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

DEMONSTRATION EXTENSION REQUEST

Draft for Public Comment – May 16, 2025; Updated May 23, 2025

State of Oklahoma
Oklahoma Health Care Authority

Submitted to CMS June 2025

Table of Contents

Overview of Oklahoma Medicaid and Behavioral Health Programs

The Oklahoma Health Care Authority (OHCA) is Oklahoma's Single State Agency for Medicaid. Medicaid is the largest health care payer in the State. The OHCA and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) work collaboratively to provide a full array of behavioral health services to Oklahomans with mental health (MH) and/or substance use disorder (SUD) treatment needs.

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

The SUD treatment continuum of care is based on the American Society of Addiction Medicine (ASAM) criteria and other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. Members have access to the full range of otherwise covered Medicaid services, including SUD treatment services. This includes high-quality, evidence-based Opioid Use Disorder (OUD)/SUD treatment and recovery services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing treatment in community-based settings. Benefits under the Demonstration include short-term stays in residential and inpatient SUD treatment settings that qualify as an Institution for Mental Diseases (IMD).

Members have access to the full range of otherwise covered Medicaid services, including psychiatric treatment services for individuals with a serious mental illness (SMI) or serious emotional disturbance (SED). These SMI/SED services range in intensity from early intervention, short-term crisis stabilization, and acute care in an inpatient or residential setting to ongoing treatment in community-based settings. Benefits under the Demonstration include short-term stays in residential and inpatient SMI/SED treatment settings that qualify as an IMD.

In SFY 2024, the OKDMHSAS delivery system served over 34,000 individuals with SUD and over 197,000 individuals in need of mental health services. Nearly 83,000 individuals were identified as having an SMI and over 42,000 youth were identified as having an SED.[1]

Behavioral Health Delivery System

Behavioral health services are available statewide through a network of private and government-operated programs. This includes 13 Certified Community Behavioral Health Clinics (CCBHCs) and approximately 70 contracted SUD treatment providers, including nine State-certified Comprehensive Community Addiction Recovery Centers (CCARCs).

[1] http://www.odmhsas.org/eda/oonqus_standard.htm

ODMHSAS supports 13 Community-Based Structured Crisis Centers (CBSCCs) located throughout the State, including three operated by the State (two serving adults and one serving children and adolescents). Ten of these CBSCCs also operate behavioral health urgent recovery clinics (URCs) that provide 23-hour respite and observation to help prevent psychiatric emergencies and admissions to inpatient or crisis beds, with another 11 stand-alone URCs operating across the State. These facilities also address substance abuse emergencies.

Integrated Care Delivery

In October 2016, Oklahoma was one of eight states selected by SAMHSA and CMS to pilot Certified Community Behavioral Health Clinics (CCBHCs). Care coordination underpins all aspects of behavioral health care in the CCBHC model. Oklahoma adopted the CCBHC model for statewide expansion; at the time of its request to CMS for the IMD Demonstration, six of the 13 CMHCs in Oklahoma achieved CCBHC designation. Under the current Demonstration's SMI/SED Implementation Plan, the remaining CMHCs achieved CCBHC designation by Demonstration Year Two (one year ahead of schedule).

CCBHCs provide a broad array of services and care coordination across settings and providers on a full spectrum of health, including acute, chronic, and behavioral health needs. The CCBHC model requires the integration of mental health, substance use disorder, and physical health treatment services at one location.

In addition, there are two "Recovery After an Initial Schizophrenia Episode" (RAISE) NAVIGATE programs to assist individuals who are experiencing their first episode of psychosis, along with one early serious mental illness (eSMI) crisis care program, and 13 statewide eSMI outreach programs provided through CMHCs. These programs develop and maintain collaborative partnerships with local higher education institutions and local hospitals to increase exposure to young adults within the age range that is most at risk for eSMI.

Substance Use Treatment

Oklahoma also supports the delivery of residential and outpatient substance abuse services such as medically supervised withdrawal management, residential treatment, sober living, Drug Court, criminal justice diversion treatment services, and other outpatient services. Oklahoma's SUD treatment and recovery services network currently provides services across the State and includes CCBHCs and other ODMHSAS-funded and/or Medicaid-enrolled providers. The ODMHSAS-funded services are primarily purchased through contracts with private, for-profit, and non-profit, certified agencies to provide multiple levels of withdrawal management, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services using substance abuse block grant funds and State appropriations.

All SUD treatment organizations must be certified by ODMHSAS, except for tribal entities located on land not subject to State jurisdiction. Facilities can be certified as basic alcohol and drug treatment programs providing specific sets of services, opioid treatment programs, or as

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

Qualified Residential Treatment Programs

The Oklahoma Human Services Department (OHS) currently operates residential care facilities for children in State custody. Under the current Demonstration, the OHCA worked with OHS to enhance residential policies and developed a quality oversight structure to ensure that all treatment facilities offered a quality care model in alignment with Qualified Residential Treatment Programs (QRTPs). Programs are small scale in nature and none of the current or planned Oklahoma QRTPs meet the definition of an IMD.

Demonstration Overview and Objectives

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

All enrollees eligible under the State Plan for full Medicaid coverage, and between the ages of 21-64, are eligible for services under the Demonstration. Additionally, Medicaid enrollees under the age of 21 may qualify for services under the Demonstration when receiving residential SUD treatment or QRTP services (although none of the current or planned QRTPs qualify as IMDs).

History and Background

The Demonstration was implemented to ensure that beneficiaries have access to a full array of SUD and SMI/SED treatment services, including inpatient and residential treatment services provided by facilities that classify as IMDs. The IMD Demonstration also was implemented in anticipation of Medicaid expansion. Oklahoma's ballot question (SQ 802) expanding Medicaid to the new adult group was passed in June of 2020 with expansion beginning in July of 2021.

At the time of the State's initial Demonstration request to CMS, like other states nationally, Oklahoma faced high rates of overdose-related deaths. Opioid analgesics were involved in more unintentional poisoning deaths in the state than any other medication, representing 69.1 percent of all unintentional poisoning deaths associated with medications from 2007-2012.[2] Oklahoma also was one of the leading states in painkiller prescriptions per capita. In 2018-2022,

[2] https://www.oklahoma.gov/content/dam/ok/en/health/health2/documents/up-data-charts-tables.pdf

opioids were identified as the most common substance involved in drug overdose-related hospitalizations.[3]

In addition, Oklahoma consistently had among the highest rates nationally for mental illness and substance use disorder, as reported in the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). The percentage of individuals with a SUD in the past year was estimated as 19.66 percent for persons 18 years old and older in the 2021-2022 NSDUH report. Individuals in this age group who needed, but did not receive SUD treatment was estimated at 77.44 percent. The percentage of individuals with an SMI in the past year was estimated at 6.57 percent.[4]

At the time of its request to CMS, Oklahomans were also experiencing long waits for acute treatment of SMI and SUD, including waiting lists for inpatient and residential treatment. For residential treatment of substance abuse alone, ODMHSAS reported that 158 women were on the waiting list (with an average wait time of 29 days to get into treatment) and 415 men were on the list (with an average wait time of 203 days to get into treatment).

At the outset of the current Demonstration, the State invested in community residential treatment capacity and reduced the waiting list to zero. Access to treatment has been maintained with no further wait lists throughout the Demonstration period.

Project Description

The Demonstration provides the State with authority to provide medically necessary residential treatment, facility-based crisis stabilization, and inpatient treatment services within qualified IMDs for Medicaid beneficiaries with SMI, SED, and/or SUD diagnoses. The current Medicaid authority also includes coverage for Qualified Residential Treatment Programs (QRTPs) that meet the definition of an IMD for beneficiaries under age 21.

Progress Toward Meeting Demonstration Goals and Plans for the Future

The Demonstration's mid-point assessment was submitted in March of 2024. Overall, the assessment found that the State is meeting the goals and objectives of the Demonstration and making progress in all areas of the SUD and SMI Implementation Plans that are on-going. For both SUD and SMI/SED populations, the average length of stay in an IMD was less than the 30-day threshold set by CMS. Relative to the SUD and SMI Implementation Plans, the majority of proposed activities have been completed within the timelines approved by CMS.

[3] https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/prevention-and-preparedness/injury-prevention/drug-overdose/Drug%20Overdose%20Data%20Graphs%20and%20Maps.pdf

[4] 2021-2022 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia) at https://www.samhsa.gov/data/sites/default/files/reports/rpt44484/2022-nsduh-sae-tables-percent-CSVs/2022-nsduh-sae-tables-percent.pdf

SUD Implementation Plan Milestones

All SUD milestones/activities were met or otherwise on track for completion. Under Milestone One, *Access to critical levels of care for OUD and other SUDs,* new levels of care were added to the State Plan. In 2022, coverage was added for: ASAM Level 2.5 (Partial Hospitalization); Methadone for MAT; and ASAM Levels 3.1, 3.3, 3.5 and 3.7 (Intensive Residential) including adolescent residential treatment and medically managed withdrawal services. All service delivery requirements and service expectations are aligned with the ASAM levels of care for SUD treatment. The State also provided support for Opioid Treatment Programs to enroll as Medicaid providers. Accreditation and certificate of need requirements were added to the administrative rules for residential SUD treatment facilities.

Under Milestone Two, *the widespread use of evidence-based, SUD-specific patient placement criteria*, the OHCA implemented new compliance tools and oversight processes for all facilities. Online tools were developed that support ASAM level of care determinations. These tools can also be accessed by clinicians who use the Addiction Severity Index to determine level of care needs. The online tool allows for a streamlined prior authorization process based on the results of the assessment. Provider training and the dissemination of educational guides were developed in the first years of the Demonstration.

Under Milestone Three, *the use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications*, the OHCA now requires national accreditation for residential facilities and developed a certificate of need process for new programs to demonstrate compliance with all state and federal standards of care. Standards that require access to medication assisted treatment in all residential programs were added to administrative rule.

Under Milestone Four, *sufficient provider capacity at each level of care,* the State Plan coverages added under Milestone One assure that all levels of care are available across the treatment system. The midpoint assessment found that in the first two and one half years of the Demonstration, SUD providers enrolled in Medicaid increased by over six percent and those qualified to deliver medication assisted treatment increased by over ten percent.

Milestone Five, *implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD*, has been a priority for the OHCA for many years. In 2017, opioid prescribing guidelines were developed to help improve communication between clinicians and patients about the risks and benefits of opioid therapy for pain management, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death, while preserving patient access to needed medical treatment. The OHCA engaged in extensive provider education and practice facilitation related to best practices in opioid prescribing. The Demonstration's SUD IT plan supported updates to the Prescription Drug Monitoring Program (PDMP). In addition, the Health Information Exchange (HIE) allows providers to review prescribed and dispensed medication history prior to issuing a new or refilled prescription.

During the Demonstration period, the State's overall opioid dispensing rates fell from 66.4 per 100 in 2019 to 52.9 per 100 in 2023[5]. Medicaid metrics tracked as part the SUD Monitoring Protocol show that the use of opioids at a high dose in persons without cancer fell by nearly 23 percent at the time of the midpoint assessment and the concurrent use of opioids and benzodiazepines dropped by just over 20 percent.

Milestone Six, *improved care coordination and transitions between levels of care*, was met upon approval of the Demonstration.

SMI/SED Implementation Plan Milestones

Nine of the ten SMI/SED milestones/topic areas were assessed as meeting expectations. Under Topic Area One, *ensuring quality of care in psychiatric hospitals and residential settings*, the State was meeting all quality criteria for IMDs at the outset of the Demonstration. As part of the quality improvement initiative for the children's residential treatment system, the State developed rules for QRTP programs and worked with providers statewide to enhance policy and operational practices to meet those standards. The use of the Child and Adolescent Needs and Strengths (CANS) assessment was adopted for all QRTP placement decisions.

Under SMI/SED Topic Two*, improving care coordination and transitions to community-based care,* the OHCA integrated existing Medicaid requirements related to discharge planning, community-based referrals, and continuity of care post discharge into the rules for QRTPs. In addition, the ODMHSAS expanded access to Certified Community Behavioral Health Clinics (CCBHC) statewide. These providers are responsible for the full integration of physical and mental health care and SUD treatment on behalf of members participating in the program. The CCBHC expansion was completed in Demonstration year two, one year ahead of schedule.

Under SMI/SED Topic Three, i*ncreasing access to continuum of care, including crisis stabilization services,* the State began planning for the conversion to the national 988 crisis number. The ODMHSAS serves as the central organizing entity for planning, readiness, and implementation. The national 988 number was integrated into the statewide crisis call center system and launched in July 2022. As part of the integration, crisis services provided through Urgent Recovery Clinics (URCs) have been expanded in strategic areas of the State. Mobile crisis teams are available across the State to address callers' needs when appropriate. These efforts allow for triage and referral for all adult callers. The centralized system also assists law enforcement to appropriately manage and refer crisis situations.

SMI/SED Topic Four, e*arlier identification, engagement in treatment, and increased integration,* was met at the outset of the Demonstration. There were no new activities identified in the approved Implementation Plan.

[5] https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html

As part of the SMI/SED finance plan (Topic Five) the State has maintained and/or increased spending from the baseline level of effort in SFY 2020.

Future Goals

During the upcoming Demonstration period, the State seeks to maintain progress on all the current CMS-defined goals for SUD and psychiatric treatment.

SUD Treatment 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 Treatment Goals:

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

Requested Revisions

The State is not requesting any changes to the Demonstration apart from the elimination of authorities no longer needed, as outlined below.

List of Proposed Waiver and Expenditure Authorities

The State is not seeking any new Demonstration authorities. The State is requesting to continue the current Demonstration authority to provide medically necessary residential treatment, facility-based crisis stabilization, and inpatient treatment services within qualified Institutions for Mental Diseases (IMD), for Medicaid beneficiaries with serious mental illness (SMI), serious emotional disturbance (SED) and/or substance use disorder (SUD) diagnoses.

Authority No Longer Needed

The State has completed an assessment of its residential care treatment system for children and youth. While quality enhancements have been made, there are no existing or planned residential treatment programs for youth with an SED that are sixteen or more beds. The coverage authorities for Qualified Residential Treatment Programs (QRTPs) that meet the definition of an IMD for beneficiaries under age 21 were never enacted. The OHCA requests elimination of this authority.

Expenditure Authority Requested

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

Quality Assurance

The OHCA monitors a variety of metrics as part of the Demonstration's SUD and SMI Monitoring Protocol. Those deemed critical by CMS were assessed as part of the midpoint assessment.

Critical metrics related to the use of SUD treatment services were meeting and exceeding utilization targets across all levels of care. Increases in the number of members accessing services during the first two and one half years of the Demonstration include the following::

- Treatment for SUD in an IMD increased by 77 percent

- Outpatient treatment increased by more than 55 percent
- Intensive outpatient and partial hospitalization services increased by approximately 73 percent
- Residential and inpatient services increased by more than 111 percent
- Withdrawal management services increased by more than 230 percent
- Medication-assisted treatment increased by 121 percent

At the same time, SUD provider availability increased by over six percent and providers qualified to deliver medication assisted treatment increased by over ten percent. Initiation and engagement in alcohol and other drug treatment increased, as did the percentage of ED visits for SUD in which the member received follow-up within 7 and 30 days of the ED visit.

A preliminary review of CY2023 data shows that performance in these critical SUD-related metrics continues to improve. The OHCA will continue to monitor these successes during the requested extension period.

The State continues to work on improved performance related to the following: ED visits for mental illness in which the member received follow-up within 7 and 30 days of the ED visit; overdose deaths; continuity of pharmacotherapy for opioid use disorder; emergency department utilization for SUD; and readmissions among members with SUD. At the time of the midpoint assessment, performance in these areas was either unchanged or declining.

For members with an SMI/SED, the State saw improvements at the midpoint assessment such as:

- A 14 percent increase in the percentage of members 18 years and older who received follow-up within 7 days after discharge from a psychiatric inpatient setting and a nine percent increase for follow-up within 30 days post discharge
- A one percent increase in follow up care for adults who are newly prescribed an antipsychotic medication
- A 17 percent increase in the percentage of ED visits for SUD for which the members with SMI received follow-up within 7 days and a 26 percent increase for follow-up within 30 days of the ED visit

The State continues to work on improving performance related to metrics where there was no change or slight declines in performance at the midpoint assessment. These include: use of first-line psychosocial care for children and adolescents on antipsychotics; 30-day all-cause unplanned readmission following psychiatric hospitalization; percentage of psychiatric hospital discharges for which children (ages 6-17) received follow-up within 7 and 30 days after discharge; access to preventive/ambulatory health services; and percentage of children and adolescents on antipsychotics who received metabolic monitoring (e.g., blood glucose and cholesterol testing).

A preliminary review of CY2023 data shows that the State is seeing an improvement in performance related to percentage of children and adolescents on antipsychotic medications who received metabolic monitoring (e.g., blood glucose and cholesterol testing).

Budget Neutrality

The Demonstration renewal is expected to be budget neutral. The State is in the process of modifying previously reported enrollment and expenditures under the Demonstration. Current expenditure and enrollment data and projections for the renewal period are provided on the following pages.

Budget Neutrality Summary: Demonstration Years 1 - 5

	DEMONSTRATION YEAR (DY) AND CALENDAR YEAR (CY)					TOTAL
	DY1 (CY21)	DY2 (CY22)	DY3 (CY23)	DY4 (CY24)	DY5 (CY25) *Projected*	
PMPM Limits, per STCs						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$10,452	$11,037	$11,655	$12,308	$12,997	
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$4,643	$4,903	$5,177	$5,467	$5,774	
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$4,299	$4,539	$4,793	$5,062	$5,345	
Enrollment: Actual and Projected						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	1,596	5,800	6,531	6,431	*6,817*	27,175
IMD Services MEG 2: SUD Adults, Ages 18 to 64	2,078	10,585	12,394	9,258	*9,813*	44,128
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	42	200	236	135	*143*	756
Total	3,716	16,585	19,161	15,824	16,773	72,059
Aggregate Spending Limit						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$16,681,153	$64,015,470	$76,120,307	$79,152,234	*$88,599,820*	$324,568,983
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$9,647,967	$51,897,302	$64,169,563	$50,617,282	*$56,658,912*	$232,991,026
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$180,540	$907,858	$1,131,264	$683,361	*$764,927*	$3,667,949
Total	**$26,509,660**	**$116,820,630**	**$141,421,134**	**$130,452,876**	***$146,023,659***	**$561,227,958**
Expenditures: Actual and Projected						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$6,989,354	$31,697,353	$35,316,871	$46,805,610	*$52,392,328*	$173,201,515
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$7,931,239	$31,031,393	$41,704,900	$30,706,870	*$34,372,042*	$145,746,445
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$691,294	$741,603	$978,916	$553,821	*$619,925*	$3,585,560
Total	**$15,611,888**	**$63,470,348**	**$78,000,687**	**$78,066,301**	***$87,384,295***	**$322,533,519**
Difference in Expenditures: Waiver Limit v. Actual						
Surplus (Deficit)	**$10,897,772**	**$53,350,282**	**$63,420,447**	**$52,386,575**	***$58,639,364***	**$238,694,439**
Cumulative Surplus (Deficit)	**$10,897,772**	**$64,248,054**	**$127,668,501**	**$180,055,075**	***$238,694,439***	**$238,694,439**

Budget Neutrality Summary: Demonstration Years 6-10

	DEMONSTRATION YEAR (DY) AND CALENDAR YEAR (CY)					TOTAL
	DY6 (CY26)	DY7 (CY27)	DY8 (CY28)	DY9 (CY29)	DY10 (CY30)	
PMPM Limits						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$13,725	$14,494	$15,305	$16,162	$17,067	
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$6,097	$6,438	$6,799	$7,180	$7,582	
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$5,645	$5,961	$6,295	$6,647	$7,019	
Enrollment: Projected						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	7,226	7,659	8,119	8,606	*9,122*	40,733
IMD Services MEG 2: SUD Adults, Ages 18 to 64	10,402	11,026	11,688	12,389	*13,133*	58,639
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	152	161	170	181	*192*	855
Total	17,780	18,847	19,977	21,176	22,447	100,227
Aggregate Spending Limit						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$99,175,095	$111,012,634	$124,263,102	$139,095,146	*$155,697,542*	$629,243,519
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$63,421,720	$70,991,736	$79,465,310	$88,950,289	*$99,567,395*	$402,396,450
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$856,228	$958,428	$1,072,826	$1,200,878	*$1,344,215*	$5,432,575
Total	**$163,453,043**	**$182,962,798**	**$204,801,237**	**$229,246,313**	***$256,609,153***	**$1,037,072,544**
With Waiver Expenditures: Projected						
IMD Services MEG 1: SMI Adults, Ages 21 to 64	$58,645,876	$65,645,848	$73,481,336	$82,252,068	*$92,069,675*	$372,094,803
IMD Services MEG 2: SUD Adults, Ages 18 to 64	$38,474,689	$43,067,028	$48,207,508	$53,961,557	*$60,402,408*	$244,113,190
IMD Services MEG 3: SUD Adolescents, Ages 17 and Under	$693,919	$776,746	$869,458	$973,237	*$1,089,402*	$4,402,762
Total	**$97,814,484**	**$109,489,621**	**$122,558,303**	**$137,186,862**	***$153,561,485***	**$620,610,755**
Difference in Expenditures: Waiver Limit v. Projected Expenditures						
Surplus Carryforward: Years 1 - 5	**$238,694,439**					
Annual Surplus (Deficit)	**$65,638,558**	**$73,473,176**	**$82,242,935**	**$92,059,451**	***$103,047,668***	**$416,461,788**
Cumulative Surplus (Deficit)	**$304,332,997**	**$377,806,173**	**$460,049,108**	**$552,108,560**	***$655,156,227***	**$655,156,227**

Evaluation

The current evaluation design was approved by CMS on June 10, 2022 and includes interrupted time series and coarsened exact matching comparison strategies. The independent evaluator completed the Draft Interim Evaluation Report, and it was submitted to CMS in December 2024. A summary of the preliminary evaluation findings is presented below.

SUD-Related Findings and Interim Report

The SUD portion of the evaluation included six questions, each with related hypotheses and measures[6]. The evaluation also contained an exploratory expenditure analysis. The questions/ hypotheses and interim findings are summarized below.

Evaluation Question One - Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?

Four hypotheses were examined relating to utilization of treatment services and engagement in treatment.

1. The Demonstration will maintain or increase utilization of SUD treatment services.
2. The Demonstration will maintain or increase SUD provider availability.
3. The Demonstration will maintain or increase follow-up after emergency department (ED) visit for alcohol or other drug dependence.
4. The Demonstration will maintain or increase initiation and engagement in treatment.

The four hypotheses were tested through evaluation of 12 discrete measures. Of the 12, seven maintained performance and five improved, providing support for the evaluation question studied.

The percentage of Medicaid members engaging in any type of SUD treatment has been increasing over time. During the Demonstration period, there was a statistically significant increase in utilization trends for withdrawal management/detox services and Medication Assisted Treatment (MAT).

The total number of SUD treatment providers enrolled in Medicaid increased by eight percent. Those qualified to deliver MAT increased by 16 percent. There was a statistically significant increase in the percentage of members who had follow-up within seven days after an ED visit for SUD. There were no changes associated with the Demonstration for initiating and engaging in SUD treatment; however, the general trend showed an increase in initiation over time.

[6] Evaluation question four – "Does the Demonstration contain or reduce overdose deaths?" – was suspended. Data on opioid-related deaths was not available and overdose death data has a considerable lag. The OHCA reports overdose deaths as part of its monitoring reports to CMS.

Evaluation Question Two - Does the Demonstration maintain or increase adherence to, and retention in, treatment for alcohol or other drug use?

The Demonstration was associated with maintaining trends (i.e., no statistically significant sustained effect) in the percentage of members with continuity of pharmacotherapy (i.e., having 180 days of continuous Medication Assisted Treatment for Opioid Use Disorder (OUD)).

Evaluation Question Three - Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?

The percentage of members receiving opioids at a high dosage showed significantly improved performance. There was a 50 percent decrease in the percentage of members receiving opioids at high doses by 2023 (lower numbers are preferred).

Evaluation Question Five - Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with an SUD?

Two hypotheses were examined relative to ED and inpatient use.

1. The Demonstration will contain or reduce the rate of ED visits for individuals with an SUD.
2. The Demonstration will contain or reduce inpatient admissions.

There were no significant changes in the rate of ED visits or inpatient admissions associated with the Demonstration period.

Evaluation Question Six - Does the Demonstration contain or reduce readmissions to the same or higher levels of care?

There were no significant changes in the percentage of readmissions to the same or higher level care associated with the Demonstration period.

Evaluation Question Six - Does the Demonstration maintain or improve access to care for physical health conditions?

There was a statistically significant increase in the percentage of members who had ambulatory and preventive care visits associated with the Demonstration period.

Exploratory Expenditure Analysis

Total expenditures were examined for physical and SUD-related categories of services, with breakouts for SUD-IMD and other residential treatment services. Cost drivers including ED and inpatient use, pharmacy, outpatient and long term care also were assessed.

There were statistically significant increases associated with start of the Demonstration in per member per month (PMPM) trends for total cost, as well as breakouts for SUD-related, SUD-IMD, SUD-Other and physical health care. The expansion population was associated with increases in all breakouts, apart from the PMPM trend related to physical health care.

The generalized linear model showed that older members and women were associated with fewer expenditures in every category. Members residing in rural counties also were associated with fewer expenditures in every category, apart from physical health care.

There were no statistically significant sustained changes in trend related to expenditures for any cost driver (outpatient, inpatient, ED, pharmacy and long term care services) during the Demonstration period. When expansion members were removed from the analysis, there was a significant reduction in PMPM for all cost drivers, with the exception of long term care, which showed a very slight increase.

The relationship between the use of community-based SUD treatment services (i.e., outpatient, intensive outpatient/partial hospitalization, and MAT services) was also examined. Each unit of community-based service received was associated with lower ED and inpatient costs. The ED PMPM decreased by $1.79 and the inpatient PMPM decreased by $19.47.

Overall SUD IMD Findings

The evaluation found that the Demonstration maintained or improved performance across all areas (hypotheses) studied. Eleven of the 18 measures (61 percent) maintained pre-Demonstration trends, while seven (39 percent) showed improvements. Maintaining pre-Demonstration levels of performance related to SUD treatment during the pandemic should be

considered a success under the Demonstration. No statistically significant declines in performance were documented. A summary of findings by evaluation question and hypothesis is provided on the following page.

Summary of Interim Findings - SUD			
Evaluation Question and Hypotheses	**Number of Measures**		
	Maintained	**Improved**	**Declined**
Evaluation Question 1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?			
Hypothesis 1. The Demonstration will maintain or increase utilization of SUD treatment services.	**4**	**2**	
Hypothesis 2. The Demonstration will maintain or increase SUD provider availability.		**2**	
Hypothesis 3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.	**1**	**1**	
Hypothesis 4. The Demonstration will maintain or increase initiation and engagement in treatment.	**1**	**1**	
Evaluation Question 2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?			
Hypothesis 1. The Demonstration will maintain or increase continuity of pharmacotherapy	**1**		
Evaluation Question 3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?			
Hypothesis 1. The Demonstration will contain or reduce the use of opioids at a high dosage.		**1**	
Evaluation Question 4. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with an SUD?			
Hypothesis 1. The Demonstration will contain or reduce the rate of ED visits for individuals with an SUD.	**1**		
Hypothesis 2. The Demonstration will contain or reduce inpatient admissions.	**1**		
Evaluation Question 5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?			
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care	**1**		
Evaluation Question 6. Does the Demonstration maintain or improve access to care for physical health conditions?			
Hypothesis 1. The Demonstration will maintain or increase access to care for physical health conditions	**1**		

SMI/SED-Related Findings and Interim Report

The SMI/SED IMD portion of the evaluation examined eight questions, each with related hypotheses and measures[7]. The evaluation also contained two additional evaluation questions related to an exploratory expenditure analysis. The questions/hypotheses and interim findings are summarized below.

Evaluation Question 1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI?

Utilization trends related to the use of the emergency department for mental health conditions declined; however, the change was not statistically significant.

Evaluation Question 2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?

Readmission rates showed a slight decline during the Demonstration; however, the change was not statistically significant.

Evaluation Question 3. Does the Demonstration result in increased treatment for comorbid SUD and physical health conditions after IMD discharge?

There was a slight improvement in access to SUD treatment or physical health care post SUD-IMD discharge; however, the change was not statistically significant.

Evaluation Question 4. Does the Demonstration result in improved availability of crisis outreach and response services?

The number of crisis call centers maintained baseline levels, while the number of crisis response teams increased by seven percent. However, the number of members identified with an SMI/SED also rose. Thus, the ratio of members-to-outreach service providers did not improve during the Demonstration.

It should be noted that mobile crisis response teams have the ability to respond to several emergency calls at a given time, especially in more populated areas with larger response teams. Using a member-to-team ratio therefore is likely to undercount the availability of services.

[7] Analysis related to performance before and after CCBHC designation should be considered preliminary. CCBHCs continued to be designated through Demonstration Year (DY) 2 (2022) leaving only one year of complete data post-designation. Results are exploratory and will be updated in the summative report for a more balanced representation of outcomes.

Evaluation Question 5. Does the Demonstration result in improved availability of non-residential, non-hospital crisis outreach and response services?

During the Demonstration period, the State expanded the number of crisis observation/assessment centers from five to 25, and crisis stabilization units from 11 to 17. This resulted in improved ratios of members-to-providers.

Evaluation Question 6. Does the Demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED?

Two hypotheses were examined under evaluation Question 6:

1. Demonstration will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.
2. Expanding CCBHCs statewide will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED.

The number of psychiatrists and providers authorized to prescribe increased by seven percent under the Demonstration. Ninety-nine percent of psychiatrists and providers authorized to prescribe were enrolled in the Medicaid program in DY3.

The number of licensed mental health practitioners enrolled in Medicaid fell by over 65 percent, despite an increase in licensed practitioners. However, this may be an artifact of data collection and the date of the assessment period. The ODMHSAS staff noted that licensure data is compiled from multiple independent entities across the State, each with separate data collection processes. This may contribute to variation in results year to year.

In addition, the annual assessment period occurs during the provider reenrollment period. At the time of the count, Medicaid enrollment may not be complete, resulting in an undercounting of availability.

In examining the difference between a treatment (CCBHC) and comparison group, there were no significant differences in the use of first-line psychosocial care for youth on antipsychotics. However, CCBHC members did show improved performance over the comparison group with respect to medication continuation for adults discharged from psychiatric inpatient care.

In a preliminary analysis of performance before and after CCBHC designation, the overall rate for continuation of medications improved in the time period following CCBHC designation.

Evaluation Question 7. Does the Demonstration improve the integration of primary and behavioral health care to address the chronic mental health care needs of members with SMI/SED?

In examining the difference between a treatment (CCBHC) and comparison group, there was no significant difference in metabolic monitoring for youth on antipsychotics. Thus, performance did not improve post CCBHC designation.

However, CCBHC members did show improved performance over the comparison group with respect to accessing ambulatory/preventive care during the measurement period. In a preliminary analysis of performance before and after CCBHC designation, ambulatory/preventive care improved in the time period following CCBHC designation.

Evaluation Question 8. Does the Demonstration result in improved care coordination for members with SMI/SED?

CCBHC members ages 6 – 16 showed improved performance over the comparison group with respect to having follow-up after hospitalization for mental health care. Follow-up within 7 and 30 days was stronger in the CCBHC group than the comparison group. In addition, in a preliminary analysis of performance before and after CCBHC designation, follow-up improved in the time period following CCBHC designation for both metrics studied.

CCBHC members ages 18 and older also outperformed the comparison group on follow-up after the use of the emergency department for mental health care. Follow-up after an ED visit within 7 and 30 days was stronger in the CCBHC group than the comparison group.

In a preliminary analysis of performance before and after CCBHC designation, follow-up rates declined in the time period following CCBHC designation, which also coincided with the novel coronavirus pandemic. It is possible that the PHE response strained emergency department resources and also limited the availability of community-based staff to gain access to clients and discharge planning during the ED visit.

Exploratory Expenditure Analysis

An exploratory analysis was performed to examine changes in expenditures over time (evaluation Question 9) and cost drivers (evaluation Question 10). There were no significant changes in the PMPM trend related to total costs of care during the Demonstration period, apart from the mental health-IMD PMPM. As expected, there was a significant increase in IMD-related PMPM cost associated with the Demonstration start and during the Demonstration period.

The expansion group was associated with an increase in the total cost of care (physical and mental health) seen in quarters three and four of Demonstration Year 1, which coincided with the start of Medicaid expansion. Expenditures in these categories then leveled off for expansion members and showed no significant differences from the aggregate analysis. However,

expansion group members were associated with higher SMI-IMD expenditures throughout the Demonstration period.

In examining cost drivers (evaluation Question 10), there were no statistically significant trends associated with outpatient, inpatient, ED or long term care expenditures. Pharmacy-related expenditures showed a statistically significant sustained increase during the Demonstration period.

When expansion group members were removed from the analysis, there was an increase in the inpatient PMPM, suggesting that the remaining members were associated with overall higher expenditures. Conversely, expansion group members were associated with an increase in outpatient expenditures in quarters three and four of DY1.

Expansion group pharmacy and ED expenditures also showed an initial increase and continued to show an increase throughout the Demonstration period. However, the expansion group was not associated with substantial changes in the long term care PMPM.

A subsidiary analysis of service utilization with respect to ED and inpatient expenditures found that each CCBHC service was associated with lower inpatient expenditures, while CCBHC services showed a small increase in ED PMPM, although the association was weak.

Overall SMI/SED Findings

The evaluation found that the Demonstration maintained or improved performance across six of the nine areas (hypotheses) studied. Five of the 21 measures (24 percent) maintained pre-Demonstration trends, while 11 (52 percent) showed improvements and five (24 percent) declined. Maintaining pre-Demonstration levels of performance related to psychiatric treatment during the pandemic should be considered a success under the Demonstration.

A summary of findings by evaluation question and hypothesis is provided on the following page.

Summary of Interim Findings - SMI			
Evaluation Question and Hypotheses	Number of Measures		
	Maintained	Improved	Declined
Evaluation Question 1. Does the Demonstration result in reductions in emergency department utilization among members with an SMI?			
Hypothesis 1. Demonstration will contain or reduce mental health-related ED use for adults with an SMI	**1**		
Evaluation Question 2. Does the Demonstration result in reductions in preventable readmissions to acute care hospitals or residential settings for members with an SMI?			
Hypothesis 1. Demonstration will contain or reduce readmissions to acute care hospitals or residential settings for adults with an SMI	**1**		
Evaluation Question 3. Does the Demonstration result in increased treatment for comorbid SUD and physical health conditions after IMD discharge?			
Hypothesis 1. Demonstration will maintain or increase access to physical health and/or SUD treatment post-discharge for adults with an SMI	**1**		
Evaluation Question 4. Does the Demonstration result in improved availability of crisis outreach and response services?			
Hypothesis 1. Demonstration will maintain or improve the availability of crisis outreach and response services throughout the state			**1**
Evaluation Question 5. Does the Demonstration result in improved availability of non-residential, non-hospital crisis outreach and response services?			
Hypothesis 1. Demonstration will maintain or improve the availability of non-residential, non-hospital crisis outreach and response services		**1**	
Evaluation Question 6. Does the Demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED?			
Hypothesis 1. Demonstration will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED			**1**
Hypothesis 2. Expanding CCBHCs statewide will maintain or improve the availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED		**2**	**1**
Evaluation Question 7. Does the Demonstration improve the integration of primary and behavioral health care to address the chronic mental health care needs of members with SMI/SED?			
Hypothesis 1. expanding CCBHCs statewide will maintain or improve the integration of primary and behavioral health care to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED	**2**	**2**	
Evaluation Question 8. Does the Demonstration result in improved care coordination for members with SMI/SED?			
Hypothesis 1. Expanding CCBHCs statewide will maintain or improve care coordination for members with an SMI/SED		**6**	**2**

Interim Evaluation Conclusion

Maintaining pre-Demonstration utilization levels for treatment during the pandemic should be considered a success under the Demonstration. In many cases, trends analyzed as part of the Interrupted Time Series approach showed no significant change.

Overall, there were no statistically significant declines in performance for any SUD-related measure during the Demonstration period. SMI-related results maintained or improved performance in all but five of the measures studied (76 percent).

The inclusion of additional data under the Demonstration will be important to understand if utilization and engagement in SUD and psychiatric treatment begin to show further improvements following the end of the public health emergency.

Ongoing Evaluation Under the Extension

The State is not requesting changes to the Demonstration. Pending the incorporation of CMS feedback on the Draft Interim Evaluation Report and potential design enhancements, the State does not anticipate substantive changes to the currently approved evaluation design.

The OHCA will collaborate with CMS and its independent evaluator to ensure that revisions to the design during the requested Demonstration extension support the academic rigor of the current approach.

Draft Interim Evaluation Report

The Draft Summative Evaluation Report was submitted to CMS in December of 2025. The report, attached below, is still under review.

OK IMD Demonstration Draft I

Documentation of Public Process

To be completed following the close of the public process period and incorporation of stakeholder feedback

Public Notice Process

Tribal Consultation

Summary of Public Comment and State Response

Summary of Changes Made Due to Public Feeback and Tribal Consultation