicaid aid category codes (enumerated below). The evaluator will perform a separate analysis for each year; thus, the year will enter as a covariate.

Since propensity score is a common, but not the only method of comparing multi-dimensional/multi-attributed objects by collapsing the many dimensions to a one-dimensional score, the evaluator will also look at the coarsened exact matching to produce good covariate balancing between the treatment and comparison groups. After

[3] The central role of the propensity score in observational studies for causal effects. Rosenbaum P.R., Rubin D. B., Biometrika (1983), 70, 1, pp. 41-55

matching, the evaluator will compare the two groups on the aforementioned demographic factors to determine if there are statistically significant differences in any of those factors.

Ideally, the evaluator should not find such differences, thereby attributing greater explanatory power to the variation in the metrics of interest to the member's association with the comparison or the treatment group.

The propensity score matching formula is defined as:

$$P(Z_i|gender, age, geo, one-hot\ encoded\ aid\ codes) = p$$
$$= \frac{1}{1 + e^{-(\beta_0+\beta_1(gender)+\beta_2(gender)+\beta_3(age)+\beta_4(\text{aidcode1})+\beta_5(\text{aidcode2})+\cdots)}}$$

The aid category field which determines how a member qualified for Medicaid will be one-hot encoded to become the following binary variables:

- New Adult
- Aged, Blind and Disabled (ABD) Medicaid Only
- ABD-Dual Medicaid/Medicare
- Non-ABD Adult
- Non-ABD Child

The propensity score provides balancing such that conditional on a propensity score, the distribution of the demographic variables enumerated above is not statistically significantly different. After deriving the propensity scores, the control and treatment groups are matched using the "nearest neighbor" search. Then the design will verify that covariates above are all balanced in the post-matching groups and then compare the results using a t-test.

If the evaluator cannot find appropriately balanced comparison and treatment groups, the hypothesis being studied will be evaluated using a Logistic Regression. The Logistic Regression will compare results for the baseline year of CY2019, to each year of the Demonstration.

Logistic Regression

If either the comparison or ITS analysis cannot be performed due to data limitations, logistic regression will be used to measure change over a baseline year. If this secondary assessment method is employed, the first year of the Demonstration (2021) will be used as the baseline year.

The outcome of interest in the majority of measures is binary, in that the member either received/engaged in the outcome of interest or did not (yes or 1 /no or 0) as denoted. The probability of 'yes' is 'p' and the probability of 'no' is thus '1-p'. 'l = log(p/1-p)' is the log odds (or logit) which we estimate with the year where the base year is typically 2021 (the effect is captured in the intercept) and the years following 2021 are interpreted as incremental effects compared to the base year 2021. The design examines whether the incremental years are statistically significant on the log-odds of saying yes vs no to the measures of interest.

If they are statistically significant, the interpretation is that the year in question (e.g., each year of the Demonstration extension) shows a marked difference compared to the base year. This combined with a comparison of the rates (p = # saying yes/total # of that year) shows that there was a statistically significant increase (or decrease) in the rate of yes to a measure from the base year 2021 to a future year. Outcomes (which are always binary in these cases) will be calculated annually for each of the five Demonstration years and a baseline period.

$$l = ln\frac{p}{1-p} = \beta_0 + \beta_1(year) + \varepsilon$$

which is solved algebraically for p:

$$p = \frac{1}{1 + e^{-(\beta_0+\beta_1(year)+\varepsilon)}}$$

Autocorrelation in Time Series Data

Autocorrelation is likely to be observed. IMD and other continuum of care services were available to enrollees prior to the Demonstration, although not cost-shared with Medicaid. Quality improvement efforts in the behavioral health system also have been ongoing. It is likely that the distribution is stable and highly correlated to the previous year(s)'data. Due to the Medicaid expansion, it is also likely that increases in utilization because of new eligibility rules would be maintained year over year.

Part of the intent of the Demonstration is to measure shifts in these measures over time. Removing autocorrelation by removing newly eligible members would also mean not being able to measure the effect of expansions or the true shift over time on the measures.

Identifying autocorrelation is important relative to violating assumptions of time series modeling and inference. However, autocorrelation is mostly a concern when using time series modeling for forecasting where accuracy may be impacted.

To identify autocorrelation, the findings will include a plot of the actual time series and a plot of the partial autocorrelation function (pACF) for each outcome measure to show which lags (if any) are significant at a 5% level.

Impact of the Novel Coronavirus Public Health Emergency

Given the unique circumstances of 2020, the evaluator will assess whether 2020 data will be used in the interrupted time series analysis. The analysis will be performed using data collected during CY2020 as part of the baseline period 2017 - 2020. If the 2020 analysis yields noticeable anomalies in the trend line, the results will be presented with and without 2020 data.

Expenditure Analysis

Cost of Care and Cost Drivers

In addition to hypothesis testing, the evaluation will monitor the impact of the demonstration and expanded Medicaid eligibility on expenditures for members with an SUD or SMI/SED diagnosis. Cost of care measures, not associated with a hypothesis, will be examined for year-over-year change and utilization trends. This will include total cost and SUD, SMI/SED treatment related cost trends. Expenditures will be examined relative to drivers such as ED utilization, inpatient hospitalization, and pharmacy services. For example, access to IMD services may result in improved engagement in MAT treatment and, subsequently, an increase in expenditures, while a decline in ED use and hospitalizations may result in corresponding decreases in expenditures.

Descriptive statistics such as frequency, average, percent change, and comparison to national results, where applicable, will be employed for all cost measures. The evaluation will include an exploratory examination of utilization and cost patterns and trends, for recipients, by categories of service. Cost trends will be explored in alignment with CMS guidance for SMI/SUD IMD Evaluation Design Appendix C.

Eligibility Expansion and Treatment Related Expenditures

The evaluator will also employ an ITS model to analyze the cost of SUD and SMI/SED services over time, as associated with Medicaid eligibility expansion (effective 7/1/2021) and the increased federal share of IMD expenditures (effective 1/1/2021). The intervention period (i.e., effective date) and quarterly data will be used to assess whether there is a change in total cost following the start of the Demonstration and following the Medicaid expansion.

To study cost drivers associated with SUD and SMI/SED expenditures, the evaluator will analyze quarterly and yearly data (the two should lead to similar conclusions) to regress community-based service utilization against (a) ED costs and (b) inpatient costs. The regression will follow the following parametric form, where x represents service utilization and ε is an error term.

$$Cost_{ED} = \beta_0 + \beta_1 * x + \varepsilon_{ED}$$

$$Cost_{inpatient} = \beta_2 + \beta_3 * x + \varepsilon_{ip}$$

The evaluator will report out β_1 and β_3, which can be interpreted as "for each unit increase in community-based service utilization, what is the change in ED costs" and "for each unit increase in community-based service utilization, what is the change in inpatient costs?", respectively. The evaluator will also report the 95% confidence interval of the estimates of β_1 and β_3. It is important to note here that if the 95% confidence interval includes 0 in the range, then there is not a significant correlation between cost and utilization.

The evaluator may engage further analysis and impact assessments depending on staff and budget, data availability, administrative burden, and value to program managers and policymakers.

Isolating Effects of the Demonstration

Behavioral Health Delivery System

Activity related to the behavioral health delivery system involves assessing service gaps and identifying opportunities for quality improvement. In most cases, quality planning and improvement activities as they relate to the Medicaid program are outlined in the approved SUD and SMI/SED Implementation Plans and are accounted for in the Logic Model Diagrams (e.g., national accreditation, CCBHC certification, PDMP use, online ASAM screening tools).

Community, provider, and member educational efforts not targeted exclusively for Medicaid enrollees may be occurring at the same time as the Demonstration. These initiatives will be documented and provide context for findings but cannot be controlled for in the analysis.

Medicaid Expansion

To account for the effects of Medicaid Expansion, the evaluator will compare outcomes during the pre-expansion period (2017-2020) and during the demonstration with and without the expansion group included in the calculation. The evaluator will measure the significance of the difference between the pre-expansion and demo period with and without expansion group. The evaluator will perform a regression with the outcome of interest for members in the New Adult eligibility group as well as examine the interaction between the expansion and Demonstration using the following equation:

$$\begin{aligned} Y_{t,exp} = {} & \beta_0 + \beta_1 T_t + \beta_2 X_t + \beta_3 X_t T_t + \beta_4 D_{AGE} + \beta_5 D_{AGE} T_t + \beta_6 D_{AGE} X_t + \beta_7 D_{AGE} X_t T_t \\ & + \beta_8 D_{GENDER} + \beta_9 D_{GENDER} T_t + \beta_{10} D_{GENDER} X_t + \beta_{11} D_{GENDER} X_t T_t \\ & + \beta_{12} D_{URBANRURAL} + \beta_{13} D_{URBANRURAL} T_t + \beta_{14} D_{URBANRURAL} X_t \\ & + \beta_{15} D_{URBANRURAL} X_t T_t + \varepsilon \end{aligned}$$

$$\Delta_t = Y_{t,exp=1} - Y_{t,exp=0}$$

The variables are defined as:

- $Y_{t,exp=0}, Y_{t,exp=1}$ (the variable of interest for excluding and including expansion populations, respectively)
- T_t (time since beginning of data collection)
- X_t (dummy variable indicating if the current time period is pre-intervention (X_t =0) or post-intervention (X_t =1))
- D_{AGE}, D_{GENDER}, $D_{URBANRURAL}$ (demographic and geography variables)
- X_t, T_t, $D_{GENDER}T_t$, $D_{GENDER}X_t$, $D_{GENDER}X_tT_t$, $D_{AGE}X_t$, $D_{AGE}T_t$, $D_{AGE}X_tT_t$, $D_{URBANRURAL}T_t$, $D_{URBANRURAL}X_t$, and $D_{URBANRURAL}X_tT_t$ (interaction variables)
- Δ_t (the estimate of the upper bound of the effect of Medicaid expansion on the variable of interest)

Although causal inference cannot be concluded, the evaluator will estimate an upper bound on the effect of the expansion as well as any synergistic effects associated with being simultaneously enrolled in the demo and being part of the expansion population.

The evaluator cannot disentangle all interaction effects between the expansion and all other factors (demographic and otherwise) because there is not sufficient variation in the data for all covariates across all affected measures to estimate all such interaction effects. However, a difference between the effects on the traditional (non-expansion) and expansion eligible groups should yield a conservative upper bound on the effects of the expansion on the outcomes of interest.

Sensitivity Analysis

The Evaluation Design does not rely on sampling methods. Measures are constructed using CMS recognized, reliable, and valid measure sets, and include all members who meet the criteria for the outcome being studied (e.g., diagnostic, age, gender). All eligible members are included in the design. Thus, there are limited evaluation design elements that may skew findings.

However, to test the robustness of results derived from the interrupted time series and/or propensity score matching with t-test analysis the evaluator will apply the following procedures.

- For the analyses using interrupted time series, the evaluator will test the robustness of findings by removing outliers (e.g., +/- 2 standard deviations from the mean) and re-running the original analysis to determine if trends and results are significantly different. This will be in addition to comparisons of annualized results with quarterly findings for each measure to determine if the analysis has either lost meaningful variation or introduced artificial variation by increasing the frequency of measurement.

- For the analyses using propensity score matching the evaluator will test the robustness of findings associated with the comparison strategy by using two types of matching algorithms (specifically propensity score matching and coarsened

exact matching) to create subgroups that are balanced on observable demographic factors. The evaluator will compare their resulting matched groups for balance. The evaluator will conduct t-tests on the demographic factors post-matching to ensure that any differences in means are statistically insignificant.

Findings will report any occurrence where the results of statistical probability at the 0.05 level conflict between methods.

Qualitative Methods

Qualitative methods will be employed to measure providers' perception of the length of time members are in the ED while awaiting treatment in specialized mental health settings. The evaluator will work with the OHCA to identify hospitals with Medicaid behavioral health ED visits. Structured interviews or focus groups with representatives of hospitals, CCBHC program staff and specialized treatment providers will be conducted in each CCBHC region of the State.

Structured interviews will be conducted by phone, via Zoom/Microsoft Teams or face-to-face and will last approximately 30 to 45 minutes. The State and its employees will not conduct, transcribe, or have access to interview notes or transcripts. Interview questions will be finalized by the independent evaluator and approved by the OHCA. The interview will examine:

- Whether the CCBHC model of care contributed to decreased length of stay in the ED.
- How the CCBHC model of care contributed to reductions in utilization and lengths of stays in ED.
- What components or characteristics of the CCBHC model providers feel are most effective in reducing utilization and lengths of stays in EDs.
- Whether there are obstacles that hinder the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs.

A Thematic Analysis will be used to assess interview responses. These analyses examine structured interview data for patterns across interviews. Themes will be defined based on their appearance in the data and not on a pre-defined content structure. Thematic analysis will be conducted separately on each structured interview transcript, for each group of interviewees using an inductive approach. Patterns in the transcripts will be identified and grouped into themes. Themes will be checked against the original transcripts for validity. To ensure inter-coder reliability and the reliability of the analyses, both methods will utilize at least two coders. The analysis is not intended to support comparison between groups of interviewees or follow principles of statistical significance.

D. METHODOLOGICAL LIMITATIONS

Due to the quasi-experimental nature of the design and the limitations identified below, the evaluation results cannot be attributed to causal inference. The findings may suggest an association or correlation with various aspects of the Demonstration. However, language suggesting causation or analyses of counterfactuals may not be appropriate when describing results.

The IMD evaluation has been designed to yield accurate and actionable findings but does have methodological limitations, most of which are inherent to Section 1115 demonstrations. Data and design limitations are outlined below.

Data Limitations

Use of Administrative Data: The evaluation may be limited by its reliance on claims and diagnostic codes to identify the beneficiary population with SUD. These codes may not capture all participants especially if the impact or severity of the SUD is not evident on the initial assessment. For example, an ED visit for a broken arm due to inebriation may not be coded as SUD-related, if the member does not present as inebriated, the ED provider has not ascertained causation, or the member fails to disclose the cause. These limitations will be noted in the findings report.

Additionally, due to the nature of some measures, sufficient variability to estimate the effect of covariates (demographic and geography) on the outcome of interest is not observed and thus cannot be estimated. This means some interaction effects or effects due to covariates cannot be controlled and cannot be estimated.

Design Limitations

Lack of True Experimental Control Groups: Many IMD facilities serve residents from across the State. Thus, regional control or comparison groups for IMD service recipients are not available. In addition, residential placement decisions are made based on nationally recognized mental health and ASAM level of care guidelines; thus, individuals admitted to a residential SUD program or a psychiatric facility have a clinically different profile and level of care need than those who are not admitted. These clinical differences eliminate the possibility of a matched sample of IMD enrollees who receive services versus those who did not. Lastly, all Medicaid enrollees who meet SUD and SMI/SED criteria are eligible for the Demonstration. The design will employ propensity score matching and interrupted time series techniques to mitigate the impact of these limitations. The design will also consider coarsened exact matching as an alternative to propensity score matching and evaluate which one to use based on if one yields better balanced covariates post matching.

Comparison Group Limitations: The evaluation will employ a comparison strategy to study delivery system transformation of CMHC programs to CCBHCs. However, as the CCBHC expansion nears completion (expected in Demonstration year three) the likelihood of a

balanced comparison sample decreases over time. The design will employ logistic regression techniques in the event that a balanced matching group cannot be found.

Medicaid Enrollment/Disenrollment: Medicaid enrollment changes on an annual basis related to eligibility. For example, someone may be attributed to a study cohort in year one, disenroll in year two and reenroll in year three. The design will examine trends using an interrupted time series to mitigate this limitation.

E. SPECIAL METHODOLOGICAL CONSIDERATIONS

SUD and SMI/SED IMD treatment facilities are existing statewide providers that have been delivering care to Medicaid enrollees prior to the implementation of the Demonstration. The Demonstration allows the State to continue services that have been in place albeit with a new funding partner. Independent variables expected to result in change throughout the Demonstration are based on delivery system enhancements and quality improvement strategies and not new IMD expenditure authorities.

ATTACHMENTS

1. Independent Evaluator

The OHCA procures evaluation services through a qualification RFP process, in which potential contractors furnish information on their qualifications, along with references through which the OHCA can verify past performance. The OHCA has signed a task order with one of these contractors, The Pacific Health Policy Group (PHPG), to perform the independent evaluation.

The OHCA selected PHPG because the firm has performed multiple independent evaluations of SoonerCare Choice program components over the past decade, including the first and second generation SoonerCare HMP and the Health Access Networks. PHPG's evaluations included the use of comparison groups where applicable, consistent with the methodological considerations and guidance outlined by CMS.

PHPG also serves as the OHCA's contractor for the calculation of core measures for reporting to CMS. The firm, therefore, is knowledgeable about the OHCA MMIS and the process for generating HEDIS rates using OHCA administrative data. PHPG assurances including "No Conflict of Interest" are on file with the OHCA.

2. Evaluation Budget

Assuming no Demonstration amendments or changes to the Evaluation Design, independent evaluator costs are expected to be $598,390 over the project period 2021-2027. The estimated budget amount will cover independent evaluation expenses, including salary, fringe, administrative costs, other direct costs such as travel for data collection, conference calls, etc., as well as all costs related to data collection, validation, analysis, and report development.

OHCA also will incur costs for State staff to support the independent evaluator efficiently and effectively. The State data, analytic, and program staff will have to undertake data gathering, prepping, and submitting information to the evaluator in line with the evaluation goals and objectives. State staff will provide technical assistance and share their in-depth knowledge of existing State programs; State populations; Medicaid operations; and will leverage existing relationships with partner organizations, as needed.

The evaluation budget may be modified to address contract deliverables and analytical needs and if the terms of the current Demonstration agreement are amended during the project period. The OHCA will report on progress and any known challenges to the evaluation budget, timelines, and implementation in its quarterly and annual reports to CMS.

Exhibit A2-1 offers an overview of external evaluator costs by evaluation activity and Exhibit A2-2 provides total costs including State staff and administrative expenses.

Exhibit A2-1. Independent Evaluator Budget

Project Deliverable	CY2021	CY2022	CY2023	CY2024	CY2025	CY2026	CY2027	Total
Evaluation Design and Approval								
Develop Evaluation Design	$45,000							$45,000
Review CMS feedback and collaborate on revisions	$7,580							$7,580
Evaluation Implementation								
Define data extraction specifications and timelines for each data source	$15,000							$15,000
Clean and validate data received	$49,375	$49,375	$49,375	$49,375	$49,375	$49,375		$296,250
Analyze data		$20,000	$20,000	$20,000	$20,000	$20,000		$100,000
CMS Reporting								
Draft Annual Monitoring Report summary on progress		$10,000	$10,000	$10,000	$10,000			$40,000
Submit Draft Interim Evaluation Report to CMS				$33,000				$33,000
Submit Final Interim Evaluation Report to CMS					$7,580			$7,580
Submit Draft Summative Evaluation Report to CMS						$46,400		$46,400
Submit Final Summative Evaluation Report to CMS							$7,580	$7,580
Annual Total	$116,955	$79,375	$79,375	$112,375	$86,955	$115,775	$7,580	
Grand Total								$598,390

Exhibit A2-2. Total IMD Evaluation Budget

Project Expense	CY2021	CY2022	CY2023	CY2024	CY2025	CY2026	CY2027	Total
Independent Evaluator	$116,955.00	$79,375.00	$79,375.00	$112,375.00	$86,955.00	$115,775.00	$7,580.00	$598,390.00
OHCA Admin	$203,950.56	$203,950.56	$203,950.56	$203,950.56	$203,950.56	$203,950.56	$203,950.56	$1,427,653.92
DMH Admin	$112,222.68	$112,222.68	$112,222.68	$112,222.68	$112,222.68	$112,222.68	$112,222.68	$785,558.76
Grand Total	$433,128.24	$395,548.24	$395,548.24	$428,548.24	$403,128.24	$431,948.24	$323,753.24	$2,811,602.68

3. Timeline and Major Milestones

MILESTONE	CY2021 (DY 1)				CY2022 (DY 2)				CY2023 (DY 3)				CY2024 (DY 4)				CY2025 (DY 5)				CY2026				CY2027			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Evaluation Design and Approval																												
Develop Evaluation Design																												
Submit draft Evaluation Design to CMS																												
Review CMS feedback and collaborate on revisions																												
Submit revised final Evaluation Design to CMS																												
Evaluation Implementation																												
Define data extraction specifications for each data source																												
Define data extraction timelines for each data source																												
Clean and validate data received																												
Analyze data																												
CMS Reporting																												
Draft Annual Monitoring Report summary on progress																												
Submit Draft Interim Report to CMS																												
Review CMS feedback and collaborate on revisions																												
Submit Final Interim Evaluation Report to CMS																												
Submit Draft Summative Report to CMS																												
Review CMS feedback and collaborate on revisions																												
Submit Final Summative Evaluation Report to CMS																												
Post Final Summative Evaluation Report																												