NOTICE OF PUBLIC COMMENT PERIOD FOR IMD WAIVER

Pursuant to Section 431.408 of Title 42 of the Code of Federal Regulations, the Oklahoma Health Care Authority (OHCA) is required to provide public notice of its intent to submit a new 1115(a) waiver request to the Centers for Medicare & Medicaid Services (CMS) to reimburse for short-term residential treatment or inpatient stabilization services in an Institution for Mental Disease (IMD); the waiver request will be effective for a five-year period. This notice provides details about the waiver submission and serves to open the 30-day public comment period, which closes on May 31, 2020. In addition to the 30-day public comment period, during which the public will be able to provide written comments to the OHCA, the agency will host two public hearings, during which the public may provide oral comments. Due to the Center for Disease Control and Prevention's (CDC) COVID-19 social distancing recommendations, these public hearings will be hosted virtually only.

VIRTUAL PUBLIC HEARING
May 6, 2020, at 3 p.m.
Register for Public Hearing:
https://okhca.zoom.us/webinar/register/WN_KHdFenQIS6GEeBZNwLfXHg

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

Prior to finalizing the proposed 1115 SMI/SUD IMD waiver, the OHCA will consider all written and verbal public comments received. The comments will be summarized and addressed in the final version to be submitted to CMS.

SMI/SUD IMD WAIVER PROPOSAL SUMMARY AND OBJECTIVES

Beginning no sooner than October 1, 2020, and contingent upon CMS approval, the 1115 IMD waiver for serious mental illness (SMI) and substance use disorder (SUD) will further provide access to mental health and substance use treatment by allowing Medicaid coverage and reimbursement for services provided to eligible adults with SMI/SUD, ages 21-64, within an IMD. Additionally, individuals under the age of 21 will be eligible to receive residential SUD services within an IMD. The state also plans to transition current congregate care facilities for children in state custody to Qualified Residential Treatment Programs (QRTPs) October 1, 2021, and through this waiver seeks federal authority to reimburse for short-term stays of less than 60 days in QRTPs determined to be IMDs. This waiver seeks to improve quality, accessibility, and outcomes of SMI/SUD treatment services in the most cost-effective manner possible. Through this demonstration, Oklahoma seeks to support the overall health and long-term successful outcomes of individuals with SMI and SUD. The overarching premise this demonstration supports is that, if the full continuum of care is provided, individuals who access the system will receive the least restrictive, most effective provision of services, which is continually evaluated so that individuals' changing needs translate to changing services to meet those needs.

The SMI/SUD IMD waiver proposal will implement policies that will improve the current system's capacity to appropriately address acute behavioral health needs, improve rates of morbidity and mortality for covered populations, and decrease utilization of less appropriate services. The proposed waiver has separate goals for targeting substance use disorders and for addressing SMI/SED.

Goals targeting substance use disorders:

- Increase rates of identification, initiation, and engagement in treatment;
- Increase adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;
- Reduce 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;
- Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
- Improve access to care for physical health conditions among beneficiaries.

Goals addressing SMI/SED:

- Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings;
- Reduce preventable readmissions to acute care hospitals and residential settings;
- Improve 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;
- Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care; and
- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

ELIGIBILITY

Individuals eligible under the SMI/SUD IMD waiver include mandatory and/or optional eligibility groups approved for full Medicaid coverage who are between the ages of 21-64 and provided with short-term residential treatment or inpatient stabilization services in an IMD. Additionally, Medicaid eligible individuals under 21 years of age who receive SUD services within an IMD are also eligible under the waiver.

ENROLLMENT AND FISCAL PROJECTIONS

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

This 1115 SMI/SUD IMD waiver is not anticipated to impact SoonerCare enrollment over the course of the five-year demonstration, as there are no waiver-specific eligibility criteria included. Additionally, the SMI/SUD IMD demonstration will have no impact on Medicaid eligibility and is expected to have no fiscal impact, as depicted in the table below.

Without-Waiver Total Expenditures

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

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TOTAL	$101,317,852	$112,551,998	$125,031,776	$138,895,269	$154,295,991	$632,092,887

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

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

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

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

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

Cost Sharing Exemptions
Individuals exempt from cost sharing include pregnant women and individuals who are American Indian/Native American.

Delivery System
The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) work collaboratively to provide a wide array of behavioral health services for Oklahomans. Medicaid compensable inpatient services are largely administered by the OHCA, while Medicaid compensable outpatient behavioral health services and other state-funded supports are largely administered by the ODMHSAS. A combined payer system consolidates eligibility determinations, claims, authorizations, and outcomes data for publicly funded services, including both Medicaid compensable and state-funded services.

Services and supports are currently available statewide through a network of private and government-operated programs that will also serve as providers for this waiver. These include facility-based crisis centers, psychiatric hospitals, residential substance use disorder (SUD) treatment providers, and Qualified Residential Treatment Programs (QRTPs), when the provider(s) also qualifies as an IMD.

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

Payment Rates for Services
Payment methodologies will be consistent with those approved in the Medicaid State Plan, where applicable. Inpatient and residential IMD services will be reimbursed via a per diem methodology, with crisis stabilization reimbursed through an hourly payment structure. Under the authority of this waiver, the state seeks to promote the outcomes and goals of the demonstration through the implementation of a value-based payment structure

for all Medicaid-enrolled residential SUD providers. The state plans to implement a system whereby providers must meet certain quality benchmarks in order to receive a 10% bonus to their per diem rate.

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

HYPOTHESIS AND EVALUATION

The SMI/SUD IMD waiver will be subject to an independent evaluation that investigates the outcomes of the following goals and hypothesis.

Substance Use Disorder

Objective/Goal	**Hypothesis**	**Evaluation Parameters/Methodology**
Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?		
GOAL 1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	**Hypothesis 1.** The demonstration will increase the percentage of beneficiaries who are referred to and engage in treatment for OUD and other SUDs.	**Data Sources:** • Claims data • Provider survey • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
GOAL 2. Increased adherence to and retention in treatment for OUD and other SUDs.	**Hypothesis 2.** The demonstration will increase the percentage of beneficiaries who adhere to treatment of OUD and other SUDs.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance • T-Test
GOAL 3. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	**Hypothesis 3.** The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.	**Data Sources:** • Claims data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Do enrollees receiving SUD services experience improved health outcomes?		

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 4. Improved access to care for physical health conditions among beneficiaries.	**Hypothesis 4.** The demonstration will increase the percentage of beneficiaries with SUD who experience care for comorbid conditions.	**Data Sources:** • Claims data • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
GOAL 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.	**Hypothesis 5.** Among beneficiaries receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.	**Data Sources:** • Claims data • Beneficiary survey **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance
Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?		
GOAL 6. Reduction in overdose death, particularly those due to opioids.	**Hypothesis 6**. The demonstration will decrease the rate of overdose deaths due to opioids.	**Data Sources:** • Claims data • Administrative data **Analytic Approach:** • Descriptive quantitative analysis • Chi square tests of significance

Serious Mental Illness

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings? How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?		

<table>
<tr><th>Objective/Goal</th><th>Hypothesis</th><th>Evaluation Parameters/Methodology</th></tr>
<tr><td>GOAL 1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.</td><td>Hypothesis 1. The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.</td><td>Data Sources:
Claims data
Medical records or administrative records
Interviews or focus groups
Analytic Approach:
Difference-in-differences model
Subgroup analyses
Descriptive quantitative analysis
Qualitative analysis</td></tr>
<tr><td colspan="3">Evaluation Question: Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings? How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?</td></tr>
<tr><td>GOAL 2. Reduced preventable readmissions to acute care hospitals and residential settings.</td><td>Hypothesis 2. The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.</td><td>Data Sources:
Claims data
Medical records
Beneficiary survey
Analytic Approach:
Difference-in-difference models
Qualitative analysis
Descriptive quantitative analysis</td></tr>
<tr><td colspan="3">Evaluation Questions: To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state? To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?</td></tr>
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<tr><th>Objective/Goal</th><th>Hypothesis</th><th>Evaluation Parameters/Methodology</th></tr>
<tr><td>GOAL 3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs; psychiatric hospitals; and residential treatment settings throughout the state.</td><td>Hypothesis 3. The demonstration will result in improved availability of crisis stabilization services throughout the state.</td><td>Data Sources:
Annual assessments of availability of mental health services
AHRF data
NMHSS survey
Administrative data
Provider survey
Analytic Approach:
Descriptive quantitative analysis</td></tr>
<tr><td colspan="3">Evaluation Questions: Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health needs? To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED? To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services? How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics? Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED improve under the demonstration?</td></tr>
<tr><td>GOAL 4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care.</td><td>Hypothesis 4. Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.</td><td>Data Sources:
Claims data
Annual assessments of availability of mental health services
AHRF
NMHSS survey
Administrative data
URS
Medical records
Analytic Approach:
Descriptive quantitative analysis
Chi squared analysis
Difference-in-differences model</td></tr>
<tr><td colspan="3">Evaluation Questions: Does the demonstration result in improved care coordination for beneficiaries with SMI/SED? Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities? How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?</td></tr>
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Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Hypothesis 5.** The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Data Sources:** • Claims data • Medical records • Interviews or focus groups • Facility records **Analytic Approach:** • Difference-in-differences model • Descriptive quantitative analysis • Qualitative analysis

WAIVER AND EXPENDITURE AUTHORITY

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

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

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