DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

October 28, 2026

Melissa Miller
Medicaid Director and Deputy Chief of Staff
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, Oklahoma 73105

Dear Ms. Miller:

The Centers for Medicare & Medicaid Services (CMS) is approving Oklahoma's request to renew its Medicaid section 1115(a) demonstration entitled, "Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder" (Project Number 11-W-00363/6), in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective January 1, 2027 through December 31, 2031, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

CMS has determined that the Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder is likely to assist in promoting the objectives of the Medicaid statute by assisting Oklahoma in increasing identification, initiation, and engagement of Medicaid beneficiaries diagnosed with a substance use disorder (SUD) and/or a serious mental illness (SMI). This demonstration will also assist the state in increasing adherence to, and retention in, SUD and SMI treatment programs, and in reducing inappropriate or preventable utilization of emergency departments and inpatient settings through improved access to a continuum of care services. This approval is in alignment with State Medicaid Director Letter (SMDL) #17-003 RE: Strategies to Address the Opioid Epidemic and SMDL #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid and Children's Health Insurance Program (CHIP) state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures under the demonstration. The state's SUD Implementation Plan, initially approved for the period from November 21, 2021 through December 31, 2026, remains in effect for the approval period from January 1, 2027 through December 31, 2031 and is affixed to the STCs as Attachment A.

Extent and Scope of Demonstration Renewal

The demonstration renewal aims to continue providing high quality, evidence-based SMI and SUD treatment services to individuals who are short-term residents in residential and inpatient treatment settings that qualify as Institutions for Mental Diseases (IMDs). This approval will include the following change: the state completed an assessment of its residential care treatment system for children and youth, and the state has no existing or planned residential treatment programs for youth with an SED that are Qualified Residential Treatment Programs (QRTPs) that meet the definition of an IMD. The state is requesting to eliminate the coverage authority for QRTPs for beneficiaries under age 21; it was never implemented. This approval will include the state's updated SMI/SED Implementation Plan that removes all references to QRTPs.

The renewal will not include any changes to the eligibility and enrollment, benefits, premiums and cost sharing, or delivery system in the demonstration.

Budget Neutrality

This demonstration project is being renewed using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.[1] However, CMS acknowledges that section 71118 of the Working Families Tax Cut (WFTC) legislation adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.[2] CMS issued SMDL #26-003[3] on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement subsection 1115(g) of the Act, and expects to provide additional guidance to states on implementation of this provision.

Under SMDL-#24-003, issued August 22, 2024, as a condition of demonstration approval, demonstrations must be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[4] The demonstration renewal is projected to be budget neutral to the federal government. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

Rebasing Without Waiver Baselines

Under this demonstration, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the WOW baseline by using a weighted average of the state's

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[2] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[3] SMDL #26-003: https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf
[4] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Mid-Course Correction
CMS has included a mid-course corrections STC in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted the Interim Evaluation Report as part of the renewal application. Findings from the Interim Evaluation Report, which covers January 1, 2017 through December 31, 2023, and the most recent Monitoring Report, which covers January 1, 2025 to December 31, 2025, show that the state has made mixed progress toward its demonstration goals.

For the SUD component, the Interim Evaluation Report showed improvements in provider capacity, treatment utilization, opioid prescribing, and access to care. The total number of Medicaid-enrolled SUD treatment providers grew eight percent from baseline, from 854 providers in 2021 to 923 in 2023, while providers qualified to deliver medication-assisted treatment (MAT) increased 16 percent over the same period, from 632 to 733. High-dose opioid prescribing declined from a baseline of 8.4 percent in 2020 to 4.1 percent in 2023. The evaluation also found statistically significant increases in service utilization, including ambulatory and preventive care, withdrawal management and detoxification services, and MAT for members with SUD. More recent monitoring data also indicate increases in the number of beneficiaries receiving MAT or any SUD-related treatment, utilization of residential and inpatient SUD services, withdrawal management services, and intensive outpatient and partial hospitalization services, as well as continued growth in SUD provider availability. Average length of stay (ALOS) in SUD IMDs slightly increased by 0.8 days from the previous reporting period, while emergency department utilization decreased by 18 percent over the same period.

For the SMI/SED component, the demonstration saw improvements in service capacity and certain care coordination and quality outcomes. The state significantly expanded crisis services, with the number of crisis observation and assessment centers increasing from five at baseline to

25 by 2023 and crisis stabilization units increasing from 11 to 17. Members receiving certified community behavioral health clinic (CCBHC) services consistently outperformed comparison members on medication continuation after psychiatric discharge, access to ambulatory and preventive care, follow-up after hospitalization among children, and follow-up after mental-health ED visits among adults. More recent monitoring data also showed increases in utilization of inpatient, outpatient, intensive outpatient, and partial hospitalization mental health services, compared to the previous year, suggesting sustained expansion in access to behavioral health care. The state also reported a 1.32-day reduction in ALOS for beneficiaries receiving SMI/SED IMD services compared with the prior reporting period.

However, the Interim Evaluation Report identified areas where progress has been more limited, including limited improvement in psychosocial care or metabolic monitoring for youth on antipsychotics, declines in adult follow-up after mental health emergency department visits in the pre/post CCBHC analyses, and provider availability, as growth in the SMI/SED population outpaced growth in psychiatrists and authorized prescribers. More recent monitoring data reinforce these ongoing challenges, showing continued declines in follow-up after hospitalization and after emergency department visits for adults with mental illness, increases in psychiatric readmissions, and continued challenges with metabolic monitoring and follow-up after new antipsychotic prescriptions.

Based on the mixed progress made thus far on its goals, as well as the ongoing opportunities for improvements in follow-up after ED visits, readmission rates for SMI, provider availability, and the unassessed goal of reducing opioid overdose deaths, the state is requesting, and CMS is granting additional time to continue the demonstration. To ensure continued accountability for progress toward the demonstration goals, the state is required under this renewal to continue conducting systematic monitoring and robust evaluation of the demonstration. In collaboration with CMS, the state must undertake demonstration monitoring, including reporting of relevant metrics data and narrative details describing progress with implementation of all components of the demonstration.

In addition, the state is also required to conduct an independent Mid-Point Assessment (MPA) of the SMI/SUD demonstration initiatives, as described in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies. The state is required to conduct an evaluation of the demonstration covering the full renewal approval period, assessing the demonstration's effectiveness for beneficiaries, providers, and the state's Medicaid program overall. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs.

Consideration of Public Comments

CMS posted the application on Medicaid.gov for a 30-day federal public comment period from July 11, 2025 through August 10, 2025. CMS received one comment from an organization which was in support of the demonstration. While the organization supports the demonstration, it would like the state to consider including requirements to screen and address co-morbid health conditions and to consider the unique needs of pregnant and postpartum patients in the development of IMD evaluation criteria. Oklahoma acknowledges the organization’s feedback

and remains committed to ensuring individuals with SMI and SUD, including pregnant and postpartum populations, will have access to high-quality care, but at this time, these recommendations will not be implemented in the demonstration. Additionally, the organization encourages Oklahoma to consider additional proposals that would maintain the opportunity for health care coverage to address the youth population's health needs. Services for this population are covered through existing Medicaid authorities, such as early periodic screening, diagnostic, and treatment (EPSDT) and state plan behavioral health services.

CMS has concluded that renewing the Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder is likely to promote the objectives of Medicaid.

Program Integrity

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX and title XXI of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Other Information

CMS's approval of this demonstration renewal is conditioned upon compliance with the enclosed set of expenditure authorities and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Rachel Bogdan, who is available to answer any questions concerning your section 1115 demonstration and his contact information is as follows:

Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Rachel.Bogdan@cms.hhs.gov

If you have questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,



Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosure

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00363/6

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

AWARDEE: Oklahoma Health Care Authority

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Oklahoma for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from January 1, 2027 through December 31, 2031, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

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

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

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment services for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00363/6

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

AWARDEE: Oklahoma Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STC) for the "Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Oklahoma Health Care Authority (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authority authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on the expenditure authority, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from January 1, 2027 through December 31, 2031.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. SUD Programs and Benefits
VI. Serious Mental Illness (SMI) Program and Benefits
VII. Cost Sharing
VIII. Delivery System
IX. Monitoring and Reporting Requirements
X. Evaluation of the Demonstration
XI. General Financial Requirements
XII. Monitoring Budget Neutrality for the Demonstration
XIII. Schedule of Deliverables for the Demonstration Period

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

Attachment A: SMI/SED Implementation Plan and Financing Plan

Attachment B: SUD Implementation Plan
Attachment C: Evaluation Design (Reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

SUD Goals:

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

SMI Goals:

1. Reduced utilization and lengths of stay in EDs among beneficiaries with SMI while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
3. Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals and residential treatment settings throughout the state;
4. Improved access to community-based services to address the chronic mental health care needs or beneficiaries with SMI, including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

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

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

8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period

authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the thirty 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
    b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
    c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
    d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.
    e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
    f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
    g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services,

continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

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

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

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

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

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

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

IV. ELIGIBILITY AND ENROLLMENT

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

V. SUD PROGRAM AND BENEFITS

17. SUD Program Benefits. The demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state is eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to STC 34, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

18. SUD Implementation Plan. The state's SUD Implementation Plan, initially approved for the period from November 21, 2021 through December 31, 2026, remains in effect for the approval period from January 1, 2027 through December 31, 2031 and is affixed to the STCs as Attachment A. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 33. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD project:

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

b. Use of Evidence-based SUD-specific Patient Placement Criteria.

i. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines;

ii. Utilization Management. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings;

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

i. Implementation of residential treatment provider qualifications. Currently, residential treatment service providers are established under current administrative rules, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is responsible for certifying SUD residential providers and maintains SUD residential provider manuals. ODMHSAS may accept accreditation granted by The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children as compliance with certain standards; however, national accreditation is not required and may not be substituted for certification by ODMHSAS. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings;

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

ii. Availability of MAT. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site;

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

e. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.

i. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;

ii. Expand coverage of and access to naloxone for overdose reversal;

iii. Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

f. Improved Care Coordination and Transitions between levels of care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities;

g. SUD Health IT Plan. Information Technology plan that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 35 and Attachment B.

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

The Health IT Plan describes how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, standards adopted by the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) in accordance with 45 CFR part 170, subpart B.

The state's Health IT Plan, initially approved for the period from November 22, 2021 through December 31, 2026, remains in effect for the approval period from January 1, 2027 through December 31, 2031 and is affixed to the STCs as Attachment A.

a. The state must monitor progress, each DY, on the SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 34).

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

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

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

e. Specific components of the Health IT Plan are listed below:

i. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP).[1]

ii. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] States should favor procurement strategies that incorporate Qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in open interfaces and exposed application program interfaces.

iii. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

20. Unallowable Expenditures Under the SUD Expenditure Authority. The state may not receive FFP for room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

VI. SERIOUS MENTAL ILLNESS (SMI) PROGRAM AND BENEFITS

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

21. SMI Program Benefits. Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI treatment services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD setting through this demonstration's SMI Program, to be monitored pursuant to STC 34.

22. SMI/SED Implementation Plan. The state's SMI/SED Implementation Plan, initially approved for the period from December 15, 2020 through December 22, 2020 through December 31, 2026, remains in effect for the approval period from January 1, 2027 through December 31, 2031 and is affixed to the STCs as Attachment A. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 34. The approved SMI Implementation Plan describes the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SMI/SED project:

a. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

i. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

ii. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

iii. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state

licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

iv. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

v. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

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

b. Improving Care Coordination and Transitions to Community-Based Care.

i. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of these settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);

ii. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;

iii. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to

this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;

iv. Implementation of strategies to prevent or decrease the length of stay in emergency departments (ED) among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

v. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

c. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

i. 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 (the state must provide a yearly update on the availability of mental health services via the Annual Monitoring report);

ii. Commitment to implementation of the SMI/SED financing plan described in STC 24. The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 34;

iii. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;

iv. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association [e.g., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to help determine appropriate level of care and length of stay.

d. Earlier Identification and Engagement in Treatment and Increased Integration.

i. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

ii. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;

iii. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED

e. The Implementation Plan must also include sections containing the SMI/SED Health IT Plan and the SMI/SED Financing Plan. Further information which describes the requirements are detailed in STC 23, STC 24 and Attachment A.

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

The state's Health IT Plan, initially approved for the period from December 15, 2020 through December 31,2026, remains in effect for the approval period from January 1, 2027 through December 31, 2031 and is affixed to the STCs as Attachment A.

a. The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 34).

b. As applicable, the state should advance HHS-adopted standards identified in 45 CFR 170 Subpart in developing and implementing the state's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

c. Where there are opportunities at the state- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care Organization (ACO) participation agreements) to leverage federal funds to acquire, upgrade, or implement health IT that can be supported by standards referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

d. Where there are opportunities at the state- and provider-level to leverage federal funds to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170 Subpart B, the state should seek to use other non-proprietary standards and

implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).[1]

e. Specific components of the Health IT Plan are listed below:

i. The Health IT Plan, as applicable, describes the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SED/SMI care delivery. The state also indicates current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

ii. The Health IT Plan describes the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.

24. SMI/SED Financing Plan. As part of the SMI/SED implementation plan referred to in STC 22(e) the state is required to submit a financing plan for approval by CMS. The state's SMI/SED Financing Plan, initially approved for the period from December 15, 2020 through December 31, 2026, remains in effect for the approval period from January 1, 2027 through December 31, 2031 and is affixed to the STCs as Attachment A. Components of the financing plan include:

a. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

b. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

25. Maintenance of Effort (MOE). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 34.

26. Average Length of Stay Requirements and FFP. Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services

furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

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

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

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

VII. COST SHARING

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

VIII. DELIVERY SYSTEM

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

IX. MONITORING AND REPORTING REQUIREMENTS

30. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non–compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non–compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

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

31. Deferral of Federal Financial Participation from IMD Claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar year and each calendar year thereafter until CMS has determined sufficient progress has been made.

32. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

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

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

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

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

34. Monitoring Reports. The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates**. Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics**. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable

milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the state is expected to report monitoring metrics for the following demonstration initiatives, as described below and per applicable CMS guidance:

- For the SUD and/or SMI/SED component(s), the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003) and/or the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).

c. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

35. SMI/SED and SUD Mid-Point Assessment. The state must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent Mid-Point Assessment and submit to CMS by December 31, 2029. This timeline will allow for the Mid-Point Assessment to capture approximately the first two and a half years of program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and execution of the Mid-Point Assessment, the state must require that the Independent Assessor consult with key stakeholders such as, representatives of MCOs, health care providers, beneficiaries, community groups, and other key partners.

1. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must

submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any.

2. Elements of the Mid-Point Assessment must include:

    a. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;

    2. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;

    3. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

    4. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement.

36. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC #10. CMS might withdraw an authority, as described in STC #10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC #10, are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

37. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

i. The Close-Out Report must comply with the most current guidance from CMS.
ii. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in STCs #46 and #47, respectively.
iii. The state will present to and participate in a discussion with CMS on the Close–Out Report.

iv. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
v. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.
vi. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC #37.

38. Monitoring Calls. CMS will convene, no less frequently than quarterly, monitoring calls with the state.

i. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.
ii. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.
iii. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
iv. The state and CMS will jointly develop the agenda for the calls.

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

X. EVALUATION OF THE DEMONSTRATION

40. Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-

state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC #32.

41. Independent Evaluator. The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

42. Evaluation Design. The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs #46 and #47.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

43. Evaluation Design Approval and Updates. The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

44. Evaluation Questions and Hypotheses. Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

a. Hypotheses for the SUD component of the demonstration must align with the goals of the program, including increasing rates of identification and initiation of and engagement in treatment as well as adherence to and retention in treatment, reducing overdose deaths, reducing utilization of emergency departments and inpatient hospitalizations as well as readmissions to the same or higher levels of care, and improving access to care for physical health conditions.

b. Hypotheses for the SMI/SED component must map to the goals of the program, including reducing utilization and lengths of stay in emergency departments, reducing preventable readmissions to acute care hospitals and residential settings, improving the availability of crisis stabilization services, improving access to community-based services, and improving care coordination.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration

policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

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

46. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs

prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

47. Summative Evaluation Report. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

48. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC #10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

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

51. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

XI. GENERAL FINANCIAL REQUIREMENTS

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

53. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

54. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up for the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
b. If CMS determines that any funding sources are not consistent with application federal statutes or regulations, the state must address CMS's concerns within the time frame allotted by CMS.
c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration .

55. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).
c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of expenditures under the demonstration.
d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are

unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

56. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

57. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

58. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 30. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

59. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section XII:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

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

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

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
SMI Adults	Hypo 1	X		X	Adult Medicaid beneficiaries diagnosed with a SMI
SUD Adults	Hypo 1	X		X	Adult Medicaid beneficiaries diagnosed with a SUD

SUD Children	Hypo 1	X		X	Child Medicaid beneficiaries diagnosed with a SUD

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

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

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

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

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

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

e. **Member Months.** Using the Budget Neutrality Monitoring Tool, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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

Table 3: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SMI Adults	Medicaid beneficiaries diagnosed with a SMI	See STC 63	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	12/22/2020	12/31/2031
SUD Adults	Medicaid beneficiaries diagnosed with a SUD	See STC 63	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	12/22/2020	12/31/2031
SUD Children	Medicaid beneficiaries diagnosed with a SUD	See STC 63	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	12/22/2020	12/31/2031

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

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

Table 4: Demonstration Years		
Demonstration Year 7	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 8	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 9	January 1, 2029 to December 31 2029	12 months
Demonstration Year 10	January 1, 2030 to December 31, 2030	12 months
Demonstration Year 11	January 1, 2031 to December 31, 2031	12 months

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

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

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

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

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

66. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Content of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 66c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to

its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

    vi. High-cost innovative medical treatments that states are required to cover; or,

    vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update**. The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
    i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

    ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

68. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 2, Master MEG Chart and Table 3, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

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

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

71. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to

variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical;" such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

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

Table 5: Hypothetical Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR 2025	TREND	DY 7	DY 8	DY 9	DY 10	DY 11
SMI Adults	PC	Both	$9,675	5.3%	$10,728.33	$11,296.93	$11,895.67	$12,526.14	$13,190.03
SUD Adults	PC	Both	$5,099.58	5.3%	$5,654.46	$5,954.15	$6,269.72	$6,602.02	$6,951.93
SUD Children	PC	Both	$7,465.67	4.5%	$8,152.70	$8,519.57	$8,902.95	$9,303.58	$9,722.24

73. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite

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

74. **Budget Neutrality Monitoring Tool and Reporting Requirements.** Per 42 CFR 431.428, the state must document the financial performance of the demonstration. The state must provide quarterly budget neutrality status updates that meet all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs (including the submission of corrected budget neutrality data upon request), using the Budget Neutrality Monitoring Tool provided through the Demonstration Evaluation & Management Oversight System (DEMOS). The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in the Monitoring Budget Neutrality for the Demonstration section. The quarterly budget neutrality status updates are due no later than 60 calendar days following the end of each demonstration quarter, while the fourth-quarter information is due no later than 90 calendar days following the end of the DY. These monitoring reports are subject to the deferral as described in STC 30.[3]

75. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from January 1, 2027 to December 31, 2031. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test(s) has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test will be based on the time elapsed through the termination date.

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

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

Table 6: Budget Neutrality Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 7	Cumulative budget neutrality limit plus:	2.0 percent
DY 7 through DY 8	Cumulative budget neutrality limit plus:	1.5 percent
DY 7 through DY 9	Cumulative budget neutrality limit plus:	1.0 percent
DY 7 through DY 10	Cumulative budget neutrality limit plus:	0.5 percent
DY 7 through DY 11	Cumulative budget neutrality limit plus:	0.0 percent

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Deliverable	Timeline	STC Reference
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STCs 42 and 43
Interim Evaluation Report	One year prior to the end of the demonstration period, or when the extension application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC 46
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 47
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC 34
Mid-Point Assessment	No later than December 31, 2029	STC 35

Deliverable	Timeline	STC Reference
CMS-64 Quarterly Medicaid Expenditure Report	30 calendar days after the end of each quarter	STC 53
Quarterly Budget Neutrality Monitoring Report	60 calendar days after the end of each demonstration quarter except the 4th quarter which is due 90 days after the end of each DY	STC 74
Annual Budget Neutrality Monitoring Report	90 calendar days after the end of each demonstration year	STC 74

ATTACHMENT A
SMI/SED Implementation Plan and Financing Plan

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

State Point of Contact:
Name and Title: Melissa Miller, State Medicaid Director
Telephone Number: (405) 693-8260
Email Address: Melissa.Miller@okhca.org

Name and Title: Heather Cox, Deputy State Medicaid Director
Telephone Number: (405) 522-7229
Email Address: Heather.Cox@okhca.org

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

State	*Oklahoma*
Demonstration name	*Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder*
Approval date	*XX/XX/XX*
Approval period	*1/1/2027 through 12/31/2031*
Implementation date	*1/1/2027*

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

Prompts	Summary
	The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities. Facility-based crisis units must have certification from ODMHSAS as a Community-Based Structured Crisis Center (CBSCC) and be contracted with ODMHSAS. Provider qualifications are established in OAC 450:23 and providers are limited to CMHCs, CCARCs (Certified Comprehensive Addiction Recovery Centers), or state operated entities by state law. All CBSCCs currently in the state are also CMHCs. CBSCCs must provide 24/7 crisis triage services, 24/7 physician supervision, and 24/7 emergency examination, evaluation, and observation.
	Future Status: Continuation of current requirements. The State will ensure all participating IMD crisis units are nationally accredited by CARF, the Joint Commission, or the Council on Accreditation through the Medicaid enrollment process to ensure compliance with this milestone.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* The OHCA conducts onsite service quality reviews (SQR) of facilities providing behavioral health services to SoonerCare members. The audited facilities include acute free-standing psychiatric facilities, psychiatric units within acute general care hospitals, psychiatric residential treatment facilities (PRTFs), community-based treatment (CBT) units and therapeutic foster care (TFC) agencies. The reviews are conducted pursuant to federal regulations requiring the periodic inspection of institutions for mental diseases and Oklahoma regulations requiring these facilities to "maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities." The overarching purpose of these periodic reviews is to verify that facilities are safe for residents, as verified through physical inspections, and that they provide medically necessary care, as documented through patient records. Safety issues and other areas of non-compliance are subject to corrective action plans or, in extreme cases, termination; services not shown to be medically necessary are subject to recoupment. ODMHSAS conducts regular certification site visits for CBSCCs to ensure compliance with all requirements in OAC 450:23 and correction of any previously identified deficiencies. Failure to meet requirements results in suspension or revocation of certification. Unannounced site visits are conducted when necessary to investigate complaints and when initial certification/recertification results in compliance below a minimal threshold.

Prompts	Summary
	Future Status: Continuation of current oversight activities for hospitals and CBSCCs.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status:* Medical necessity criteria and prior authorization requirements for acute psychiatric admissions are stated in Oklahoma Administrative Code 317:30-5-95.1. Facility-based crisis services are currently authorized by ODMHSAS through an instant prior authorization process. OHCA currently provides utilization review for enrolled adults aged 21-64 receiving inpatient services. ODMHSAS requires providers to complete a Client Assessment Record (CAR) for each member to assist in identifying the level of care need. This standardized tool captures information across multiple domains including cognition, mood, substance use, and self-care.
	Future Status: Prior authorization will be required for all newly eligible inpatient stays for adults and residential stays for adolescents authorized within the waiver through a process developed by OHCA in partnership with ODMHSAS (for adult inpatient) .
	Summary of Actions Needed: OHCA will update Administrative Code 317:30-5-41.1 and 317:30-5-95 to reflect reimbursement for acute psychiatric services in IMDs under this demonstration. OHCA will create a reporting structure for purposes of monitoring the ALOS in IMDs.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* In order to receive reimbursement under Medicaid, participating psychiatric hospitals and facility-based crisis units must be enrolled to participate in Oklahoma Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. The OHCA Program Integrity (PI) division spearheads an agency wide effort to identify, recover and prevent inappropriate provider billings and payments. This effort includes the full continuum of behavioral

Prompts	Summary
	health services. OHCA ensures proper payment to providers and recovers misspent funds leveraging staff in three PI units to perform or assist in provider record review audits. These PI units are Clinical Provider Audits, Behavioral Health Audits, and Data Analytics and Payment Accuracy.
	Future Status: Continued operation of current requirements for psychiatric hospital and crisis units.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* OAC 317:30-5-95.4 requires an individual plan of care for adults aged twenty-one (21) to sixty-four (64) based on a thorough assessment immediately before or upon admission. This plan of care is reviewed every seven (7) days. The plan must incorporate information from required medical, psychiatric, and social evaluations that review physical health, substance use disorders, and suicide ideation. Discharge plans are required to include recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, to include the specific appointment information (time, date, and name, address, and telephone number of provider and related community services); and a summary of the member's condition at discharge (317:30-5-95.10). OAC 450:23-3-3 requires emergency triage, screening for co-occurring disorders, and integrated mental health and SUD examination for facility based crisis stabilization providers.
	Future Status: Continued operation of current requirements for hospitals.
	Summary of Actions Needed: Develop and/or integrate procedures and compliance monitoring of discharge planning by 12.01.2021. Provide technical assistance and outreach to providers by 10.01.2021.
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* Quality of care issues are also identified through client satisfaction surveys. For example, Griffin Memorial Hospital and Tulsa Center for Behavioral Health use a mutual client satisfaction survey which is administered at discharge to everyone leaving the facility. Many of the items were taken from the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey. Other inpatient facilities use similar surveys. CBSCCs have developed a survey for discharging clients as well.
	Future Status: Continued administration of client satisfaction surveys.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	

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

Prompts	Summary
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status*: State Hospitals providing acute inpatient services are required under OAC 450:30-9-8 to provide continued treatment planning which begins with the consumer and, pursuant to releases signed by the consumer, the family and the local community mental health center as soon as the consumer is admitted to the state-operated psychiatric inpatient unit. Discharge planning must also include a written discharge plan to address the basic needs of the consumer including but not limited to housing, income maintenance and social support as well as specific provisions for ongoing community based mental health or substance abuse treatment needs. CMHCs who partner in the discharge planning are also required to provide services to individuals with housing insecurity, including linkage and contacts with local housing authorities to assist with accessing income benefit programs and housing programs, among other services *(OAC 450:17-3-161).* OAC 450:23-3-8 requires CBSCCs to make specific referrals and linkages for homeless individuals, including housing authorities, shelters, and food banks.
	Future Status: Continue policy with monitoring by ongoing review of documentation of linkage activities and agreements; clinical records; PICIS reporting data; and CMHC policy and procedures.
	Summary of Actions Needed: N/A –milestone requirements already met.
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* ODMHSAS administrative code 450:17-3-103 requires CMHC case management services for consumers admitted to higher levels of care including: (a) Case managers shall maintain contact with existing CMHC consumers, and establish contact with newly referred persons who are receiving services in inpatient psychiatric settings, Community Based Structured Crisis Centers, (CBSCC), or 24-hour settings providing substance use disorder treatment; and (b) Each CMHC shall assign at least one (1) staff member who is responsible for linkage between psychiatric inpatient units, CBSCCs, and/or the substance use disorder treatment facility and the CMHC. In addition, CMHCs are required to maintain regular visits or communication with the psychiatric inpatient unit, CBSCC, and/or substance use disorder treatment facility to monitor progress of those consumers hospitalized and/or in facility-based substance use disorder treatment from the CMHC's service area. CMHCs must also provide knowledge and communication to other CMHC staff regarding psychiatric inpatient unit admission, CBSCC and/or substance use disorder treatment facility and discharge procedures. For admissions, case managers from the CMHC to which the consumer will be discharged must assist the consumer and psychiatric inpatient unit, CBSCC, and/or substance use disorder treatment facility with discharge planning for consumers returning to the community. Individuals discharging from an inpatient psychiatric unit setting, CBSCC, and/or substance use disorder treatment facility, who have not already been engaged, shall be offered case management and other supportive services by CMHCs. This must occur as soon as possible but shall be offered no later than one (1) week post-discharge. CMHCs,

Prompts	Summary
	which are statewide, are also required to assign designated staff and provide ongoing visits and communication with inpatient psychiatric units, CBSCCs, and substance use disorder treatment facilities. CCBHCs must make and document reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge. The CCBHC is also required to collaborate with all parties involved including the discharging/admitting facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s). Compliance is monitored by a review of the following: clinical records; staff interviews; information from ODMHSAS operated psychiatric inpatient units; CBSCC facilities, substance use disorder treatment facilities; meetings minutes (CMHC or state-operated psychiatric inpatient unit); and a review of a minimum of ten (10) clinical records of consumers who received services at an inpatient unit, CBSCC, and/or 24-hour setting providing substance use disorder treatment within the past twelve (12) months.
	Future Status: Continuation of existing requirements for CMHCs. . Statewide expansion of CCBHCs. The State is aiming for this to be achieved by Year 3 of the demonstration. Steps will include ongoing technical assistance to CMHCs, including continuation of regular meetings with these providers.
	Summary of Actions Needed: N/A - Milestone criteria is met. Develop requirements and procedures for required post-discharge follow up by 10.01.2021.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* Oklahoma implemented a Behavioral Health Home (BHH) program. Oklahoma's BHH service delivery model is designed to improve care coordination and service integration, with the goal to improve health outcomes and control future health care costs for individuals with serious mental illness (SMI) or serious emotional disturbance (SED). Care is delivered using an integrated team that comprehensively addresses physical, mental health and substance use disorder treatment needs to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote the use of Health Information Technology (HIT), and avoid unnecessary care. There are 21 Health Homes for adults with SMI and 20 Health Homes for children with SED within the provider network; all CMHCs are certified as Health Homes. These Health Homes are required to provide care coordination and care management to ensure integrated behavioral health and health care.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A-milestone met
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* In addition to CMHCs, Oklahoma currently certifies Certified Community Behavioral Health Centers (CCBHC), with four CCBHCs serving a significant portion of the state and two additional CCBHCs in the process of being certified. CCBHCs must develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Emergency Departments, Psychiatric Residential Treatment Facilities (PRTF), ambulatory and medical withdrawal management facilities or other system(s) to ensure a formalized structure for transitional care planning, to include

Prompts	Summary
	communication of inpatient admissions and discharges of BHH participants. Transitional care will be provided by the CCBHC for consumers who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities. The CCBHC will make and document reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge. The CCBHC is also required to collaborate with all parties involved including the discharging/admitting facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s). Transitional care is not limited to institutional transitions but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services. The CCBHC must document transitional care provided in the clinical records. Oklahoma implemented a Behavioral Health Home (BHH) program. BHHs must develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Psychiatric Residential Treatment Facilities (PRTF) or other system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of BHH participants. May 2017 outcomes measures for Health Homes indicate that follow up rates after hospitalization for Mental Illness within 7 days after discharge have gone from 33.8% in June 2016 to 84.2% in March 2017.
	Future Status: Expansion of CCBHCs throughout the demonstration through support and certification of additional facilities.
	Summary of Actions Needed: Expansion of CCBHCs statewide throughout the course of the demonstration. The State is aiming for this to be achieved by Year 3 of the demonstration. Steps will include ongoing technical assistance to CMHCs, including continuation of regular meetings with these providers.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists,	*Current Status:* Oklahoma provides a comprehensive statewide service array as described in the availability assessment.

Prompts	Summary
other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment	*Future Status:* OHCA, in partnership with ODMHSAS, will annually monitor the provider network through completion of the CMS-designated Mental Health Availability Assessment. Where geographic shortage areas are identified, targeted outreach to non-Medicaid enrolled providers in those areas will be conducted. In addition, the state will add the capability to assess the number of providers accepting new patients with implementation of managed care (anticipated 10.01.2021).
	Summary of Actions Needed: Annual completion of the CMS-designated Mental Health Availability Assessment and provider outreach, as applicable. Review of managed care RFP responses to ensure entities can provide data on providers accepting new patients, as required in the RFP, by 03.01.2021. Monitor to ensure this data is captured within overall data required to be submitted by managed care entities on an ongoing basis, beginning 04.01.2022.
a. 3.b Financing plan – See additional guidance in Attachment A	*Current Status:* Please refer to Financing Plan below.
	Future Status: Please refer to Financing Plan below.
	Summary of Actions Needed: Please refer to Financing Plan below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* ODMHSAS tracks, in real-time, state operated acute psychiatric and crisis stabilization bed availability.
	Future Status: The current functionality will be expanded to track all Medicaid-contracted inpatient facilities.
	Summary of Actions Needed: ODMHSAS, in partnership with OHCA, will implement these system changes by July 2021.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of	*Current Status:* ODMHSAS requires providers to complete a Client Assessment Record (CAR) for each member to assist in identifying the level of care need. This standardized tool captures information across multiple domains including cognition, mood, substance use, and self-care. DHS will require age-appropriate, evidence-based, validated, functional assessment to ensure appropriate placement.
	Future Status: Continue required use of CAR including submission with inpatient PA requests.

Prompts	Summary
care and length of stay	*Summary of Actions Needed:* N/A Milestone is met.
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* A tiered support system is currently in place to ensure every effort is made to use inpatient and residential beds only when clinically indicated and to support successful outcomes with outpatient services and community supports. ODMHSAS data show that 90% of urgent care clients are diverted from needing a crisis care bed; approximately 93% of individuals receiving crisis care do not move to a hospital bed; and approximately 95% of crisis care recipients are engaged with outpatient service follow-up within seven days of leaving crisis care. In the adult system, CMHCs provide emergency assessments to individuals within their communities, largely via telehealth in rural areas. During this process, Licensed Behavioral Health Professionals (LBHPs) have the opportunity to stabilize a potential mental health crisis. Seven CMHCs currently serve adults within their mobile crisis teams. There are 11 Programs of Assertive Community Treatment, all of whom respond to their clients 24/7 (some leveraging technology such as IPads) to de-escalate crisis situations and help individuals maintain independence within their own home, in their own community. ODMHSAS data shows that the average number of inpatient days for CMHC clients has gone from 29.9 in SFY 2015 to 18.7 in SFY 2019. There are nine crisis centers for adults located in the state. Currently the state has only one facility-based crisis center with 16 or more beds; however, the state requests authority under this demonstration to include eligibility for Medicaid reimbursement for such facilities that qualify as IMDs. Crisis centers serve as an important component of the continuum of care, often preventing need for inpatient admission and allowing for diversion of individuals in behavioral health crisis from emergency departments when clinically appropriate. The 13 CMHCs also participate in the Oklahoma Systems of Care (SOC) Initiative. Currently, Oklahoma has 80 local SOC sites that cover 72 counties. The SOC sites work in equal partnership with local teams and community organizations to ensure that children with SED and their families have access to the full array of services they need and want. The SOC initiative includes mobile crisis response and coordinated community response for children across most of the state, as well as community-based assessment to ensure children are placed in appropriate settings and supported in the community whenever possible. Community Based Structured Crisis Centers for children, located in Oklahoma City and Tulsa, address the emergent needs of children and their families.
	Future Status: Expanded access to facility-based crisis centers through increased beds within existing facilities as well as new facilities.
	Summary of Actions Needed: Waiver approval and implementation.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts	

Prompts	Summary
to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
b. 4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment	*Current Status:* OHCA reimburses for behavioral health services provided within a school setting, including screening, psychological evaluation and testing, psychotherapy, and therapeutic behavioral services. These school-based services are available statewide. In addition, the 13 CMHCs participate in the Oklahoma Systems of Care (SOC) Initiative. Currently, Oklahoma has 80 local SOC sites that cover 72 counties. The SOC sites work in equal partnership with local teams and community organizations to ensure that children with SED and their families have access to the full array of services they need and want. The SOC initiative includes mobile crisis response and coordinated community response for children across most of the state, as well as community-based assessment to ensure children are placed in appropriate settings and supported in the community whenever possible. Community Based Structured Crisis Centers for children, located in Oklahoma City and Tulsa, address the emergent needs of children and their families. In addition, there are 2 RA1SE NAVIGATE programs to assist individuals who are experiencing First Episode of Psychosis (FEP), along with 1 early Serious Mental Illness (eSMI) Crisis Care program, and 13 statewide early Serious Mental Illness (eSMI) Outreach Programs provided through CMHCs. These programs develop and maintain collaborative partnerships with local higher education institutions and local hospitals to increase exposure to young adults within the age range that is most at risk for eSMI. **Special Education.** Under the provision of the Individuals with Disabilities Education Act, children who are placed in a special education program because of a SED must have an Individual Education Plan (IEP). Many CMHC staff and programs particularly affiliated with local Systems of Care are actively involved in supporting families and children for whom an IEP is needed. **Supported Education:** Adult basic education, like GED classes, is offered on site at two clubhouse programs, and at some CMHCs. CMHCs and other providers also offer advocacy and support services to assist consumers with accessing GED classes within the community, as well as, other community based educational opportunities (i.e., technology centers, trade schools, colleges, universities) and promoting ongoing educational success. Through the ODMHSAS Individual Placement Services (IPS) program, training on "How to Get a GED" is offered for providers and other community stakeholders. **Employment Services.** CMHC case managers assist adults age 18 and older with job location and placement. These activities are funded by the ODMHSAS and specific service codes provide claims and reimbursement data for this. In addition, HOPE Community Services offers a supported employment program. Transitional employment programs are provided by Thunderbird Clubhouse and Crossroads Clubhouse. Both clubhouses are accredited by Clubhouse International (formerly the International Center for Clubhouse Development). The ODMHSAS and the Oklahoma Department of Rehabilitation Services (OKDRS) assist with funding various activities within this array of employment

Prompts	Summary
	services and utilize a memorandum of understanding to coordinate and monitor related activities. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has adopted Individual Placement and Supports (IPS) as their standard evidence-based supported employment and education model. The ODMHSAS believes that the best way to support self-sufficiency for those assisted with employment is to reinforce rapid entry into the competitive labor market integrated with supportive services as soon as the person feels ready. This focus on the participant's choice and strengths aligns closely with other evidence-based practices models followed by the ODMHSAS and affiliated providers and has allowed for better service provision for Oklahoma's most vulnerable. IPS has expanded to twelve teams serving 23 counties across the state of Oklahoma funded through various different grants, including the Mental Health Block Grant; State Opioid Response grant, Oklahoma Now is the Time grant, and the Assisted Outpatient Treatment grant. On July 1, 2018, the ODMHSAS activated IPS specific billing codes, and the IPS credential process for IPS employment specialists and supervisors. This allows for providers to submit payment claims for delivery of IPS services to ODMHSAS. **Housing Supports:** Assuring satisfactory access to safe, sanitary, and affordable housing for adults with mental illness continues to be a challenge to the state. Specific housing services for people with mental illness are available in urban and rural settings and are funded through the ODMHSAS, the U.S. Department of Housing and Urban Development (HUD), public housing authorities and private sources. Housing models include transitional housing and permanent supported housing (both congregate and scattered site). Although some housing continues to be developed in settings specifically for persons with mental illness (i.e., HUD funded Section 811 and HUD SHP projects), the ODMHSAS continues to place an emphasis on creating opportunities for more integrated housing, including permanent scattered site housing with available support services. Some stakeholders continue to encourage the development of transitional housing services to meet the needs of consumers whose current level of recovery would make it difficult to have success in a supported housing model. The state currently has multiple Housing First programs that support individuals with SMI. These programs are the result of multiagency partnerships at the local level between behavioral health providers and housing authorities. OHCA and ODMHSAS support these programs through reimbursement for medical and case management services, including screening and referral to needed behavioral health treatment. Additional housing related service and supports embedded in the system for adults with SMI include flexible funds available to each CMHC that can be used to augment a variety of housing supports, including rental and utility deposits; a Discharge Planning Housing Subsidy specifically for adults discharging from psychiatric inpatient care, Department of Corrections, or aging out of the foster care system; a Transition Youth Housing Subsidy program to assist very low-income young adults ages 17 – 24; a smaller subsidy program for transition youth living in rural areas (added through grant funding in FY 2014); and Residential Care Facilities can receive a higher rate for services if they

Prompts	Summary
	successfully meet criteria for designation as a Recovery Home. Efforts to improve Oklahoma's continuum of care have resulted in the development of the Enhanced Foster Care (EFC) program to support the identification of children and youth who have complex needs and get them engaged in treatment sooner to ensure that children and families have access to evidence-based treatments and specialized supports. DHS has partnered with Oklahoma's CMHC providers in the coordination of EFC services, which includes Oklahoma Systems of Care, mobile crisis response, and evidence-based treatment. Currently, there are around 120 children in the Enhanced Foster Care Program. Additionally, DHS is collaborating with ODMHSAS and other private providers to address the service gaps within rural areas of the state through quality service mapping.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A - Milestone criteria is met.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* A basic package of primary and preventive behavioral services, such as screenings for depression, anxiety and substance abuse is available to every SoonerCare member without prior authorization for services delivered by a Patient-Centered Medical Homes, Indian/Tribal/Urban (I/T/U) Clinics, and Federally Qualified Health Centers. Part of the responsibilities of SoonerCare Choice medical homes is to conduct behavioral health screenings for members age 5 and older for all tiers. OHCA has put together a Behavioral Health Screening Toolkit of available resources to help providers accomplish this task. OHCA has identified validated public domain screening tools that are available to assist physicians and behavioral health professional with screening and assessing mental health issues. OHCA has also created a behavioral health referral guide and well as a web-based Behavioral Health Provider Directory for use by non-specialty providers. The SoonerCare Psychiatric Consultation Program provides primary care physicians with access to free informal telephonic consultation with board certified psychiatrists. Consultation is available to assist with psychotropic medication management for children, adolescents and adults. ODMHSAS is building an early childhood SOC network statewide. The goal of this network is to work with local partners from the early childhood community to expand the expertise of the OKSOC providers to better serve children ages 0-5 and their families. Training in the following EBPs has been, and will continue to be, provided: Infant Massage, Circle of Security and Child Parent Psychotherapy.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A - Milestone criteria is met.

Prompts	Summary
c. 4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* Oklahoma utilizes a system of coordinated community response and mobile crisis response within the Systems of Care network to ensure children in crisis are connected with the appropriate level of care. Community-based assessments (CBAs) are completed by licensed behavioral health professionals (LBHPs) to ensure children in crisis are diverted from more restrictive inpatient settings if other community-based services are available to meet their needs. This system covers the majority of the state outside of the metropolitan areas, and Oklahoma is potentially pursuing expansion of this service to currently unserved areas. The CBA process involves a strong partnership between ODMHSAS and OHCA. CBA providers complete the assessment and work closely with OHCA to locate a proper placement for the child if medically necessary. Once placed in an inpatient setting, requests for extensions of care are provided to the CBA provider from OHCA. A determination from the CBA provider with a clinical rationale for denial or approval, as well as number of days if approved, is then given to OHCA within two hours.
	Future Status: Continued operation of current programming. Potential pursuit of expansion of CBA to metropolitan areas.
	Summary of Actions Needed: Implement expansion of CBA, pending analysis of how the implementation of managed care in 2021 will integrate/affect this process. If pursued, the state aims to achieve this by Year 2 of the demonstration. Steps include the development and award of an RFP and coordination with providers.
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* Oklahoma has twenty (20) Health Homes for children with Serious Emotional Disturbance (SED) within the provider network. In addition, there are 2 RA1SE NAVIGATE programs to assist individuals who are experiencing First Episode of Psychosis (FEP), along with 1 early Serious Mental Illness (eSMI) Crisis Care program, and 13 statewide early Serious Mental Illness (eSMI) Outreach Programs provided through CMHCs. These programs develop and maintain collaborative partnerships with local higher education institutions and local hospitals to increase exposure to young adults within the age range that is most at risk for eSMI. The Now Is The Time – Healthy Transitions (NITT-HT) grant, referred to in Oklahoma as the Oklahoma Now Is The Time (ONIT) grant, focuses on integrated services and supports for youth and young adults ages 16 through 25 with serious mental health conditions and their families. ONIT's developmentally appropriate and effective youth-guided local Systems of Care have been designed to improve outcomes in education, employment, housing, mental health and co-occurring disorders, and decrease contact with the juvenile and criminal justice systems. ONIT programs focus on a blended model of Wraparound and Transition to Independence Process (TIP). Currently ONIT has five lab sites; three in Oklahoma County, one in Okmulgee County and one in Washington County. During FY17, 693 youth and young adults were outreached; 948 were screening for behavioral health needs; and 320 were referred to services. Drawing on best practices from our Now is the Time Initiative, SOC2 has implemented successful outreach approaches to identify youth and young adults with early signs and symptoms of SED, SMI, or first episode psychosis (FEP). The goal is to engage youth into effective services and connect them with all needed supports early, thereby greatly increasing their chances of full recovery and a life of their choice.
	Future Status: Continued operation of current programming.

Prompts	Summary
	Summary of Actions Needed: N/A - Milestone criteria is met.
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status:* CMHCs and CCBHCs are required to provide crisis intervention services, including mobile crisis response as part of their certification requirements. The CMHCs have statewide coverage and are responsible for mental health crises in their service areas. In the adult system, CMHCs provide emergency assessments to their communities, largely via telehealth in rural communities. During this process, LBHPs have the opportunity to stabilize a potential mental health crisis. Seven CMHCs currently serve adults within their mobile crisis teams, with LMHPs connected 24/7 either in person or through telehealth in all but one. There are 11 Programs of Assertive Community Treatment (PACT), all of whom respond to their clients 24/7 (some via IPads) to de-escalate crisis situations and help individuals maintain in their own home in their own community. All but one is operated within a CMHC. Additionally, one CMHC that covers the northeastern corner of the state provides every client with an iPad that can be used for 24/7 emergent or non-emergent needs. This CMHC also provides iPads to law enforcement in its service area, allowing law enforcement to access a mental health professional without transporting the individual to a facility, reducing police transports and emergency room utilization. In addition, there are nine crisis centers for adults located in the state. Three more (including two for mental health and one for SUD) are planned for Oklahoma City within the next several years as part of a city improvement ballot initiative passed in December 2019. A tiered support system is currently in place to ensure every effort is made to use inpatient and residential beds only when clinically indicated and to support successful outcomes with outpatient services and community supports. ODMHSAS data show that 90% of urgent care clients are diverted from needing a crisis care bed; approximately 93% of individuals receiving crisis care do not move to a hospital bed; and approximately 95% of crisis care recipients are engaged with outpatient service follow-up within seven days of leaving crisis care. Currently, Oklahoma has 80 local SOC sites that cover 72 counties. The SOC sites work in equal partnership with local teams and community organizations to ensure that children with SED and their families have access to the full array of services they need and want. The SOC initiative includes mobile crisis response and coordinated community response for children across most of the state, as well as community-based assessment to ensure children are placed in appropriate settings and supported in the community whenever possible. Community Based Structured Crisis Centers for children, located in Oklahoma City and Tulsa, address the emergent needs of children and their families.

Prompts	Summary
	As noted in milestone 4.x, Oklahoma utilizes a system of coordinated community response and mobile crisis response within the SOC network to ensure children in crisis are connected with the appropriate level of care. Community-based assessments (CBAs) are completed by licensed behavioral health professionals (LBHPs) to ensure children in crisis are diverted from more restrictive inpatient settings if other community-based services are available to meet their needs. This system covers the majority of the state outside of the metropolitan areas, and Oklahoma is potentially pursuing expansion of this service to currently unserved areas. Crisis Intervention Training (CIT) is a community effort partnering both law enforcement officers and the community together for common goals of safety, understanding, and service to individuals with mental illness and their families. Officers participate in a 5-day, 40-hour CIT program hosted by ODMHSAS. The training program consists of sections taught by mental health and substance abuse treatment experts, specially trained officers, local Community Mental Health Centers, and representatives from the National Alliance on Mental Illness (NAMI). The training prepares officers to safely de-escalate a crisis, determine the need for emergency treatment, and get the individual to professional treatment as quickly as possible. Since 2002, ODMHSAS and all supporting CIT partners, have trained around 1,200 law enforcement officers throughout the state. In Oklahoma County alone, CIT-trained officers have saved nearly $1,000,000 in jail costs and over $500,000 in hospital costs through deescalating mental health crisis and diverting individuals to crisis centers.
	Future Status With approval of the waiver crisis stabilization units will be able to expand capacity by adding additional beds while maintaining eligibility for Medicaid reimbursement. Additionally, the State has plans to continue building upon the crisis system that has been developing over the past several years. This includes an expanded, statewide system of: crisis call centers, mobile crisis teams, and urgent care centers strategically placed in each region.
	Summary of Actions Needed: Expansion of non-residential crisis services is anticipated by January 1, 2023. Necessary steps include identification of funding sources, identification of strategic locations/providers, and provision of technical assistance to current and/or new providers.
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status*: Three CMHCs are part of the original CCBHC federal demonstration program, with current funding extended through November 2020. Additionally, a state plan amendment to move forward with new CCBHCs was approved by CMS June 4, 2019. One CMHC is certified to date, with two having active applications and one nearing application. ODMHSAS holds monthly technical assistance meetings to support and promote providers in transitioning to CCBHCs. Within the next two years, the state anticipates CCBHC implementation statewide. This model requires 24/7 mobile crisis response, as well as well as ability for crisis response up to 23 hours 59 minutes to stabilize every crisis possible and divert as many individuals are possible from the necessity of crisis center admissions and/or inpatient admissions. The State has implemented several community-based initiatives aimed at reducing inpatient admissions and readmissions such as Health Homes for Children with Serious Emotional Disturbance and Adults with Serious Mental Illness, reimbursement for transitional case management and mobile response and stabilization. The State believes that at least a portion of the decreases in the utilization of freestanding psychiatric hospital services post implementation can

Prompts	Summary
	be attributed to these initiatives. In the adult system, CMHCs provide emergency assessments to their communities, largely via telehealth in rural communities. During this process, LBHPs have the opportunity to stabilize a potential mental health crisis. Seven CMHCs currently serve adults within their mobile crisis teams, with LMHPs connected 24/7 either in person or through telehealth in all but one. There are 11 Programs of Assertive Community Treatment (PACT), all of whom respond to their clients 24/7 (some via IPads) to de-escalate crisis situations and help individuals maintain in their own home in their own community. All but one is operated within a CMHC. Additionally, one CMHC that covers the northeastern corner of the state provides every client with an iPad that can be used for 24/7 emergent or non-emergent needs. This CMHC also provides iPads to law enforcement in its service area, allowing law enforcement to access a mental health professional without transporting the individual to a facility, reducing police transports and emergency room utilization.
	Future Status: Continued operation of current programming. Promote and implement statewide expansion of CCBHCs, expand CBA to unserved areas, and explore additional opportunities for supported employment and housing.
	Summary of Actions Needed:. Implement additional supports by Year 3. Necessary steps include the provision of ongoing technical assistance to support new CCBHCs, identification of funding sources for expanded supported employment and housing supports, and obtaining necessary federal approvals if Medicaid funding is pursued for supported employment and/or housing supports.
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[4] *The HIT Plan should also describe, among other items, the:* • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	

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

Prompts	Summary
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	OHCA made great strides in the adoption of electronic health records (EHRs) through the Electronic Health Record Incentive Program. Unfortunately, behavioral health provider facilities were not eligible for the incentive payments. To bolster interoperability for behavioral health providers, the ODMHSAS applied for and received a grant through SAMHSA's Center for Integrated Health Solutions. Through a voucher program, behavioral health providers work with a certified health information organization (HIO) to connect via a secure, electronic means to communicate, share medical records, perform referrals, obtain lab and pharmacy data electronically, submit reportable data to the Oklahoma State Department of Health (OSDH), and establish interconnectivity to facilitate care coordination. The voucher funding offsets the initial cost of signing up with a certified HIO to electronically exchange health information. Because of the wide variation in the degree of health information technology and the confidentiality regulations around sharing substance use disorder data, the behavioral health voucher program was two tiered. The first tier allowed the providers to see the HIE data through a web portal and share information via DIRECT Secure Messaging to other providers using the messaging system. The second tier allowed them to share data from their EHR or other systems of records. Prior to the award there were 21 behavioral health providers linked to an HIE in the State. These providers were associated with primary care hospitals or large health centers. There were no safety net behavioral health providers who serve individuals with no resources to pay for treatment. Through this project, funding was made available to 27 behavioral health agencies for 365 clinical connections with HIEs. This is a 34% penetration rate of eligible providers. Tier 1 vouchers were used to connect 23 individual clinicians to an HIE through DIRECT and a web portal at seven agencies, and Tier 2 vouchers provided full interfaces to 20 agencies, with 342 individuals clinicians having connections. All of the providers participating in the voucher program serve individuals through Medicaid, state or federal block grant funding. Due to the lack of a statewide HIE, providers experienced barriers in identifying data for their clients. As described further below, this barrier should be remedied with the OHCA's RFP for a statewide HIE. The Office of Management and Enterprise Services, on behalf of the Oklahoma Health Care Authority (OHCA), issued an RFP in October 2019 to solicit proposals for a Supplier to provide a statewide health information exchange (HIE) to be called the Oklahoma Statewide Health Information Network and Exchange (OKSHINE). Oklahoma is looking to achieve statewide health information exchange to allow health information to flow seamlessly to and from authorized organizations and individuals in Oklahoma. OKSHINE is intended to meet the needs of end users, allowing providers and their patients, hospitals and health systems, purchasers and payers, state health agencies and local health departments, health information business associates, and an increasingly inclusive ecosystem of human service organizations to have secure, accurate data available at the right time and place, for the right purposes. All CMHCs are health homes and therefore are required to have a meaningful use certified EHR, utilize HIE and a population care management system. The State of Oklahoma has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	The OKSHINE solution will include an organization, with Oklahoma State oversight, to manage and operate the processes and technology to enable Oklahoma healthcare providers to meet the CMS Meaningful Use, Promoting Interoperability Program (PIP) requirements and Medicaid Information Technology Architecture (MITA) 3.0 and Seven Standards and Conditions. OKSHINE will include interoperability with existing state systems including the state agency interoperability system (Health-e Oklahoma), Medicaid, behavioral health and public health to support state initiatives and surveillance, Public Health Reporting including Immunizations, Electronic Laboratory Reports (ELR), Cancer Case Reports, and electronic case reports for reportable diseases. The system will also include a centralized data repository with integration of clinical and claims data to support value-based care initiatives and population health management including tracking trends and preventative care, identify health disparities, and help with management of chronic medical conditions; state use database for analytics and research. The state's SED/SPMI Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, as applicable, the state's Behavioral Health IT Plan.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[5] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Oklahoma does not currently have Medicaid managed care contracts. The state plans to work with the OKSHINE vendor to create a sustainability plan for ongoing operations in Oklahoma; and have or obtain full Electronic Healthcare Network Accreditation Commission (EHNAC) Health Information Exchange Accreditation Program (HIEAP) accreditation. The OKSHINE contract will require the supplier to work within the parameters of: • All relevant HITECH State Medicaid Director letters. • CMS Final Rule, Medicare and Medicaid Programs; Electronic Health Record Incentive Program, released by CMS on July 28, 2010 (42 CFR Parts 412, 413, 422, & 495) and any subsequent amendments or updates. • Health Insurance Portability and Accountability Act (HIPAA) of 1996 and any subsequent amendments or updates. • 42 CFR Part 2 and any subsequent amendments or updates • The Trusted Exchange Framework and Common Agreement (TEFCA). • CMS Medicaid Information Technology Architecture (MITA) 3.0 and Seven Standards and Conditions. • Requirements of the 21st Century Cures Act related to interoperability and information blocking. • Federal Information Security Management Act (FISMA)- National Institute of Technology Standards. The state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[1] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in relevant State

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

Prompts	Summary
	procurements. [1] Available at https://www.healthit.gov/isa/.
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [6] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[7]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* The State of Oklahoma currently has two private sector regional HIEs which have closed loop referrals/e-referral systems to varying degrees. However, the regional HIEs are not interoperable and therefore cannot share e-referrals between providers outside their respective HIEs. All CMHCs are health homes and therefore are required to have a meaningful use certified EHR, utilize HIE and a population care management system.
	Future State: The RFP for the OKSHINE Contract included a requirement that the vendor have experience in bidirectional exchange of clinical and behavioral health data in the latest standardized HL7 message formats in at least one (1) state for a minimum of five (5) years. OKSHINE will include a provider onboarding program including a website and processes for registration, document exchange and management, outreach, testing and implementing transport connections, and testing secure data exchange of clinical data in standard Health L7 formats; integration with existing state systems including the master person index and provider directory; admission, discharge, transfer (ADT) notifications to physicians and care management teams; care coordination through exchange of patient clinical records quickly, securely, and electronically across participating Oklahoma healthcare providers and other state and national health information exchanges; production and analytics of electronic clinical quality measures (eCQMs). The State will evaluate closed loop referrals and e-Referrals once a vendor for the OKSHINE contract is awarded. The

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

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

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

Prompts	Summary
	under development. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* Health homes utilize HIT to create, document, execute and update the comprehensive, person-centered service plan for every member that is accessible to the interdisciplinary team of providers when external partners have the capability to receive structured, electronic records. The State of Oklahoma has participated in the Promoting Interoperability Program (formally the EHR Incentive Program) January 3, 2011, being one of the first in the nation to launch. To date, Oklahoma has had 3,969 Eligible Professionals (EP) and 138 Eligible Hospitals (EH) participate in the PIP. The purpose of the incentive is to provide a financial incentive to assist eligible providers (both EP& EH) to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology. All current participants **must** use the 2015 Edition of certified electronic health record technology (CEHRT). The more up-to-date standards and functions in 2015 Edition CEHRT better support interoperable exchange of health information and improve clinical workflows. Benefits to using 2015 CEHRT are: • Improves interoperability by adopting new and updated vocabulary and content standards for the structured capture and exchange of health information, including a Common Clinical Data Set (CCDS) composed primarily of data expressed using adopted standards; and rigorously tested and identified content exchange standard (Consolidated Clinical Document Architecture (C-CDA)). Standards-based electronic exchange supports patient care by ensuring that health care data is consistently available to the right person, at the right place, and at the right time. • Includes "application access" certification criteria that requires health IT to demonstrate it can provide application access to the CCDS via an application programming interface (API). • Supports patient electronic access to health information through new functionalities and a range of potential technologies including the use of APIs. These technologies allow patients greater flexibility and choice in how they access and share their health information. • Includes a revised View, Download, and Transmit criterion that continues to support patient access to their health information, including via email transmission to any third party the patient chooses (including to any email address, so long as the patient is properly advised of the risks of doing so) and through a second encrypted method of transmission.
	Future State: Continue to expand uptake of the Promoting Interoperability Program.
	Summary of Actions Needed: See response for 1.1 and 1.2. Continue promotion/outreach; integrate functionality into OKSHINE project.

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* Health Homes utilize HIT to communicate with health facilities and other systems and to facilitate interdisciplinary collaboration among all providers, the member, family, caregivers and local supports when external partners have the capability to send and receive electronic, structured records. Health Homes are required to join a certified health information exchange and make a commitment to share information with all providers.
	Future State: Transition CMHC health homes into CCBHCs and continue to support Health Home/CCBHC HIT functionality with state HIE.
	Summary of Actions Needed: Continue promotion/outreach; integrate functionality into OKSHINE project.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The Child's Passport is a web application that allows Bridge families and other resource providers access to SoonerCare (Oklahoma's Medicaid) and education information for all children who enter care, children placed for adoption and for youth exiting care. SoonerCare records are maintained by the OHCA and education records are maintained by the OSDE; in turn these records are made available through the Child's Passport. These records include, but are not limited to: • Health care providers; • Early periodic, screening, diagnosis and treatment recommendations; • Diagnosis; • Immunizations; and • Previous and current prescription medications. The Child's Passport was specifically designed to help providers for children in the custody of OKDHS and the tribes gain current and updated information regarding the child in their care. The child's health history is based on SoonerCare claims, educational information and other pertinent information and is available 24 hours a day, seven days a week through a web-based platform. Guardians can print information and provide to a primary care physician, emergency room provider or therapist.
	Future State: See response for 1.1 and 1.2
	Summary of Actions Needed: See response for 1.1 and 1.2
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* See response for 2.3
	Future State: See response for 1.1 and 1.2
	Summary of Actions Needed: See response for 1.1 and 1.2
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* All CMHCs have electronic health records and provide services to both youth and adults. As an individual transitions to adult programs within these agencies, records remain available to staff who meet the applicable HIPPA criteria. Health homes are encouraged to use wireless technology as available to improve coordination and management of care and member adherence to recommendations made by their provider. This may include the use of telemedicine, cell phones, peripheral monitoring devices, and access member care management records, as feasible.

Prompts	Summary
	Future State: See response for 1.1 and 1.2; During the OKSHINE implementation, the State of Oklahoma will collaborate with the OKSHINE vendor and pursue statewide integration of community supports .
	Summary of Actions Needed: See response for 1.1 and 1.2 See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* All CMHCs have electronic health records. These EHR systems maintain electronic consent information for use within the organization and prior to releasing information to external stakeholders.
	Future State: OKSHINE may have a consent registry repository capable of storing and managing the consent directives issued or withdrawn by health care clients regarding the collection, use, or disclosure of their PHI, with an accompanying policy store/rules engine to enable enforcement based on roles and access rules. This repository will be compliant with 42 CFR Part 2 consent requirements.
	Summary of Actions Needed: Award and implementation of OKSHINE contract. During the OKSHINE implementation, the State of Oklahoma will collaborate with the OKSHINE vendor and pursue a secure, private patient portal as well as ensuing a patient consent registry is utilized. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* ODMHSAS has maximized technology and increased the capacity to deliver services by developing an online screening tool. The On-line Assessment Tool System (OATS) allows a provider to make a screening tool available through an email link or on a tablet within the practice. Through the use of this screening tool the client is receives a series of screening tools that look for alcohol abuse, drug abuse, depression and suicidality. Once the client completes the screening tool the provider is able to use the OATS system to pull client screening results into a report for review with the client and to be used to determine possible referral needs. This information is also then available to be kept in the client record as a part of the client's permanent record. The OATS tool is free for providers to use and the ODMHSAS provides all Technical Assistance to the practices using this tool at no cost. All CMHCs/Health Homes/CCBHCs have EHRs that capture screening and assessment data.
	Future State: See response for 1.1 and 1.2 During the OKSHINE implementation, the State of Oklahoma will pursue resourcing and integrating the OATS with OKSHINE infrastructure to promote a statewide solution for intake, assessment and screening. See ATTACHMENT 1, ***Schedule of Activities for State HIE (OKSHINE) Procurement***
	Summary of Actions Needed: See response for 1.1 and 1.2
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability	*Current State:* The SoonerCare Psychiatric Consultation Program provides primary care physicians with access to free informal telephonic consultation with board certified psychiatrists. Consultation is available to assist with psychotropic medication management for children, adolescents and adults. In addition, OHCA reimburses for an extensive list of

Prompts	Summary
of integrated mental health care and primary care	behavioral health services provided via telemedicine. Additionally, ODMHSAS maintains a statewide telemedicine network using Polycom Real Presence. Units are placed in CMHCs and satellite locations covering the entire state. These units increase access to services and information including, medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. In CY2019 (pre COVID-19), 526,289 telehealth behavioral health services were provided to 108,288 unique clients and paid for through Medicaid or state funding. Since the beginning of the COVID-19 pandemic, the State has been working with providers at all levels of care, including inpatient and residential, to promote and expand the use of telehealth as appropriate.
	Future State: Continued operation of current programming and continued promotion of telehealth services for IMD and other providers.
	Summary of Actions Needed: Evaluate long-term flexibility for the provision of services by telehealth. Utilize emergency and other funding mechanisms to support needed infrastructure for providers to offer services by telehealth, particularly in rural areas of the state.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[8])	*Current State:* As documented in the State's current Health Homes State Plan, for children with SED, the SOC Wraparound teams are required to access data from the MMIS to monitor use of psychotropic medications. Health homes providers are also encouraged to utilize HIT to monitor member outcomes, initiate changes in care and follow up on member testing, treatments, services and referrals.
	Future State: Continued operation of Health Homes program and CCBHCs.
	Summary of Actions Needed: Expansion of CCBHCs statewide throughout the course of the demonstration. The State is aiming for this to be achieved by Year 3 of the demonstration. The State is also developing its Medicaid managed care RFP to include provisions for care coordination, member engagement during transitions between levels of care, and identification of individuals accessing behavioral health services who are at risk for hospitalization. The State aims to complete the RFP by October 2020 and implement managed care by October 2021.
6.2 Health IT is being used to advance the care coordination	*Current State:* As documented in the State's current Health Homes State Plan, for children with SED, the SOC Wraparound teams are required to access data from the MMIS to monitor use of psychotropic medications. Health

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

Prompts	Summary
workflow for patients experiencing their first episode of psychosis	homes providers are also encouraged to utilize HIT to monitor member outcomes, initiate changes in care and follow up on member testing, treatments, services and referrals.
	Future State: Continued operation of Health Homes program and transition of CMHC health homes to CCBHCs.
	Summary of Actions Needed: Expansion of CCBHCs statewide throughout the course of the demonstration. The State is aiming for this to be achieved by Year 3 of the demonstration. Specific steps include: 1) continued technical assistance provided to potential CCBHCs, 2) identification of new entities for transition to CCBHC functionality, and 3) continued analysis of provider performance and expenditures.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* The State's eligibility and enrollment system can link children and parents on the same case. All CMHCs have EMRs. As comprehensive providers, multiple family members may be receiving services within the same agency. It is assumed that these records are linked based on demographic information.
	Future State: Continue with current programming.
	Summary of Actions Needed: N/A Milestone is met.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* EMRs assign case numbers to individual patients. Patients are registered and linked to this number with each service.
	Future State: Continue with current programming.
	Summary of Actions Needed: N/A - Milestone is met.

Section 3: Relevant documents

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

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

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

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

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

ATTACHMENT B:
SUD Implementation Plan

CMS' Opioid and Other SUDs 1115 Demonstration Initiative:

Goals and Milestones to be Addressed in State Implementation Plan Protocols

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

Goals:

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

Milestones:

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

Section I – Milestone Completion

Milestones

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

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

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

Current state

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

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

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

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

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

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

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

Currently, Oklahoma's Medicaid program provides coverage for two MAT medications – buprenorphine/naloxone and naltrexone. Medicaid compensable inpatient services are largely administered by the OHCA, while Medicaid compensable outpatient behavioral health services and other state-funded supports are largely administered by the ODMHSAS.

ODMHSAS, through its provider certification division, provides certification for SUD providers across the state, with the exception of tribal entities located on land not subject to state jurisdiction. Oklahoma's substance use disorder treatment and recovery services network currently provides services within all 77 Oklahoma counties. Facilities can be certified as a basic Alcohol and Drug Treatment Program providing a specific service set or as a Certified Comprehensive Addiction Recovery Center (CCARC) providing a full continuum of care, including intensive outpatient services. There are currently 16 opioid treatment programs (OTPs) in the state.

Future state

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

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

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

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

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

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

Specifications:

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

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

Current state

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

Future state

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

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

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

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

Specifications:

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

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

Current state

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

Future state

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

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

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

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

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

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

Specifications:

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

beneficiaries in the critical levels of care.

Current state

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

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

Future state

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

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

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

Specifications:

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

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

Current state

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

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

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

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

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

Future state

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

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

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

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

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

6. Improved Care Coordination and Transitions between Levels of Care

Specifications:

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

Current state

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

In addition, policies exist that address care coordination for co-occurring physical and mental health conditions. CMHCs have contractual requirements to engage with discharged patients within 7 days and are eligible for a supplemental payment based on outcome measures including patient follow up within 7 days of discharge. Four Certified Community Behavioral Health Centers (CCBHCs) operate in the state and provide transitional care for hospitalized persons. CCBHCs document attempts to contact persons within 24 hours of discharge. Inpatient psychiatric providers are required by state administrative rules to have a discharge plan for adults that documents the individual's hospitalization, recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, and a summary of the beneficiary's condition at discharge.

Future state

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

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

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

Section II – Implementation Administration

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

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

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

Section III – Relevant Documents

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

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

Section I.

Specifications

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

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

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

Enhancing the Health IT Functionality to Support PDMP Interoperability

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

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

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

DRAFT

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

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

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

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

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

Major components of this project include:

DRAFT

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

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

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

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

DRAFT

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

DRAFT

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

DRAFT

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

DRAFT

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

DRAFT

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

Attachment A, Section II – Implementation Administration

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

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

Attachment A, Section III – Relevant Documents

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

DRAFT

ATTACHMENT 1

Schedule of Activities for State HIE (OKSHINE) Procurement

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

DRAFT

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

DRAFT

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

DRAFT

ATTACHMENT C
Reserved for Evaluation Design