OKLAHOMA
Health Care Authority

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

MID-POINT ASSESSMENT OF PROGRESS

Prepared by the Pacific Health Policy Group for:
State of Oklahoma
Oklahoma Health Care Authority

Completed June 2023; Updated March 2024

INDEPENDENT MID-POINT ASSESSMENT OF PROGRESS

This Mid-Point Assessment Report presents findings from an independent review of the SoonerCare program's progress in meeting the goals and objectives outlined in the Implementation Plans and Monitoring Protocols for the Oklahoma Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder §1115(a) Demonstration (11-W-00363/6). The assessment was conducted by The Pacific Health Policy Group (PHPG).

PHPG is a national consulting firm with locations in the states of Arizona, California, Illinois, Oklahoma, and Vermont. PHPG specializes in the development and evaluation of programs to serve Medicaid beneficiaries with special health care needs.

PHPG wishes to acknowledge the cooperation of the Oklahoma Health Care Authority, the Oklahoma Department of Mental Health and Substance Abuse Services, and the Oklahoma Health Information Exchange Team in obtaining the necessary data for completion of the assessment and assisting PHPG in engaging other stakeholders. PHPG is solely responsible for the analysis and findings presented in this report.

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COMMONLY USED ABBREVIATIONS AND ACRONYMS

Abbreviation	Definition
ADT	Admission, Discharge, Transfer
AOD	Alcohol and Other Drug
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
BN	Budget Neutrality
CBSCC	Community Based Structured Crisis Center
CCARC	Comprehensive Community Addiction Recovery Center
CCBHC	Certified Community Behavioral Health Clinic
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DY	Demonstration Year
ED	Emergency Department
EHR/EMR	Electronic Health Record/Electronic Medical Record
FFP	Federal Financial Participation
FFS	Fee-for-Service
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIT	Health Information Technology
IET	Initiation and Engagement in Treatment
IMD	Institution for Mental Diseases
IP	Inpatient
LTC	Long Term Care
MAT	Medication Assisted Treatment
MCE	Managed Care Entity

Abbreviation	Definition
MMIS	Medicaid Management Information System
MOUD	Medication for Opioid Use Disorder
MP	Monitoring Protocol
MPI	Master Patient (or Person) Index
NCQA	National Committee for Quality Assurance
ODMHSAS	Oklahoma Department of Mental Health and Substance Abuse Services
OHCA	Oklahoma Health Care Authority
OTP	Opioid Treatment Program
OHS	Oklahoma Human Services
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
PHE	Public Health Emergency
PHPG	Pacific Health Policy Group
PMPM	Per Member Per Month
QRTP	Qualified Residential Treatment Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SFY	State Fiscal Year
STC	Special Terms and Conditions
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SQR	Service Quality Review
SUD	Substance Use Disorder

A. EXECUTIVE SUMMARY

The Oklahoma Institutions for Mental Diseases (IMD) Waiver for Serious Mental Illness and Substance Use Disorder Section 1115(a) Demonstration was approved by the Centers for Medicare and Medicaid Services (CMS) on December 22, 2020, effective on that same date. 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.

This Mid-Point Assessment (MPA) examines the progress of planned enhancements expected as part of the CMS approved Implementation Plan, as well as the State's performance per CMS-defined metrics, as outlined in its SUD and SMI Monitoring Protocols. The Pacific Health Policy Group (PHPG) assessed progress in each Implementation Plan area by evaluating Demonstration activities to-date and their alignment with the approved plan and timeline.

The MPA was originally completed in June of 2023. At that time, results related to the SMI and SUD monitoring protocol metrics were considered preliminary. CMS and the State were involved in discussions regarding the technical specifications, target population and a revised reporting schedule for final metric results. In addition, annual results were produced and reviewed for the first year of the Demonstration. Demonstration Year (DY) 2 results had not yet been submitted by the OHCA to CMS. This revised MPA includes updated performance results and assessment scores for the first 2.5 years of the Demonstration.

PHPG reviewed quarterly and annual reports to CMS for analysis of policy issues and progress across all Implementation Plan activities. PHPG met with stakeholders (internal and external) to discuss the Mid-Point Assessment activities and the State's progress to date.

PHPG also performed the following assessment activities to identify trends in performance, evaluate policy and operational alignment with CMS requirements, and identify successes and potential barriers to progress:

- Analysis of treatment program rules, Medicaid State Plan changes, Certificate of Need contract, and program requirements;
- Review of:
    - SUD provider letters and communications regarding accreditation and MAT requirements,
    - Patient assessment and placement tools, and provider training presentations,
    - SUD provider oversight rules and OHCA audit tools,
    - QRTP contract requirements, oversight rules and OHCA audit activities,
    - Certified Community Behavioral Health Clinic Designations, and
    - OHCA SMI/SED treatment provider availability assessments; and

- Discussions and written feedback with State staff and stakeholders, including Medicaid, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), and health information technology staff.

Overall, the assessment found that the State is meeting the goals and objectives of the Demonstration and making progress in all areas of the SUD and SMI Implementation Plans that are on-going. For both SUD and SMI/SED populations, the average length of stay in an IMD was less than the 30-day threshold set by CMS.

Relative to the SUD and SMI Implementation Plans, proposed activities have been completed within the timelines approved by CMS. One activity, the expansion of psychiatric bed tracking to the private provider system, was delayed due to staffing issues arising from the novel coronavirus Public Health Emergency (PHE).

Due to the timing of the MPA (2.5 years), annual metrics yielded only two observation points, both of which were during the PHE. Annual results were also affected by increased enrollment as a result of the State's Medicaid expansion (effective July 1, 2021), and changes in measure specifications in 2022.

Nine of the ten milestone/topic areas were assessed as low risk. SMI/SED Topic 4 was assessed as medium risk due to the lack of demonstrated progress in the associated performance metrics. However, due to the impact of the PHE on service utilization and availability, consistency in performance could be considered a positive outcome. Where performance may show a slight decline, monitoring and additional assessment may be warranted as more data points are available.

A summary of evaluation findings is provided for SUD in Exhibit A-1 on the following page and SMI/SED-related activities in Exhibit A-2 on the second following page. The exhibits present demonstration milestones and denote PHPG's assessment of the level of risk of not meeting the milestones, along with key relevant considerations.

Exhibit A-1. Overview of SUD Mid-Point Assessment Findings

SUD Mid-Point Assessment Overview		
CMS Milestone	**Assessment of Risk**	**Key Considerations**
Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs	Low	New levels of care were added to the State Plan. Requirements and service expectations are aligned with the ASAM levels of care for SUD treatment. Stakeholders had no concerns regarding the ASAM levels of care, although it was noted that transportation to/from SUD treatment services and between levels of care could be challenging in some regions. The majority of metrics are moving in the desired direction.
Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria	Low	Online tools support the ASAM level of care determinations and can also be accessed by clinicians who use the Addiction Severity Index. The online tool allows for streamlined prior authorization process based on the results of the assessment. The average length of stay (ALOS) for SUD treatment in an IMD was under the CMS requirement of 30 days or less; the ALOS in 2021 was 25 days in 2021 and the ALOS in 2022 was 28 days.
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Low	Accreditation and certificate of need requirements were added to the administrative rules for residential facilities. The OHCA implemented new compliance tools and oversight processes for all facilities.
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	Low	Services added to the State Plan support access to care across the continuum, including for Opioid Treatment Programs and Medications for OUD. Stakeholders noted that in some regions of the State availability of withdrawal management services was challenging. Both metrics identified as critical by CMS are moving in the desired direction.
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Low	This milestone was met upon approval of the Demonstration. Three of the metrics identified as critical are stable or moving in the desired direction. One metric has not been reported for 2022.
Milestone #6: Improved Care Coordination and Transitions between Levels of Care	Low	This milestone was deemed met by CMS upon Demonstration approval. Significant changes were made to measure specifications in 2022. Although many results are moving in the desired direction, results are not comparable across years.
SUD IT Plan	Low	The State has enhanced the ease of use for providers and PDMP through integration with the HIE.
Budget Neutrality	Low	The State is within budget neutrality (BN) limits for the Demonstration

Exhibit A-2: SMI Mid-Point Assessment Findings

SMI Mid-Point Assessment Overview		
CMS Topic Area	**Assessment of Risk**	**Key Considerations**
Topic #1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	Low	QRTP rules were developed and implemented. The child and adolescent needs and strengths assessment is required for all residential placement decisions.
Topic #2: Improving Care Coordination and Transitions to Community Based Care	Low	Requirements 2b-d were met upon approval of the Demonstration. The State's plan to expand CCBHC coverage statewide by DY3 was completed ahead of schedule.
Topic #3: Increasing Access to Continuum of Care, including Crisis Stabilization Services	Low	Requirements 3d-e were met upon approval of the Demonstration. Bed-tracking is in place for state-operated facilities. Tracking availability in the private provider system was delayed; however, the State is currently engaged in discussion with private providers as to how to meet this requirement. The average length of stay for all IMDs and populations is 9.43 days.
Topic #4: Earlier Identification, Engagement in Treatment, and Increased Integration	Medium	Requirements 4a-b and d were met upon approval of the Demonstration. The planned expansion of CCBHC coverage statewide by DY3 was completed ahead of schedule. Of the eight metrics examined, performance regarding metabolic screening for children and adults showed no change and access to ambulatory/preventive care declined. More individuals were identified with SMI/SED and follow-up care for adults newly prescribed antipsychotics improved slightly.
SMI Finance Plan	Low	CCBHC services have been expanded as planned. The State is exploring the expansion of non-residential crisis services in DY3.
SMI IT Plan	Low	The State is actively engaged with IT staff, providers and the HIE team to ensure that enhancements for SMI IT, EHR functionality and interoperability within the HIE environment are addressed, as appropriate.
Budget Neutrality	Low	The State is within budget BN limits for the Demonstration.

Recommendations

Stakeholders agreed that SUD and SMI/SED treatment services were available at all levels of care. However, several noted that access to withdrawal management services and transportation to and from SUD treatment services (at all levels of care) was challenging in some regions. Further discussion with providers and members may be warranted to understand the scope of transportation challenges statewide. Medicaid enhancements such as the reimbursement of specialized providers or use of peer recovery specialists as drivers could be considered. Along these lines, a focused examination of geographic access patterns for SUD withdrawal management services may also be warranted.

The State's performance on critical metrics, many of which yielded only two data points collected during the PHE, should be interpreted with caution. In many cases performance remained stable across years. Per CMS guidance, SMI/SED Topic 4 scored as medium risk due to the lack of demonstrated progress in critical metric performance. Recommendations for continued monitoring for Topic 4 are included in Section H.

As the State transitions to the use of private Managed Care Entities, it will be important to monitor network adequacy for SUD and SMI/SED services, including transportation services to/from SUD treatment. Strategies to address underserved areas could be explored as part of the annual Managed Care quality framework. Continued monitoring of SUD and SMI/SED annual metrics, where performance is stable or declining, should be considered as more post-PHE data becomes available.

B. IMD DEMONSTRATION BACKGROUND AND POLICY GOALS

The Oklahoma Institutions for Mental Diseases (IMD) Waiver for Serious Mental Illness and Substance Use Disorder Section 1115(a) Demonstration was approved by the Centers for Medicare and Medicaid Services (CMS) on December 22, 2020, effective that same date. 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 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 Oklahoma Health Care Authority (OHCA) is Oklahoma's Single-State Agency for Medicaid. Medicaid is the largest health care payer in the State. The OHCA and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) work collaboratively to provide a full array of behavioral health services to Oklahomans with behavioral health needs.

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.

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.

COVERAGE OF TREATMENT FOR SUBSTANCE USE DISORDER

The SUD treatment continuum of care is based on the American Society of Addiction Medicine (ASAM) criteria and other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. 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.

COVERAGE OF TREATMENT FOR SMI AND EMOTIONAL DISTURBANCE

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.

BEHAVIORAL HEALTH DELIVERY SYSTEM

Behavioral health services 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 nine State-certified Comprehensive Community Addiction Recovery Centers (CCARCs).

ODMHSAS supports 13 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). Ten of these CBSCCs also operate behavioral health urgent recovery clinics (URCs) that provide 23-hour respite and observation to help prevent psychiatric emergencies and admission to inpatient or crisis beds, with another 11 stand-alone URCs operating across the State. These facilities also address substance abuse emergencies.

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. Community-based programs also provide assistance with such services as housing, employment, peer advocacy, and drop-in centers.

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). 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.

Oklahoma adopted the CCBHC model for statewide expansion; at the time of its request to CMS for the IMD Demonstration six of the 13 CMHCs in Oklahoma achieved CCBHC designation. Under the Demonstration's SMI/SED Implementation Plan, the remaining CMHCs are expected to achieve CCBHC designation by Demonstration Year three.

RAISE NAVIGATE PROGRAMS

In addition, there are two Recovery After an Initial Schizophrenia Episode (RAISE) NAVIGATE programs to assist individuals who are experiencing their first episode of psychosis, 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 PROGRAMS

Oklahoma also 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 CCBHCs 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 using 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 Comprehensive Community Addiction Recovery Center (CCARC) providing a full continuum of care, including intensive outpatient services.

Currently, nine CCARCs operate across 10 counties, with 21 site locations. Twenty-one opioid treatment program locations cover 13 counties in the State. (Oklahoma has 77 counties in total.)

QUALIFIED RESIDENTIAL TREATMENT PROGRAMS

The Oklahoma Human Services Department (OHS) 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 QRTP facilities that the State determines are IMDs.

POLICY GOALS

The Demonstration includes policy goals and activities unique to each of the target groups described in the STCs. Specific goals, implementation plan and milestone activities and relevant policies are described as a preface to each assessment; see Section D for SUD and Section E for SMI/SED policies and goals.

C. MID-POINT ASSESSMENT METHODOLOGY

The Pacific Health Policy Group (PHPG) was retained as the independent evaluator for the Demonstration and to conduct the SUD and SMI Mid-Point Assessment (MPA). PHPG also serves as the independent evaluator for Oklahoma's Section 1115a managed care Demonstration and as the independent evaluator of Section 1115 SMI/SUD Demonstrations in several other states (See Appendix 1).

The MPA was originally completed in June of 2023. At that time, results related to the SMI and SUD monitoring protocol metrics were considered preliminary. CMS and the State were involved in discussions regarding the technical specifications, target population, and a revised reporting schedule for final metric results. In addition, annual results were produced and reviewed for the first year of the Demonstration. Demonstration Year (DY) 2 results had not yet been submitted by the OHCA to CMS. This revised MPA includes updated performance results and assessment scores for DY1-DY3Q2.

In developing the SUD and SMI Mid-Point Assessment methodology, PHPG collaborated with the State, Medicaid stakeholders, and treatment providers as required in the Special Terms and Conditions (STC 36). Stakeholder information and input sessions were offered in the spring of 2023, as depicted in Exhibit C-1.

Exhibit C-1. Stakeholder Meetings (2023)

Date	Meeting
March 27	OHCA and ODMHSAS policy and operation team
April 19	SMI Provider Information and Feedback Session
April 26	Health Information Exchange, OHCA and ODMHSAS IT, Data and Operations team
April 27	SUD Provider Information and Feedback Session

PHPG offered meeting attendees the option to provide input during the session, as well as by email, phone, or through one-on-one meetings any time up to May 26, 2023.

PHPG reviewed quarterly and annual reports to CMS for analysis of policy issues and progress across all Implementation Plan activities. PHPG also performed the following assessment activities to identify trends in performance, evaluate policy and operational alignment with CMS requirements, and identify successes and potential barriers to progress:

- Analysis of treatment program rules, Medicaid State Plan changes, Certificate of Need contract, and program requirements;
- Review of:
    - SUD provider communications regarding accreditation and MAT requirements,
    - Patient assessment/placement tools and related provider training presentations,

  - SUD provider oversight rules and OHCA audit tools,
  - QRTP contract requirements, oversight rules and OHCA audit activities,
  - Certified Community Behavioral Health Clinic Designations, and
  - OHCA SMI/SED treatment provider availability assessments;
- Discussions and written feedback with State staff and stakeholders, including Medicaid, ODMHSAS, and health information technology staff; and
- Analysis of CMS-required Monitoring Protocol metrics and quarterly and annual monitoring reports.

CMS-REQUIRED MONITORING METRICS

PHPG examined results of the CMS-required metrics for January 1, 2021 through June 30, 2023. In assessing progress, special consideration was given to metrics identified as "critical" by CMS in its Mid-Point Assessment technical assistance document (v.1) outlined in Exhibit C-2 and C-3.

Exhibit C-2 SUD Metrics for Assessing Milestone Progress at the Mid-Point

Critical SUD Metrics
Milestone 1. Access to critical levels of care for OUD and other SUDs • #7 Early Intervention • #8 Outpatient Services • #9 Intensive Outpatient and Partial Hospitalization Services • #10 Residential and Inpatient Services • #11 Withdrawal Management • #12 Medication-Assisted Treatment • #22 Continuity of Pharmacotherapy for Opioid Use Disorder
Milestone 2. Use of evidence-based, SUD-specific patient placement criteria • #5 Medicaid Beneficiaries Treated in an IMD for SUD • #36 Average Length of Stay in IMDs
Milestone 4. Sufficient provider capacity at each level of care • #13 Provider Availability • #14 Provider Availability – MAT
Milestone 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse • #18 Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940) • #21 Concurrent Use of Opioids and Benzodiazepines (NQF #3175) • #23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries • #27 Overdose death rate
Milestone 6. Improved care coordination and transitions between levels of care • #15 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004) • #17(1) Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605) • #17(2) Follow-up after Emergency Department Visit for Mental Illness (NQF #2605) • #25 Readmissions Among Beneficiaries with SUD

SUD Metric #15 (Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, NQF #0004) had significant changes in the technical specifications between 2021 and 2022. Rates are presented in the report; however, they are not comparable across the years. SUD Metric #17 also underwent technical changes during that same period. Section D presents detailed information for each milestone.

Exhibit C-3 SMI/SED Metrics for Assessing Milestone Progress at the Mid-Point

Critical SMI/SED Metrics
Milestone 1. Ensuring quality of care in psychiatric hospitals and residential settings • #2 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
Milestone 2. Improving care coordination and transitions to community-based care • #4 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) • #7 Follow-up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH) • #8 Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) • #9 Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD) • #10 Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)
Milestone 3. Increasing access to continuum of care including crisis stabilization services • #19 Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs)
Milestone 4. Earlier identification and engagement in treatment including through increased integration • #26 Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SMI • #29 Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) • #30 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

SUD Metrics #9 and #10 (Follow-up after an ED visit for AOD, FUA-AD; and Mental Illness, FUM-AD) underwent technical revisions between 2021 and 2022. Rates are presented in the report; however, they are not comparable across the years. Section E presents detailed information for each milestone.

PERFORMANCE ASSESSMENT

This Mid-Point Assessment examines the progress of planned enhancements expected as part of the CMS-approved Implementation Plan, as well as the State's performance per CMS-defined metrics, as outlined in its SUD and SMI Monitoring Protocols.

PHPG assessed progress in each Implementation Plan area by evaluating Demonstration activities performed to-date and their alignment with the approved plan and timeline.

PHPG assessed overall progress in accordance with CMS guidance and evaluated the State's performance on those measures identified by CMS as "critical." To assess progress between

baseline and midpoint, metrics submitted as monthly counts were converted to an average monthly count per year. Results for annual metrics are based on only two data points and should be interpreted with caution.

Absolute and percent changes from baseline were calculated for each metric designated by CMS as critical. The direction of the change was assessed against the State's desired goal. When the percent change was less than one percent, the direction of the metric performance was scored as consistent with the prior year.

The assessment of the availability of treatment services is addressed in Milestone 4 for SUD services and Topic 3 for SMI/SED treatment services.

The evaluation team defined criteria for risk assessment scores relevant to the information collected as part of the MPA, as follows:

> ***Low Risk*** - For all or nearly all of the critical metrics (i.e., 75 percent or more), the State is moving in the direction expected according to its annual goals and overall Demonstration targets. The State has fully completed most/all associated action items as scheduled to date. Few stakeholders identified risks related to meeting the milestone, and the risks identified can easily be addressed within the planned timeframe.
>
> ***Medium Risk*** - The State is moving in the expected direction relative to its annual goals and overall Demonstration targets for some (i.e., between 25 and 75 percent) of the critical metrics and additional monitoring metrics that the state reported for additional context. The State fully completed some of the associated action items as scheduled. Multiple stakeholders identified risks that could cause challenges in meeting the milestone.
>
> ***High Risk*** - The State is moving in the expected direction relative to its annual goals and overall demonstration targets for few (i.e., under 25 percent) of the critical metrics and additional monitoring metrics that the State reported for additional context. The State fully completed few or none of the associated action items as scheduled. Stakeholders identified significant risks to meeting the milestone.

Where applicable (i.e., medium, and high-risk areas) PHPG examined factors that may have had a negative impact on performance and developed recommendations for performance improvement.

D. SUD MILESTONES AND MID-POINT ASSESSMENT FINDINGS

The SUD Implementation Plan was approved concurrently with the Demonstration's start date. Two milestones were deemed to be met by CMS such that no Demonstration activities were expected as part of the Implementation Plan. These were:

- Milestone 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- Milestone 6. Improved care coordination and transitions between levels of care.

There were no modifications to the CMS protocol specifications for the SUD metrics.

The SUD Implementation Plan included a range of activities, such as adding coverage to the State Plan, augmenting current compliance and auditing activities, offering technical assistance and provider education, and implementing web enabled ASAM assessment tools. The expected Implementation Plan activity for each milestone, including the SUD-Health Information Technology (HI)T plan and the data sources used in completing the Mid-Point Assessment are summarized in Exhibit D-1.

Exhibit D-1. Overview of SUD Implementation Plan and Milestones

CMS Milestone	Implementation Activity	Data Source*
1. Access to critical levels of care for OUD and other SUDs	• Add coverage to the State Plan effective 10/1/22 for: ASAM Level 2.5 (Partial Hospitalization); Methadone for MAT; ASAM Level 3.1, 3.3, 3.5 and 3.7 (Intensive Residential); Adolescent residential treatment • Add coverage to the State Plan effective 10/1/22 for: ASAM Level 3.7 (Medically managed withdrawal services) • Support Opioid Treatment Programs (OTPs) to enroll as Medicaid Providers • Add IMD settings (including ASAM Level 4) to array of services (Demonstration Approval)	• Required CMS metrics • Rule and policy review • State Plan review
2. Widespread use of evidence-based, SUD-specific patient placement criteria	• Add use of Addiction Severity Index (ASI)/ASAM assessment to all levels of care (currently used for residential) by 1/1/21 • Adopt ODMHSAS residential prior authorization (PA) process in Medicaid by 11/1/21 • Develop provider education materials by 1/1/21 • Streamline PA process and integrate ASAM LOC tool by 1/1/21	• Required CMS metrics • Rule and policy review • ASAM Placement Tool • Training and educational materials for SUD treatment providers

CMS Milestone	Implementation Activity	Data Source*
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications	• Require national accreditation for residential facilities; develop timeline by 10/1/20 • Develop certificate-of-need (CON) process for new residential programs by 1/1/21 • Adopt current compliance review processes to SUD residential programs by 10/1/21 • Amend current OHCA rules to require access to MAT for members in residential treatment by 1/1/21	• Rule and policy review • State Plan review • Provider letters • Accreditation requirements
4. Sufficient provider capacity at each level of care	• Education and engagement for new providers • Add State Plan services listed in Milestone #1	• Rule and policy review • State Plan review • Required CMS metrics
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	• Met on CMS approval	• Rule and policy review • Required CMS metrics
6. Improved care coordination and transitions between levels of care	• Met on CMS approval	• Rule and policy review • Required CMS metrics
SUD IT Plan	• Health Information Exchange (HIE) procurement to improve interoperability between prescription drug monitoring program (PDMP) and electronic health records (EHRs) and ease of use	• State staff interview
Budget Neutrality (BN)	• Maintain expenditures at or below PMPM limits as defined in STCs	• BN amendment and workbook

* Quarterly and annual reports to CMS were reviewed for all Milestones

The remainder of Section D presents findings for each milestone, including Monitoring Protocol metrics and the State's progress in meeting its action steps and timelines outlined in the SUD Implementation Plan.

MILESTONE 1 – ACCESS TO CRITICAL LEVELS OF CARE

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

- Outpatient services;
- Intensive outpatient services (IOP);
- Medication assisted treatment (medications 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.

As outlined in its Implementation Plan, the OHCA added coverage for SUD treatment services under the State Plan. The State Plan amendments include detailed definitions and service expectations. SUD treatment services added to the State Plan are summarized in Exhibit D-2.

Exhibit D-2. State Plan Amendments for SUD Treatment

Residential Service	Target Group	Effective Date
Level 3.1 - Clinically Managed Low Intensity	Adolescents & Adults	Oct 10, 2020
Level 3.3 - Clinically Managed Population Specific High Intensity	Adults	
Level 3.5 - Clinically Managed Medium Intensity	Adolescents	
Level 3.5 - Clinically Managed High Intensity	Adults	
Level 3.7 - Medically Monitored High Intensity Inpatient	Adolescents	
Level 3.7 - Withdrawal Management Inpatient	Adults	
Level 3.1; 3.5 or 3.5 Intensive - Residential Family-Based Treatment Programs	Individuals with Dependent Children and Pregnant Women	
Partial Hospitalization	Adults	September 1, 2022
Medication Assisted Treatment in Opioid Treatment Programs	Adolescents & Adults	October 1, 2020

Combined with the Demonstration authority for IMD services, this coverage reflects a full continuum of services and alignment with ASAM levels of care and service requirements at each level. The OHCA and ODMHSAS provided support to Opioid Treatment Programs to enroll as Medicaid Providers and issued guidance on service requirements and billing, as called for in

the Implementation Plan. A summary of progress related to Milestone 1 activities is provided in Exhibit D3.

Exhibit D3. Milestone 1 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Coverage of Outpatient	Existing State Plan	Yes
Coverage of IOP	State Plan Amendment	Yes
Coverage of MAT	State Plan Amendment	Yes
	Support to Opioid Treatment Providers to enroll in Medicaid	Yes
Coverage of Intensive Levels of Care in residential and inpatient settings	State Plan Amendment	Yes
	Demonstration Approval	Yes
Coverage of Medically supervised withdrawal management	State Plan Amendment	Yes
	Demonstration Approval	Yes

MILESTONE 1 PERFORMANCE METRICS

The following performance metrics, as defined in the SUD Monitoring Protocol, are considered critical to Milestone 1 and were examined related to access to SUD treatment:

#7 Early Intervention: Number of beneficiaries who used early intervention services (such as procedure codes associated with screening, brief intervention and referral to treatment (SBIRT)) during the measurement period.

#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.

#9 Intensive Outpatient and Partial Hospitalization Services: Number of unique 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.

#10 Residential and Inpatient Services: Number of beneficiaries who used residential and/or inpatient services for SUD during the measurement period.

#11 Withdrawal Management: Number of beneficiaries who used withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.

#12 Medication Assisted Treatment (MAT): Number of beneficiaries who had a claim for MAT for SUD during the measurement period.

#22 Continuity of Pharmacotherapy for Opioid Use Disorder: Percentage of adults in the denominator with pharmacotherapy for OUD who had at least 180 days of continuous treatment.

In addition, PHPG reviewed the following performance measures associated with Milestone #1 and the CMS topic area "Assessment of Need" to augment the assessment and provide context to the findings:

#3 Medicaid Beneficiaries with SUD Diagnosis (monthly): Number of beneficiaries who received 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.

#4 Medicaid Beneficiaries with SUD Diagnosis (annually): Number of beneficiaries annually who received 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.

#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.

To assess progress across years, metrics submitted as monthly counts were converted to an average monthly count of beneficiaries by year. Exhibits D-4 and D-5, below and on the following page, provide the results progress-to-date status for each Milestone 1 measure.

Exhibit D-4. SUD Milestone 1 Critical Metric Results

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
7	Early Intervention	1.75	6.83	5.08	290.48%	Increase	Increase	Yes
8	Outpatient Services	3,626.75	6,025.67	2,399.92	66.19%	Increase	Increase	Yes
9	Intensive Outpatient and Partial Hospitalization Services	47.67	80.00	32.33	67.83%	Increase	Increase	Yes
10	Residential and Inpatient Services	491.33	1,017.83	526.5	107.16%	Increase	Increase	Yes
11	Withdrawal Management	75.42	248.17	172.75	229.06%	Increase	Increase	Yes
12	Medication Assisted Treatment (MAT)	2,599.42	5,884.67	3,285.25	126.38%	Increase	Increase	Yes
22	Continuity of Pharmacotherapy for Opioid Use Disorder	39.84%	37.30%	-2.54%	-6.38%	Decrease	Increase	No

Exhibit D-5. Other SUD Metric Results

Metric		Results					State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
3	Medicaid Beneficiaries with SUD Diagnosis (average per month)	6,660.58	12,086.33	5,425.75	81.46%	Increase	Increase	Yes
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	27,454	38,677	11,223	40.88%	Increase	Increase	Yes
6	Medicaid Beneficiaries with any SUD Treatment (average per month)	6,942.58	12,485.33	5,542.75	79.84%	Increase	Increase	Yes

During the stakeholder outreach, SUD treatment providers confirmed that services are available across the ASAM continuum of care. Providers cited a lack of transportation options to and from addiction treatment services and for members transitioning between facilities as a barrier to access.

Driver shortages and prior authorization requirements for Medicaid transportation services were cited as challenges. SUD treatment providers reported using local taxi and ride share services to address transportation needs on a case-by-case basis.

MILESTONE 1 OVERALL ASSESSMENT

The OHCA has completed all expected Implementation Plan activities and met all timelines. The number of people served is steadily increasing over time. The average number of members per month who received SUD treatment services at all levels of care has increased.

SUD Milestone 1 Assessment			
Assessment Area	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	8/8	All activities expected under the SUD Implementation Plan were completed.	Low Risk 94% progress in actions and metrics (17/18)
Critical Metrics	6/7	The majority of the metrics are moving in the desired direction. One metric (Continuity of Pharmacotherapy) declined, change over time should be monitored as more data points are available.	
Other Metrics	3/3	The number of beneficiaries identified and receiving treatment has increased.	
Stakeholder Input	Few Concerns	There were no concerns related to ASAM levels of care. However, discussion on how to improve the availability of transportation to/from SUD treatment services may be warranted.	

MILESTONE 2 – USE OF EVIDENCE-BASED SUD-SPECIFIC PATIENT PLACEMENT CRITERIA

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.

PATIENT PLACEMENT CRITERIA

The OHCA has expanded the use of the Addiction Severity Index and the ASAM placement assessment to all SUD providers. These tools support the goal of matching the client to the least restrictive and most clinically appropriate level of care and align with Milestone 2 requirements for having evidence-based, SUD-specific patient placement criteria.

A link for the ASAM assessment tool was added to the ODMHSAS online client information system used by providers (known as PICIS). Outpatient SUD providers complete an ASAM assessment prior to referring clients to a higher level of care. Through PICIS, all providers can access necessary ASAM placement information for clients they are serving.

Residential providers may also complete the tool for clients who self-refer or walk-in, in conjunction with an ASI completed by a licensed behavioral health professional. If an ASI assessment has been performed and composite scores are available, the provider can minimize duplication by completing an abbreviated ASAM placement tool on the portal using the ASI composite scores.

Once the online ASAM placement is completed, the ASAM level of care score is automatically calculated. If residential treatment is appropriate, the system generates a bed availability list that allows the outpatient staff to locate a residential treatment facility at the appropriate ASAM level. Providers were required to use the web-enabled tools as of January 18, 2021.

UTILIZATION MANAGEMENT REQUIREMENTS

The web enabled ASAM placement tool also allows for a prior authorization for up to 30 days of treatment. The 30-day authorization is initiated based on the date of admission to the treatment program.

Residential care providers may request extensions of this initial prior authorization in 15-day increments by completing the ASAM placement tool for each extension period. The OHCA and ODMHSAS monitor utilization and requests for continued stay. The utilization management process allows for an objective and evidence-based assessment of need.

The OHCA and ODMHSAS have developed provider training materials and offer on-going technical assistance to providers in the use of the ASAM tools and on best practices in addiction treatment. The State also hosts a monthly SUD provider meeting to offer training and technical assistance, and to discuss best practices, systemic challenges, and quality improvement strategies.

A summary of progress related to Milestone 2 activities is provided in Exhibit D6.

Exhibit D6. Milestone 2 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Assessment of treatment needs with multidimensional evidence-based assessment tool	Development of tool for decision making at all levels of care	Yes
	Update prior authorization (PA) manual requirements	Yes
UM approach that ensures beneficiaries have access at the appropriate level of care	Update State rules	Yes
	Provider education and training	Yes
	Update PA manual	Yes
UM approach that ensures interventions are appropriate for the diagnosis and level of care	Streamline PA process and integrate ASAM level of care tool	Yes
	Update PA manual	Yes
	Develop additional PA oversight process	Yes

MILESTONE 2 PERFORMANCE METRICS

Exhibit D-7 on the following page provides the results for each Milestone 2 measure, along with the status of progress to date.

Exhibit D-7. Milestone 2 Critical Metric Results

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
5	Medicaid Beneficiaries Treated in an IMD for SUD	376	665	289	76.86%	Increase	Increase	Yes
36	Average Length of Stay in IMDs	25.49	28.39	2.90	11.36%	Increase	Stabilize	No

MILESTONE 2 ASSESSMENT

The OHCA has completed all expected Implementation Plan activities and met all timelines. The State maintained an average length of stay of 30 days or less in each year, with 25 days in 2021 and 28 days in 2022.

SUD Milestone 2 Assessment			
Assessment	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	8/8	All activities expected under the SUD Implementation Plan were completed.	Low Risk 90% progress in actions and metrics (9/10)
Critical Metrics	1/2	More members are receiving treatment services, including from IMD providers. While the average length of stay in IMDs increased between baseline and midpoint, the average length of stay was below 30 days each year.	
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

MILESTONE 3 – USE OF NATIONALLY RECOGNIZED SUD-SPECIFIC PROGRAM STANDARDS

Through the Section 1115 SUD Demonstration initiative, states receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid beneficiaries residing in residential treatment facilities that qualify as IMDs. Milestone 3 requires that the following residential treatment criteria be 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.

RESIDENTIAL TREATMENT PROVIDER QUALIFICATIONS

The OHCA revised its administrative rules for coverage of residential SUD treatment to align with ASAM level of care service expectations and CMS residential treatment facility requirements under the Demonstration. The revisions were effective September 1, 2021.

All residential providers are required to obtain national accreditation from either: the Joint Commission, the Commission on the Accreditation of Rehabilitative Facilities, or the Council on Accreditation. Existing providers had until January 1, 2022, to obtain accreditation.

The OHCA also established a CON process for the certification of new residential treatment providers. To-date, no new providers have applied for certification.

COMPLIANCE REVIEWS

Effective September 1, 2021, the State's service quality review process (SQR) was adopted for all residential SUD treatment facilities. The SQR is an annual review that includes an assessment of facility policy and operations (clinical and administrative), staffing type, levels and credentials, medical records, and physical plant characteristics for alignment with State and federal requirements. Deficiencies may result in partial or full recoupment of paid claims and/or suspension from Medicaid-enrollment until corrective actions are accepted by the OHCA.

The OHCA SQR review team utilizes a review tool that is customized for each ASAM level of care and includes an assessment of the facility's:

- Informed consent processes
- Admission criteria
- Clinical records (e.g., client specific assessments and clinical evaluations, service plans and updates, transition/discharge assessments, discharge summaries)
- Provision of active treatment (e.g., dates and type of services, staff credentials and oversight of services provided)
- Alignment with ASAM service requirements for each population served (e.g., number and type of service hours)
- Use of restrain/seclusion in alignment with all State and federal rules

The OHCA to-date has completed educational reviews for 25 SUD residential treatment providers. It also has completed 19 formal annual reviews.

The educational review is conducted as an informal quality assessment for providers who have never before been through the process. Providers meet with the review team to better understand the Medicaid requirements and SQR process. The OHCA oversight team offers feedback on the requirements for each ASAM level of care offered by the treatment facility and areas for improvement are identified in advance of the formal annual review.

ACCESS TO MAT

The OHCA issued special provisions for all Medicaid enrolled Substance Use Disorder Residential Treatment Facilities requiring the provision of medication assisted OUD treatment either directly or through a formal relationship with a MAT treatment provider. These same requirements are incorporated into ODMHSAS rules and SUD provider agreements. A summary of progress related to Milestone 3 activities is provided in Exhibit D8.

Exhibit D8. Milestone 3 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Nationally recognized program standards for residential treatment providers (e.g., ASAM)	Add SUD Residential providers service requirements to the Medicaid Manual	Yes
	Develop timeline for requirement national accreditation for residential SUD programs	Yes
	Provider education	Yes
	Develop CON process for new residential programs	Yes
	Update State rules	Yes
Implement a process for compliance reviews for residential programs	Medicaid enrollment of new providers	Yes
	Conduct compliance reviews	Yes
Require residential programs to offer MAT onsite or facilitate access offsite	Amend State rules	Yes
	Modify provider contract requirements	Yes
	Provider education and timeline for compliance	Yes

MILESTONE 3 ASSESSMENT

The OHCA has completed all expected Implementation Plan activities and met all timelines. There are no CMS defined critical metrics for Milestone 3.

SUD Milestone 3 Assessment			
Assessment Area	**Completed or Progressing/Expected**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	10/10	All SUD Implementation plan activities were accomplished.	**Low Risk** **100% progress in actions (10/10)**
Critical Metrics	N/A	There are no critical metrics under this milestone.	
Stakeholder Input	No concerns	No concerns were raised during stakeholder sessions.	

MILESTONE 4 – SUFFICIENT PROVIDER CAPACITY AT CRITICAL LEVELS OF CARE

To meet Milestone 4, 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 the availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as the availability of MAT and medically supervised withdrawal management, throughout the State. This assessment should help to identify gaps in the availability of services for beneficiaries in the critical levels of care.

As part of its SUD Implementation Plan the OHCA expanded access to ASAM levels of care as reported under Milestone 1. In addition, residential treatment programs report capacity and waiting list information to the ODMHSAS daily through an online reporting system. During the stakeholder feedback session, SUD treatment providers noted that access to detox services can be challenging for certain regions of the State.

A summary of progress related to Milestone 4 activities is provided in Exhibit D9.

Exhibit D9. Milestone 4 Implementation Plan Progress

Milestone Requirements	Actions	Completed
Complete Assessment of Availability	Seek approval for Medicaid Demonstration to expand service continuum	Yes
	State Plan Amendment for ASAM level 2.5 partial hospitalization	Yes
	State Plan Amendment for ASAM residential levels 3.1, 3.3, 3.5 and 3.7	Yes
	Add Adolescent residential services to Medicaid array	Yes
	Education and engagement of new Medicaid Providers	Yes

ASSESSMENT OF STATE'S CAPACITY TO PROVIDE SUD SERVICES

State Capacity at Midpoint

The SUD treatment continuum of care is based on the American Society of Addiction Medicine (ASAM) criteria and other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. 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.

Oklahoma also 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 CCBHCs 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 using 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 Comprehensive Community Addiction Recovery Center (CCARC) providing a full continuum of care, including intensive outpatient services. Currently, nine CCARCs operate across 10 counties, with 21 site locations. Twenty-one opioid treatment program locations cover 13 counties in the State. (Oklahoma has 77 counties in total.)

Changes in State Capacity

The total number of SUD providers increased by 6.4 percent between the base period and midpoint. Although changes in staffing levels within CMHCs/CCBHCs would not be recognized as part of the SUD provider counts, CMHC/CCBHC utilization has increased significantly, providing additional evidence that SUD treatment capacity has increased. In addition, the number of providers offering Medication-Assisted Therapy (MAT) also increased by approximately 10 percent.

Identified Needs for Additional Capacity

While a need for additional SUD treatment capacity has not been identified, the State continues its monitoring of the delivery system and will assess/monitor the Managed Care Entities' SUD provider networks.

MILESTONE 4 PERFORMANCE METRICS

PHPG examined the following critical performance metrics, as defined in the SUD Monitoring Protocol, related to Milestone 4:

> ***#13 SUD provider availability***: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.

#14 SUD MAT provider availability: 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.

Exhibit D-10 offers an overview of the results for Milestone 4 metrics.

Exhibit D-10. Milestone 4 Critical Metric Results

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
13	SUD provider availability	854	909	55	6.44%	Increase	Increase	Yes
14	SUD provider availability - MAT	632	696	64	10.13%	Increase	Increase	Yes

MILESTONE 4 ASSESSMENT

The OHCA has completed all expected Implementation Plan activities and met all timelines. The number of Medicaid enrolled providers increased in DY2.

SUD Milestone 4 Assessment			
Assessment Type	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	5/5	All expected SUD Implementation Plan activities were completed.	Low Risk 100% progress in actions and metrics (8/8)
Assessment of State Capacity	1/1	No identified service needs	
Critical Metrics	2/2	The number of Medicaid enrolled SUD treatment providers increased in DY2.	
Stakeholder Input	Few Concerns	Stakeholders noted that some regions of the State experience challenge with access to SUD withdrawal management services. Further examination of geographic access patterns and identification of strategies to address underserved areas may be warranted.	

MILESTONE 5 – IMPLEMENTATION OF COMPREHENSIVE TREATMENT AND PREVENTION STRATEGIES

Milestone 5 requires states to implement opioid prescribing guidelines along with other interventions to prevent prescription drug misuse. This includes:

- Expanded coverage of, and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve the functionality of the Prescription Drug Monitoring Program (PDMP).

The OHCA and CMS agreed that Milestone 5 requirements relative to opioid prescribing and access to naloxone were met concurrent with the Demonstration's approval. The implementation of strategies to increase utilization and improve functionality of the PDMP was deferred until the State procured a vendor for its statewide HIE.

The implementation of the statewide HIE is in process. CMS has approved the Operational Advance Planning Document and sustainability plan. Specific steps to improve PDMP functionality are delineated in the SUD Health IT Plan, in Section F of this report.

A summary of progress related to Milestone 5 requirements is provided in Exhibit D11.

Exhibit D11. Milestone 5 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Implementation of opioid prescribing guidelines and other interventions to prevent prescription drug abuse	Existing prescribing guidelines and prior authorization procedures	Yes
	Existing provider education regarding pain management and prescribing	Yes
Expand coverage and access to Naloxone	Existing overdose education and naloxone distribution program	Yes
Implement strategies to increase utilization and improve functionality of the prescription drug monitoring program	Existing ad hoc PDMP advisory committee and procurement of HIE vendor	Yes

MILESTONE 5 MONITORING PROTOCOL METRICS

PHPG examined the following critical performance metrics, as defined in the SUD Monitoring Protocol, related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD:

> ***#18 Use of Opioids at High Dosage in Persons without Cancer***: Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.
>
> ***#21 Concurrent Use of Opioids and Benzodiazepines***: Percentage of beneficiaries with concurrent use of prescription opioids and benzodiazepines.
>
> ***#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.
>
> ***#27 Overdose Deaths (rate)***: Rate of overdose deaths during the measurement period per 1,000 adult Medicaid beneficiaries affected by the Demonstration.

DY2 results for Metric #27 were not available at the time of the MPA. Exhibit D-12 provides an overview of other critical metrics for Milestone 5.

Exhibit D-12. Milestone 5 Critical Metric Results

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
18	Use of Opioids at High Dosage in Persons Without Cancer	3.43%	2.65%	-0.78%	-22.64%	Decrease	Decrease	Yes
21	Concurrent Use of Opioids and Benzodiazepines	9.12%	7.29%	-1.83%	-20.02%	Decrease	Decrease	Yes
23	Emergency Department Utilization	165.44	166.17	0.73	0.44%	Consistent	Decrease	No

MILESTONE 5 ASSESSMENT

Requirements under this Milestone were deemed met by CMS upon approval of the Demonstration. Enhancements to the PDMP are discussed in Section F. Results for all metrics are stable or improving in DY2.

SUD Milestone 5 Assessment			
Assessment Area	**Completed or Progressing/Expected**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	4/4	CMS requirements were met prior to DY1. No activities were expected under this milestone.	**Low Risk** **86% progress in actions and metrics (6/7)**
Critical Metrics	2/3	Metrics are stable or moving in the desired direction. ED utilization increased by less than one percent. More data points are needed to assess change over baseline.	
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

MILESTONE 6 – IMPROVED CARE COORDINATION AND TRANSITIONS BETWEEN LEVELS OF CARE

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

The OHCA and CMS agreed that Milestone 6 requirements were met concurrent with the Demonstration's approval. No additional activities are planned as part of the CMS approved SUD Implementation Plan.

A summary of Milestone 6 requirements is provided in Exhibit D13.

Exhibit D13. Milestone 6 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Ensure residential and inpatient facilities link clients with community-based services following stays	Existing care coordination and transition of care requirements	Yes
	Existing use of the Addiction Severity Index for level of care and discharge planning	Yes
	Existing community-based provider requirements for case management services within a week of discharge	Yes
Policies to ensure care coordination for physical and mental health conditions	Existing discharge planning requirements for inpatient providers	Yes
	Existing performance incentives for community-based providers providing follow up	Yes
	Existing requirements for Certified Community Behavioral Health Clinic and Targeted Case Management programs	Yes

MILESTONE 6 PERFORMANCE METRICS

PHPG examined the following critical performance metrics, as defined in the SUD Monitoring Protocol, related to improved care coordination and level of care transitions:

#15 Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):

- Initiation of AOD Treatment - Percentage of beneficiaries (total and by service subgroup) who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis; and

- Engagement of AOD Treatment - The percentage of beneficiaries (total and by service subgroup) who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

#17 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence:

- Percentage of ED visits for beneficiary's diagnosis of AOD abuse or dependence and who had a follow-up visit for AOD within 7 days of the ED visit;
- Percentage of ED visits for which the beneficiary received a follow-up visit for AOD within 30 days of the ED visit;
- Percentage of ED visits for beneficiary's diagnosis of mental illness which the beneficiary received a follow-up visit for mental illness within 7 days of the ED visit; and
- Percentage of ED visits for which the beneficiary received a follow-up visit for mental illness within 30 days of the ED visit.

#25 Readmissions Among Beneficiaries with SUD: Total number of inpatient discharges per 1,000 beneficiaries in the measurement period.

Exhibit D-14 provides performance results for Milestone 6 critical metrics.

Exhibit D-14. Milestone 6 Critical Metric Results

Metric		Result					State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
15	**Initiation and Engagement**							
	Initiation - Total Score	28.35%	31.99%	3.64%	12.83%	Increase	Increase	*
	Engagement - Total Score	5.32%	11.07%	5.75%	108.08%	Increase	Increase	*
17	**Follow-up After ED Discharge**							
	Follow-up AOD - 30 days	10.62%	26.11%	15.49%	145.86%	Increase	Increase	*
	Follow-up AOD - 7 days	6.87%	16.62%	9.75%	141.80%	Increase	Increase	*
	Follow-up MH - 30 days	51.14%	46.51%	-4.63%	-9.05%	Decrease	Increase	*
	Follow-up MH - 7 days	39.10%	33.86%	-5.24%	-13.40%	Decrease	Increase	*
25	Readmissions for SUD *(Lower is preferred)*	0.12	0.14	0.02	21.02%	Increase	Decrease	No

*Technical specifications changed significantly in 2022, results are not comparable

SUD Metrics 15 and 17 are calculated using HEDIS specifications. The technical specifications were revised in 2022. For Metric #15, Initiation and Engagement in Treatment, the identification of a single index episode as the starting point was modified to include all eligible

SUD episodes, thereby expanding the intake period. In addition, there were changes in the negative history criteria, and changes in denominator and numerator logic. For Metric #17, the revised specifications introduced new procedure, medication, and diagnostic codes to the value sets used to identify members in the denominator and numerator.

MILESTONE 6 ASSESSMENT

Requirements under this Milestone were deemed met by CMS upon approval of the Demonstration. The technical specifications for measure 15 and 17 changed significantly between 2021 and 2022 such that results are not comparable across years.

SUD Milestone 6 Assessment			
Assessment Area	**Completed or Progressing/Expected**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	6/6	CMS requirements were met prior to DY1. No activities were expected under this milestone.	**Low Risk** **86% progress in actions and metrics (6/7)**
Critical Metrics	0/1	For two metrics which include six reported results, specifications changed in 2022, which should be considered as the new baseline, assuming no further significant changes in measure specifications occur. In one metric, readmission rates showed a slight decline in performance. All metrics in this category should be monitored closely by the State.	
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

E. SMI MILESTONES AND MID-POINT ASSESSMENT FINDINGS

The SMI Implementation Plan was approved concurrently with the Demonstration's start date. Eight requirements across three topic areas were deemed to be met by CMS. These were:

- Topic 2 – Improving Care Coordination
  - 2b (assessment of housing needs and address prior to discharge)
  - 2c (post-discharge contacts within 72 hours)
  - 2d (strategies to prevent or reduce stays in the ED)
- Topic 3 – Increasing Access to Continuum of Care
  - 3d (use of patient placement assessments)
  - 3e (policies to improve access to continuum of care)
- Topic 4 – Identification, Engagement, and Integration
  - 4a (early engagement of clients with SED/SMI)
  - 4b (integration of behavioral health in community settings to support early identification of SED/SMI)
  - 4d (other State efforts at early identification and engagement)

The SMI Implementation Plan included a range of activities, such as developing rules for QRTPs, providing technical assistance to providers, and expanding CCBHCs statewide. The expected Implementation Plan activities for each topic area, including the SMI-HIT plan, and the data sources used in completing the Mid-Point Assessment are summarized in Exhibit E-1.

Exhibit E-1. Overview of SMI Implementation Plan and Topic Areas

CMS Topic Area	Implementation Activity	Data Source*
1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	• Develop QRTPs rules by 12/1/21 • Provide technical assistance (TA) to QRTP providers by 10/1/21 • Use of Child and Adolescent Needs and Strengths (CANS) assessment for QRTP placement	• Required CMS metrics • QRTP Contract Requirements and Technical Assistance Activities
2. Improving Care Coordination and Transitions to Community Based Care	• Develop QRTP rules by 12/1/21 • Expand CCBHCs statewide by DY3	• Required CMS metrics • State policies and procedures • CCBHC Designations
3. Increasing Access to Continuum of Care, including Crisis Stabilization Services	• Complete Annual Assessment of Availability • Add all Medicaid enrolled IP psychiatric facilities to current tracking system by 7/1/21 • Request IMD Demonstration Authority	• Provider Availability Assessments • State policies and procedures

CMS Topic Area	Implementation Activity	Data Source*
4. Earlier Identification, Engagement in Treatment, and Increased Integration	• Examine viability of expanding Community Based Assessment (CBA) for youth to metro areas. If CBA expansion is viable procure contractor by DY2	• Required CMS metrics • State policies and procedures
5. SMI Finance Plan	• Expansion of non-residential crisis services by 1/1/2023 (DY3) • Expand and provide TA for CCBHCs (DY3) • Explore CBA expansion (DY3) • Identify funding sources for supported employment and housing expansion and pursue Medicaid authorizations if needed (DY3)	• CCBHC and program expansion activities
6. SMI IT Plan	• Expand functionality through HIE procurement	• State Staff Interview
Budget Neutrality	• Maintain expenditures at or below PMPM limits as defined in STCs	• BN amendment and workbook

* Quarterly and annual reports to CMS were reviewed for all Topic Areas

CMS approved the following modifications to the technical specification requirements for the OHCA's SMI Monitoring Protocol metrics:

- Due to data limitations, SMI MP metric #23 Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) was replaced with the following State-specific measure:
    - S1. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
- Mental health practitioner, telehealth, and place of service codes were added to the CMS value sets to reflect those used by the OHCA's mental health delivery system. These changes affected the following SMI utilization and cost metrics:
    - Metric #32 Total Costs Associated with Mental Health Services among Beneficiaries With SMI/SED - Not Inpatient or Residential
    - Metric #14 Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization
    - Metric #15 Mental Health Services Utilization - Outpatient
    - Metric #16 Mental Health Services Utilization - ED
    - Metric #17 Mental Health Services Utilization - Telehealth
    - Metric #18 Mental Health Services Utilization - Any Services

The remainder of Section E presents findings for each topic, including Monitoring Protocol metrics and the State's progress in meeting its action steps and timelines outlined in the SMI Implementation Plan.

TOPIC 1 – ENSURING QUALITY OF CARE IN PSYCHIATRIC HOSPITALS AND RESIDENTIAL SETTINGS

Topic 1 includes the following six subsections:

1-A. Participating hospitals are licensed or approved as meeting standards for licensing established by the agency responsible for licensing hospitals. Participating residential treatment providers are licensed, or otherwise authorized, by the State. They must also be accredited by a nationally recognized accreditation entity.

1-B. Establishment of oversight processes that include unannounced visits for ensuring participating facilities meet State licensure or certification requirements, as well as a national accrediting requirement.

1-C. Use of a utilization review process to ensure beneficiaries have access to the appropriate care levels and types and ensure lengths of stay are medically necessary.

1-D. Compliance with federal program integrity requirements and State compliance assurance process.

1-E. State requirements that participating facilities screen enrollees for co-morbid physical health conditions and substance use disorders and suicidal ideation and facilitate access to treatment for those conditions.

1-F. Other State requirements/policies to ensure good quality care in inpatient and residential settings.

Prior to the implementation of the Demonstration, the OHCA met all requirements under Topic 1 for psychiatric care facilities and hospitals. Special provisions were added to the provider agreements for Community-Based Structured Crisis Centers designated as IMDs to require national accreditation from either: the Joint Commission, the Commission on the Accreditation of Rehabilitative Facilities, or the Council on Accreditation.

As part of the SMI Implementation Plan, the OHCA developed for newly enrolled QRTP providers corresponding rules, compliance processes, and contract standards for each of the requirements under Topic 1. QRTP contracts require facilities to be nationally accredited by: the Commission on Accreditation of Rehabilitation Facilities; the Joint Commission; the Council on Accreditation; or any other federally approved, independent, not-for-profit accrediting organization. The OHCA also provided outreach and technical assistance to QRTP programs enrolling in the Medicaid program.

The CANS assessment tool was implemented in the fall of 2022 to support QRTP placement decisions. The CANS is completed for all youth prior to entering the QRTP and every six months thereafter while still in the placement. The CANS also serves as the basis for short- and long-term treatment planning and goal setting.

The OHCA and ODMHSAS work collaboratively with the State's Specialized Placements and Partnerships Unit (SPPU) within the OHS Child Welfare Division to provide technical assistance to Medicaid enrolled QRTPs. Representatives from each State agency meet at least quarterly to discuss additional support related to QRTP implementation, changes to practices or policy, and quality improvement.

Additionally, the SPPU team has developed a bi-monthly qualitative review process that assesses the main requirements of QRTP, such as the quality of treatment plans and treatment team meetings and transitioning planning efforts. The team also has developed a survey that liaisons conduct with their assigned programs to identify and address in real time any concerns/barriers to compliance and to inform ongoing strategies to improve outcomes.

A summary of Topic 1 requirements and progress is provided in Exhibit E-2.

Exhibit E-2. Topic 1 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Assuring participating residential and inpatient programs are licensed and residential facilities have national accreditation	Existing adult psychiatric facility rules	Yes
	Require national accreditation for IMD crisis units	Yes
	Develop administrative rules and enrollment processes for QRTPs	Yes
	Develop compliance protocol and staff for QRTP oversight	Yes
	Provide outreach and education to QRTP providers	Yes
	Provide TA to residential providing transitioning to QRTP standards	Yes
Oversight processes to ensure hospital and residential settings meet standards	Develop administrative rule and contract requirements for QRTPs	Yes
	Develop compliance protocols for monitoring of QRTP provider qualifications, staffing, treatment planning and discharge planning	Yes
Utilization review process to ensure proper level of care and lengths of stay	Update administrative rules to include psychiatric residential and IMD treatment programs	Yes
	Create reporting structure to monitor length of stay in IMDs	Yes
	Develop QRTP prior authorization processes	Yes
Compliance with program integrity requirements	Existing rules for adult psychiatric programs	Yes
	Integrate QRTP programs into existing rules	Yes
Screening for co-morbid conditions in psychiatric hospital and residential settings and facilitate access to treatment	Implement Child and Adolescent Needs and Strengths Assessment (CANS) for authorization of QRTP placement	Yes
	Develop QRTP compliance monitoring protocols for discharge planning	Yes
Other Requirements to ensure good quality care in inpatient and residential settings	Integrate QRTP programs into existing quality monitoring and oversight procedures	Yes

TOPIC 1 PERFORMANCE METRICS

Exhibit E-3 provides results for the Topic 1 critical performance measure, along with the status of progress to date.

Exhibit E-3. Topic 1 Critical Monitoring Protocol Metrics

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	58.57%	55.52%	-3.05%	-5.20%	Decrease	Increase	No

TOPIC 1 ASSESSMENT

The OHCA has completed all expected Implementation Plan activities and met all timelines.

SMI/SED Topic Area 1 Assessment			
Assessment Area	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	16/16	All expected SMI/SED Implementation Plan activities were completed, and requirements met.	Low Risk 94% progress in actions and metrics (16/17)
Critical Metrics	0/1	Results show a 5% decline and should be monitored as more data points become available.	
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

TOPIC 2 – IMPROVING CARE COORDINATION AND TRANSITIONS TO COMMUNITY-BASED CARE

Topic 2 includes the following five subsections:

2-A. Actions to ensure facilities carry out intensive pre-discharge planning and include community-based providers in care transitions.

2-B. Actions to ensure facilities assess the member's housing situation and coordinate with coordinate housing service providers when needed and available.

2-C. State requirements to ensure facilities contact each discharged member and their community-based provider through the most effective means possible e.g., email, text, or phone within 72 hours of discharge.

2-D. Strategies to prevent or decrease the length of stay in Emergency Departments among beneficiaries with SMI or SED prior to admission.

2-E. Other State requirements/policies to improve care coordination and connections to community-based care.

As part of requirement 2-A, the OHCA integrated existing Medicaid requirements related to discharge planning, community-based referrals, and continuity of care post discharge into the rules for QRTPs. Annual reviews for QRTPs began August 1, 2022, and the first round of reviews was completed March 10, 2023.

The Contract Performance Review (CPR) team conducted site visits and meetings with 27 providers. The CPR team noted that discharge planning, documentation of discharge planning, and staffing for follow-ups post-discharge are areas of continued focus/quality improvement for most QRTP programs.

The CPR team stated that in its activities subsequent to the first round of reviews it has found marked improvement in this area. The team will continue to work with QRTP providers to enhance the quality of discharge planning.

Requirements 2B-2D were met by the OHCA concurrent with the effective date of the Demonstration. There are no activities contemplated in the SMI Implementation Plan.

Other activities planned under requirement 2-E related to the expansion of CCBHC statewide by year three of the Demonstration. The OHCA met this goal by the end of year two.

A summary of Topic 2 requirements and progress is provided in Exhibit E-4, on the following page.

Exhibit E-4. Topic 2 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Ensure residential and inpatient programs carry out intensive pre-discharge planning and include community-based providers in care transitions	Existing adult psychiatric facility rules	Yes
	Existing requirements for adult psychiatric facilities and community-based providers	Yes
	Integrate QRTP programs into existing program standards and develop requirements to engage caretakers and include child welfare specialist in discharge planning and family-based aftercare	Yes
Ensure residential and inpatient settings assess housing needs and coordinate with community-based housing agencies	Existing program and treatment planning requirements	Yes
Ensure residential and inpatient settings contact beneficiaries and community-based providers within 72-hours post discharge	Existing program and discharge planning requirements	Yes
	Integrate QRTPs into existing requirements	Yes
Strategies to prevent or decrease length of stay in the EDs prior to admission in specialized settings	Existing program and treatment planning requirements	Yes
Other policies to improve care coordination and connection to community-based care	Expansion of CCBHC programs statewide	Yes

TOPIC 2 PERFORMANCE METRICS

Exhibit E-5 provides the results for each Topic 2 measure identified as critical by CMS, along with the status of progress to date. Exhibit E-6 on the following page provides results for one additional metric.

Exhibit E-5. Topic 2 Critical Monitoring Protocol Metrics

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization (IPF) *(Lower is preferred)*	9.07%	10.85%	1.78%	19.63%	Increase	Decrease	No
7a	Follow-up after Hospitalization for Mental Illness - 30 day: Ages 6-17 (FUH-CH)	64.22%	63.79%	-0.43%	-0.67%	Consistent	Increase	No
7b	Follow-up After Hospitalization for Mental Illness – 7 day: Ages 6-17 (FUH-CH)	40.37%	37.05%	-3.32%	-8.23%	Decrease	Increase	No

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
8a	Follow-up After Hospitalization for Mental Illness – 30-day: Age 18 and older (FUH-AD)	34.45%	37.58%	3.13%	9.09%	Increase	Increase	Yes
8b	Follow-up After Hospitalization for Mental Illness 7-day: Age 18 and older (FUH-AD)	19.19%	22.01%	2.82%	14.68%	Increase	Increase	Yes
9a	Follow-up After ED Visit for Alcohol and Other Drug Abuse – 30-day (FUA-AD)	10.62%	26.11%	15.49%	145.86%	Increase	Increase	*
9b	Follow-up After ED Visit for Alcohol and Other Drug Abuse – 7-day (FUA-AD)	6.87%	16.62%	9.74%	141.80%	Increase	Increase	
10a	Follow-Up After ED Visit for Mental Illness - 30-day (FUM-AD)	51.14%	46.51%	-4.63%	-9.05%	Decrease	Increase	
10b	Follow-Up After ED Visit for Mental Illness – 7-day (FUM-AD)	39.10%	33.86%	-5.24%	-13.40%	Decrease	Increase	

*Change in technical specifications in 2022, results are not comparable

SMI/SED Metric 9 and 10 are calculated using HEDIS specifications. The technical specifications were revised in 2022. The revised specifications introduced new procedure, medication, and diagnostic codes to the value sets used to identify members in the denominator and numerator.

Exhibit E-6. Topic 2 Other Monitoring Protocol Metrics

Metric		Results					State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
6	Medication Continuation Following Inpatient Psychiatric Discharge	62.25%	63.37%	1.12%	1.82%	Increase	Increase	Yes

TOPIC 2 ASSESSMENT

The OHCA has completed all expected Implementation Plan activities and met all timelines. Technical specifications for metric 9 and 10 (representing four results) were revised in 2022 and are not comparable to prior years.

SMI/SED Topic Area 2 Assessment			
Assessment Area	**Completed or Progressing/Expected**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	8/8	All SMI/SED Implementation Plan activities were completed. In addition, the planned expansion of CCBHC programs was completed ahead of schedule.	**Low Risk** **78% progress on actions/metrics (11/14)**
Critical Metrics	2/5	Performance in follow-up after hospitalization for 6-17 years old declined when measured within 7 days and showed no change when measured at 30 days. However, on the same measure performance improvement for members 18 and older. Psychiatric readmissions increased slightly in DY2. Specifications for measures of follow-up after the ED were changed in 2022 and are not comparable to prior years. Change over baseline should be monitored as more data points become available.	
Other Metrics	1/1	Medication continuation is showing an improvement in performance in DY2.	
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

TOPIC 3 – INCREASING ACCESS TO CONTINUUM OF CARE INCLUDING CRISIS STABILIZATION SERVICES

Topic 3 includes the following five requirements:

3-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.

3-B. Commitment to implementation of the SMI/SED financing plan described in STC 103(e). (See end of Section E)

3-C. Strategies to improve State tracking of availability of inpatient and crisis stabilization beds.

3-D. State requirement that providers use a widely recognized, publicly available patient assessment tool, to determine the appropriate level of care and length of stay.

3-E. Other State requirements/policies to improve access to a full continuum of care, including crisis stabilization.

The OHCA provided a baseline assessment of the availability of mental health services to CMS at the start of the Demonstration. The assessment was updated on February 15, 2022. The State made additional investments in mental health treatment in SFY 2022 (see SMI Financing Plan at the end of Section E).

During the first year of the Demonstration, the State began planning for the conversion to the national 988 crisis number. The ODMHSAS serves as the central organizing entity for planning, readiness, and implementation.

The national 988 number was integrated into the statewide crisis call center system and launched in July 2022. In the first quarter after the launch, the State experienced a 30-day average call volume of approximately 3,000 calls (100 per day).

As part of the integration, crisis services provided through Urgent Recovery Clinics (URCs) have been expanded in strategic areas of the State. Mobile crisis teams are available across the State to address callers' needs when appropriate. These efforts allow for triage and referral for all adult callers. The centralized system also assists law enforcement to appropriately manage and refer crisis situations.

The State currently supports real-time tracking of State-operated acute psychiatric and crisis stabilization beds and had originally expected to extend this system to private providers by July 1, 2021. Due to staffing changes and workload priorities, the timeline has been delayed. The State currently is engaged in discussions with private hospital providers on how to report capacity.

As of March 2023, these providers have expressed an interest in exploring an alternative to the real time bed tracking system used by the State-operated facilities. Additional discussion is planned for subsequent meetings with these providers.

A summary of Topic 3 requirements and progress is provided in Exhibit E-7.

Exhibit E-7. Topic 3 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Complete Annual Assessment of Availability of Mental Services	Complete CMS-defined workbook annually	Yes
	Include tracking of providers who are accepting new patients in requirements for MCE procurement	Yes
	Monitor MCE reporting (MCEs are expected to begin operation in mid-2024)	N/A
Complete Financing Plan	Complete finance plan	Yes
Improve tracking of inpatient and crisis stabilization beds	Expand existing bed tracking functionality all Medicaid contracted facilities	No
Use of nationally recognized assessment tools for patient placement and length of stay decisions	Existing provider rules and requirements	Yes
	Develop and integrate QRTPs into existing rules and requirements	Yes
Other requirements to improve access to a full continuum of care including crisis stabilization	Expanded access to facility-based crisis centers through the IMD Demonstration	Yes

ASSESSMENT OF STATE'S CAPACITY TO PROVIDE SMI/SED SERVICES

State Capacity at Midpoint

Members have access to the full range of otherwise covered Medicaid services, including SMI/SED treatment services. 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.

ODMHSAS supports 13 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). Ten of these CBSCCs also operate behavioral health urgent recovery clinics (URCs) that provide 23-hour respite and observation to help prevent psychiatric emergencies and admission to inpatient or crisis beds, with another 11 stand-alone URCs operating across the state. These facilities also address substance abuse emergencies.

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. Community-based programs also provide assistance with such services as housing, employment, peer advocacy, and drop-in centers.

In October 2016, Oklahoma was one of eight states selected by SAMHSA and CMS to pilot Certified Community Behavioral Health Clinics (CCBHCs). Oklahoma adopted the CCBHC model for statewide expansion; at the time of its request to CMS for the IMD Demonstration six of the 13 CMHCs in Oklahoma achieved CCBHC designation. Under the Demonstration's SMI/SED Implementation Plan, the remaining centers achieved designation, over a year ahead of the expected timeline.

As of February 2022, the Oklahoma delivery network included 77 crisis call centers, 72 mobile crisis units, and 13 crisis stabilization units.

Changes in State Capacity

The OHCA prepared Annual Assessments of Availability of Mental Health Services at baseline and during the Demonstration. The 2021 report was delayed until 2022 due to the impact of the PHE. The following reports were examined:

Report	Measurement Period
2020 Baseline Submitted with Demonstration Request	Feb 2020
2022 Assessment DY1	Feb 2021
2023 Assessment DY2	Feb 2022

The Oklahoma Medicaid program experienced significant enrollment growth between 2020 and 2022, with total enrollment increasing from approximately 773,000 to over 1 million beneficiaries. During that time, the number of Medicaid beneficiaries with an identified SMI/SED treatment need grew at the same rate. As a result, the percentage of beneficiaries with an identified SMI/SED treatment need remained constant. This suggests that sufficient service capacity exists to identify and engage members, even during periods of rapid growth in Medicaid enrollment. Exhibit E-8 provides a summary of Medicaid enrollment and beneficiaries with an SMI/SED designation.

Exhibit E-8. Topic 3 Assessment of Availability (2020-2022) – Medicaid Enrollment and SMI/SED Designation

	2020	2021	2022	Percentage Change
Number of Medicaid Beneficiaries	772,636	947,749	1,029,460	33.2%
Number of Medicaid Beneficiaries with SMI or SED Designation	117,459	144,162	157,598	34.2%
Percentage of Beneficiaries with SMI or SED Designation	15.2%	15.2%	15.3%	0.7%

Between 2020 and 2022, Oklahoma reported an increase in the number of licensed psychiatrists, other prescribers, and other mental health practitioners. Over this same time period, Oklahoma reported a decline in the number of Medicaid-enrolled providers. However, there appear to be reporting anomalies related to Medicaid-enrolled providers. For example, the reported number of Medicaid-enrolled psychiatrists and other prescribers in certain counties exceeds the number of licensed providers in those counties.

Payments to CCBHCs increased from $17.5 million to $31.3 million between State Fiscal Years 2020 and 2022, representing an increased investment in CCBHCs of 78.7 percent. While CMHC/CCBHC staffing levels likely increased significantly over this period, data related to the number of clinical staff at each site is not available, making it impractical to assess provider capacity based on the number of enrolled providers or member-to-provider ratios. However, increases in expenditures and utilization are indicators of increased capacity.

The number of providers offering intensive outpatient services doubled between 2020 and 2022, from 6 to 12 providers. Exhibit E-9 presents a summary of community-based/outpatient capacity.

Exhibit E-9. Topic 3 Assessment of Availability (2020-2022) – Community-Based/Outpatient Services

Provider	Provider Count/Percentage	2020	2021	2022	Percentage Change
Psychiatrists and Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Licensed Providers	457	485	521	14.0%
	Medicaid-Enrolled Providers	444	380	362	-18.5%
	Percentage Enrolled in Medicaid	*97.2%*	*78.4%*	*69.5%*	*-28.5%*
Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Licensed Providers	8,410	10,521	10,307	22.6%
	Medicaid-Enrolled Providers	6,252	6,086	4,868	-22.1%
	Percentage Enrolled in Medicaid	*74.3%*	*57.8%*	*47.2%*	*-36.5%*
CMHCs	Licensed Sites	77	77	77	0.0%
	Medicaid-Enrolled Sites	77	77	77	0.0%
	Percentage Enrolled in Medicaid	*100.0%*	*100.0%*	*100.0%*	*0.0%*
Intensive Outpatient Services	Licensed Providers	6	12	12	100.0%
	Medicaid-Enrolled Providers	6	12	12*	100.0%
	Percentage Enrolled in Medicaid	*100.0%*	*100.0%*	*100.0%*	*0.0%*

** Enrollment was modified from 18 to 12 (the reported Medicaid enrolled count exceeded licensed count)*

Residential/inpatient treatment capacity increased by 149 beds, or approximately 7.1 percent, between 2020 and 2022. The number of inpatient/residential sites decreased from 46 to 43 over the same period. A summary of inpatient/residential capacity is provided in Exhibit E-10, on the following page.

Exhibit E-10. Topic 3 Assessment of Availability (2020-2022) – Inpatient/Residential Services

Provider	Count/Beds	2020	2021	2022	Percentage Change
Residential Mental Health Treatment Facilities (Adult)	Providers	15	13	13	-13.3%
	Beds	701	591	591	-15.7%
Psychiatric Residential Treatment Facilities (PRTF)	Providers	4	4	4	0.0%
	Beds	179	191	191	6.7%
Public Psychiatric Hospitals, Private Psychiatric Hospitals and Psychiatric Units in Acute Care/Critical Access Hospitals	Providers	27	28	26	-3.7%
	Beds	1,229	1,475	1,476	20.1%
Total	**Providers**	**46**	**45**	**43**	**-6.5%**
	Beds	**2,109**	**2,257**	**2,258**	**7.1%**

Oklahoma maintained its network of crisis call centers and mobile crisis units between 2020 and 2022. The number of crisis observation centers more than doubled, from five centers in 2020 to 11 centers in 2022. The number of crisis stabilization units also increased, from 11 units in 2020 to 13 units in 2022. Exhibit E-11 provides a summary of crisis stabilization capacity.

Exhibit E-11. Topic 3 Assessment of Availability (2020-2022) – Crisis Stabilization Services

Crisis Service Provider	2020	2021	2022	Percentage Change
Crisis Call Centers	77	77	77	0.0%
Mobile Crisis Units/Coordinated Community Crisis Response Teams	72	72	72	0.0%
Crisis Observation/Assessment Centers	5	11	11	120.0%
Crisis Stabilization Units	11	13	13	18.2%

<u>Identified Needs for Additional Capacity</u>

Annual assessments of provider availability show a decline in psychiatrists and prescribers (18 percent) and in other licensed practitioners who are enrolled in Medicaid (22 percent). The number of psychiatric units in acute care settings decreased by one, and one unit identified in a critical access hospital also closed. However, an additional free-standing facility was added to the network and overall bed capacity increased from 2,109 beds to 2,258 beds.

While the assessment data reports a decline in Medicaid-enrolled providers, monthly utilization metrics show a four percent increase in members receiving any mental health service. Inpatient care increased by 31 percent; intensive outpatient and partial hospitalization utilization increased by 27 percent. Outpatient and telehealth utilization increased by four and five

percent respectively. Also, the number of beneficiaries who received treatment in IMDs increased by 34 percent.

OHS 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 QRTP facilities that the State determines are IMDs.

TOPIC 3 PERFORMANCE METRICS

Exhibit E-12 below provides the results for each Topic 3 measure defined as critical by CMS, along with the status of progress-to-date.

Exhibit E-12. Topic 3 Critical Monitoring Protocol Metrics

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
19	Average Length of Stay in IMDs for all IMDs and populations	9.43	8.70	-0.73	-7.71%	Decrease	Stabilize	Yes*

**CMS guidance indicates that shorter lengths of stay are preferred*

Exhibit E-13 provides an overview of other utilization metrics related to Topic 3.

Exhibit E-13. Topic 3 Other Monitoring Protocol Metrics (average number of service recipients per month by year)

Metric		Results					State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
13	Mental Health Services Utilization – Inpatient	220.92	289.50	68.58	31.04%	Increase	Consistent	No
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	95.00	121.50	26.50	26.84%	Increase	Increase	Yes
15	Mental Health Services Utilization - Outpatient	3,154.25	3,274.33	120.08	3.81%	Increase	Increase	Yes
16	Mental Health Services Utilization - ED	74.92	75.58	0.67	0.89%	Consistent	Consistent	Yes
17	Mental Health Services Utilization - Telehealth	50.75	53.50	2.75	5.42%	Increase	Consistent	No
18	Mental Health Services Utilization - Any Service	3,226.17	3,366.75	140.58	4.36%	Increase	Increase	Yes

Metric		Results					State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	4,781	6,445	1,664	34.80%	Increase	Consistent	No

TOPIC 3 ASSESSMENT

The OHCA has accomplished all expected Implementation Plan activities, apart from requirement 3-C (strategies to improve State tracking of availability of inpatient and crisis stabilization beds). The OHCA has a bed-tracking system in place for State-operated psychiatric facilities. However, a planned enhancement for the private providers was delayed due to staffing impacts created during the novel coronavirus PHE. After the initial delay in planning, the OHCA now is engaged with private providers to determine the best option to track bed availability in their programs.

The 2022 Annual Assessment of the Availability of Mental Health Services showed a decline in the number of Medicaid-enrolled psychiatrists, other prescribers and other licensed mental health professionals. However, the number of licensed providers and mental health service utilization both increased across all levels of care. The largest increases in 2022 were seen in Inpatient, IMD and Intensive Outpatient/Partial Hospitalization programs. Overall inpatient/residential bed capacity increased over the period.

The baseline period for the Annual Assessment of Availability of Mental Services reflects February 2020 data, one month before the novel coronavirus pandemic began. As the State transitions to private Managed Care Entity delivery system, it will be important to monitor network adequacy and utilization of mental health services.

SMI/SED Topic Area 3 Assessment			
Assessment Area	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	6/7	Planning has resumed on bed tracking in private facilities, following a delay created by the PHE. All other activities have been completed.	Low Risk 75% progress actions and metrics (12/16)
Assessment of State Capacity	1/1	A review and validation of reporting specifications for Medicaid-enrolled providers where enrolled count exceeds licensed counts may be warranted. The potential expansion of CCBHC staffing is not reflected in provider counts. The development of Qualified Residential Treatment Programs (QRTPs) for children and adolescents will further enhance Medicaid capacity.	

SMI/SED Topic Area 3 Assessment			
Assessment Area	**Completed or Progressing/Expected**	**Key Considerations**	**Assessment of Risk**
Critical Metrics	1/1	Average length of stay in an IMD is under 30 days or less with 9.43 days in 2021 and 8.70 days in 2022.	
Other Metrics	4/7	Inpatient and IMD utilization were expected to be 'consistent' under the Demonstration, utilization increased in 2022 by 31 and 35 percent, respectively.	
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

TOPIC 4 – EARLY IDENTIFICATION, ENGAGEMENT IN TREATMENT, AND INCREASED INTEGRATION

Topic 4 includes the following four requirements:

4-A. Strategies for identifying and engaging members with or at risk of SMI/SED in treatment sooner (e.g., supported employment and education).

4-B. Plan for increasing integration of behavioral health care in non-specialty care settings, to improve early identification of SMI/SED and linkages to treatment.

4-C. Establishment of specialized settings and services, including crisis stabilization services, for young people experiencing SMI or SED.

4-D. Other State strategies to increase earlier ID, engagement, integration, and specialized programs for young people.

Topic requirements for 4A, B and C were met by the OHCA concurrent with the effective date of the Demonstration. There are no activities contemplated in the SMI Implementation Plan. As part of the SMI Implementation Plan, the OHCA engaged in an examination of the feasibility of expanding Community Based Assessments for youth in crisis in the metro regions.

The State enacted legislation (SB 1337) on May 26, 2022, to transition most Medicaid beneficiaries to private MCEs in early calendar year 2024. (The exceptions are Aged, Blind and Disabled beneficiaries and long-term care recipients.) Due to this delivery system transition, the OHCA has decided not to pursue the expansion of the expansion of Community-Based Assessments. These and other related activities for identifying and engaging youth in treatment are expected to be performed by the MCEs.

A summary of Topic 4 requirements and progress is provided in Exhibit E-14.

Exhibit E-14. Topic 4 Implementation Plan Requirements and Progress

Milestone Requirements	Actions	Completed
Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner	Existing programs and policies	Yes
Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification and linkages to treatment	Existing programs and policies	Yes
Establish specialized settings including crisis stabilization for young people experiencing SMI/SED	Assess the impact of MCE procurement on the need to expand community-based assessment (CBA)	Yes
Other State strategies to increase earlier identification/engagement, integration, and specialized programs for young people	Existing programs and policies	Yes

TOPIC 4 PERFORMANCE METRICS

Exhibit E-15 below provides the results for each Topic 4 measure defined as critical by CMS, along with the status of progress-to-date.

Exhibit E-15. Topic 4 Critical Monitoring Protocol Metric Results

Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
26	Access to preventive/ambulatory health services for Medicaid beneficiaries with SMI	63.39%	57.62%	-5.77%	-9.10%	Decrease	Increase	No
29a	Percentage of children and adolescents on antipsychotics who received blood glucose testing	41.90%	41.66%	-0.24%	-0.57%	Consistent	Increase	No
29b	Percentage of children and adolescents on antipsychotics who received cholesterol testing	20.14%	20.03%	-0.11%	-0.51%	Consistent	Increase	No
29c	Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	19.39%	19.28%	-0.11%	-0.55%	Consistent	Increase	No
30	Follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication	69.58%	70.49%	0.91%	1.32%	Increase	Increase	Yes

Exhibit E-16 provides an overview of other metrics related to Topic 4.

Exhibit E-16: Topic 4 Other Monitoring Protocol Metric Results

Metric		Results					State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
21	Count of Beneficiaries With SMI/SED (average monthly)	3,454	3,680	226	6.53%	Increase	Increase	Yes
22	Count of Beneficiaries With SMI/SED (annually)	10,139	11,547	1,408	13.89%	Increase	Increase	Yes

Metric		Results					State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
S1	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (Substitute for SUD MP #23)	71.61%	71.38%	-0.23%	-0.32%	Consistent	Increase	No

TOPIC 4 ASSESSMENT

CMS deemed that OHCA met requirements under this Milestone on approval of the Demonstration. The OHCA chose to pursue one activity as part of its implementation plan to assess expansion of assessment services. In assessing critical metric performance, performance regarding metabolic screening for children and adults showed no change and access to ambulatory/preventive care declined. More individuals were identified with SMI/SED and follow-up care for adults newly prescribed antipsychotics improved slightly. Due to the impact of the PHE on service utilization and availability, consistency in performance could be considered a positive outcome.

SMI/SED Topic Area 4 Assessment			
Assessment Area	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	4/4	Requirements under this Milestone were deemed met by CMS on approval of the Demonstration.	**Medium Risk** **58% progress in action and metrics 7/12**
Critical Metrics	1/5	Performance on access to ambulatory care declined in 2022. Performance on metabolic monitoring for children on antipsychotics remained consistent. Performance for follow-up care in adults who are newly prescribed antipsychotics improved.	
Other Metrics	2/3	The number of members who are identified with SMI/SED increased in 2022. Diabetes screening in members using antipsychotics was unchanged.	
Stakeholder Input	No Concerns	No concerns were raised by stakeholders during the sessions.	

SMI FINANCING PLAN

The CMS SMI Financing Plan includes the following three requirements:

A. Increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to: crisis call centers, mobile crisis units, coordinated community response services that include law enforcement and other first responders, and observation/assessment centers.

B. Increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

C. A finance 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 IMD treatment.

The OHCA and ODMHSAS collaborated with community partners across the State to expand access to CCBHC services and support the integration of care for individuals with an SMI/SED. Statewide coverage was achieved in the fall of 2022, in advance of the Demonstration's year three timeline. In addition, a SPA for partial hospitalization services was approved by CMS on June 10, 2022.

The total amount of State expenditures for SFY 2022 represents a decrease of approximately $3.5 million dollars compared to SFY 2021. However, CHIP and CCBHC spending has increased significantly. Health Home spending is significantly reduced for SFY 2022 due to the program sunsetting in September 2021. The State portion of regular Title XIX is reduced due to enhanced FMAP and ACA FMAP savings. Overall, the State has maintained and/or increased spending from the SFY 2020 level of effort.

An overview of the OHCA's State spending on behavioral health is provided in Exhibit E-17.

Exhibit E-17. State Expenditures for Behavioral Health

Program	State Dollars (SMI/SED)			
	SFY 2020 (Pre-Demo)	SFY 2021 (Demo-6mos)	SFY 2022	Change From Pre-Demo
Regular TXIX	$54,898,648	$55,115,363	$43,071,740	($11,826,908)
CHIP	$2,608,734	$7,481,445	$11,373,731	$8,764,997
Health Homes	$6,614,172	$4,002,923	$632,255	($5,981,917)
CCBHC	$17,505,607	$23,352,812	$31,288,545	$13,782,938
Total	**$81,627,161**	**$89,952,543**	**$86,366,271**	**$4,739,110**

F. INFORMATION TECHNOLOGY PLAN

In March 2022, the Oklahoma Legislature enacted SB1369, requiring all health care providers to report data to, and utilize the State Designated Entity (SDE) for Health Information Exchange (HIE) beginning July 1, 2023. The State is now promulgating rules for HIE implementation.

As part of the MCE procurement described earlier, the OHCA is requiring that all MCE contractors participate in the HIE. Participation includes but is not limited to the submission of encounter data and exchange of clinical information to improve the quality and efficiency of health care delivery in numerous ways, including: reducing medical errors, decreasing duplicative or unnecessary services, improving data quality for public health research, promoting population health management, reducing manual, labor-intensive monitoring and oversight, and reducing fraud and abuse.

The SUD and SMI IT plans rely on a variety of separate IT systems and platforms at the State and local level. However, expected enhancements through the HIE will further support the OHCA in achieving alignment with CMS goals and expectations regarding Health IT planning.

The remainder of this section provides an overview of CMS Health IT requirements for the IMD Demonstration and the status of the OHCA's strategic planning. A review of IT measures as defined in the SUD and SMI/SED Monitoring Protocol also is included.

SUD IT PLAN

In establishing SUD Information Technology (IT) requirements for 1115a Demonstrations, CMS seeks the following assurances from states:

- **Assurance 1**: The State has a sufficient health IT infrastructure ecosystem at every appropriate level to achieve the goals of the Demonstration.
- **Assurance 2**: The State's SUD Health IT Plan is aligned with the State's broader State Medicaid Health IT Plan and, if applicable, the State's BH 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.

The State provided these assurances as part of its Demonstration application and approval. Outlined below is an overview of CMS PDMP requirements and the status of PDMP functionality, strategic planning, and SUD IT measures.

PRESCRIPTION DRUG MONITORING (PDMP) FUNCTIONALITIES

CMS requirements include: enhanced interstate data sharing to better track patient-specific prescription data; enhanced "ease of use" for prescribers and other State and federal stakeholders; enhanced connectivity between the State's PDMP and any statewide, regional, or

local health information exchange (HIE); and enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns.

- **Interstate Data Sharing**: CMS determined that this milestone was met upon approval of the SUD IT plan. No further action is contemplated under the Demonstration.
- **Ease of Use and HIE Connectivity**: The State successfully procured a vendor for its HIE. The vendor implemented IT functionality that offers prescribers a direct link from the HIE and pass-through login to the PDMP. The functionality was tested in December 2022[1].
- **Clinician Prescribing and Long-Term Opioid Use**: CMS determined that this milestone was met upon approval of the SUD IT plan. No further action is contemplated under the Demonstration.

CURRENT AND FUTURE PDMP QUERY CAPABILITIES

This CMS requirement includes facilitating 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). The MPI for the HIE is undergoing an extensive refinement process to increase the accuracy of matching and reduce the number of records that must be manually reviewed and merged. This effort supports the accuracy of the PDMP integration under the HIE.

USE OF PDMP – SUPPORTING CLINICIANS WITH CHANGING OFFICE WORKFLOWS/ BUSINESS

CMS requirements include: developing 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; and developing 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.

The Oklahoma HIE includes IT functionality that offers prescribers a direct link from the HIE and pass-through login to the PDMP. In addition, the HIE allows providers to review prescribed and dispensed medication history prior to issuing a new or refilled prescription.

MASTER PATIENT INDEX/IDENTITY MANAGEMENT

This CMS requirement focuses on enhancing the MPI (or master data management service, etc.) in support of SUD care delivery. The MPI for the HIE is undergoing an extensive refinement

[1] Subsequent to the mid-point assessment period, the State elected to not renew its agreement with the vendor responsible for PDMP and HIE connectivity. The State intends to undertake a competitive procurement that will include integration of the PDMP and HIE; and is working to secure this functionality on an interim basis through an existing vendor.

process to increase the accuracy of matching and reduce the number of records that must be manually reviewed and merged. This effort supports the accuracy of the PDMP integration under the HIE.

OVERALL OBJECTIVES FOR ENHANCING PDMP FUNCTIONALITY AND INTEROPERABILITY

This requirement includes leveraging 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 ensure Medicaid does not inappropriately pay for opioids.

In accordance with Oklahoma rules and laws regarding opioid prescribing, Oklahoma is designing an alert system within the HIE that will notify providers when a threshold is met in accordance with Oklahoma rules and laws regarding opioid prescribing.

SMI IT PLAN

At the outset of the SMI-IMD Demonstration amendment CMS determined the State to be in compliance with the following assurances:

Assurance 1: The State has a sufficient health IT infrastructure ecosystem at every appropriate level to achieve the goals of the Demonstration.

Assurance 2: The State's SMI Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's BH 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.

The State provided these assurances as part of its Demonstration application and approval. Outlined below is an overview of CMS SMI/SED Health IT requirements and the status of functionality, strategic planning, and IT measures.

1. CLOSED LOOP REFERRALS AND E-REFERRALS

CMS identified the following three requirements regarding closed-loop and electronic referrals:

1.1 Closed-loop referrals and e-referrals from physician/mental health provider to physician/mental health provider.

1.2 Closed-loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider.

1.3 Closed-loop referrals and e-referrals from physician/mental health provider to community-based supports.

While the HIE does not provide a closed loop referral system, it does support the provider's ability to close a referral by providing access to medical records and events. Providers can access needed information and share records using the HIE functionality.

In addition, the State's MCE RFP requires managed care entities to develop strategies for providing enrollees with referrals to social services based on assessed needs, as well as tracking outcomes of the referrals. Contractors are expected to develop strategies to provide referrals to social services, track and report the outcomes of those referrals.

The RFP also requires that care managers know how to locate and arrange community-based services. The OHCA and ODMHSAS subject matter experts reported that managed care entities have proposed closed-loop referral systems to address this and other managed care program requirements.

2. ELECTRONIC CARE PLANS AND MEDICAL RECORDS

CMS identified the following five requirements for electronic care planning and medical records:

- 2.1 The State and its providers can create and use an electronic care plan.
- 2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers.
- 2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.
- 2.4 Electronic care plans transition from youth-oriented systems of care to the adult BH system through electronic communications.
- 2.5 Transitions of care and other community supports are accessed and supported through electronic communications.

Oklahoma was an early adopter of the electronic health record incentive program now known as the Promoting Interoperability Program. At the time of the Demonstration's approval, over 4,000 providers and hospitals participated in the program. The State continues to promote updated certified electronic health record technology (CEHRT) standards across the health care system.

In addition, providers connected to the HIE have access to their patients' medical records, to support development of care plans. Electronic care plans can be made accessible to the HIE using USCDI standard language or shared among other providers through Direct Secure Messaging.

The MCE RFP also includes requirements for contractors to develop and share coordinated care plans, update, and communicate new information to all team members, and to support all aspects of care transitions.

3. ELECTRONIC CONSENT

CMS identified one requirement for electronic consent:

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)

Although not currently in scope, the HIE development team is considering electronic consent capability as future enhancement. Discussions are ongoing and will also consider updated federal rules around 42 CFR Part 2.

4. INTEROPERABILITY IN ASSESSMENT DATA

CMS identified one requirement for interoperability in assessment data:

4.1 Intake, assessment and screening tools are part of a structured data capture process and information is interoperable with the HIT ecosystem.

The CCBHCs and other providers maintain EHRs that integrate all aspects of care, from screenings to intake and assessments. All CCBHCs participate in the HIE and can share information with the member's care team as needed or requested by the member.

The HIE supports commonly used mental health screening instruments such as the Patient Health Questionnaire-9 (PHQ-9) for screening, diagnosing, monitoring, and measuring the severity of depression; and the Generalized Anxiety Disorder 7 (GAD7) for screening and measuring the severity of generalized anxiety disorder.

The HIE also supports Social Determinants of Health assessments through a mobile screening system offered in partnership with its Oklahoma health care partners. The system helps individuals with needs find assistance from services and resources offered in the community with respect to: housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation needs beyond medical transportation.

Through this program, individuals receive a text message with a link to a screening that invites the person to seek assistance with one or more of the health-related social needs. If the individual identifies a need, the program provides a customized list of resources based on location.

Eligible individuals may also be offered the chance to receive Navigation services through the Tulsa City/County or Oklahoma City-County Health Departments. In these cases, a Navigator will contact the individual to learn about their unique situation and help connect them with community service providers in their area[2].

5. ELECTRONIC OFFICE VISITS

CMS identified one requirement for electronic office visits (Telehealth):

5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care.

The ODMHSAS maintains a statewide telemedicine network using Polycom Real Presence. As part of its COVID-19 PHE response, the State collaborated with providers across the continuum of care to promote and expand the use of telehealth as appropriate. In addition, the HIE's provider portal supports the provider's ability to offer Telehealth by granting access to the patient's complete medical records.

6. ALERTING ANALYTICS

CMS identified the following two requirements for electronic alerts and analytics:

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 to ensure treatment continues or resumes.

6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis.

CCBHC teams monitor member outcomes and service utilization and are expected to adjust care plans as needed to support access to care and engagement in treatment. As part of the children's wraparound response, care teams are required to access data from the MMIS to monitor the use of psychotropic medications and address gaps in services and supports for youth involved in the program.

HIE capabilities include the analysis of care gaps and production of gap reports. This capability is currently used by the OHCA Population Care Management Department to support members with special health care needs.

The MCE procurement includes requirements for care coordination, monitoring services, and utilization and predictive analytics related to risk levels and care needs. As part of the

[2] (Oklahoma and Tulsa counties operate independent health departments, while the Oklahoma State Department of Health has responsibility for the other 75 counties.)

procurement, potential contractors were also asked to propose programs and services for high needs populations, including members with a first episode psychosis.

7. IDENTITY MANAGEMENT

CMS identified the following two requirements for identity management:

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.

7.2 Electronic medical records capture all episodes of care and are linked to the correct patients.

The HIE includes enterprise master patient index capability for all exchanges supported through network. At the local level, CCBHCs provide services to children and families in a comprehensive manner and all employ EMRs with master patient index functionality. In addition, the State's eligibility and enrollment system can link parents and children under the same case file.

G. BUDGET NEUTRALITY FINDINGS

Annual data on budget neutrality is presented here as contextual. CMS and the State continue to monitor progress quarterly. Interpretation of results and progress is assessed directly by CMS. At the end of DY1 the State showed a hypothetical surplus for the SMI/SUD eligibility group of over $6 million. At the end of DY2 the hypothetical surplus was over $29 million[3].

Exhibit G-1 provides an overview of budget neutrality as reported by the OHCA.

Exhibit G-1. Budget Neutrality Reporting as of December 31, 2022

	DY1	DY2
With Waiver (Actual)		
FFS-SMI/SED Aged 18-64	$6,989,354	$12,928,614
FFS-SUD Aged 18-64	$7,931,239	$10,178,571
FFS-SUD Aged 17 and under	$691,294	$831,232
Total Expenditures (Actual)	**$15,611,888**	**$ 23,938,417**
Without Waiver Limit	**$22,335,924**	**$52,944,489**
SURPLUS (DEFICIT)	**$6,724,036**	**$ 29,006,072**

[3] On July 1, 2021, the State expanded State Plan eligibility to the New Adult Group. Utilization and cost of services for the expansion population is reported to CMS separately and is not included in the IMD budget neutrality calculations.

H. ASSESSMENT SUMMARY AND RECOMMENDATIONS

Overall, the OHCA has completed the activities outlined in the SUD and SMI/SED Implementation plans as expected and within the expected timelines. Where on-going work is anticipated, the OHCA is meeting expectations outlined in its Implementation Plan. The ALOS in IMDs is under the 30-day threshold set by CMS for both populations. Expenditures for the first two years of the Demonstration are within budget neutrality limits.

Stakeholders agreed that SUD treatment services were available at all ASAM levels of care. However, several noted that access to withdrawal management services and transportation to and from treatment services (at all levels of care) was challenging in some regions. Further discussion with providers and members may be warranted to understand the scope of transportation challenges statewide. Medicaid enhancements such as the reimbursement of specialized providers or use of peer recovery specialists as drivers could be considered. Along these lines, a focused examination of geographic access patterns for SUD withdrawal management services may also be warranted.

Stakeholders participating in a review of the SMI/SED aspects of the Demonstration did not raise concerns.

The results of the Annual Assessment of Availability of Mental Services were reviewed. The baseline report reflects February 2020 data, one month prior to the onset of the PHE. While the 2022 Annual Assessment of the Availability of Mental Health Services showed a decline in the number of psychiatrist/other prescribers and in other licensed professionals, mental health service utilization has increased across all levels of care.

The largest increases in 2022 were seen in Inpatient, IMD and Intensive Outpatient/Partial Hospitalization programs. These are all programs that have been promoted under new State Plan authorities and through the Demonstration. Increases in outpatient and telehealth services were also noted for the same measurement period. Follow up to validate underlying data and continued monitoring during the transition to private MCEs is warranted.

Due to the timing of the MPA (2.5 years), annual metrics yielded only two observation points, both of which were during the PHE. Annual results were also affected by increased enrollment resulting from the State's July 2021 Medicaid expansion, and from changes in measure specifications in 2022. Due to the impact of the PHE on service utilization and availability, consistency in performance could be considered a positive outcome.

As the State transitions to the use of private Managed Care Entities, it will be important to monitor network adequacy for SUD and SMI/SED services, including transportation services to/from SUD treatment. Strategies to address underserved areas could be explored as part of the annual Managed Care quality framework. Continued monitoring of SUD and SMI/SED

annual metrics, where performance is stable or declining, should be considered as more data, post-PHE becomes available.

A summary of assessment findings and progress is outlined in H-1 for SUD Implementation Plan activities and H-2 for SMI/SED Implementation Plan activities, on the following pages. Each table includes recommendation for those Milestones/Topic Areas at medium or high risk.

Exhibit H-1. Overview of SUD Mid-Point Assessment Findings

SUD Mid-Point Assessment Overview			
CMS Milestone	**Assessment of Risk**	**Key Considerations**	**Recommendations**
Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs	Low	New levels of care were added to the State Plan. Requirements and service expectations are aligned with the ASAM levels of care for SUD treatment. Stakeholders had no concerns regarding the ASAM levels of care, although it was noted that transportation to/from SUD treatment services and between levels of care could be challenging in some regions. The majority of metrics are moving in the desired direction.	None
Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria	Low	Online tools support the ASAM level of care determinations and can also be accessed by clinicians who use the Addiction Severity Index. The online tool allows for streamlined prior authorization process based on the results of the assessment. The average length of stay (ALOS) for SUD treatment in an IMD was under the CMS requirement of 30 days or less; the ALOS in 2021 was 25 days in 2021 and the ALOS in 2022 was 28 days.	None
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Low	Accreditation and certificate of need requirements were added to the administrative rules for residential facilities. The OHCA implemented new compliance tools and oversight processes for all facilities.	None
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	Low	Services added to the State Plan support access to care across the continuum, including for Opioid Treatment Programs and Medications for OUD. Stakeholders noted that in some regions of the State availability of withdrawal management services was challenging. Both metrics identified as critical by CMS are moving in the desired direction.	None
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Low	This milestone was met upon approval of the Demonstration. Three of the metrics identified as critical are stable or moving in the desired direction. One metric has not been reported for 2022.	None
Milestone #6: Improved Care Coordination and Transitions between Levels of Care	Low	This milestone was deemed met by CMS upon Demonstration approval. Significant changes were made to measure specifications in 2022. Although many results are moving in the desired direction, results are not comparable across years.	None
SUD IT Plan	Low	The State has enhanced the ease of use for providers and PDMP through integration with the HIE.	None
Budget Neutrality	Low	The State is within budget neutrality (BN) limits for the Demonstration	None

Exhibit H-2: SMI Mid-Point Assessment Findings

SMI Mid-Point Assessment Overview			
CMS Topic	**Assessment of Risk**	**Key Considerations**	**Recommendations**
Topic #1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	Low	QRTP rules were developed and implemented. The child and adolescent needs and strengths assessment is required for all residential placement decisions.	None
Topic #2: Improving Care Coordination and Transitions to Community Based Care	Low	Requirements 2b-d were met upon approval of the Demonstration. The State's plan to expand CCBHC coverage statewide by DY3 was completed ahead of schedule.	None
Topic #3: Increasing Access to Continuum of Care, including Crisis Stabilization Services	Low	Requirements 3d-e were met upon approval of the Demonstration. Bed-tracking is in place for state-operated facilities. Tracking availability in the private provider system was delayed; however, the State is currently engaged in discussion with private providers as to how to meet this requirement. The average length of stay for all IMDs and populations is 9.43 days.	None
Topic #4: Earlier Identification, Engagement in Treatment, and Increased Integration	Medium	Requirements 4a-b and d were met upon approval of the Demonstration. The planned expansion of CCBHC coverage statewide by DY3 was completed ahead of schedule. Of the eight metrics examined, performance regarding metabolic screening for children and adults showed no change and access to ambulatory/preventive care declined. More individuals were identified with SMI/SED and follow-up care for adults newly prescribed antipsychotics improved slightly.	Continue to monitor metabolic screening for children and adults and access to ambulatory and preventive care.
SMI Finance Plan	Low	CCBHC services have been expanded as planned. The State is exploring the expansion of non-residential crisis services in DY3.	None
SMI IT Plan	Low	The State is actively engaged with IT staff, providers and the HIE team to ensure that enhancements for SMI IT, EHR functionality and interoperability within the HIE environment are addressed, as appropriate.	None
Budget Neutrality	Low	The State is within budget BN limits for the Demonstration.	None

STATE RESPONSE

ODMHSAS/OHCA continue to work closely with the evaluation team to monitor the progress of the State towards the goals and objectives of the waiver. As noted in the mid-point assessment, activities outlined in the State's implementation plans have been accomplished within expected timelines. In addition, the State will work to identify potential strategies to address concerns raised by stakeholders that can support the overall goals of the waiver. We will also continue to monitor metrics identified as medium and high risk.

APPENDIX 1. INDEPENDENT EVALUATOR AND CONFLICT OF INTEREST STATEMENT

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 of various programs operated by the OHCA, including the Section 1115 IMD Demonstration and Mid-Point Assessment.

The OHCA selected PHPG because the firm has performed multiple independent evaluations of SoonerCare program components over the past decade, including the State's Section 1115a SoonerCare Choice Demonstration.

PHPG also serves as the OHCA's contractor for 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.

In addition to its evaluation and Mid-Point Assessment work in Oklahoma, PHPG serves as the Independent Evaluator and Mid-Point Assessor for Section 1115a evaluations in New Hampshire and Maine and previously served in this role in New Mexico (under subcontract to Deloitte Consulting) and Vermont.

The OHCA schedules regular meetings with PHPG's Project Manager/Principal Investigator to receive updates on the evaluation and address any issues that arise with respect to data collection and clarity/accuracy of findings.

PHPG signed a "No Conflict of Interest" declaration in 2018 covering Section 1115a evaluation activities. The declaration remains in force. A scanned image of the document is included on the next page.

PHPG
The Pacific Health Policy Group

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December 18, 2018

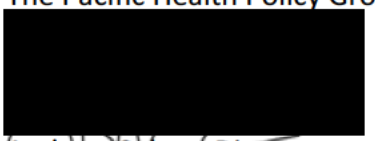
Catina Baker
Senior Research Analyst
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

Dear Ms. Baker:

The purpose of this letter is to affirm that the Pacific Health Policy Group (PHPG) has no conflict of interest with respect to serving as a independent evaluator of the SoonerCare Choice Section 1115a waiver program.

Very truly yours,

The Pacific Health Policy Group



Andrew Cohen, Director

APPENDIX 2. SUMMARY OF SUD CRITICAL METRICS

SUD Milestone 1

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Annual goal	Metric Risk Assessment
7	Average monthly count of members using Early Intervention	1.75	6.83	5.08	290.48%	Increase	Increase	Low
8	Average monthly count of members using Outpatient Services	3,626.75	6,025.67	2,399.92	66.19%	Increase	Increase	
9	Average monthly count of members using Intensive Outpatient and Partial Hospitalization Services	47.67	80.00	32.33	67.83%	Increase	Increase	
10	Average monthly count of members using Residential and Inpatient Services	491.33	1,017.83	526.50	107.16%	Increase	Increase	
11	Average monthly count of members using Withdrawal Management	75.42	248.17	172.75	229.06%	Increase	Increase	
12	Average monthly count of members using Medication-Assisted Treatment	2,599.42	5,884.67	3,285.25	126.38%	Increase	Increase	
22	Continuity of pharmacotherapy for opioid use disorder	39.84%	37.30%	-2.54%	-6.38%	Decrease	Increase	

SUD Milestone 2

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Annual goal	Metric Risk Assessment
5	Medicaid beneficiaries treated in an IMD for SUD	376	665	289	76.86%	Increase	Increase	Medium
36	Average length of stay in IMDs	25.49	28.39	2.90	11.36%	Increase	Stabilize	

SUD Milestone 4

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Annual goal	Metric Risk Assessment
13	SUD Provider Availability	854	909	55	6.44%	Increase	Increase	Low
14	SUD Provider Availability - MAT	632	696	64	10.13%	Increase	Increase	

SUD Milestone 5

Note: Critical Metric 27 (Overdose Death Rate) has not been reported for 2022

	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Annual goal	Metric Risk Assessment
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	3.43%	2.65%	-0.78%	-22.64%	Decrease	Decrease	Medium
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	9.12%	7.29%	-1.83%	-20.02%	Decrease	Decrease	
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	165.44	166.17	0.73	0.44%	Consistent	Decrease	

SUD Milestone 6

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Annual goal	Metric Risk Assessment
15a	Initiation of AOD Treatment - Total Score AOD abuse of dependence (IET-AD)	28.35%	31.99%	3.64%	12.83%	*	Increase	N/A
15b	Engagement of AOD Treatment - Total Score AOD abuse of dependence (IET-AD)	5.32%	11.07%	5.75%	108.08%	*	Increase	
17(1a)	Percentage of ED visits for AOD for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) (FUA-AD)	10.62%	26.11%	15.49%	145.86%	*	Increase	
17(1b)	Percentage of ED visits for AOD which the beneficiary received follow-up within 7 days of the ED visit (8 total days) (FUA-AD)	6.87%	16.62%	9.74%	141.80%	*	Increase	
17(2a)	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) (FUM-AD)	51.14%	46.51%	-4.63%	-9.05%	*	Increase	
17(2b)	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days) (FUM-AD)	39.10%	33.86%	-5.24%	-13.40%	*	Increase	
25	Readmissions Among Beneficiaries with SUD	0.12	0.14	0.02	21.02%	Increase	Decrease	High

* Technical specifications changed in 2022, results are not comparable to prior years

APPENDIX 3. SUMMARY OF SMI/SED CRITICAL METRICS

SMI/SED Topic 1

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Goal	Metric Risk Assessment
2	Use of first-line psychosocial care for children and adolescents on antipsychotics (APP-CH)	58.57%	55.52%	-3.04%	-5.20%	Decrease	Increase	High

SMI/SED Topic 2

Note: Critical Metric #3 (All cause ED use, PMH-20) was eliminated from reporting by CMS in 2021

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Goal	Metric Risk Assessment
4	30-day all-cause unplanned readmission following psychiatric hospitalization in an Inpatient Psychiatric Facility (IPF)	9.07%	10.85%	1.78%	19.63%	Increase	Decrease	Medium
7a	Percentage of hospital discharges for mental illness for which children ages 6-17 received follow-up within 30 days after discharge (FUH-CH)	64.22%	63.79%	-0.43%	-0.67%	Decrease	Increase	
7b	Percentage of hospital discharges for mental illness for which children ages 6-17 received follow-up within 7 days after discharge (FUH-CH)	40.37%	37.05%	-3.32%	-8.23%	Decrease	Increase	
8a	Percentage of hospital discharges for mental illness for which the members ages 18 and older received follow-up within 30 days after discharge (FUH-AD)	34.45%	37.58%	3.13%	9.09%	Increase	Increase	
8b	Percentage of hospital discharges for mental illness for which the members ages 18 and older received follow-up within 7 days after discharge (FUH-AD)	19.19%	22.01%	2.82%	14.68%	Increase	Increase	
9a	Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (FUA-AD)	10.62%	26.11%	15.49%	145.86%	*	Increase	N/A
9b	Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (FUA-AD)	6.87%	16.62%	9.75%	141.80%	*	Increase	
10a	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (FUM-AD)	51.14%	46.51%	-4.63%	-9.05%	*	Increase	
10b	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (FUM-AD)	39.10%	33.86%	-5.24%	-13.40%	*	Increase	

* Technical specifications changed in 2022, results are not comparable to prior years

SMI/SED Topic 3

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Goal	Metric Risk Assessment
19a	Average length of stay for all IMDs and populations	9.43	8.70	-0.73	-7.71%	Decrease	Stabilize	High

SMI/SED Topic 4

#	Metric name	2021	Mid-Point	Absolute Change	Percent Change	Direction	Goal	Metric Risk Assessment
26	Access to preventive/ambulatory health services for Medicaid beneficiaries w/SMI	63.39%	57.62%	-5.77%	-9.10%	Decrease	Increase	High
29a	Percentage of children and adolescents on antipsychotics who received blood glucose testing	41.90%	41.66%	-0.24%	-0.57%	Consistent	Increase	
29b	Percentage of children and adolescents on antipsychotics who received cholesterol testing	20.14%	20.03%	-0.11%	-0.51%	Consistent	Increase	
29c	Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	19.39%	19.28%	-0.11%	-0.55%	Consistent	Increase	
30	Follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication	69.58%	70.49%	0.91%	1.32%	Increase	Increase	