

Attachment 1.State’s Compliance with CCBHC Criteria Checklist

STATE: Oklahoma

This compliance checklist includes the criteria required for the Certified Community Behavioral Health Clinics (CCBHCs) and their Designated Collaborating Organizations (DCOs) which together form the CCBHC. For each item below, write in one of the following ratings in the space provided that describes the CCBHCs readiness, as a whole in your state to implement each criteria:

- 1. Ready to implement
- 2. Mostly ready to implement
- 3. Ready to implement with remediation
- 4. Unready to implement

Program Requirement 1: Staffing

Criteria 1.A. General Staffing Requirements

1.a.1 Needs Assessment and Staffing Plan

- 1 CCBHCs have completed a state approved needs assessment.
- 2 CCBHC needs assessments addresses cultural, linguistic, treatment and staffing needs and resources of the area to be served by the CCBHCs and addresses transportation, income, culture, and other barriers.
- 1 CCBHC needs assessments addresses work-force shortages.
- 1 Consumers and family members and relevant communities (e.g., ethnic, tribal) were consulted in a meaningful way to complete the needs assessment.
- 1 There is recognition of the CCBHCs’ obligation to update the assessment at least every 3 years.
- 1 The state approved a staffing plan for each CCBHC that reflects the findings of the needs assessment.
- 1 The state based its requirements for services at each CCBHC, including care coordination, on the needs assessment findings.

1.a.2 Staff

2 CCBHC staff (both clinical and non-clinical) is appropriate in size and composition for the population to be served by each of the CCBHCs.

2 If veterans are served by the CCBHC, staffing satisfies the requirements of criteria 4.K.

1.a.3 Management Staffing

1 CCBHC management staffing is adequate for the needs of CCBHCs as determined by the needs assessment and staffing plan.

1 CCBHCs have a management team structure with key personnel identified by name, including a CEO or Executive Director/Project Director and a Medical Director (may be the same person and Medical Director need not be full time).

N/A CCBHCs that are unable to employ or contract with a psychiatrist are located in Health Resources and Services Administration (HRSA) behavioral health professional shortage areas and have documented reasonable and consistent efforts to obtain a psychiatrist as Medical Director.

CCBHC name(s): _____

N/A For those CCBHCs without a psychiatrist as Medical Director, provisions are made for psychiatric consultation and a medically trained behavioral health provider with appropriate education and licensure to independently prescribe is the Medical Director.

1.a.4 Liability/Malpractice Insurance

1 CCBHCs maintain adequate liability/malpractice insurance.

Criteria 1.B. Licensure and Credentialing of Providers

1.b.1 Appropriate Licensure and Scope of Practice

1 CCBHC practitioners providing demonstration services will furnish these services within their scope of practice in accordance with all applicable federal, state, and local laws and regulations.

1 CCBHCs have policies or procedures in place to ensure continuation of licensure (non-lapse).

2 CCBHCs have formal agreements in place with their Designated Collaborating Organizations (DCOs), ensuring the DCO staff members serving CCBHC consumers also have appropriate licensure.

1.b.2 Required Staffing

1 CCBHC staffing plans meet requirements of the state behavioral health authority and any accreditation or other standards required by the state and identify specific staff disciplines that are required.

2 CCBHCs staffing plans require a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine, naltrexone and other medications used to treat opioid and alcohol use disorders.

1 CCBHCs staffing plans require credentialed substance abuse specialists.

1 CCBHCs Staffing plans require individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

1 CCBHCs staffing plans require other disciplines that can address needs identified by the needs assessment.

2 CCBHCs have taken steps to alleviate workforce shortages where they exist.

Criteria 1.C. Cultural Competence and Other Training

1.c.1 Training Plans

1 CCBHC training plans realistically address the need for culturally competent services given the needs identified in the needs assessment.

1 CCBHC training plans require the following training at orientation and annually thereafter: (1) risk assessment, suicide prevention and suicide response; and (2) the roles of families and peers.

1 CCBHC training plans require the following training at orientation and thereafter as needed: (1) cultural competence; (2) person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care; (3) integration of primary care and behavioral health care; and (4) a continuity plan.

1 CCBHCs have policies or procedures in place to implement this training, ensure the competence of trainers and trainees, and keep track of training by employee.

1 If active duty military and/or veterans are served, CCBHC cultural competency training includes information related to military culture.

1.c.2 – 1.c.4 Skills and Competence

1 CCBHCs have written policies and procedures that describe the methods used for assessing skills and competencies of providers.

1 CCBHC in-service training and education programs are provided.

1 CCBHCs maintain a list of in-service training and educational programs provided during the previous 12 months.

1 CCBHCs maintain documentation of completion of training and demonstration of competencies within staff personnel records.

1 Individuals providing training to CCBHC staff have the qualifications to do so as evidenced by their education, training, and experience.

Criteria 1. D. Linguistic Competence

1.d.1 – 1.d.4 Meaningful Access

1 If the CCBHCs serve consumers with Limited English Proficiency (LEP) or with language based disabilities; the CCBHCs take reasonable steps to provide meaningful access to their services for such consumers.

2 CCBHCs interpretation and translation service(s) (e.g., bilingual providers, onsite interpreter, and language telephone line) are appropriate and timely for the size and needs of the LEP CCBHC consumer population identified in the needs assessment.

2 CCBHC interpreters are trained to function in a medical setting.

2 CCBHC auxiliary aids and services are readily available and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletype [TTY] lines).

1 On the basis of the findings of the CCBHCs needs assessment, documents or messages vital to a consumer's ability to access CCBHC services (e.g., registration forms, sliding-scale fee discount schedule, after-hours coverage, and signage) are available for consumers in languages common in the community served. The documents take into account the literacy levels of the community as well as the need for alternative formats (e.g., for consumers with disabilities), and they are provided in a timely manner.

1 CCBHCs Consumers are made aware of resources designed to provide meaningful access.

1.d.5 Meaningful Access and Privacy

1 CCBHC policies have explicit provisions for ensuring that all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), patient privacy requirements specific to care for minors, and other state and federal laws.

1 CCBHC consumer consent documentation is regularly offered, explained, and updated.

1 CCBHCs satisfy the requirements of privacy and confidentiality while encouraging communication between providers and family of the consumer.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

1.a.1, 1.a.2, and 1.b.2: All three CCBHCs benefitted from the State's needs assessment and utilized their own means to expand upon it locally. All have identified work force shortages and have already taken many steps to correct. For example, Grand Lake hired 155 staff during state planning year. All are still hiring now.
1.b.1: There are a few locations which are getting a few more formal agreements in place by the time the demonstration starts.
1.d.1-1.d.4: All CCBHCs have completed much work, are mostly ready. A few locations are still expanding capabilities in a few areas, such as getting specialty language and occupational therapies such as speech and hearing in place. **As stated in the narrative, CCBHC locations in 16 counties have been issued certifications under OK's "Permission to Temporarily Operate" category. This means they have all policies and procedures in place, but are not yet formally operating as a CCBHC. Once OK is notified that we are included in the demonstration, Provider Certification will schedule the follow up visits with all at which time they will be evaluated as a CCBHC that is operating. This will ensure that they are following the CCBHC standards that are in place.**

Program Requirement 2: Availability and Accessibility of Services

Criteria 2.A. General Requirements of Access and Availability

2.a.1-2.a.8 Access and Availability Generally

1 CCBHCs take measures to ensure provision of a safe, functional, clean, and welcoming environment for consumers and staff.

1 CCBHCs comply with all relevant federal, state, and local laws and regulations regarding client and staff safety, cleanliness, and accessibility.

1 CCBHC outpatient clinic hours include some night and weekend hours and meet the needs of the population served.

1 CCBHC locations are accessible to the consumer population being served.

1 CCBHCs provide transportation or transportation vouchers for consumers as resources allow.

1 CCBHCs plan to use mobile in-home, telehealth/telemedicine, and/or online treatment services, where appropriate, and have either sufficient experience or preparation to do so effectively.

1 CCBHCs engage in outreach and engagement activities to assist consumers and families to access benefits and services.

1 CCBHC services are aligned with state or county/municipal court standards for the provision of court-ordered services.

1 CCBHCs have adequate continuity of operations/disaster plans in place.

1 CCBHCs provide available and accessible services that will accommodate the needs of the population to be served as identified in the needs assessment.

Criteria 2.B. Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers

2.b.1 Timing of Screening, Evaluation and Provision of Services to New CCBHC Consumers⁴

1 For new CCBHC consumers with an initial screening identifying an urgent need, the CCBHC complies with either: (1) the criteria requirement that clinical services and initial evaluation are to be provided/completed within 1 business day of the time the request is made, or (2) a more stringent state standard of _____.

1 For new CCBHC consumers with an initial screening identifying routine needs, the CCBHC complies with either: (1) the criteria requirement that clinical services and initial evaluation are to be provided/completed within 10 business days, or (2) a more stringent state standard of _____.

1 For new consumers, the state either: (1) uses the criteria requirement that a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation be completed within 60 calendar days of the first request for services, or (2) has a more stringent time standard of _____.

1 CCBHCs have in place policies and/or procedures for new consumers that include administration of a preliminary screening and risk assessment to determine acuity of needs in accordance with state standards.

⁴ Also see Criteria 4.D, related to the content of these evaluations.

1 ___ CCBHCs have in place policies and/or procedures for conducting: (1) an initial evaluation, and (2) a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation in accordance with state standards.

1 ___ CCBHCs have in place policies and/or procedures to ensure immediate, appropriate action, including any necessary subsequent outpatient follow-up if the screening or other evaluation identifies an emergency or crisis need.

1 ___ CCBHCs have in place policies and/or procedures for initial evaluations that are conducted telephonically that require the initial evaluation to be reviewed and the consumer to be seen in person at the next encounter, once the emergency is resolved.

2.b.2 Updating Comprehensive Person-Centered and Family-Centered Diagnostic and Treatment Planning Evaluation⁵

1 ___ CCBHC treatment teams update the comprehensive person-centered and family-centered diagnostic and treatment planning evaluation, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred

1 ___ Assessment must be updated no less frequently than every (1) 90 calendar days; (2) has a more stringent time standard of ___ days; or (3) has an existing less stringent time standard that is acceptable. If the third option is chosen, the time standard and the justification for using it are described below.

Established OK Medicaid and ODMHSAS standards require assessment and service plan updates every six months. The MMIS payment system is configured to require update reporting at this interval; however, more frequent updates are to be done when needed.

2.b.3 Timing of Services for Established Consumers

1 ___ CCBHCs comply with the state standard for established CCBHC consumers seeking an appointment for routine needs. The state standard may either: (1) uses the criteria requirement that outpatient clinical services for established CCBHC consumers seeking an appointment for routine needs are provided within 10 business days of the requested date for service and, for those presenting with an urgent need, within 1 business day of the request, (2) has a more stringent time standard of ___ days, or (3) has an existing less stringent time standard that is acceptable. If the third option is chosen, the time standard and the justification for using it are:

_____.

⁵ See criteria 3.D and 4.E for other requirements related to the treatment planning process.

1 CCBHCs have in place policies and/or procedures for established CCBHC consumers who present with an emergency/crisis need, that include options for appropriate and immediate action.

Criteria 2.C. Access to Crisis Management Services⁶

1 CCBHCs provide crisis management services that are available and accessible 24 hours a day and required to be delivered within 3 hours.

1 CCBHCs have policies or procedures in place requiring communication to the public of the availability of these services, as well as to consumers at intake, and that the latter is provided in a way that ensures meaningful access.

1 CCBHCs have policies or procedures in place addressing: (1) coordination of services when consumers present to local emergency departments (EDs); (2) involvement of law enforcement when consumers are in psychiatric crisis; and (3) reducing delays in initiating services during and after a consumer has experienced a psychiatric crisis.

1 CCBHCs are required to work with consumers at intake and after a psychiatric emergency or crisis to create, maintain and follow a crisis plan.

Criteria 2.D. No Refusal of Services Due to Inability to Pay

1 CCBHCs has a policy that services cannot be refused because of inability to pay.

1 CCBHCs have policies or procedures that ensure (1) provision of services regardless of ability to pay; (2) waiver or reduction of fees for those unable to pay; (3) equitable use of a sliding fee discount schedule that conforms to the requirements in the criteria; and (4) provision of information to consumers related to the sliding fee discount schedule, available on the website, posted in the waiting room, and provided in a format that ensures meaningful access to the information.

Criteria 2.E. Provision of Services Regardless of Residence

1 CCBHCs have a policy that services cannot be refused due to residence.

1 CCBHCs have in place policies or protocols addressing services for those living out of state.

1 CCBHCs have policies or procedures ensuring: (1) services will not be denied to those who do not live in the catchment area (if there is one), including provision of crisis services,

⁶ See criteria 4.C regarding content of crisis services and 3.a.4 regarding crisis planning in the context of care coordination.

provision of other services, and coordination and follow-up with providers in the individual's catchment area; and (2) services will be available for consumers living in the CCBHC catchment area but who are distant from the CCBHC.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

Program Requirement 3: Care Coordination⁷

Criteria 3.A. General Requirements of Care Coordination

- 1 CCBHCs coordinate care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person.

- 1 CCBHCs have procedures in place that comply with HIPAA, 42 CFR Part 2, requirements specific to minors, and other privacy and confidentiality requirements of state or federal law addressing care coordination and in interactions with the DCOs,

- 1 CCBHCs have policies and/or procedures in place to encourage participation by family members and others important to the consumer in care coordination, subject to privacy and confidentiality requirements and subject to consumer consent.

- 1 CCBHC have policies and procedures in to assist consumers and families of children and adolescents in obtaining appointments and keeping the appointment when there is a referral to an outside provider, subject to privacy and confidentiality requirements and consistent with consumer preference and need.

- 1 CCBHCs have procedures for medication reconciliation with other providers.

⁷ If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

Criteria 3.B. Care Coordination and Other Health Information Systems

- 1 CCBHCs have health information technology (HIT) systems in place that (1) include EHRs; (2) can capture demographic information, diagnoses, and medication lists; (3) provide clinical decision support; and (4) can electronically transmit prescriptions to the pharmacy.
- 1 CCBHC HIT systems allow reporting on data and quality measures required by the criteria.
- 1 CCBHCs have plans in place to use the HIT system to conduct activities such as population health management, quality improvement, disparity reduction, outreach and research.
- 1 If a CCBHC HIT system is being newly established, it is certified to accomplish the activities above; to send and receive the full common data set for all summary of care records; to support capabilities including transitions of care, privacy, and security; and to meet the *Patient List Creation* criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC's Health IT Certification Program.
- 1 CCBHCs recognize the requirement to have a plan in place by the end of the 2-year demonstration program, focusing on ways to improve care coordination between the CCBHCs and DCOs using HIT. The plan should include how the CCBHC can support electronic health information exchange to improve care transitions to and from the CCBHC using the HIT system they have or are developing related to transitions of care.

Criteria 3.C. Care Coordination Agreements

CCBHCs are expected to work towards formal agreements (contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU)) during the time of the demonstration project but should at least have some informal agreement (letter of support, letter of agreement, or letter of commitment) with each entity at certification. The agreement must describe the parties' mutual expectations and responsibilities related to care coordination.

- 1 CCBHCs have an agreement in place with ***Federally Qualified Health Centers (FQHCs) and, where relevant, Rural Health Clinics (RHCs)***, unless health care services are provided by the CCBHC.
- 1 CCBHCs have protocols for care coordination with other primary care providers when they are the provider of health care for consumers.
- 1 CCBHCs have an agreement in place with ***Inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs.***

1 CCBHCs have provisions for tracking consumers admitted to and discharged from these facilities (unless there is a formal transfer of care).

1 CCBHCs have protocols for transitioning consumers from EDs and these other settings to a safe community setting, including transfer of medical records, prescriptions, active follow-up, and, where appropriate, a plan for suicide prevention and safety, and for provision of peer services.

2 CCBHCs have an agreement in place with **Community or regional services, supports, and providers**. These include the following specified in the statute: schools; child welfare agencies; juvenile and criminal justice agencies and facilities including drug, mental health, veterans and other specialty courts; Indian Health Service (IHS) youth regional treatment centers; state licensed and nationally accredited child placing agencies for therapeutic foster care service; and other social and human services. Also noted in the criteria as potentially relevant are the following: specialty providers of medications for treatment of opioid and alcohol dependence; suicide/crisis hotlines and warm lines; other IHS or tribal programs; homeless shelters; housing agencies; employment services systems; services for older adults, such as Aging and Disability Resource Centers; and other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

1 CCBHCs have an agreement in place with the nearest **Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department**

- 1 CCBHCs explored agreements with each of the facilities of different types are nearby.

1 CCBHCs have an agreement in place with **Inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers**.

- 1 CCBHCs have provisions for tracking consumers admitted to and discharged from these facilities (unless there is a formal transfer of care from a CCBHC).
- 1 CCBHCs have procedures and services for transitioning consumers from EDs and these other settings to CCBHC care, for shortened lag time between assessment and treatment, and for transfer of medical records, prescriptions, active follow-up.
- 1 CCBHCs have care coordination agreements that require coordination of consent and follow-up within 24 hours, continuing until the consumer is linked to

services or is assessed as being no longer at risk, for consumers presenting to the facility at risk for suicide.

- 1 CCBHCs make and document reasonable attempts to contact all consumers discharged from these settings within 24 hours of discharge.

Criteria 3.D. Treatment Team, Treatment Planning and Care Coordination Activities⁸

1 CCBHC treatment planning includes the consumer, the family of child consumers, and, if the consumer chooses, the adult consumer’s family or others designated by the consumer.

1 CCBHC treatment planning and care coordination are person-centered and family-centered.

1 CCBHC treatment planning and care coordination comply with HIPAA and other privacy and confidentiality requirements.

1 CCBHCs coordinate care provided by DCOs.

1 CCBHCs designate interdisciplinary treatment teams composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers that may include traditional approaches to care for consumers who may be American Indian or Alaska Native as appropriate for the individual’s needs.

1 CCBHCs provide recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native.,

Provide the pertinent criteria number and explain any response with rating higher than 1.

3.c Most have the agreements specified in statute in place. A few locations have formal agreements with many hospitals, the OKC VA, IHS, residential treatment centers, and social service agencies and letters of commitment with child welfare, juvenile justice, law enforcement that they will work with them on a care coordination process and agreements are in process.

⁸ See criteria 2.b.2 and 4.E related to other aspects of treatment planning.

Program Requirement 4: Scope of Services⁹

Criteria 4.A. General Service Provisions

- 1 CCBHCs directly provide, at a minimum, the four required services.
- 1 CCBHC formal agreements with DCOs in the state make clear that the CCBHC retains ultimate clinical responsibility for CCBHC services provided by DCOs.
- 1 All required CCBHC services, if not available directly through the CCBHC, are provided through a DCO.
- 1 CCBHC consumers have freedom to choose providers within the CCBHC and its DCOs.
- 1 CCBHC consumers have access to CCBHC grievance procedures, including for CCBHC services provided by a DCO.
- 1 With regard to CCBHC or DCO services, the grievance process satisfies the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities.
- 1 CCBHC services provided by DCOs meet the same quality standards as those required of the CCBHC.

Criteria 4.B. Person-Centered and Family-Centered Care

- 1 CCBHCs and its DCOs provide are person-centered and family-centered and recovery oriented, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self- direction of services received.
- 1 The services that CCBHCs and its DCOs provide for children and adolescents are family-centered, youth-guided, and developmentally appropriate.
- 1 CCBHC services are culturally appropriate, as indicated in the needs assessment.

Criteria 4.C. Crisis Behavioral Health Services¹⁰

- 1 The following services are explicitly included among CCBHC services that are provided directly or through an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services: (1) 24 hour mobile crisis teams, (2) emergency crisis intervention services, (3) crisis stabilization services, (4) suicide crisis

⁹ If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

¹⁰ See criteria 2.C regarding access to crisis services.

response, and (5) services for substance abuse crisis and intoxication, including ambulatory and medical detoxification services.

1 Crisis services are provided by CCBHCs or by an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. Please indicate how crisis services are provided.

- 1 The CCBHCs directly
- 1 An existing system or network with which the CCBHCs have a formal agreement. Describe the existing system.

The state sanctioned system includes state-run and contracted crisis units, 23 hour and 59 minute urgent care units, and acute inpatient services.

Criteria 4.D. Behavioral Health Screening, Assessment, and Diagnosis¹¹

1 CCBHCs directly provide behavioral health screening, assessment, and diagnosis, including risk assessment, in the state.

1 The state requires that all of the following (derived from the Appendix A quality measures) occurs: (1) tobacco use: screening and cessation intervention; (2) unhealthy alcohol use: screening and brief counseling; (3) child and adolescent major depressive disorder suicide risk assessment; (4) adult major depressive disorder suicide risk assessment; and (5) screening for clinical depression and follow-up plan.

1 CCBHC's initial evaluation of consumers includes the following: (1) preliminary diagnoses; (2) source of referral; (3) reason for seeking care, as stated by the consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnoses for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow-up as required); (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services; and (10) such other assessment as the state may require as part of the initial evaluation.

- N/A Describe additional requirements (if any) established by the state, based on the population served, for the initial evaluation.

¹¹ See criteria 2.B regarding timing of evaluations and assessments.

1 ___ CCBHCs regularly obtain release of information consent forms as feasible as part of the initial evaluation.

1 ___ Licensed behavioral health professionals, performing within the state’s scope of practice and working in conjunction with the consumer as members of the treatment team, complete a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation within 60 days of the first request for services by new CCBHC consumers.

1 ___ CCBHCs meet applicable state, federal or applicable accreditation standards for comprehensive diagnostic and treatment planning evaluations

1 ___ CCBHCs conduct screening, assessment and diagnostic services in a timely manner as defined by the state and in a time period responsive to consumers’ needs.

1 ___ CCBHC screening, assessment and diagnostic services are sufficient to assess the need for all services provided by the CCBHCs and their DCOs.

1 ___ CCBHCs use standardized and validated screening and assessment tools, and, where appropriate motivational interviewing techniques.

1 ___ CCBHCs use culturally and linguistically appropriate screening tools.

1 ___ CCBHCs use tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.

1 ___ CCBHCs conduct a brief intervention and provide or refer the consumer for full assessment and treatment if screening identifies unsafe substance use including problematic alcohol or other substance use.

Criteria 4.E. Person-Centered and Family-Centered Treatment Planning¹²

1 ___ CCBHCs directly provide person-centered and family-centered treatment planning in the state.

- Describe additional state requirements, if any, based on the population served, as to what must be included in person-centered and family-centered treatment planning within the CCBHC care system.

The state requires that planning address needs, strengths, physical and behavioral health goals, consumer preferences, and overall health and wellness needs. Also encourages inclusion of family members and significant others.

¹² See criteria 2.b.2 and 3.D regarding other aspects of treatment planning.

1 CCBHCs provide for collaboration with and endorsement by (1) consumers, (2) family members or caregivers of child and adolescent consumers, and (3) to the extent adult consumers wish, adult consumers' families.

1 CCBHCs use Individualized treatment planning that includes shared decision-making; addresses all required services; is coordinated with the staff or programs needed to carry out the plan; includes provision for monitoring progress toward goals; is informed by consumer assessments; and considers consumers' needs, strengths, abilities, preferences, and goals, expressed in a manner capturing consumers' words or ideas and, when appropriate, those of consumers' families/caregivers.

1 CCBHCs seek consultation for special emphasis problems and the results of such consultation are included in the treatment plan.

1 CCBHCs document consumers' advance wishes related to treatment and crisis management or consumers' decisions not to discuss those preferences.

Criteria 4.F. Outpatient Mental Health and Substance Use Services

1 CCBHCs directly provide outpatient mental health and substance use services.

1 CCBHCs provide state identified evidence-based or best practices outpatient mental health and substance use services.

1 CCBHCs make available specialized services for purposes of outpatient mental and substance use disorder treatment, through referral or formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services.

1 CCBHCs provide evidenced-based services that are developmentally appropriate, youth guided, and family or caregiver driven to children and adolescents.

1 CCBHCs consider the individual consumer's phase of life, desires and functioning and appropriate evidenced-based treatments.

1 CCBHCs consider the level of functioning and appropriate evidenced-based treatments when treating individuals with developmental or other cognitive disabilities.

1 CCBHCs deliver treatment by staff with specific training in treating the segment of the population being served.

1 CCBHCs use approaches when addressing the needs of children that comprehensively address family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

Criteria 4.G. Outpatient Clinic Primary Care Screening and Monitoring

1 CCBHCs are responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk and that care is coordinated. If primary care screening and monitoring are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

1 CCBHCs are collecting and reporting the following (derived from the Appendix A quality measures) : (1) adult body mass index (BMI) screening and follow-up; (2) weight assessment and counseling for nutrition and physical activity for children and adolescents; (3) care for controlling high blood pressure; (4) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications; (5) diabetes care for people with serious mental illness: Hemoglobin A1c (HbA1c); (6) metabolic monitoring for children and adolescents on antipsychotics; (7) cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications; and (8) cardiovascular health monitoring for people with cardiovascular disease and schizophrenia?

1 CCBHCs ensure that children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions

Criteria 4.H. Targeted Case Management Services

1 CCBHCs are responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. If targeted case management services are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

1 The state established requirements, based on the population served, as to what targeted case management services must be offered as part of the CCBHC care system, including identifying target populations. The population(s) targeted is (are)

Criteria 4.I. Psychiatric Rehabilitation Services

1 CCBHCs are responsible for evidence-based and other psychiatric rehabilitation services. If psychiatric rehabilitation services are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

Criteria 4.J. Peer Supports, Peer Counseling and Family/Caregiver Supports

1 CCBHCs are responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. If peer support, peer counseling and family/caregiver support services are offered by a DCO(s), the CCBHCs have a formal agreement with the DCO(s).

Criteria 4.K. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

1 CCBHCs are responsible for intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. The state has demonstrated efforts to facilitate the provision of intensive community-based behavioral health services to veterans and active duty military personnel.

1 CCBHC care provided to veterans is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

1 CCBHCs ask and document asking all individuals inquiring about services, whether they have ever served in the U.S. military. For those affirming current or former service in the U.S. military CCBHCs either direct them to care or provide care through the CCBHC as required by criterion 4.k.2.

1 CCBHCs offer assistance with enrollment in the VHA for the delivery of health and behavioral health services to persons affirming former military service.

1 CCBHCs provide coordination between the care of substance use disorders and other mental health conditions for veterans and active duty military personnel who experience both, to the extent those services are appropriately provided by the CCBHC in accordance with criteria 4.k.1 and 4.k.2.

1 CCBHCs provide for integration and coordination of care for behavioral health conditions and other components of health care for all veterans and active duty military personnel who experience both, to the extent those services are appropriately provided by the CCBHC in accordance with criteria 4.k.1 and 4.k.2.

1 CCBHCs assign a Principal Behavioral Health Provider to every veteran seen, unless the VHA has already assigned a Principal Behavioral Health Provider.

1 CCBHCs provide care and services for veterans that are recovery-oriented, adhere to the guiding principles of recovery, VHA recovery, and other VHA guidelines.

1 CCBHC staff who work with military or veteran consumers are trained in cultural competence, and specifically military and veterans' culture.

1 CCBHCs develop a behavioral health treatment plan for all veterans receiving behavioral health services compliant with provisions of Criteria 4.K.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

Program Requirement 5: Quality and Other Reporting¹³

Criteria 5.A. Data Collection, Reporting, and Tracking

1 The state has the capacity to annually report any data or quality metrics required of it, including but not limited to CCBHC-level Medicaid claims and encounter data. The data include a unique consumer identifier, unique clinic identifier, date of service, CCBHC service, units of service, diagnosis, Uniform Reporting System (URS) information, pharmacy claims, inpatient and outpatient claims, and any other information needed to provide data and quality metrics required in Appendix A of the criteria. Data are reported through the Medicaid Management Information System (MMIS/T-MSIS).

1 The state has to capacity to provide Treatment Episode Data Set (TEDS) data and other data that may be required by HHS and the evaluator.

1 CCBHCs evidence the ability (for, at a minimum, all Medicaid enrollees) to collect, track, and report data and quality metrics as required by the statute, criteria, and PPS guidance, and as required for the evaluation and annually submit a cost report with supporting data within six months after the end of each demonstration year to the state.

¹³ If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

1 CCBHCs have policies and procedures in place requiring and enabling annual submission of the cost report within 6 months after the end of the demonstration year.

1 CCBHCs have formal arrangements with the DCOs to obtain access to data needed to fulfill their reporting obligations and to obtain appropriate consents necessary to satisfy HIPAA, 42 CFR Part 2, and other requirements.

Criteria 5.B. Continuous Quality Improvement (CQI) Plan

1 CCBHCs have written CQI plans that satisfy the requirements of the criteria and have been reviewed and approved by the state as part of certification.

1 CCBHC's CQI plans specifically address (1) consumer suicide attempts and deaths, (2) 30-day hospital readmissions, and (3) whether the state has required that the plans address any other state-specific subjects; if so, these subjects include the following:

_____.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

Program Requirement 6: Organizational Authority, Governance, and Accreditation¹⁴

Criteria 6.A. General Requirements of Organizational Authority and Finances

1 CCBHCs organizational authority is among those listed in the statute and criteria.

1 CCBHCs not operated under or in collaboration with the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, reached out to these entities within their geographic service area and entered into arrangements with them to assist in the provision of services to and to inform the provision of services to AI/AN consumers.

¹⁴ If the answer to any question is "No," please provide justification at the end of the program requirement checklist.

1 The CCBHCs have a procedure for an annual financial audit and correction plan, when the latter is necessary.

Criteria 6.B. Governance

1 CCBHCs board members are representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders. The CCBHCs incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers through the options listed below. Identify which method was used to certify the CCBHCs. If more than one option was used in the state, please identify the CCBHC to which the option applies.

- 1 51 percent of the board are families, consumers or people in recovery from behavioral health conditions. The CCBHC has described how it meets this requirement or developed a transition plan with timelines appropriate to its governing board size and target population to meet this requirement that is satisfactory to the state.
- N/A A substantial portion of the governing board members meet this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services, The state has reviewed and approved and documented its approval of the proportion of the governing board members and methods to obtain meaningful input to the board.
- N/A The CCBHC is comprised of a governmental or tribal entity or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership. The state has specified and documented the reasons why the CCBHC cannot meet these requirements and the CCBHC has developed an advisory structure and other specifically described methods for consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

Provide the pertinent criteria number and explain any response with a rating higher than 1.

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Attachment 2: Target Medicaid Population(s)

(Statement describing target Medicaid population(s) to be served under the demonstration grant)

Oklahoma's Certified Behavioral Health Clinics (CCBHCs) will serve Oklahomans with mental illness and substance abuse disorders.

Within this framework, Oklahoma has identified the following populations, as special populations:

Definition of Special Population 1: High Risk SMI or Co-Occurring

Individuals with SMI (as defined in OAC 317:30-5-240.1) or Co-Occurring SUD, and at least one high cost condition:

- Cardiovascular Disease
- Diabetes
- Hypertension
- Respiratory Disorders

Plus an inpatient hospitalization (psychiatric or non-psychiatric) within the past fiscal year

Or

Individuals with SMI (as defined in OAC 317:30-5-240.1) or co-occurring SUD, with no high cost condition and either:

- Two non-psychiatric hospital admissions within the fiscal year; or
- One psychiatric hospital admission within the fiscal year; or
- Two Crisis Center admissions

Definition of Special Population 2: High Risk SED or Co-Occurring

SED (as defined in OAC 317:30-5-240.1) or disorders with individual Client Assessment Record (CAR) scores that meet criteria for Level 3 or a substance use diagnosis;

OR

A caregiver rated Ohio Scale shows critical impairment (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales;

And

Attachment 2: Target Medicaid Population(s)

(Statement describing target Medicaid population(s) to be served under the demonstration grant)

At least one of the following conditions:

- Substance use;
- Psychiatric hospitalization within the past one year;
- Multiple psychiatric hospitalizations, ER use and/or crisis center admissions (at least two);
- Intensive array of services are in place, including (at a minimum): case management, therapy, and medication management;
- Chronic physical health condition, such as diabetes, asthma or other chronic physical health condition;
- Child was in the custody of OKDHS or OJA, or had been in and out of court multiple times, within the past six months; or

A child at high-risk of out of home/out of school and/or community placement as indicated by an attestation signed by a LBHP (form provided by the State). The attestation will include narrative explaining the changes and challenges in function and the circumstances surrounding imminent out of home/community placement and an updated psychosocial assessment with support CAR scores.

Definition of Special Population 3:

Adults with Significant Substance Use Disorder

ASAM Level of Care 2.1: Intensive Outpatient Services [Age 18 and over]

- Adults who meet the following specifications:
 - Dimension 2 (biomedical conditions or problems exist) and
 - Dimension 3 (if any emotional behavioral, or cognitive conditions, or problems exist), and
- At least one of the following:
 - Dimension 4 (Readiness to Change),
 - Dimension 5 (Relapse, continued use, or continued problem potential), or
 - Dimension 6 (Recovery Environment)

Definition of Special Population 4:

Adolescents with Significant Substance Use Disorder

ASAM Level of Care 2.1: Intensive Outpatient Services [Age 12 through 17]

Adolescents who meet the stability specifications:

- Dimension 1 (if any withdrawal problems exist) and
- Dimension 2 (if any biomedical conditions or problems exist), and

Attachment 2: Target Medicaid Population(s)

(Statement describing target Medicaid population(s) to be served under the demonstration grant)

- At least one of the following:
 - Dimension 3 (if any emotional behavioral, or cognitive conditions, or problems exist,
 - Dimension 4 (Readiness to Change),
 - Dimension 5 (Relapse, continued use, or continued problem potential), or

Dimension 6 (Recovery Environment)

Special Population 5:

Chronic Homelessness or First Time Psychosis Episode for Children and Adults

An individual with Mental Health or Substance Use Diagnosis:

- That meets the HUD Category 1 Definition

OR

- That meets the first time psychosis episode criteria

Attachment 3: Certified Community Behavioral Health Clinics and DCOs

(Include list of participating certified community behavioral health clinics including designated collaborating organizations (DCOs))

Red Rock

- OCCIC: Oklahoma County Crisis Intervention Center
- OCRU: Oklahoma Crisis Recovery Unit

Grand Lake

- None

North Care

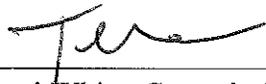
- Integris Ambulatory Care Corp.
- Variety Care – all locations
- Midtown Pediatrics
- OU Family Medicine Center and OU Physicians NE Wellness Community
- OCCHD
- OKC Indian Clinic
- OCCIC: Oklahoma County Crisis Intervention Center
- OCRU: Oklahoma Crisis Recovery Unit
- Red Rock Behavioral Health Adult and Child Crisis Center

Attachment 4: State agrees to pay CCBHC services at the rate established under the pps
(Include a signed statement that verifies that the State has agreed to pay for CCBHC services at the rate established under the prospective payment system.)

Statement

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is Oklahoma's single state authority for mental health and substance abuse services, with the authority to manage Oklahoma's state Medicaid match for behavioral health.

As Commissioner of the ODMHSAS, I agree on behalf of our state that we will pay the rate established under the proposed payment system for Community Behavioral Health Centers (CCBHCs), during the two year demonstration period.



Terri White, Commissioner
ODMHSAS

Attachment 5: Scope of Services

(Include a description of the scope of services required by the state in compliance with CCBHC Criteria, Scope of Services, provided by/through CCBHCs in your state, available under the state Medicaid program, and that will be paid for under one of the selected PPS methodologies either CC PPS-1 or CC PPS-2 tested in the demonstration program.)

Scope of Services in Oklahoma

The ODMHSAS promulgated rules for CCBHCs during the state planning year. These rules received public comment, passed through all the state levels of approval, and were signed by Governor Mary Fallin.

The required scope of services is delineated in the rules, as follows:

450:17-5-177. General service provisions

(a) Facility is responsible for the provision of the following services:

- (1) Screening, assessment and treatment planning;
- (2) Crisis Services;
- (3) Outpatient behavioral health services;
- (4) Outpatient primary care screening and monitoring;
- (5) Case management;
- (6) Psychiatric rehabilitation;
- (7) Peer and family supports;
- (8) Intensive community-based outpatient behavioral health care for members of the US Armed Forces and veterans.

(b) Many of the services may be provided either directly by the facility or through formal relationships with other providers. Whether directly supplied by the facility or by a Designated Collaborating Organization (DCO) through a formal arrangement, the facility is ultimately clinically responsible for all care provided. The facility must have policies and procedures that ensure DCO-provided services for facility's consumers must meet the same quality standards as those provided by the facility.

(c) Compliance with this Section shall be determined by a review of policies, procedures and consumer records.

Description of CCBHC Services in Oklahoma

A brief description of these services is provided below:

- (1) Screening, assessment, and treatment planning:** This includes screening, assessment and diagnosis, including risk assessment, for behavioral health conditions. For new

Attachment 5: Scope of Services

(Include a description of the scope of services required by the state in compliance with CCBHC Criteria, Scope of Services, provided by/through CCBHCs in your state, available under the state Medicaid program, and that will be paid for under one of the selected PPS methodologies either CC PPS-1 or CC PPS-2 tested in the demonstration program.)

consumers, an **integrated screening approach** will be used to determine the consumer's range and acuity of needs. The facility will use standardized and validated screening and assessment tools, and where appropriate, brief motivational interviewing techniques. A licensed behavioral health professional (LBHP) or licensure candidate, acting within the scope of her/his practice requirements, must complete an **initial assessment** for consumers who have not been assessed by the facility within six months. For consumers presenting with emergency or urgent needs, the initial assessment may be conducted by telemedicine. A **comprehensive evaluation** must be completed by the interdisciplinary team performing within each team member's scope of practice consistent with each consumer's immediate needs. The facility must directly develop a **consumer directed and family-centered, integrated active care plan** for each enrolled consumer that reflects input of the team and others the consumer chooses to involve. The plan must address all services necessary to assist the consumer in meeting his or her physical and behavioral health goals.

- (2) **Crisis Services:** The facility shall make crisis management services available through clearly defined arrangements, for behavioral health emergencies during hours when the facility is closed. The facility will also provide crisis management services that are available and accessible 24 hours a day. The facility will make available the following co-occurring capable services: a) 24 hours mobile crisis teams; b) emergency crisis intervention services; and c) crisis stabilization.
- (3) **Outpatient Therapy Services:** Outpatient services include: a) individual therapy; b) group therapy; c) family therapy; d) psychological/psychometric evaluations or testing; and e) psychiatric assessments.
- (4) **Outpatient Primary Care Screening and Monitoring:** The facility is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Facility shall have policies and procedures to ensure that these services are received in a timely fashion, whether provided directly by the facility or through a DCO. Required primary care screening and monitoring of key health indicators and health risk.
- (5) **Case Management Services:** The facility is responsible for high quality targeted case management (TCM) services that will assist individuals in recovery. TCM should include supports for persons deemed at high risk of suicide. The service will be made available to all consumers as appropriate and identified in the service plan.
- (6) **Behavioral Health Rehabilitation Services:** The facility is responsible for providing evidence-based and other psychiatric rehabilitation services, to include: a) medication education; b) self-management; c) community integration services; d) recovery support services including Illness Management & Recovery; e) financial management; and f) dietary and wellness education.
- (7) **Peer Support Services:** The facility is responsible for the availability of peer recovery support and family/caregiver support services. These services will be made available to

Attachment 5: Scope of Services

(Include a description of the scope of services required by the state in compliance with CCBHC Criteria, Scope of Services, provided by/through CCBHCs in your state, available under the state Medicaid program, and that will be paid for under one of the selected PPS methodologies either CC PPS-1 or CC PPS-2 tested in the demonstration program.)

all consumers and their families/caretakers, as appropriate and identified in the individual service plan. Efforts to enhance a peer's role within the behavioral health system include amending administrative rules to expand the age range and administer specialization training tracts to better serve populations with unique lived experiences; specifically youth and young adults and those involved with the Child Welfare or Department of Corrections. Furthermore, training for staff members who supervise PRSS is provided regularly as a way to increase the level of acceptance, understanding and efficacy of peer support statewide.

In 2005 Oklahoma established a credentialing program for Peer Recovery Support Specialists (PRSS). Those early years provided a strong foundation from which the statutorily mandated PRSS Certification evolved was codified in law and administrative code in 2010.

(8) Community-based mental health care for members of the Armed Forces and Veterans:

The facility is responsible for intensive, community-based behavioral health care for certain members of the US armed forces and veterans, particularly those armed forces members located 5 miles or more from a military treatment facility and veterans living 40 miles or more from a VA medical facility. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including guidelines contained in the Uniform Mental Health Services Handbook of such Administration. Clinical care and services for veterans will adhere to SAMHSA's definition and guiding principles of recovery, VHA recovery and other VHA guidelines.

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A. Solicitation of input by stakeholders

Oklahoma's CCBHC steering committee. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) utilizes the Oklahoma (OK) Planning and Advisory Council (PAC) as the primary advisory group for state planning for Certified Community Behavioral Health Centers (CCBHCs). This is efficient and optimal since this group has a long history of collaboration and has contributed greatly to system development over many years. The group meets bi-monthly with a standing CCBHC slot on the agenda. The PAC revised its bylaws in 2012 to expand and rename itself to more thoroughly embrace a larger constituency reflective of integrated and holistic behavioral health services in OK. Also, additional membership positions were added in 2013 to include individuals with experience in substance use disorder (SUD) recovery, treatment, and prevention services. The bylaws require that 51 percent of the membership be persons in recovery from mental illness or SUD, or family members.

The PAC consists of 40 members. It includes representatives of (1) principal state agencies involved in MH, substance abuse and prevention and related support services (State Departments of Medicaid, Education, Health, Corrections, Juvenile Justice, Housing, Human Services, Child Welfare, and Rehabilitations Services); (2) public and private entities concerned with the need, planning, operation, funding, and use of mental health (MH), SUD and prevention services, and related support activities; (3) adults with serious mental illnesses and/or addictions who are receiving, or have received, services; (4) families of such adults; and (5) families of children with emotional disturbances and/or addictions. The PAC will be voting on revisions of PAC bylaws in the fall of 2016, which will include the addition of youth representatives with serious emotional disturbances and/or SUDs who are receiving (or have received) services.

Presentations at meetings are around topics for which one or more PAC members has requested additional information. This process has been very helpful to the ODMHSAS in development of new initiatives, most recently the development of Behavioral Health Homes (BHHs) for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Therefore, it was the perfect group to tag as the primary advisory body for CCBHC planning and development. All three agencies selected for the CCBHC certification process are BHHs.

The CCBHC state planning core team presents at each PAC meeting to apprise them of progress and to receive their advice and counsel for the next phase of planning. The Director of the National Association for Mental Illness (NAMI) OK chairs this group and ensures the involvement of its affiliates statewide. The PAC was particularly helpful early on by advising on the focus group and survey questions to be utilized, and by giving the council's viewpoint on each facet of the current system. They continue to give special focus and guidance regarding *access to services*. They are vocal in their support of the initiative and need for a demonstration. They are appreciative of the inclusion of outpatient SUD services as a core requirement for CCBHCs and have offered advice and council on the specific gaps in SUD and co-occurring services. A longstanding PAC member chairs the OK Recovery Alliance (OKRA), an advocacy group comprised of consumers and family

members. He has engaged OKRA's members in the feedback process at its regular meetings. Local youth and family groups were engaged through OK Systems of Care (OKSOC) and participated in the surveys and focus groups.

The ODMHSAS has increased youth and young adult partnerships in the past year. The Young Adult State Advisory Board (YSAB) is still in the beginning stages of development. The ODMHSAS, through SAMHSA grant funding, has hired two youth and young adult specialists to enhance the youth and young adult voice in relation to MH, SUD, or co-occurring disorders and overall leadership. YSAB meets once a month and has participated in several state level and community speaking events. Due to a very moving panel presentation by three YSAB members concerning their very negative experiences with engagement and intake, community mental health center (CMHC) Directors (CMHCs/CCBHCs) appointed a work group and will streamline the intake process in January, 2017, to ensure that engagement with the youth or young adult takes precedence over the completion of paperwork and duplicative questions. They continue to provide input into the ongoing development of the CCBHCs and are giving feedback on youth and young adult engagement, services, retention, policy changes, and other topics as they arise.

Oklahoma's outreach, recruitment, and engagement of the population of focus. OK's stakeholder involvement began with the online survey conducted in conjunction *with the state planning application* OK submitted to SAMHSA. The results have informed all subsequent activities. Adults with SMI, families of children with SED, and other stakeholders confirmed that access to services in OK must improve, and there must be a more robust spectrum of services available, especially in rural areas. Shortly after SAMHSA announced state planning funding, planning meetings were held with NAMI OK and Evolution Foundation in preparation for them to help lead the state level stakeholder engagement. The ODMHSAS Director of Peer Integration worked closely with these organizations to conduct a variety of surveys and focus groups. He continued as a part of the CCBHC implementation team, devoting 10% of his time to the effort. Existing contracts were quickly amended to expand the work of these agencies.

After the Request for Proposal (RFP) process and selection of three CMHCs to participate in the state planning year, a kick-off meeting was held, with teams from each of the three CMHCs, Evolution Foundation, NAMI OK, and the core CCBHC state planning grant team of the ODMHSAS. This was an intensive planning session lasting all afternoon. Priority activities were outlined and organized around each of the four essential planning components delineated by SAMHSA for the CCBHC planning initiative. During this meeting, the group **planned** each of the following types of stakeholder involvement: (1) *online surveys*, (2) *regional meetings*, (3) *focus groups*, (4) *engaging existing advisory groups and advocacy organizations*, and (5) *issuing emails at least monthly to keep stakeholders advised of activities*. Specific assignments were given to team members both at the state and local levels in order to ensure these activities take place. The group discussed the important ongoing tasks of broadening consumer involvement and training consumers in leadership and board participation.

Meaningful consumer input was discussed at length at the kick-off meeting, with the Director of Peer Integration and Jeff Tallent of the Evolution Foundation leading. Mr. Tallent chairs several state level consumer and stakeholder advisory groups. He was the main contact to keep these groups engaged and ensure their input was included in the state level needs assessment and planning.

During the second quarter, OK conducted a flurry of surveys and focus groups. A statewide survey was conducted by NAMI OK with approximately 400 responses. This included responses from adults with SMI, families of children with SED, state and other agencies who refer people for services in CMHCs, and other interested stakeholders.

In addition, the Evolution Foundation conducted a survey of the board members of the three CMHCs selected for state planning grant activities, as well as surveys specifically for veterans and tribal members. Regular reports and discussions have been conducted at the State Advisory Team for OKSOC, an advisory group for the MH service spectrum for children, monthly meetings, and for the PAC bi-monthly meetings. The state and the three participating CMHCs have learned valuable information from all these efforts. To name just a few examples, NAMI OK was able to learn that families need more social connectedness and group opportunities. NAMI OK and the three selected CCBHCs have already *increased group opportunities for families* based on this information. The ODMHSAS learned that there are *specific types of staff* that need improvement in their interactions with those served. In particular, the clinical staff who are conducting intakes are not always providing a warm, conversational type of interview. This has been discussed in both monthly CMHC Directors' meetings and Clinical Directors' meetings. A *paperwork reduction workgroup* was formed, and has already drastically *reduced paperwork* by eliminating redundancy and unnecessary questions. In addition, the group has agreed to *produce training videos* to increase the interview competency of intake professionals. *Additional important feedback* was given concerning days and hours that services are offered, locations, environmental factors, and customer service.

Coordination of efforts to ensure that services are accessible and available. The ODMHSAS has utilized its extensive existing networking relationships with other state and federal agencies and tribes to garner their input for CCBHC development. Tribal participation is particularly important in OK, due to the presence of 38 federally recognized tribes. A brief presentation about state planning efforts was given to the Oklahoma Health Care Authority's (OHCA) formal tribal consultation meeting in April, 2016. Those present were able to offer valuable input. They expressed some overarching issues to consider, such as how to best approach tribal nations and Indian Health Service clinics about establishing processes for referrals and linkages. Also, an informal consultation was held with the Chickasaw Nation Behavioral Health Director and others April. Several issues were discussed, including one specific area where two tribal members expressed inability to access the local CMHC for treatment. The ODMHSAS was able to follow up immediately on the specific issue while also applying the information to the broader CCBHC

plan. Also, *several additional local tribal consultations* have occurred, all bringing valuable perspective and input.

The state has laid a firm foundation for increasing access to services for OK's veterans. The ODMHSAS enjoys the expertise of two veteran liaisons on staff: Kerry Mucker, Specialty Courts Veterans Liaison for ODMHSAS, and John Wilson, Veterans Mental Health Liaison. Mr. Wilson was appointed as the Oklahoma Department of Veterans Administration (ODVA) Veterans Mental Health Programs Administrator in October 2015 and is outsourced at the ODMHSAS. He is working to ensure the 340,000 veterans who reside in OK are informed about and make greater use of the mental health services that are available to them. Both are experts in veteran's affairs and are familiar with the CCBHC goals. The liaisons give regular updates to the monthly Veterans Alliance group and at other formal veterans meetings. Mr. Mucker is continuing to assist with connecting the ODMHSAS and the CCBHCs to specific meetings that are scheduled pertaining to veterans with tribal affiliations.

An overview of CCBHC development was presented to the Veterans Alliance. A good discussion was held regarding how to meet the needs of veterans and those who have served or are in the reserves but considered inactive duty and cannot receive VA benefits. The two veteran liaisons were able to facilitate a meeting between CCBHC staff and Major General Deering, Secretary of Veteran Affairs and the Executive Director of the Oklahoma Department of Veteran Affairs, to educate on the CCBHC and how this evolution of services could benefit veterans, dishonorable discharged veterans, and individuals that are inactive duty but still in the reserves. The latter two populations are uninsured or underinsured and have been linked to having trauma, MH, and/or SUD issues that cannot be addressed. Initial connections are made and the foundation is laid for greater Veterans' access to services.

The three CMHCs have also been busy with Tribal Listening Sessions and Veterans Affairs meetings. They have worked hard making connections and have learned valuable information from all of these efforts. To name just a few examples, the veteran's focus group indicated veterans do not reach out for MH or SUD services due to fear of repercussions and concerns that if the military found out it would affect the direction of their careers, trainings, and promotions. Many veterans are not even aware of the services available both on and off base.

The formal and informal regional tribal consultations have provided valuable information to both the CMHCs and tribal entities. Tribal entities reported they handle outpatient services for MH, SUD, and health services. They reach out to other service systems for residential, detox, and youth services. Gaps in services that were identified at these meetings were for: children, suicidality, medical detox, and crisis. Most people felt they knew who the local CMHC was, but lacked contact information, which has since been provided to everyone who attended.

Through these connections, the three participating agencies have received VA Cultural training from the Veterans Affairs and future training is in the works for Native American population to be

provided by the Indian Health Clinic in Oklahoma City. The VA cultural training provided by Alan Doerman, Psy.D, of the VA Medical Center presented excellent information that increased understanding of military and veteran culture and the right approach working with this population. Successful outreach tools developed by the Reaching out to Educate and Assist Caring Healthy Families (REACH) program, start by asking the veterans and their families what they would like to be different in their lives. A handout on resources, questions to ask in order to engage this population, and information about their unique health risks was provided to all participants.

Additional stakeholder information was collected through the tribal listening sessions. Tribal and military/veteran sessions provided valuable information on strengths, needs and gaps. An overview on CCBHC development was given to OK Veterans Council Department of Veterans Affairs in May and June. The Choctaw Nation hosted a formal tribal consultation meeting in June. The ODMHSAS provided an overview of community based services, prevention and specialty court services. Those present were able to offer valuable input. They expressed some overarching issues to consider, such as identifying how their data can connect into ODMHSAS data so their numbers can be counted. It was agreed the next formal tribal consultation will focus on data analysis. This will be held in November.

The CCBHC model was presented to the board of inpatient providers and the Oklahoma Psychiatric Hospital Association to ensure there is good communication on how to best connect with providers once an individual returns to the community. This will ensure a continuum of care that will benefit the individual receiving services. Because of *feedback regarding lack of coordination between inpatient and outpatient services*, a Building Bridges project will be established during the first year. This is a model championed by Dr. Gary Blau of SAMHSA. It fosters warm handoffs and family centered care between outpatient and inpatient levels of care, and helps inpatient facilities develop a culture of connection with other levels of services. Meanwhile, the CCBHCs (all of which are behavioral health homes for adults with SMI and children with SED) are **required** to establish connection and to ensure smooth transition back and forth between outpatient and inpatient services.

Many additional groups are actively engaged at the state and local levels, such as health departments, schools, domestic violence agencies, legal aid, homeless alliances, child welfare, juvenile justice, rehabilitation services, occupational therapists, youth services agencies, therapeutic foster care agencies, domestic violence shelters, etc. The process of engagement for CCBHC development has opened doors for many exciting new partnerships.

B. Oklahoma's Approach for CCBHC Certification

OKs application process and review procedures. The ODMHSAS conducts the state statutory certification processes by which facilities in OK are granted a license/certification to provide behavioral health services and related supports. The OHCA and the ODMHSAS enter into an annual Memorandum of Agreement agreeing on the use of this certification and monitoring

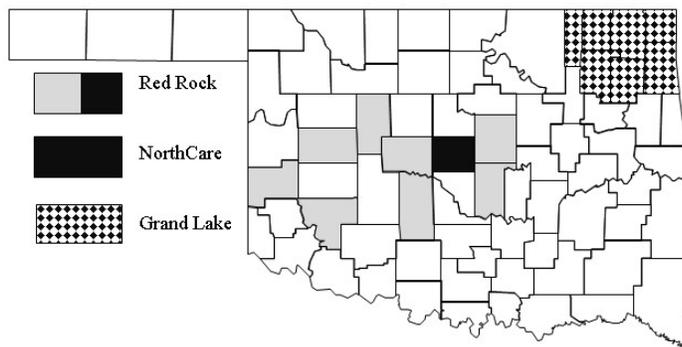
process in order to ensure compliance with standards. The ODMHSAS is also responsible for promulgating state administrative code which establishes specific processes that must be followed by certified providers as well as articulates detailed standards and criteria related to behavioral health services offered to the citizens of OK. ODMHSAS staff members review all organizations that apply for certification in accordance with specific protocols, including quality, access, and availability of services. Subsequently, a certification status is recommended to the ODMHSAS Board of Directors for approval. In order to be certified as CCBHCs under the new standards and criteria, agencies submitted an application to the ODMHSAS provider certification, along with the required application fees. Provider certification staff members performed a rigorous and thorough review of application materials (agency policies and procedures for providing the required services, staffing, and credentials). After staff members determined that the agency's policies and procedures met the established criteria, a site review was performed. Once the agency successfully completed all of these steps, the agency was recommended for certification by the ODMHSAS Board. After initial certification and Permit to Temporarily Operate (PTO), the agency is reviewed again after six months to ensure that all quality clinical standards are being met. Certification can be one to three years depending on the provider's score and approval of the ODMHSAS Board. Time-limited certification ensures that access to quality care is available to persons eligible for CCBHC services.

Working closely with our Medicaid partners at OHCA, rules for CCBHCs were promulgated and submitted to the Governor's office for approval to move forward during the first few months after notice of award for planning. Once approved, they were posted for public comment. The legislature approved them during the spring session, and the Governor signed them in June of 2016. They went into effect on September 1, 2016.

In order to ensure that certification of selected CMHCs would take place prior to October 31, the ODMHSAS Provider Certification division sent out application packets to the three agencies on June 14, 2016. Upon receipt of the completed applications, desk reviews of policies and procedures began and pre-certification site visits were scheduled. These visits ensured that the CMHCs were on target in their preparation to meet standards. This process ensured certification of those who met standards and was completed by September 30, 2016. This includes three CMHCs with 16 locations, including satellites. ***These certifications took place on schedule!***

In addition to certification, our agency has a contract monitoring team that will provide ongoing support and technical assistance as it relates to the CCBHC contract with the ODMHSAS. The contracts division will write a report on any items that may need improvement and will refer to ODMHSAS program staff for technical assistance if the area is out of their scope of practice.

The ODMHSAS creates an overall statement of work (SOW) for CMHCs and CCBHCs for each state fiscal year. In addition to the SOW, innovative and evidence based practices (EBPs) are disseminated through grant and other specialized funding. Each of these has an accompanying SOW. It is through the deliverables in the various SOWs that the ODMHSAS continually works with contracted agencies to improve the access and quality of the services, as well as the dissemination of core, state-chosen EBPs that meet the needs of Oklahomans and the financial constraints of our public behavioral health system. The ODMHSAS offers required training, technical assistance, and ongoing consultation after EBP training. Data and required reports are used to monitor quality. Invoices can be held due to deficit in delivering the contracted service and when necessary contracts are terminated.



Diversity of CCBHCs. The counties selected to participate in the CCBHC demonstration program vary dramatically. The seven-county GL service area in far northeast OK is rural and is in the heart of the Cherokee Nation. NC’s service area is in central OK and contains the capitol city of Oklahoma City (OKC). RR’s area covers nine counties

with both the central urban region, including OKC, and rural Southwestern OK. The population density varies from 1,035/square mile in OK County, included in two of the CCBHC service areas, to 18.2/square mile in a GL County (Index Mundi, 2010). The demonstration sites include 37% of the State’s population. A county in the RR area has the highest median household income (\$64,200) and the lowest poverty rate (7.7%), while counties in the GL area have the lowest median household income (\$36,198) and the highest poverty rate (22.1%). High school graduation rates range from 91.5% in a RR county to only 83.5% in GL’s area. The rate of languages other than English spoken at home ranges from 2% in the GL area to 16.6% in the RR and NC areas. The percent of the population that is “White alone” ranges from 88.4% in a RR county to 66.7% in GL’s area. While OK has the second largest Native American population in the nation at 9%, the rate varies from 3.4% in a RR county in southwest OK to 21.7% in a northeast GL county (American Community Survey, 2015).

The majority of Oklahoma is designated by Health Resources and Services Administration (HRSA) as a medically underserved area (MUA), including six of RR’s counties, NC’s county and five of GL’s counties. The other two GL counties are designated as having medically underserved populations. Of the 77 counties in OK, only six are not designated as a primary care health professional shortage area (HPSA). Three of the nine counties located in the RR services area are HPSAs and five of the seven counties in the GL service area are HPSAs. Sixty-nine counties are designated as MH professional shortage areas: three in the RR area and all of the GL area. Sixty-

one counties are designated as dental health professional shortage areas. This includes the RR area and all but one of the GL counties (OK State Department of Health, 2016).

How the state facilitated cultural, procedural, and organizational changes to CCBHCs. The ODMHSAS has conducted major systemwide cultural and operational changes over the past decade. Because of this successful experience, a bi-directional development model has advanced wherein new initiatives are developed interactively with providers. The SAMHSA funding opportunity for a state planning year was discussed in monthly provider meetings, the decision to move forward was agreed upon, and initial plans were developed. A request for proposal was quickly released upon notice of award. Once providers were selected, monthly working meetings were established. Implementation teams from each agency participated regularly, including clinical directors, chief financial officers, technology designees, and often, the chief executive officers. When necessary, special meetings were called to drill down into specific areas. For example, several working meetings were held regarding selection of the PPS and preparation of cost reports. In addition, the ODMHSAS employed a temporary field service staff member to travel to the CCBHCs to facilitate changes, and contracted with an accounting firm to consult with them on their cost reports. These processes were absolutely critical to the successful planning year.

The ODMHSAS is requiring providers to use EBPs that are client-centered and recovery-oriented such as a *high fidelity Wraparound Model* for children (Bruns, et al., 2004). The ODMHSAS maintains a staff of coaches that train and coach in Wraparound fidelity. Wraparound is under review for inclusion in the National Registry of Evidence-based Programs and Practices (NREPP) as an EBP. It is a promising practice that is gaining in research evidence (Suter and Bruns, 2009). In 2005, Bob Friedman and David Drews stated in *Evidence-Based Practices, Systems of Care, and Individualized Care*, “It should be noted at the outset that the Wraparound process may be considered to be an evidence-based process by itself.” The ODMHSAS has enjoyed great success in disseminating the Wraparound process and outcomes, as analyzed and reported by external evaluators, the University of Oklahoma E-TEAM (Educational Training, Evaluation, Analysis and Measurement), and results continue to prove strong each year.

The ODMHSAS contracts for 11 teams of the intensive adult model, *Programs of Assertive Community Treatment (PACT/ACT)*, which is a comprehensive EBP for adults who are SMI with high needs (SAMHSA, 2008). Both RR and NC offer the model in Oklahoma City. Since this EBP has been operating since 2003 in Oklahoma, there is currently a process underway to strengthen and update PACT programs. The ODMHSAS is conducting analysis of data, review of the literature, and a study of ACT implementation in other states, which will result in updates of rules and contract language, and increased training and technical assistance.

In January, 2015, the ODMHSAS established BHHs for adults with SMI and children with SED which is reimbursed through a per-member, per-month payment rather than the previous fee-for-service method. This has allowed providers to do whatever the client and their families need rather than providing only the services for which they can bill 15-minute increments. The motto is “do

whatever it takes” to meet the individual client and family’s needs. The ODMHSAS and our providers are excited to take this philosophy to the next level with the CCBHC model. BHHs will remain at the heart of CCBHCs and they will continue with integrated services. The state plan amendment for BHHs was made possible through the Centers for Medicare and Medicaid (CMS) because of the Affordable Care Act. Care coordination is the lynchpin of the core BHH services, utilizing the evidence-based ***Chronic Care Model*** for care coordination (Wagner, 2000). The CCBHCs certified for participation in the demonstration have been implementing integrated care for almost two years as BHHs. This makes them uniquely qualified to conduct a successful CCBHC demonstration.

According to the 2014 Child Trends report, Oklahoman’s have consistently high rates of adverse childhood experiences (ACEs) due to high rates of child abuse and neglect, high rates of incarceration, a large military presence experiencing deployments, natural disasters, and other risk factors (Child Trends, 2014). The ODMHSAS conducted a several-year process throughout the public behavioral health system designed to create a trauma-informed culture. Organizational models such as the Sanctuary model and the Systemic, Therapeutic, Assessment, Resources and Treatment (START) model were implemented by some agencies. The Strengthening Hope and Resiliency Everyday (SHARE) website was created to provide free introductory training in trauma issues and links to a plethora of information. Screening for trauma has become universal throughout the system as a result of this multi-year process. And, once identified, trauma is treated specifically. The ODMHSAS, through a contract with the University of Oklahoma Child Study Center, provides regularly scheduled trauma-focused cognitive behavioral therapy (CBT) training and follow up consultation calls where cases are staffed in real time for all CMHCs.

As stated previously, creating a trauma-informed system that delivers trauma-specific services has been underway for several years. Beginning in July, 2016, CMHCs are required to screen all adults entering the system for trauma. This requirement was already in place for children. Fidelity to these practices is monitored through site visits that include chart reviews and interviews with clients and family members, when appropriate. In addition, fidelity scales that quantitatively measure the degree of fidelity are used at each site. The ODMHSAS produces a report in real-time that shows providers which clients are not showing improvement on assessment scores at each update, indicating the current treatment modality or medication is not having the desired effect and a change may be in order. Early in the state planning year, the ODMHSAS asked the CCBHCs to conduct a cultural and linguistic competency self-assessment checklist survey. Through this process, RR discovered some areas in which improvement could be made which includes: lack of pictures, posters, artwork, and other printed materials in the reception area that reflect the different cultures and ethnic background of clients served; printed information that take into account the average literacy levels of clients and families served; keeping abreast and being well versed of major health concerns and issues for ethnically and racially diverse client populations residing in the area. GL determined it needs to have signage and welcoming and informational materials translated into Spanish. While it does not serve a diverse population,

Spanish is the most prevalent language after English with <2% of its community speaking it. NC utilized the Promoting Cultural and Linguistic Competency Self-Assessment Checklist and addressed the concerns revealed through their needs assessment and planning process throughout this planning year.

Oklahoma's CCBHC Needs Assessment Process. The ODMHSAS conducted a multi-faceted needs assessment. From February through September, 2016, 23 different events were held across the State to gather meaningful stakeholder input. These included listening sessions, surveys, and focus groups with participants comprised of youth and adult clients, family members, military groups, tribes, and community and state organizations. The CCBHCs as well as ODMHSAS staff were able to hear this input loud and clear and take action to improve care. In addition, data analysis was conducted utilizing several sources for the needs assessments. County-level census data was heavily employed to compare the general population's demographics to persons currently served and also to the staff. Examples of demographic and cultural variables include race, ethnicity, language, disability, and military status. Multiple tables were produced to display data by agency locations so weaknesses at the site or agency level could be addressed. In addition, a staff survey was administered by the ODMHSAS to determine distribution of sexual orientation, disability, lived experience/family member, race, age, gender, languages spoken, length in the MH system and at agency, license/certificate/credential held, EBPs trained in, and primary age group of clients seen. Staff were also questioned about attitudes concerning training and development program, opportunities for advancement, salary, benefits program, working conditions and hours, co-workers, supervisors, overall satisfaction, and likelihood of leaving the field within five years. The results of these analyses were provided to CCBHCs to augment their own needs assessments and take appropriate actions to correct any gaps.

Prevalence of BH Needs and Gaps. OK has a high prevalence rate, with 22.4% experiencing mental illness (3rd highest among states), and 11.9% experiencing a SUD disorder (2nd highest among states). Between 700,000 to 950,000 Oklahomans are in need of MH or SUD treatment (Mental Health America, 2015). There are 189,454 youth, ages 0-18, estimated to have a mental illness. It is estimated that 144,510 Oklahomans have an SMI (SAMHSA, 2012). Estimates of children suffering from serious emotional/behavioral problems vary significantly depending on the study cited. The ODMHSAS utilizes SAMHSA's prevalence rate for SED of 10%. This means that out of approximately 954,000 children in the State of Oklahoma, approximately 95,400 can be expected to have an SED (Census Bureau, 2015).

Half of all lifetime cases of mental illness begin by age 14; however, four out of ten children in OK with MH problems do not get access to treatment, services, or support. This is unacceptable, for the reason that if intervention occurs early, resilience can be built and life outcomes can drastically improve.

Race and Ethnicity. When looking at clients served by race, Whites are served roughly equivalent to the distribution in the population. African Americans and American Indians are overrepresented

in the client mix at the three CCBHCS. It is the Hispanic population that is found to be underrepresented. In the GL region, the percent of Hispanics in the population is larger than that of the staff or clients served (3.9% vs. 2.3%, 2.1%, respectively); however, the larger disparity is in OK County, with the greatest concentration of Hispanics at 16.2%, but only 6.4% and 1% of the clients seen at NC and RR are Hispanic, respectively.

Language: In OK, 3.8% of the population has limited English proficiency. Reporting on a county basis only includes specific languages if more than 499 persons or five percent of the population speak the language. In the GL region, the only language meeting these criteria was Spanish in three counties with an average of 1.4% speaking it. OK County, served by RR and NC, had the most diversity with 6.2% of the population speaking Spanish. Vietnamese, Chinese, 'other Asian languages,' and Arabic were spoken by more than 500 people but each by less than 1% of the population. In the other RR counties, an average of 5.3% of the population speak Spanish, with Vietnamese spoken in one other county at less than 1% of the population.

SUD Services. Traditionally in OK, the CMHCs have not been funded or trained to do comprehensive outpatient treatment of SUD, and there has been somewhat of a chasm separating a smooth transition to and from outpatient services to residential SUD treatment. This has been changing in recent years, especially with the advent of the BHH model which requires integration of all needed services. However, it is clear from the ODMHSAS data analysis and all of the surveys and focus groups that more must be done to accomplish integration of fully co-occurring services. With the demonstration, the remaining pieces will be put into place to ensure a fully comprehensive scope of outpatient services within the three CCBHCs, as well as a smooth coordination of services between these and OK's inpatient and residential services.

RR has implemented an internal credentialing process to build skills to provide SUD services for clinical staff. All new employees are required to complete Motivational Interviewing (MI), validated screening, assessment and placement tool training within the first six months of hire. In all subsequent years, clinical staff are asked to complete one-hour of SUD-related CEUs annually. The RR trainer will also provide SUD training for RR staff included in the 20 hours of free CEUs provided for clinical staff. RR has just opened a Medication Assisted Treatment (MAT) unit composed of a medical doctor, licensed alcohol and drug counselor (LADC), case manager and peer recovery support specialist.

GL has designated a Director of Addiction Services and will begin expanding the number of LADCs on staff. Its electronic bio-psychosocial already contains screens for ASAM compilation. In becoming a CCBHC, GL will be expanding its SUD services to include consumers diagnosed with a primary diagnosis of a SUD. It will be prepared to provide outpatient and intensive outpatient services utilizing EBP-based curriculum, as well as 24-hour crisis intervention services, including ambulatory and medical detoxification.

NorthCare currently provides MAT for 25 consumers and is expanding that to 100 in this upcoming year. It has hired additional peer support staff in recovery from SUD in order to provide additional individual and group support. It continues to send therapists to *Adolescent Community Reinforcement Approach* training, an EBP, in order to reach the transition age youth and will provide family SUD education groups.

Military. A population that surfaced as underserved in the needs assessment is that of military personnel, veterans, and their families. To address this issue, the CCBHCs have reached out to and networked with referral sources for this population. GL has established a contract with the US Department of Veterans Affairs (VA) to provide services for their members if they live more than 40 miles away from the VA outpatient center in the GL service area or if they are on a waiting list for services with the VA. It has produced flyers and is doing public relations communications in all of its communities. It has prominent posters in all outpatient clinics to advertise veteran services. Staff have visited American Legion Posts and Veterans of Foreign Wars posts, left flyers and/or are scheduled to come back to speak to the members.

RR is working to enhance its abilities to provide services to veterans. The Oklahoma City Veterans Administration (OKCVA) is currently working on obtaining approval from the VA Director to co-locate staff within RR offices.

The NC veteran liaison is the point of contact for any veteran seeking services in the community. He attends numerous collaborative meetings and provides group services in the Veteran's Diversion program. He educates staff on the needs of veterans and their families, and is an advocate within the agency to help better serve this population.

Transportation and Income. Since OK is a relatively large rural state, transportation has long been a challenge for lower socio-economic groups. Even in the four large metro areas, the public transportation system is not as well developed and widespread as urban cities in other states. The CCBHCs have had to be resourceful and innovative to meet the transportation needs of their clients. GL serves a very poor and large rural area and is utilizing many approaches to address income and transportation barriers. It has vans and cars to provide transportation for consumers. It also purchases vouchers for the only public transportation system in the area and utilizes flex funds to help purchase gasoline when necessary. Further, it provides services in the consumer's homes and schools. Part of the intake process is to determine the best place for services to be offered to the consumers. It also maximizes use of telemedicine services. In FY 2014-2015, GL submitted 25,813 claims that were delivered through telemedicine. More recently, GL has initiated a program to address transportation using health information technology. To date, the agency has deployed 179 iPads to clients, staff, emergency workers and law enforcement officers. These devices are distributed to clients and families who have difficulty accessing services due to transportation or financial difficulties or inability to consistently receive services in a traditional office setting. The iPads are wiped of all applications except a HIPAA compliant connection which allows the consumer to connect with their service provider from any location. Local sheriff and police

departments, the Juvenile Detention Facility, residential care facilities, and ERs have also received iPads to utilize for consultation with GL staff when dealing with an individual with MH and/or SUD issues. Licensed behavioral health professionals, case managers, and care coordinators have been given iPads to assist with engagement, therapy, assessment, and crisis resolution.

RR's urban offices have transportation vouchers available to clients who need assistance to attend services. In its rural areas, RR vans provide transportation for clients to attend psychosocial rehabilitation programs. RR is modeling the success GL has had using iPads and is developing procedures for clients to access services through this technology in the near future. RR also plans to expand the use of telemedicine. Currently all offices are equipped to provide services and telemedicine services for medication management and are already being used on a regular basis. In FY 2014-2015, RR submitted 17,172 telemedicine claims. Both rural agencies will expand use of telemedicine services to further meet the demands of large rural areas with sparse populations.

Responsible for an area of town where many people with SMI live, as well as a large number of homeless individuals, NC is preparing to move to a new building located next to a city bus stop for which it provides bus tokens to its clients needing transportation. Its van transportation runs five days a week on a route that includes three homeless shelters and a peer-run drop-in center, to encourage socialization. Also, this new building is located next door to the Oklahoma City Crisis Intervention Center (OCCIC) and NC has an MOU for utilizing OCCIC for immediate access to crisis beds if needed. In addition, NC is preparing to implement the digital health solution called myStrength. With myStrength, NC clinicians will have the ability to augment direct intervention with 24/7 virtual care for their consumers and families. The myStrength system offers a range of mood-improving resources for the mind, including step-by-step e-learning modules, interactive tools, weekly action plans and daily inspiration personalized to each consumer. This consumer-centric and highly confidential HIPAA-compliant platform reduces the stigma and provides inexpensive access to evidence-based resources. Using the digital tools available with myStrength, NC will expand service capabilities through the use of technology to reach more clients; provide relapse management post-intervention; offer interactive, evidence-based tools to assist clinicians in case management and treatment planning; and provide emotional wellness resources to staff to cultivate their own health and wellbeing.

Accessibility. There is clearly a need for the providers to be accessible to people with disabilities and language barriers. All have demonstrated plans for increasing accessibility. RR offices are equipped to provide services to persons with physical disabilities and have ramps for persons in wheel chairs as well as handicap bathroom facilities. RR is planning on making additional improvements such as automated doors for persons in wheel chairs. GL's site locations are handicap accessible and it utilizes iPads and telemedicine as well as home-based services to assist consumers who have limited mobility. It utilizes speech-to-text software to assist consumers with completion of documentation and will further expand by looking at new software possibilities for access to services for speech and hearing impaired consumers.

The two urban centers recognize and were reminded through the needs assessment process that there are those who are still unserved individuals who speak languages other than English. RR is contracting with the Language Line, providing access to 240 professional linguists twenty-four hours, seven days a week. Language Line provides phone, video, and onsite interpreting, translating, and localization. RR is revising the sliding scale to be more linguistically appropriate for clients with limited English proficiency. Clients are screened for services and based on income may be able to attend services for no or reduced charge. RR has always been available for those clients most in need and will continue to serve the communities with that philosophy.

NC's new building was designed to be accessible to those with disabilities. All services are on the first floor, the hallways are wider, and there are individual bathrooms and double doors leading into the clinical area. It is working to make access to all types of services needed by the population served more available. NC has staff embedded at the Health Department, located in the part of the city with the worst health outcomes, and has domestic violence liaisons at each location. Staff from the Child Abuse Response and Evaluation Center, who serve families impacted by physical and sexual abuse are co-located at NC. Others services co-located at NC include: GED classes, Legal Aid, adult art classes; Narcotics Anonymous groups; and Spanish speaking *Seeking Safety* groups. Forms and handouts have been translated into Spanish, and individual therapy, family therapy, and case management services are also provided in Spanish. Its Intensive Transition Team makes rounds at all private and state funded psychiatric hospitals and crisis centers in its area to meet with consumers who are discharging and works to engage them in outpatient services. A pilot program to provide juvenile bureau involved youth and their families with comprehensive and integrated health care and service coordination has been implemented. Also, NC co-locates clinicians and case managers with Child Welfare and Juvenile Court to provide assessment and care coordination for child welfare families. NC is currently working with a federally qualified health center (FQHC) on a collaboration with St. Anthony hospital, for those patients hospitalized due to chronic disease issues that also have MI and SUD.

Workforce. Critical needs that have long been recognized are staff shortages and an aging work force. OK is 48th in the nation for MH spending per capita. Services rates have rarely increased in the last 10 years. Publically funded behavioral health organizations have stretched their budgets and staff to keep their doors open but, as a result, it is difficult to hire and retain staff. Some of this has been alleviated through the use of telemedicine, which OK invested heavily in during the early 2000s through a SAMHSA state incentive grant. Another service extension has been through the use of Peer Recovery Support Specialists. However, staff shortages have led to clients getting what services can be provided by what staff are available rather than what they need. A large part of the CCBHC planning grant was spent determining the workforce needed to provide a wide range of services and holistic care. RR plans to raise salaries for licensed therapists currently employed by \$5,000 across the board and intends to add 20 new therapists to expand the service array to meet CCBHC requirements. RR will offer a sign-on bonus for new therapists who agree to remain with the agency for two years and will continue to fully cover medical and other insurance premiums

for employees, as well as encourage continuing education through dedicated professional growth funds. RR supports staff continuing education by offering 20 hours of in-house trainings through RR's trainer at no cost to the staff and offers no-cost licensure supervision for staff pursuing licensure status. Healthy competitions to help staff focus on personal wellness such as walking challenges and a drawing for persons who complete their annual wellness check-up are just a couple of events sponsored throughout the year to encourage employee wellness.

In order to meet the new standards of care required to become a CCBHC and improve the quality of care and outcomes for its clients, GL has been in the process of actively expanding the number of clinicians serving in its seven-county area. Due to the fact that its clinics all reside in rural areas, this also required it to increase the salaries for qualified clinicians in order to attract new staff and retain current staff, particularly for its 24-hour unit requirements. It has already begun to see a difference in the scope and level of service it is able to provide. By actively recruiting additional staff and by paying more competitive rates to existing and future staff, GL firmly believes that it will be able to provide a higher level of service, at ultimately a reduced overall cost per service by reducing employee turnover and by being able to accept only the best of candidates. To date, new hires include seven nurses and one nurse practitioner, 16 behavioral health professionals, 13 peer recovery support specialists, 11 family support specialists, 13 care coordinators, 11 rehab specialists, and administrative staff such as a medical records specialist and human resource administrator.

In an effort to hire and retain staff, NC is providing frequent training and consultation in EBPs, offering strong clinicians the opportunity to become trainers in EBPs, taking on the additional expense of recruiting and supervising larger number of practicum students, offering flexible schedules and increased autonomy, increasing salaries to be competitive in the market, and offering a new campus with diverse clinical experiences, modern amenities, and an onsite café. They anticipate hiring a adult and a child psychiatrist, two psychiatric nurses, a SUD specialist, 12 case managers, one peer recovery support specialist, 14 licensed behavioral health professionals, a nurse practitioner, a medical assistant, and three van drivers.

EBPs Required by Oklahoma. The ODMHSAS disseminates evidence based practices (EBPs) and promising practices strategically and systematically. It starts with analyzing need, readiness, and sustainability prior to model selection. Once a model is selected, a budget is developed for contracting with purveyors for training. Models which provide a train the trainer model are preferred, and at times the ODMHSAS has been successful negotiating with purveyors who have not previously offered that option. In addition, training is not put into place without follow-up consultation and/or coaching. The agency enjoys a successful track record of statewide dissemination. It typically utilizes grants to contract with purveyors and offer training and consultation free of charge. When possible through grant funding, agencies are reimbursed for lost billing time in order to bring effective practices to scale with fidelity. EBPs that are practical and affordable for statewide implementation within a public behavioral health system are chosen, with

preference to those tested on a wide group of persons. EBP models that will not eventually result in state capacity to sustain, without ongoing high payments to the purveyor, are rejected.

The following models were chosen for statewide dissemination and the state planning process has reinforced this direction and fit all the criteria explained above. In addition, they are effective for prevalent MH and SUD issues and conditions in our state. Oklahomans experience a high degree of trauma from a variety of sources which predisposes them to negative MH, overall health, and SUD outcomes. We are consistently ranked near the top nationally in percentage of adults with serious mental illness and unhealthiest citizens. For all of the reasons given in the previous two paragraphs, the following models were chosen:

1) *Cognitive Behavior Therapy (CBT)* is one of the few forms of psychotherapy that is scientifically tested and found to be effective in hundreds of clinical trials for many different disorders. In contrast to other forms of psychotherapy, CBT is more focused on the present, is more time-limited, and is more problem-solving oriented (Beck Institute, n.d.). The ODMHSAS has provided CBT training to CMHCs through the Beck Institute. All CMHCs employ clinical staff trained in CBT. This will be a requirement for CCBHCs ongoing. Also, a review of literature of EBPs reveals quickly that CBT is the most common element between EBPs.

2) *Collaborative Assessment and Management of Suicidality (CAMS)* is being implemented at the state level as the required clinical training for the treatment of clients presenting with risk of suicide. CAMS is an evidence based approach to the care of clients at risk of suicide. It can be used by a clinician regardless of his or her preferred form of therapy. CAMS has been proven to reduce suicidal thoughts of patients in six published, peer reviewed trials and one randomized clinical trial (Jobes, 2012). A number of trials show success in working with veterans, an identified at-risk population in OK. The ODMHSAS chose this framework based on its adaptability across a variety of therapeutic disciplines and efficacy in reducing symptoms. CAMS is the chosen model for the OK Zero Suicide Initiative. The ODMHSAS provided training and consultation to clinical staff in all CMHCs, and will continue to do so. This will be a requirement for CCBHCs ongoing.

3) *Trauma-focused Cognitive Behavioral Therapy (TF-CBT)* has consistently demonstrated its usefulness in reducing symptoms of PTSD, depression, and behavioral difficulties in children who have experienced sexual abuse and other traumas (Cohen and Mannarino, 1996; Deblinger, et al., 1996; Stauffer and Deblinger, 1999; Cohen and Mannarino, 1997; Deblinger, et al., 1999; King et al., 2000; Deblinger et al., 2001; and Cohen et al., 2004). Furthermore, TF-CBT is identified as a model program by SAMHSA (SAMHSA, 2005). TF-CBT is effective for children in foster care who have experienced any trauma, including multiple traumas. It has been demonstrated to be effective with children from diverse backgrounds and works in as few as 12 treatment sessions. It is used in home-based and residential treatment facilities. The model works even if there is no parent or caregiver to participate in treatment. To provide a culturally competent approach TF-CBT has been used effectively in a variety of languages and countries. OK has been involved with training the workforce in the TF-CBT model. TF-CBT training is required for all CMHCs, along

with the screening tool and protocol selected through the BeMe initiative, and will be required ongoing for all CCBHCs.

4) *Wraparound*: Wraparound is under review for inclusion in the NREPP as an EBP. It is a promising practice that is gaining in research evidence (Suter and Bruns, 2009). In 2005, Bob Friedman and David Drews stated in *Evidence-Based Practices, Systems of Care, and Individualized Care*, “It should be noted at the outset that the Wraparound process may be considered to be an evidence-based process by itself.” The ODMHSAS has enjoyed great success in disseminating the Wraparound process, and outcomes and results, as analyzed and reported by external evaluators, continue to prove strong each year. Wraparound is the process model that OK has chosen for children up to age 21 who experience SED. It is also listed as an EBP by the California Evidence-Based Clearinghouse for Child Welfare, the State of Oregon Inventory of EBPs, and the Washington Institute for Public Policy.

5) *Motivational Interviewing (MI)* is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI is applied to a wide range of problem behaviors related to SUD, as well as health promotion, medical treatment adherence, and MH issues. As of 2013, MI is implemented at more than 30,000 sites in all 50 states and around the world, with an estimated 3 million clients (SAMHSA, 2005). This is one of the foundational models to ensure successful outcomes and will be an ongoing requirement for all clinicians in CCBHCs.

6) *Chronic Care Model* is well established within primary care as best practice for managing chronic illnesses. However, this model has not been fully established in specialty care settings, such as MH (Woltmann, et al., 2012). Chronic diseases are the leading cause of disability and death in the United States (CDC, n.d.). People with mental illness are especially vulnerable: 68% of people with a mental illness also have a physical health condition such as cardiovascular disease, diabetes, and hypertension. These high-need individuals often receive uncoordinated, inefficient care, resulting in higher costs and poorer health outcomes (SAMHSA, 2012). This model has been adopted for BHHs in OK and will be required for the CCBHCs. Training in integrated care is provided and required.

In addition to the required EBPs for CCBHCs, the ODMHSAS is disseminating the following EBPs to address service gaps already known and/or identified in the needs assessment process:

Adolescent Community Reinforcement Approach (ACRA): Selection of A-CRA was based on the strength of evidence as an effective treatment model and the documented skill of the purveyor to efficiently disseminate the practice through training and consultation. In addition, it is a cost effective approach which must be a priority for a publicly-funded behavioral health system. The effectiveness of A-CRA is supported by several randomized clinical trials (Godley et al., 2001).

This will assist in addressing the following statistics listed by SAMHSA: “An estimated 1.3 million U.S. adolescents 12 to 17 had an SUD in 2014 which is 5% of all adolescents and youth transitioning into adulthood have some of the highest rates of SUD.

Seeking Safety is a very cost effective evidence based model for helping individuals with SUD or co-occurring disorders. There is currently a pilot project that trained Peer Recovery Supports in this model to provide the service, which will assist in addressing the workforce shortage issues. This EBP addresses cultural needs around trauma for youth and adults. All three CCBHCs have been trained and are actively utilizing the model. The blended Wraparound/Transition to Independence Process (TIP) model will also be used to serve the young adults with SED or severe SUD issues (Clark, 2009; Suter and Bruns, 2009). The Wraparound/TIP model is an adaptation to meet the growing need for youth and young adults who are transitioning through life, potentially without familial support.

Child Parent Psychotherapy is a treatment for trauma-exposed children ages birth to five (0-5). This will be offered within the demonstration period to enhance the services for the birth to five population who are in need of early infant MH services. *Circle of Security*® (COS) protocol is an early intervention program designed to prevent insecure attachment and child mental disorders. It includes a user-friendly, visually-based approach, utilizing extensive graphics and video clips to help parents better understand the needs of their children. It is based upon attachment theory and current affective neuroscience. COS is considered a promising practice based on research to date. All providers are trained in *Strengthening and Celebrating Families* Programs (SAMHSA, n.d.) to meet the cultural needs of the whole family whether they have SUD, MH, or familial issues. RR will be trained in the *RAISE NAVIGATE Early Treatment Program* (ETP) model and provide this program within the year to serve youth and young adults in transition with a first episode of psychosis (NIMH.nih.gov, n.d.).

OK’s guidance regarding the CCBHCs organizational governance. The ODMHSAS promulgated CCBHC rules which took effect September 1, 2016, as follows:

450:17-5-171. Organizational authority, governance, and accreditation: In addition to the board composition requirements found in 450:17-25-2, facilities certified under this Part will incorporate meaningful participation by adult consumers with mental illness, adults recovering from SUD, and family members of facility consumers, either through 51 percent of the board being families, consumers, or people in recovery from behavioral health conditions, or through a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the facility’s policies, processes and services. Any alternative to the 51% standard must be approved by the Director of Provider Certification.

The ODMHSAS has a long history of including consumers and family members in decision making processes. In 2001, when the SOC model was introduced, the ODMHSAS required the

Advisory Board to consist of 51% youth or care givers and meetings were initially held on Saturdays to accommodate their schedules. OK was one of the first states to develop a Peer Recovery Support Staff (PRSS) certification and provides incentives to CMHCs for utilizing PRSS services. CCBHCs were asked to survey their board members to determine the ratio of consumers, persons in recovery, and family members. All board members at GL said they or a family member have lived with a mental illness. Historically, a GL board requirement is recruitment of members who represent their respective communities. Currently GL recruits board members who have issues with MH and/or SUD (in recovery) or have a family member with MH/SUD issues. In addition, GL asks its clients to complete Customer Satisfaction Surveys every quarter. It also has a Consumer Advisory Panel that meets quarterly. Stakeholder surveys are done with clients attending Medication Clinic and the Intensive Outpatient Center, and with referral sources for Wraparound and residential care owners/operators. Data collected during this continuous process helps the management team make decisions about quality care.

Of the RR governing board, 83% self-reported that they are either consumers of services or have family members who are/were consumer of services. RR's bylaws state that persons on the board must have knowledge of the MH or SUD field, must include minorities, and must represent the population. No more than 40% of the members shall be providers of MH services. Bylaws also prohibit the board membership from being composed of individuals who are not familiar with the field of work. RR policy and procedures require that board membership must be at a minimum, 51% composed of persons who have been consumer's themselves or family members of persons who have been consumers of services.

The NC Board of Directors is committed to the continuing appraisal of behavioral health services to ensure that each client receives the best care possible with the resources available. In a recent survey by the ODMHSAS, 56% of NC's board members reported being current or previous consumers of services and/or having a family member(s) who currently or previously received services. NC's bylaws outline the eligibility for the board to include: skills and knowledge of NC's vision and mission to provide recovery oriented, culturally competent, trauma-informed, and co-occurring capable services. This eligibility may be met through personal and/or professional experiences.

Additional guidance is provided to CCBHCs regarding meaningful input by consumers, persons in recovery, and family members, as follows: In addition to board governance rules, CCBHCs are encouraged to identify additional methods for consumers, people in recovery, and family members to provide meaningful input to the board about the CCBHCs policies, processes, and services. For example, a CCBHC may facilitate formation of an advisory group consisting of active consumers and their family members. The CCBHC will create a policy/procedure for this process and submit to the Director of Provider Certification.

C. CCBHC Data Collection and Reporting.

The ODMHSAS has successfully collected and reported Government Performance Results Act (GPRA) measures, National Outcome Measures (NOMs), Client Level Data (CLD), Uniform Reporting System (URS) tables, the Mental Health Treatment Episode Data Set (TEDS), and is currently developing processes to submit quality measures used in the CMS Health Home Quality Reporting Program. The Decision Support Services (DSS) Division will oversee the data collection and performance measurement and utilization. The DSS has considerable experience devising, managing, and coordinating large and complex data collection efforts and has been responsible for evaluating a number of SAMHSA-funded programs. All of the DSS analytic staff hold masters or doctorate degrees in research fields and have years of experience evaluating behavioral health programs.

Claims and encounter data. The ODMHSAS designed and manages the prior authorization system which is integrated with the Medicaid Management Information System (MMIS). The prior authorization system, the Person-centered Integrated Client Information System (PICIS), not only authorizes services and payment amounts but also collects data for outcome measures and reporting requirements such as the TEDS and URS tables. These data are collected on *all* clients served and include information about such things as: living arrangements; employment; income; legal and marital status; language proficiency; education; disabilities; diagnoses; level of functioning; drugs of choice, including tobacco; frequency of use; and client assessment results. Consumer information is collected and reported at admission, six-month update, and discharge transactions. Comparisons can be made from admission to updates/discharge on items such as employment status, housing status, frequency of substance use, and level of functioning. PICIS data on age, race, ethnicity, gender, marital status, language, physical disabilities, drugs of choice, level of functioning scores, and other elements will be cross-tabulated with services, retention, and outcome information to determine where behavioral health disparities are occurring.

The PICIS/MMIS system uses a unique identifier that allows consumers to be linked across providers and over time. Because it is a relational database, pharmacy and dental claims and all encounter data in the MMIS, including inpatient and outpatient claims, can be linked back to the individual. Demographics, diagnosis, assessment scores, and outcome data are also linked. This unique identifier is used to compile the TEDS and URS tables.

EHR and patient registries. All CMHCs are required to have a meaningful use certified electronic health record (EHR). Two of the CCBHCs utilize the *Netsmart myAvatar* EHR. The third CCBHC, GL, uses the *Echo Group's Clinician's Desktop* EHR. GL was the first behavioral health center in the nation to qualify for meaningful use incentive funding.

The ODMHSAS has procured a population health analytics tool (registry) to which all claims are populated from the MMIS. The registry maintains current specifications of measures, including the CCBHC measures which use claims data, collects the needed data, and provides ongoing monitoring at the individual and facility-level. This continual feedback to the facilities addresses

gaps in services and identifies risks and appropriate evidence-based practices to ensure members receive the highest quality of integrated primary and behavioral health care.

Surveys: Through a CMHS-sponsored initiative in the mid-1990s, Oklahoma worked with other states to develop a framework of performance indicators within the domains of access, appropriateness, outcome, and prevention, to be applied in MH service programs. From this work came the Mental Health Statistics Improvement Program (MHSIP) Consumer-Oriented Report Card, introduced in 1996. Since that time, the ODMHSAS has utilized the MHSIP Consumer Survey, and later the Caregiver Survey, as an ongoing source for client and family input. In addition to the standardized questions, Oklahoma has added questions related to physical health and tobacco use to monitor the overall well-being of the people it serves. It has also adapted it for use with its SUD treatment centers.

Administrative reports. DSS staff produces meaningful reports that can be used for finance, operations, and clinical and outcome monitoring. Since merging data systems in 2010 with the OHCA, the Medicaid agency, DSS staff has developed over 80 continuous quality improvement (CQI) reports, available on the ODMHSAS website. Data are integrated from claims, patient demographics, eligibility, encounter data, and other data sources. Topics include survey results, data quality, consumer demographics, financial, provider performance, and provider requested reports. Reports are available at the facility and client level and user-specified time frames. Some of the financial reports include reconciliation reports; financial summary for ODMHSAS services; amount paid by week, contract source, and fiscal year; pended services; provider budget in MMIS; services paid by Medicaid; special payments and recoupments; corrections reconciliation; Medicaid reimbursable services by fiscal year; and reprocessed claims. Any reports necessary for reporting for the PPS2 will be developed in collaboration with finance staff.

Cost and Staffing. PICIS-MMIS records include information about which staff (and at which agency) provided the service, who received the service, what service was delivered (determined through the use of over 100 HIPAA-compliant procedure code and modifier combinations), the duration or intensity of the service (duration and frequencies are recorded), and the rate attached to each service for cost determination. Services can be designated as screening, prevention and treatment, care coordination, and other care processes.

Data on all clients served at each of the CCBHCs and potential designated collaborating organizations (DCOs) are reported to the PICIS-MMIS integrated system. All state-level quality measures with the exception of the consumer satisfaction surveys will be compiled through the data reporting system. DCOs will report CCBHC services to the data reporting system as “zero pay” services with the DCO clinician as the rendering provider and the CCBHC as the pay-to-provider. This will allow the State to compile these services in the quality measures while ensuring the DCOs are not being paid inappropriately and providing documentation for CCBHC payment. All required data elements will be submitted to the evaluators at the client-level using a consistent unique client identifier.

Data Collection Systems. As stated above, all CMHCs are required to have a meaningful use certified EHR. All CMHCs, by virtue of being a BHH, must electronically exchange data through a health information exchange (HIE). The HIE is a vehicle for improving quality and safety of patient care by reducing medication and medical errors, increasing efficiency by eliminating unnecessary paperwork, and providing caregivers with clinical decision support tools for more effective care and treatment. Two CCBHCs use the MyHealth Access Network HIE and one uses the Care Coordination Oklahoma HIE. Another requirement is that the CCBHCs use the population management analytics tool (registry) provided by the ODMHSAS.

GL currently partners with Coordinated Care Health Oklahoma (CCHO) for their pharmaceutical needs. The pharmacy has developed a data system that enables the CCBHC to produce a report card of consumer and agency progress. The report card provides key health indicators such as blood pressure, medication adherence, cholesterol, hemoglobin A1c (to screen for, diagnose, and monitor diabetes), toxicology, and other key health indicators. A fundamental piece of the report card is the toxicology/hematology lab test that reveals whether the client is taking the prescribed medication and if the client is taking unauthorized substances. Clients not following their medication regimens can be identified early before circumstances escalate to a crisis. Clients who are adhering to medications but not making sufficient progress can be changed to a new regimen. The other two CCBHCs are in the process of interfacing their systems with the CCHO.

These EHR, registry, and HIE systems working together ensure the CCBHCs have access to the most complete picture of the client's past and current medical records, can communicate with other treating providers and have the predictive analytical tools that provide best practice recommendations on a client-by-client basis.

The SAMHSA Transformation State Incentive Grant served as a major source for ODMHSAS to establish a statewide telemedicine network. Units were placed in CMHCs and satellite locations serving rural settings. These units increase access to services, including medication clinics, therapy sessions, court commitment hearings, and administrative meetings. The network supports 54 different provider agencies located in 144 locations. Locations include MH facilities, ERs/hospitals, court houses, and other type of entities that work with people with MH and SUD issues. In addition to the entities supported through the telemedicine network, users telecommunicate with numerous other entities in the delivery of services. In FY2015-2016, 26,000 behavioral health claims were submitted using telehealth services.

Supporting CCBHC CQI Efforts. The ODMHSAS is contracting with the University of Oklahoma, School of Medical Informatics to provide technical assistance to the BHH through its Learning Collaborative and will continue to assist providers in the transition to CCBHCs. Dr. Eric Vanderlip, the primary trainer and consultant, is a former Senior Fellow at the University of Washington where he studied integrated health services design and delivery. During monthly learning collaborative workshops, Dr. Vanderlip has worked with providers on using data at the client level to guide treatment practices and at the aggregate level for population care management.

A large focus has been on the use of patient registries and measurements, patient-centered outcomes, quality improvement, and benchmarking. He is currently working to record videos that can be utilized to train new staff and develop online training modules on topics such as the chronic care model, population management, and use of data.

Health information technology has also been used to develop performance measurement infrastructure and guide CQI processes. Through a HRSA-SAMHSA-funded Behavioral Health and Physical Health Care Data Exchange grant, safety net providers were able to secure health information exchange (HIE) connectivity and secure direct messaging at no initial cost to the agencies. All 14 CMHCs have contracts with an HIE. The ODMHSAS has procured a Behavioral Health Home Information Management System, referred to as the “registry” through Care Management Technologies (CMT). The registry provides abstraction, aggregation, analysis and interpretation of data, both prospectively and retrospectively, to aid clinical risk analysis and management of a population. The registry integrates large volumes of disparate data (including claims data, medical services, and pharmacy data) and analyzes this convergence of information for the eligible population in respect to proportional risk, including adherence markers, gaps in care, substandard or inappropriate care, co-morbid physical and MH conditions that are associated with elevated cost burden, and chemical dependency or underlying addictions that may be undermining overall health care and increasing costs. The registry provides secure, 24/7 access to patient health care analytics by providing data on best practice for psychopharmacologic application relative to psychotropic and pain medicines and disease management flags relative to gaps in care for chronic disease states most frequently associated with those suffering from mental illness. All data and data analytics are displayed for each patient in an Integrated Health Profile (IHP) for holistic health management. These data are used by care coordinators, quality improvement staff and clinical and financial administrators to understand the patient/population needs and to direct intervention. CMT staff have trained each CMHC individually, using its own respective data, to demonstrate actionable insights in population management, compliance measurement, and complex case management.

Support for CQI, including fidelity to EBPs, and person-centered and recovery-oriented care. The ODMHSAS has worked with its providers for several years to establish robust continuous quality improvement systems. Its performance monitoring system began in 1994 and has evolved over the years as new lessons are learned and technology advances. Today the system produces a variety of reports, including provider report cards, a web-based dashboard, an executive information system for the agency’s management, and population demographic data at the county level. Individuals can build their own specific reports on the dashboard. Each facility is required in the ODMHSAS contract to have a CQI policy, conduct routine and ongoing improvement practices, and must have at least two measures which specifically address consumer suicide attempts and deaths, and 30-day hospital readmissions.

The ODMHSAS Data Integrity Review Team (DIRT) was formed in the fall of 2007 to educate treatment staff about performance measures and how to properly report the data, and the use of

various reports available at the facility and individual level to use the data to improve treatment performance. The DIRT staff members provide webinars to provider agencies, and present at various conferences and numerous agency meetings regarding CQI. In July 2016, the ODMHSAS procured the Care Management Technology's population health analytics registry, ProAct, discussed above. The registry has provided agencies with the ability to query clients based on certain attributes, such as diabetes or tobacco use, and provided targeted interventions to the groups, greatly enhancing quality improvement practices.

One of the most effective promotions of CQI has been through pay-for-performance. In 2009, the ODMHSAS established an Enhanced Tier Payment System in which CMHCs were given incentive payments for good outcomes based on use of best practices. Benchmarks were established based on the prior six months of performance data; one standard deviation was used to establish the upper and lower performance levels. If, for example, a CMHC saw 10 percent of clients during a set amount of time, the CMHC was allocated 10 percent of the total maximum funding for each measure, with the payment for each measure allocated as follows: more than one standard deviation below the benchmark: 0%; below benchmark, but not more than one standard deviation: 50%; above the benchmark, but not more than one standard deviation: 100%. One standard deviation above the benchmark: 100%, plus the allocation of the providers who were below the benchmark, distributed based on the percent of clients served during the reporting period.

The improvement in the measures has been dramatic. For example, for the measure of time to first service, only five CMHCs were seeing clients within three days. Within nine months all CMHCs had achieved this goal, with many of the CMHCs offering same-day, walk-in services. Approximately \$32 million in performance pay has been distributed and CMHCs have become very invested in improving performance and learned very quickly how to implement rapid change models using Plan-Do-Study-Act (PDSA) cycles (NASMHPD, 2011).

For the CCBHC CQI process, historic data claims already in the registry will be used to develop baseline measurements. Based on these, each CCBHC will select at least four measures they are doing the poorest on for their annual CQI plans, which will be evaluated annually in conjunction with the DSS staff. Selected measures will change as each target is achieved.

To ensure fidelity to EBPs, the ODMHSAS uses several processes based on what has been proven effective in statewide dissemination. Follow-up consultation and coaching is routinely paired with training. In most cases, a supervisory training is also developed to ensure that supervisors of those trained in EBPs also understand the EBP models and how they apply to day-to-day clinical practice. This model continues to work well for the system and will be adhered to with the CCBHC development. The ODMHSAS sets out training and EBP requirements in program-specific statements of work attached to providers' annual contracts. ODMHSAS program staff members conduct site visits that include chart reviews and interviews with clients and family members, when appropriate. The results of these coaching sessions, site visits, and chart reviews, and any plans of correction are documented and used to inform the evaluation of adherence to the models.

In addition, many of the EBPs selected have fidelity scales such as for motivational interviewing, ACT, CBT, and MI that can quantitatively measure the fidelity.

CCBHC Data Format and Access. Client-level data will flow from the CCBHCs to the State where identifying information will be removed, and a “dumb” persistent identifier will be used to link a client’s records together. The data will then be sent to the evaluator, in the specified time frame. Demographics and clinical information are submitted at admission and must successfully go through edits of the data system before claims can be filed and paid. For outpatient services, these data must be updated every six months before payment is continued. This encourages the timely submission of data. Claims must be filed within six months of the date of services but are submitted much more frequently as payments are made weekly. Historical data can be provided to the evaluators very quickly once file formats and layouts have been clarified. A data dictionary will also be made available. The data are collected and stored at the State level as structured query data (SQL). Data can be submitted in any format requested by the evaluators, including the formats of comma separated value, pipe delimited, flat files, etc. In addition, data can be transmitted to the evaluators through the method they request. The ODMHSAS staff have provided data to numerous entities, including federal partners, universities, research organizations, and other state agencies and will work with the evaluators to ensure the needed data is provided in the correct format and in a timely manner.

D. Evaluation of the Demonstration Program.

Capacity and Willingness to participate in the National Evaluation. The ODMHSAS has participated in multiple cross-site evaluations and is willing to provide the needed data in the appropriate format in a timely manner. As stated earlier, the ODMHSAS captures over 100 unique services including inpatient, emergency, and ambulatory services and distinguishes among MH, SUD, and co-occurring treatment services. The codes are used for Medicaid-funded (including CCBHC services), state-funded, and services paid through other funding sources. Because of the unique client identifier, behavioral health services can be linked to other types of services to determine the scope and cost. These codes will continue to be reported by the CCBHCs at a zero-pay so the PPS payment can be compared to the fee-for-service costs paid under the previous payment structure. The CCBHCs, ODMHSAS, and OHCA will provide state-match costs and other payments made to the CCBHCs and the comparison sites for a complete cost comparison. The quality measures can be compiled for the three years previous to the initiation of CCBHCs to determine quality in relation to costs. During the TA Data Collection group calls, several variables and data sources were discussed. The ODMHSAS feels confident it will have access to the required fields once the evaluation plans have been finalized and is eager to participate in the national evaluation.

Through participating in the TA Data Collection group calls and listening to various strategies, the ODMHSAS sought a comparison group that would be as similar as possible with respect to other factors that could influence the outcomes being studied (eliminating possible confounding factors)

and information collection could be as accurate and as comparable as possible for both groups to avoid biasing association. The preferred method for OK is to use clients seen at CMHCs that are not participating in the CCBHC Demonstration project. Clients would be matched on similar demographics, level of functioning, symptomatology, and other variables. This method would allow for a more robust comparison because very detailed data are being collected on all CMHC consumers and submitted to the registry, including data needed to compile cost reports and quality measures. Another benefit of using this population is that the severity of behavioral health and physical health problems are documented to allow for a fairer comparison with the CCBHC population. Just as with the CCBHC populations, data for the comparison group can be accessed through the ODMHSAS prior authorization system, claims, eligibility files, administrative reports, and MHSIP surveys.

Institutional Review Board (IRB) Status. An IRB application was submitted to the ODMHSAS IRB and legal staff. The opinion is that no IRB approval is needed for the CCBHC or comparison groups because no data other than that collected for normal business operations will be completed. If this should change, the IRB has agreed to review the application quickly.

E. Impact of Oklahoma's Participation in the CCBHC Demonstration.

Oklahoma Selected Goals. *OK has chosen Goals 1, 2, and 3.* Goals 1 and 2 will be explained together, as many of OK's proposed solutions address both goals.

Goals 1 and 2. The ODMHSAS has built a strong comprehensive community MH center model through dissemination of innovative best practices and evidence based practices. This is accomplished through utilization of detailed rules and contracts, a healthy certification and contract monitoring process, and an interactive continuous quality improvement process with our centers based on a multitude of data reports. Furthermore, multiple EBPs are continuously trained with consulting/coaching components in place. For these reasons, OK has a very good behavioral health system in place in spite of very low state spending per capita compared to other states (Kaiser Family Foundation, 2013). However, *more must be done* to ensure the clients are *easily accessing the services, are getting a full scope of services, and all of their mental health/health/SUD needs are met in an integrated manner.* And, it is critical that those with SMI and SED receive intensive care coordination and have access to peer support, with a full Wraparound approach utilized for children. OK can ensure this and therefore, can assure SAMHSA that they will receive a full scope of services. Our philosophy is "whatever it takes."

Adults with SMI and children with SED remain a priority population. The decreased life span of persons with SMI has been well documented (Brown, 1997; Harris and Barraclough, 1998; Saha et al., 2007). The majority of excess deaths in this population are due to physical illnesses, in particular cardiovascular disease, respiratory illness, and cancer (Kisely et al., 2005; Lawrence et al., 2001; Leucht et al., 2007). A meta-analysis of quality of medical care for people with comorbid mental illness reported that the majority of studies demonstrate significant inequalities in

the provision of medical care for people with SMI (McIntyre, et al., (2007). Children with SED are (1) least likely to graduate from high school (Hagner, et al., 1999); (2) three times more likely to be involved in criminal activity (Vander Stoep, et al., 2000); (3) more likely to engage in substance use (HHS, 2002); (4) less likely to find, obtain, and keep a job (Pandiani, et al., 2004); and (5) least likely to achieve independent living in a community of their choice.

The mind/body connection is vitally important. OK will ensure that our CCBHCs provide *integrated treatment*, utilizing their BHH model of practice. Because BHHs are in place in all three selected CCBHCs, OK can assure SAMHSA that individuals will be offered *integrated treatment services and supports*. We can assure this because CCBHCs are built on the firm foundation of CMHCs/BHHs, and because the State has committed deeply to improving the overall health and wellbeing of all persons.

Based on the needs assessment, the CCBHCs are intensifying their linguistic and cultural abilities in order to serve more Oklahomans who are veterans, Hispanic, or who are LGBT. There are plans to expand the bi-lingual workforce and use translational services. CCBHCs have: reached out to veteran groups for advice and counsel for effective methods for outreaching to military personnel, veterans and their families; conducted cultural assessments and made adjustments to be more welcoming to all cultures; and are training staff in additional EBPs. *Therefore the goals of (1) providing the most complete scope of services required in the CCBHC, and (2) improving the availability of, access to, and participation in, services have been selected.*

Thanks to OK's experience and lessons learned during the first two years of our BHH implementation, and the CCBHC planning year, we are poised to accomplish these goals. We are confident that with the enhanced standards, expanded scope of services required, increased workforce and the new payment methodology of the CCBHC demonstration, OK will demonstrate greatly improved *availability, accessibility, and scope of services*.

Goal 3: OK's third goal is improving the availability of, access to, and participation in assisted outpatient mental health treatment. Based on the 2014 National Survey on Drug Use and Health report, the national rate of SMI among adults 18 or older was 4.0%, and OK ranked among states with the highest SMI rates at 5.2%. These individuals and families get caught in a revolving door which includes: non-compliance – law-enforcement intervention – possible hospitalization and/or jail time – outpatient treatment – and back to non-compliance, which begins the cycle again. Those that are in need of medication possibly are not receiving or adhering to treatment. Their disorders create deficits in their ability to make good and healthy choices about their treatment needs. The ODMHSAS is very concerned with the increase in negative outcomes for individuals who are not receiving necessary services due to their hesitance to seek or adhere to treatment.

Over the past few years, ODMHSAS leadership team has spent countless hours meeting with local law enforcement, court officials, and providers to analyze better ways to reach out to those individuals with SMI who are not yet able to realize the importance of treatment in order to recover

and live in the community safely. Beginning in OK County, a model of a 23-hour/59-minute crisis center has been very effective in adding a layer of service as a safety net for this group, as well as the community response team that follows up with these individuals to ensure they are linked to outpatient services. Most recently, in 2016, the leadership team worked with the OK legislature as it crafted a change to OK's MH statute to encourage the therapeutic use of civil court commitments for assisted outpatient treatment (AOT). The new law became effective November 1, 2016. OK's AOT law is treatment-oriented and provides the impetus for developing a strong, treatment-oriented system. The ODMHSAS recently was awarded SAMHSA funding for AOT implementation. All CCBHCs are creating community outreach teams, which will include MH staff and crisis intervention trained (CIT) trained police officers when needed, to assist with community outreach visits, and will have full-time coordinators.

The ODMHSAS is working with its provider agencies to have an adequate workforce trained in AOT to serve this population and build a strong infrastructure of procedures, protocols, and treatment guidelines. Local community summits/trainings to educate the local judicial systems and the public in appropriate use of this treatment modality are scheduled. Because of the groundwork laid, the new law and the state's firm commitment, ***OK will be able to improve the availability of, access to, and participation in assisted outpatient mental health treatment.***

CCBHC Measures to Show Impact. Goals 1 and 2. Provide the most complete scope of services required in the CCBHC criteria to individuals that are eligible for medical assistance under the State Medicaid program and improve availability of, access to, and participation in, services to individuals eligible for medical assistance under the State Medicaid program.

- Increase the number of services to adults age 16—25 years of age - *ensure age-appropriate services are being provided and address gaps identified through the needs assessments.*
- Increase the number of SUD services provided.
- Increase the number of mobile crisis services - *targeted towards the span of services that the needs assessment identified as lacking in the treatment system.*
- Increase the number of MOUs or other formal agreements with consulting physicians - *ensure coordination with and inclusion of primary care in the CCBHCs.*
- Increase the number of clients served - *demonstrate the improved availability to persons who may not have been able to access services in the past.*
- Increase the number of clients receiving PRSS services - *PRSSs foster hope and promote a belief in the possibility of recovery (SAMHSA, 2015). Measure promotes PRSS use.*
- Increase the number of clients engaging in treatment as defined by a 3rd and 4th service within 30 days of the 2nd service - *ensure improved participation in services.*
- Increase the number of veterans and military personnel served.
- Increase the number of Hispanics served.
- Increase the number of LGBT community served - *address underserved populations identified through the needs assessments.*

Goal 3. Improve availability of, access to, and participation in AOT in the State.

- Increase in treatment adherence for persons served through the AOT program.
- Reduction of inpatient hospitalizations for persons served through the AOT program.
- Reduction in homelessness for persons served through the AOT program.
- Reduction in arrests/incarceration for persons served through the AOT program - *address treatment adherence and the desired outcomes of the AOT programs.*

Table 1: SFY2016 Baseline Data for Measures from the three CCBHCs

| Measure | # / % |
|--|---------------|
| The number of services to adults age 16—25 years of age | 3,563 / 17% |
| The number of SUD services provided | 316 / .02% |
| The number of mobile crisis services | 0 |
| The number of MOUs with consulting physicians* | 112 / 23% |
| The number of clients served | 20,499 / 100% |
| The number of clients receiving PRSS services | 6,742 / 33% |
| The number of clients engaging in treatment | 44.8% |
| The number of veterans and military personnel served | 21 / .001% |
| The number of Hispanics served | 1,137 / 6% |
| The number of LGBT community served | 17 |
| Treatment adherence for persons served through the AOT program | Unknown |
| Inpatient hospitalizations for persons served through the AOT program. | Unknown |
| Homelessness for persons served through the AOT program. | Unknown |
| Arrests/incarceration for persons served through the AOT program. | Unknown |

*Percent is the number of clients' PCPs with which the agency has an MOU.

Data Collection, Documentation, Tracking of Outcomes, and Analysis. Data will come primarily from two sources: the prior authorization system and claims data. The following measures will be compiled from claims: clients served; services provided to transitional youth age 16-25; SUD and mobile crisis services; clients receiving services from a PRSS; clients engaging in treatment; and inpatient hospitalizations and treatment adherence for persons served through the AOT program (a procedure code will be submitted to the MMIS for tracking no-shows and claims will be used to determine length in treatment).

The number of veterans and military personnel, Hispanics, and homelessness and arrests/incarceration for persons served through AOT will use data from the prior authorization system, as the demographics and outcomes are collected at admission and each update.

MOUs with primary care physicians (PCP) will be collected from the CCBHCs quarterly (assigned PCPs for clients are tracked through the MMIS so a percentage can be calculated). For the number of members of the LGBT community served, a demonstration project will be used due to the State not being able to collect this information from the general population. The Oklahoma Now Is The Time - Healthy Transitions (ONITT) project focuses on transitional age youth and give participants the option of reporting their sexual orientation (heterosexual, lesbian or gay, bisexual, other, refused, don't know). Only 3% of participants refuse to answer.

For each measure, the numerator and denominator will be defined and disseminated to the CCBHCs so they are aware of how each measure is calculated and can monitor their progress internally for CQI processes. Measures will be compiled quarterly by the DSS staff and reports will be available to the CCBHCs on the PICIS website. CCBHCs will only be allowed to see their own data but can drill down to satellite location and individual client. Trend lines, starting with the baseline numbers, will be used to display results for each subsequent quarter. Predictive analysis, such as multiple regression, can be used to establish relationships among three or more variables so combinations can be created to further define the relationship. For instance, if veterans’ outcomes are lower than non-veterans, models can be used to explore if it is all veterans or specific groups such as American Indian veterans. Data will also be analyzed by agency to isolate any program or contextual effects.

Table 2 OK’s projected impact of the intervention on the measures. To account for the difference in the three CCBHCs’ baseline numbers, impacts are given as percent increases based on each CCBHC baseline measure. In conjunction with the federal project officer, measures will be reviewed after the first year to determine if modifications need to be made.

Table 2: Projected Impact on Target Population

| |
|---|
| Measure |
| Goal 1. Increase in the number of young adults age 16-25 years of age served by 3% each year |
| Goal 1. Increase in the number of SUD services provided by 5% each year |
| Goal 1. Increase in the number of clients receiving mobile crisis services by 3% each year |
| Goal 1. Increase in the number of MOUs with consulting physicians by 5% each year |
| Goal 2. Increase in the number of clients served by 5% each year |
| Goal 2. Increase in the number of clients receiving services from a PRSS by 5% each year |
| Goal 2. Increase in the number of clients engaging in treatment by 5% each year |
| Goal 2. Increase in the number of veterans and military personnel served by 10% each year. |
| Goal 2. Increase in the number of Hispanics served in the OK County by 8% each year. |
| Goal 2. Increase in the number of LGBT community served in the ONITT project by 5% each year. |
| Goal 3. Increase in treatment adherence by 30% and 25% of participants who voluntarily stay in treatment three months after their orders expire for AOT participants. |
| Goal 3. Reduction in homelessness by 15% one year pre/post admission to AOT. |
| Goal 3. Reduction in arrests/incarceration by 25% one year pre/post admission to AOT. |
| Goal 3. Reduction of inpatient hospitalizations by 25% one year pre/post admission to AOT. |

OK will capitalize on the high standards required for CCBHCs to build on the foundation laid the past several years with our pay-for-performance and BHH initiatives to ensure: (1) better access to and availability of service; (2) integration of MH, SUD, and primary care to individualize holistic care for all individuals; (3) high quality of service through disseminating EBPs with an OK-proven method to ensure fidelity; (4) innovative financial solutions to ensure service regardless of ability to pay; (5) formal relationships with emergency departments and other crisis services; (6) ability to assist with transportation and/or deliver service through telemedicine; and 7) meaningful consumer involvement and voice at every level of the system.

We assure SAMHSA, CMS, and ASPE that OK possesses the experience with system change, success with EBP and BHH implementation, innovative thinking, and a can-do attitude to carry out a successful demonstration of the CCBHC model.

Part 3: Prospective Payment System Methodology Description

Using the following format, describe the state’s prospective payment system (PPS) methodology. This part of the Guidance will be scored up to a total of 20 points and your response may not exceed 30 pages. Each section of this part of the application corresponds to the same section of the CCBHC PPS Guidance. Sections 1-4 of this form pertain to fee for service prospective payment; managed care payment is addressed in section 5.

Section 1: Introduction

Section 223 of the Protecting Access to Medicare Act of 2014 (known as PAMA or “the statute”), requires payment using a prospective payment system (PPS) for Certified Community Behavioral Health Clinic (CCBHC) services provided by qualifying clinics and related satellite sites established prior to April 1, 2014. The Centers for Medicare & Medicaid Services (CMS) offers a state the option of using either the Certified Clinic (CC) PPS (CC PPS-1) or the CC PPS alternative (CC PPS-2) demonstration-wide for payments that are either fee for service (FFS) or made through managed care payment systems. The PPS guidance (Appendix III from the Planning Grant for CCBHCs) provides information about each of the allowed PPS payment methodologies.

Section 2: CCBHC PPS Rate-Setting Methodology Options

CMS offers a state the option of either the CC PPS-1 or CC PPS-2 for use demonstration-wide. The state chooses the following methodology (select one):

- Certified Clinic PPS (CC PPS-1) (Continue to Section 2.1)
- Certified Clinic PPS (CC PPS-2) (Continue to Section 2.2)

Section 2.1: Certified Clinic PPS (CC PPS-1)

The CC PPS-1 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. The state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves at least the six required measures as shown in Table 3 of the PPS guidance.

Section 2.1.a Components of the CC PPS-1 Rate Methodology

Demonstration Year One (DY1) Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

PPS-1 Rate Updates from DY1 to DY2

The DY1 CC PPS-1 rates will be updated for DY2 by (select one):

- The MEI
- Rebasing CC PPS-1 rate

If rebasing the DY2 rate to reflect DY1 cost experience, provide in the box below an explanation of the interim payment methodology¹. Specify how the interim rate plus the DY2 rebased rate will cover the expected cost of care in DY2 and how long the interim payment will be in effect during DY2. If more space is needed, please attach and identify the page that pertains to this section.

¹ An interim rate is requested because as it is likely that DY1 data will not be available to the state in time to analyze and rebase the rate for the DY2 payment.

Section 2.1.b CC PPS-1 Quality Bonus Payments (QBPs)

When using the CC PPS-1 method, a state may elect to offer a QBP to any CCBHC that has achieved all of the six required quality measures as shown in Table 3 of the PPS guidance in section 2.1. The state can make a QBP on the basis of additional measures provided in the PPS Guidance and may propose its own quality measures. Any additional state-defined measure must be approved by CMS. The state chooses to (select one):

- Not offer QBP(s) (Continue to Section 3)
- Offer QBP(s)

In the box below provide a list of the quality measures that will be used (in addition to the six required measures shown in Table 3 of the PPS guidance) for QBPs. Note any measure that is state-defined and provide a full description of the measure. If additional space is needed, please attach and identify the page that pertains to this section.

Description of Quality Bonus Payment Methodology

In the box below describe the CC PPS-1 QBP methodology, specifying (1) factors that trigger payment, (2) the methodology for making the payment, (3) the amount of the payment, and (4) how often the payment is made to CCBHCs. Also provide an annual estimate of the amount of QBP payment by demonstration year (DY) for all CCBHCs, including an estimate of the percentage of QBP payment to payment made through the PPS rate. If additional space is needed, please attach and identify the page that pertains to this section.

If Section 2.1 is completed, skip Section 2.2 and continue to Section 3.

Section 2.2: CC PPS Alternative (CC PPS-2)

The CC PPS-2 methodology is implemented as a fixed monthly rate that reflects the expected cost of all CCBHC visits provided within any given month to a Medicaid beneficiary. This is a cost-based, per clinic rate that applies uniformly regardless of the number of services rendered within the month by a CCBHC and qualified satellite facilities established prior to April 1, 2014. Under this method, separate rates are developed for both the base population and clinic users with certain conditions. As part of the rate setting CC PPS-2 methodology, outlier payments paid for costs exceeding state-defined thresholds are considered. Finally, this methodology requires the state to select quality measure(s) and make bonus payments to incentivize improvements in quality of care.

DY1 Rate Data

In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation. If more space is needed, please attach and identify the page that pertains to this section.

PPS-2 Rate Updates from DY1 to DY2

The DY1 CC PPS-2 rates will be updated in DY2 by (select one):

- The Medicare Economic Index (MEI)
- Rebasing CC PPS-2 rate

If rebasing the DY2 rate to reflect DY1 cost experience, provide in the box below an explanation of the interim payment methodology². Specify how the interim rate plus the DY2 rebased rate will cover the expected cost of care in DY2 and how long the interim payment will be in effect during

² An interim rate is requested because as it is likely that DY1 data will not be available to the state in time to analyze and rebase the rate for the DY2 payment.

DY2. If more space is needed, please attach and identify the page that pertains to this section.

PPS-2 Identification of Populations with Certain Conditions

In the box below, identify populations with certain conditions for which separate PPS rates will be determined by the state and explain the criteria used to identify them. If more space is needed, please attach and identify the page that pertains to this section. Note: the populations listed below should match those shown on the sample cost report submitted by the state.

PPS-2 Outlier Payments

Outlier payments are reimbursements to clinics in addition to PPS rates for participant costs that exceed a state-defined threshold to ensure that clinics are able to meet the costs of serving their users.

In the box below provide a description of the outlier payment methodology including an explanation of the threshold for making payment and how much of total allowable cost is set aside for outlier payment; how often outlier payment is calculated; and, how often certified clinics receive outlier payment. If more space is needed, please attach and identify the page that pertains to this section.

Section 2.2.b CC PPS-2 Quality Bonus Payments

Under the CC PPS-2 method, a state *must* offer a QBP to any CCBHC that demonstrates it has achieved all of the six required quality measures as shown in Table 3 of the PPS guidance. The state can make a QBP on the basis of additional measures provided in Table 3 of the PPS guidance and may propose its own quality measures for CMS approval.

In the box below provide a list of the quality measures that will be used (in addition to the six required measures shown on Table 3 of the PPS guidance) and provide a full description of any state-defined measure. If more space is needed, please attach and identify the page that pertains to this section.

In the box below describe the CC PPS-2 QBP methodology, specifying (1) factors that trigger payment, (2) the methodology for making the payment, (3) the amount of the payment, and (4) how often the payment is made. Also provide an annual estimate of the amount of QBP payment by DY for all clinics expected to be certified, including an estimate of the percentage of QBP payment to payment made through the PPS rate. If more space is needed, please attach and identify the page that pertains to this section.

Section 3: Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities

In some instances, a CCBHC already may participate in the Medicaid program as a Federally Qualified Health Center (FQHC), clinic services provider or Indian Health Service (IHS) facility that receives payment authorized through the Medicaid state plan. In these instances, the state should

refer to the guidance for how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration.

- The state will require each certified clinic on its CCBHC cost report to report whether it is dually certified as a FQHC, clinic services provider or IHS facility.

Section 4: Cost Reporting and Documentation Requirements

In order to determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services.

Section 4.1: Treatment of Select Costs

CMS provides additional guidance for the state regarding how to treat select costs, including uncompensated care, telehealth, and interpretation or translation service costs.

- The state excludes the cost of uncompensated care from its calculation of the CCBHC PPS.

Section 4.2: Cost Report Elements and Data Essentials

Cost Reporting

- The state will use the CMS CCBHC cost report and has attached a sample completed form plus an explanatory narrative that demonstrates the rate for DY1.
- The state will use its own cost report and has attached a sample completed form plus an explanatory narrative that demonstrates the rate for DY1.

The attached state-developed cost report template includes following key elements as specified in section 4.2 of the PPS guidance:

- Provider Information
- Direct and Indirect Cost-Identification
- Direct and Overhead Cost-Allocations
- Number of Visits
- Rate Calculations

Section 5: Managed Care Considerations

The statute requires payment of PPS and allows payment to be made FFS and through managed care systems for demonstration services. If the state chooses to include CCBHC service coverage in

their managed care agreements, CCBHCs must still receive the actual PPS rates, or their actuarial equivalent. The state has two options for incorporating the CCBHC rate into the managed care payment methodology: (1) fully incorporate the PPS payment into the managed care capitation rate and therefore require the managed care plan to pay the full PPS, or (2) have the managed care plans pay a rate that another provider would receive for a similar service and use a supplemental payment (wraparound) to ensure that total payment is equivalent to CCBHC PPS.

Section 5.0.a Managed Care Capitation CCBHC PPS Rate Method

- The PPS methodology selected in Section 2 will apply to services delivered in both managed care payment and FFS.
- The PPS Methodology will not apply to managed care payment. The state does not have managed care arrangements.

Section 5.0.b Building CCBHC PPS Rates into Managed Care Capitation

Explain how the state will ensure access to CCBHC services from Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plans (PAHP) through network adequacy requirements. If additional space is needed, please attach and identify the page that pertains to this section.

CMS offers states the option of using either of the following methodologies for incorporating the CCBHC rate into the managed care payment methodology (select one):

- Fully incorporate the PPS payment into the managed care capitation rate and require the managed care plans to pay the full PPS or its actuarial equivalent.

Explain how the state will provide adequate oversight for CCBHCs that receive the actual PPS rates or their actuarial equivalent, including provisions for special populations and outlier payments. If

additional space is needed, please attach and identify the page that pertains to this section.

OR

- Require the managed care plans to pay a rate to the CCBHCs that other providers would receive for similar services then use a supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS.

Explain how the state will provide adequate oversight related to reconciling managed care payments with full PPS rates, including provisions for special populations and outlier payments. If additional space is needed, please attach and identify the page that pertains to this section.

Explain the frequency and timing of the wraparound payment used by the state:

Section 5.0.c PIHP and PAHP Coverage Areas in Managed Care States

- The state contracts with a PIHP or PAHP and intends to use these delivery systems as part of CCHBC service delivery.

Describe which managed care plans will be responsible for providing CCBHC services and what services provided in other managed care plans may duplicate the CCBHC services.

Explain the methodology for removing services that duplicate CCBHC demonstration services from the managed care plans not responsible for the CCBHC services, how managed care capitation rates will be changed, the timing/process for determining that the new managed care rates will be actuarially sound, and how the state will ensure no duplication of expenses. If additional space is needed, please attach and identify the page that pertains to this section.

If a state chooses not to include all demonstration services under one contractor, define the delineation of services between contractors. If this delineation will require a change to managed care capitation rates, explain how rates will be affected, the timing and process for determining that the new managed care rates will be actuarially sound, and how the state will ensure non-duplication of payments. If additional space is needed, please attach and identify the page that pertains to this section.

Section 5.0.d Data Reporting and Managed Care Contract Requirements

Describe the data reporting policies and processes, including specific data deliverables to be reported by each entity, collection of data, timing of reporting, and contract language for data reporting. If additional space is needed, please attach and identify the page that pertains to this section.

Section 5.0.e Identification of Expenditures Eligible for Enhanced Federal Matching Percentage (FMAP)

Describe the process whereby the state will ensure proper claiming of enhanced FMAP for CCBHC services by identifying the portion of the capitation payment(s) applicable to the new adult group rate cells and the existing managed care population associated with CCBHC services. If additional space is needed, please attach and identify the page that pertains to this section.

Funding Questions: Section 223 Behavioral Health Demonstration

The questions below should be answered relative to all payments made to CCBHCs reimbursed pursuant to Section 223 of P.L. 113-93 Protecting Access to Medicare Act of 2014³ and the methodology described in the state’s application to participate in the demonstration program.

CMS requests the following information about the source(s) of the non-federal share of payment made for demonstration services.

³ H.R. 4302, 113th Congress. Protecting Access to Medicare Act of 2014. PL No 113092; April 2, 2014. <https://www.congress.gov/bill/113th-congress/house-bill/4302>

1. Section 1902(a)(2) stipulates that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Describe how the non-federal share of each type of Medicaid payment (e.g., basic PPS rate, outlier payment and quality bonus payments) is funded.

- Describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share.

Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

- If any of the non-federal share of payment is being provided using IGTs or CPEs, fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

- If certified public expenditures (CPEs) are used, describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or intergovernmental transfers (IGTs), please provide the following:
 - I. A complete list of the names of entities transferring or certifying funds
 - II. The operational nature of the entity (state, county, city, other)
 - III. The total amounts transferred or certified by each entity
 - IV. Whether the certifying or transferring entity has general taxing authority
 - V. Whether the certifying or transferring entity received appropriations (identify level of appropriations)
 - VI. A cost report for CMS approval for any CPE-funded payment(s)

2. Do CCBHC providers receive and retain the total Medicaid expenditures claimed by the state for demonstration services (includes basic PPS and enhanced payments) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization?

If providers are required to return any portion of payments, provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (e.g., general fund, medical services account, etc.).

A1: DY1 Rate Data (continued from PPS Section 2.2)

It also includes the cost of care associated with the Designated Collaborating Organizations (DCOs) with which each CCBHC has, or will have formal relationships with during the demonstration. The State provided to each participating CCBHC a matrix of covered CCBHC services based on billing and reporting codes, to assist them in removing uncompensated care and appropriately allocate expenses.

Visit Data – The source of the visit data used for the rate calculation was collected from OK’s Medicaid Management Information System (MMIS) paid claims history aligned to the same time period as the cost data. In 2010, the State implemented a consolidated claims processing (CCP) system, which utilizes a “waterfall” type payment processing method for all consumers admitted to the public mental health system. A mental health clinic can submit one claim for processing, and the MMIS edits will review the claims data for accuracy, then compare the claim to the consumer’s file to check for eligibility and programs. Claims for covered services for non-Medicaid eligible consumers will “waterfall” for payment from other payment sources rather than deny, so the services provided are still captured.

To determine covered CCBHC services, the State grouped individual CPT and HCPC reporting codes into the 9 (or 8 excluding Veterans’ services) required CCBHC services and ran a report to obtain expenditures and the unduplicated number of consumers who had at least one visit per month. Claims data was also compared to the provider’s own records for reconciliation; therefore, the State feels confident that the base year utilization (visit) data is an accurate representation of the monthly visits for the majority of the CCBHC population to be served.

Base PPS Formula: The base PPS rate is determined by total annual allowable CCBHC costs (excluding costs for services to clinic users with certain conditions and outlier payments), divided by the total number of CCBHC unduplicated monthly visits per year excluding clinic users with certain conditions.

Base PPS for Special Populations (SPs): The state identified clinic users with certain conditions and assessed utilization using the state-defined condition criteria and claims payment data from SFY2016. Costs were allocated to SPs either based on historical monthly visits divided by total visits, or by the cost-to-charge ratio for SPs for which there was no historical claims data. To determine the PPS rates for special populations, we divided the total annual allowable CCBHC costs (including only CCBHC users with certain conditions and excluding outlier payments) by the total number of CCBHC monthly visits per year (including only CCBHC users with certain conditions).

Anticipated Costs and Updates – Overall, the State estimated that DY1 allowable PMPM costs would increase approximately thirty-six percent (36%) over historical costs. This is primarily due to the increased staffing and service requirements for this new model. This change also assumes a five percent (5%) increase in growth, anticipating an uptake in access to current services, and expanded access to substance abuse services and 24-hour mobile crisis. One of the prospective clinic’s costs will increase substantially, due to a significant change in the scope of their service delivery model in order to be able to operate as a CCBHC. DY1 total allowable

costs were updated utilizing the Medicare Economic Index (MEI) forecast from the midpoint of the cost period (12/31/15) to the midpoint of the rate period (Q4 2016 and Q2 2017).

Consideration for Care Coordination – The State has an approved State Plan for Health Home services and uses a monthly PMPM rate that is targeted to individuals with SMI and SED. In order to ensure the HH philosophy and approach continues within the three CCBHCs without any duplication of CMS reimbursement, the State has established a separate rate for *care coordination* activities, and used the enhanced rate for CPT code 99490 for CY2016 as the basis for the payment. The enhanced rate is 140% of the Medicare Physician Fee Schedule, which is equivalent to the rate for State employed physician’s services approved in the Medicaid State Plan. This brings the rate to \$53.69. An adjustment was made to indirect costs in consideration of this payment. In accordance with CMS guidance, this rate may be paid only when at least one CCBHC service has been delivered within the month for SMI and SED Health Home enrollees.

A2:PPS-2 Identification of Populations with Certain Conditions (continued from PPS Section 2.2)

**Definition of Special Population 1:
High Risk SMI or Co-Occurring**

Individuals with SMI (as defined in OAC 317:30-5-240.1) or Co-Occurring SUD, and at least one high cost condition:

- Cardiovascular Disease
- Diabetes
- Hypertension
- Respiratory Disorders

Plus an inpatient hospitalization (psychiatric or non-psychiatric) within the past fiscal year

Or

Individuals with SMI (as defined in OAC 317:30-5-240.1) or co-occurring SUD, with no high cost condition and either:

- Two non-psychiatric hospital admissions within the fiscal year; or
- One psychiatric hospital admission within the fiscal year; or
- Two Crisis Center admissions

A2: (Continued from above) - PPS-2 Identification of Populations with Certain Conditions

**Definition of Special Population 2:
High Risk SED or Co-Occurring**

SED (as defined in OAC 317:30-5-240.1) or disorders with individual Client Assessment Record (CAR) scores that meet criteria for Level 3 or a substance use diagnosis;

OR

A caregiver rated Ohio Scale shows critical impairment (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales;

And

At least one of the following conditions:

- Substance use;
- Psychiatric hospitalization within the past one year;
- Multiple psychiatric hospitalizations, ED use and/or crisis center admissions (at least two);
- Intensive array of services are in place, including (at a minimum): case management, therapy, and medication management;
- Chronic physical health condition, such as diabetes, asthma or other chronic physical health condition;
- Child was in the custody of OKDHS or OJA, or had been in and out of court multiple times, within the past six months; or

A child at high-risk of out of home/out of school and/or community placement as indicated by an attestation signed by a LBHP (form provided by the State). The attestation will include narrative explaining the changes and challenges in function and the circumstances surrounding imminent out of home/community placement and an updated psychosocial assessment with support CAR scores.

**Definition of Special Population 3:
Adults with Significant Substance Use Disorder**

ASAM Level of Care 2.1: Intensive Outpatient Services [Age 18 and over]

- Adults who meet the following specifications:
 - Dimension 2 (biomedical conditions or problems exist) and
 - Dimension 3 (if any emotional behavioral, or cognitive conditions, or problems exist), and
- At least one of the following:
 - Dimension 4 (Readiness to Change),
 - Dimension 5 (Relapse, continued use, or continued problem potential), or
 - Dimension 6 (Recovery Environment)

A2: (Continued from above) PPS-2 Identification of Populations with Certain Conditions

**Definition of Special Population 4:
Adolescents with Significant Substance Use Disorder**

ASAM Level of Care 2.1: Intensive Outpatient Services [Age 12 through 17]

Adolescents who meet the stability specifications:

- Dimension 1 (if any withdrawal problems exist) and
- Dimension 2 (if any biomedical conditions or problems exist), and
- At least one of the following:
 - Dimension 3 (if any emotional behavioral, or cognitive conditions, or problems exist,
 - Dimension 4 (Readiness to Change),
 - Dimension 5 (Relapse, continued use, or continued problem potential), or
 - Dimension 6 (Recovery Environment)

**Definition of Special Population 5:
Chronic Homelessness or First Time Psychosis Episode
for Children and Adults**

An individual with Mental Health or Substance Use Diagnosis:

- That meets the HUD Category 1 Definition
- OR**
- That meets the first time psychosis episode criteria

A3: Classification Considerations for Special Populations (Continued from PPS Section 2.2)

The State determined five (5) groups of clinic users as special population (SP) groups to include in the demonstration, and developed a protocol for CCBHCs to classify and reclassify individuals.

Hierarchy

After identifying the SP groups (Attachment 2), the state determined the criteria that should be met for initial classification within a SP group and how an individual may be reclassified during the demonstration. Based on the special population groups selected, a single individual could not qualify for more than one special population group; thus, there was not a need for hierarchy to be established.

A3: (continued from above) Classification Considerations for Special Populations

Responsibility for categorization

Each participating CCBHC will be responsible for categorization.

Criteria for Classification/Reclassification

While it is reasonable that an individual transitioning from a special population group would require less care when moving to the standard population, this change in status should NOT drive a change in the level of care or the frequency of services provided. The services provided should be determined based on care needs.

Frequency of Classification

In addition to determining the criteria for classification/reclassification, the state determined how frequently reclassifications may occur. The State will take into consideration the characteristics of the population group and determine a reasonable frequency for an individual to move between populations. The underlying characteristics of these groups helped to identify which factors would trigger reclassification to and from standard population and how frequently these individuals should reasonably be reclassified. In general, a consumer is evaluated to determine their classification every 3 months.

Factors that will automatically trigger a change in classification

An individual's birthday would automatically trigger a change in classification. (e.g. SED to SMI; SUD classifications).

Limitation of the number of times a consumer could be reclassified within a certain period

There is no limit on the number of time a consumer could be reclassified.

Reclassification during the middle of a payment period.

If a consumer qualifies for reclassification anytime during the month, payment will begin on the first day of the following month.

A4: Outlier Payments (continued from PPS Section 2.2)

Based on state-wide Medicaid data, monthly outlier thresholds have been set at:

STD Population: \$1300

Special Population 1: \$2200

Special Population 2: \$2400

Special Population 3: \$2500

Special Population 4: \$2400

Special Population 5: \$1800

A4: (Continued from above) Outlier Payments

The total outlier payment pool will be \$4,278,000 which represents an estimate of approximately 5% of total costs. The State determined that separate thresholds for each of the population groups will best reduce the risk to CCBHCs. Based on this, outlier pools are set up for each of the population groups across all providers to ensure that one population group is not supporting the cost of another:

| | |
|-----------------------------|-----------|
| Standard Population: | \$441,381 |
| Special Population 1 (SMI): | \$746,952 |
| Special Population 2 (SED): | \$814,857 |
| Special Population 3 (SUD) | \$848,810 |
| Special Population 4 (SUD) | \$814,847 |
| Special Population 5 (HOM) | \$611,143 |

Outlier payments will be calculated and distributed on a quarterly basis, no later than 145 days after the end of the quarter. Ninety percent (90%) above the threshold will be reimbursed. Each quarter, the state will distribute up to 25% of the annual outlier pool. At the end of the year, a settlement will occur to distribute any excess outlier funds, proportionate to the CCBHC population expenses to statewide expenses. Final outlier distributions will be made no later than 160 days after the close of the fiscal year.

A5: CC PPS-2 QBP methodology (continued from Section 2.2b)

For example, if Agency A denominator is 35% of all providers, Agency A will be able to earn 35% of 1/6 of the total funds available for the six month period. If they do not meet the benchmarks, the money will not be distributed. To earn the quality bonus payment, each provider must meet benchmark for the second six month period. For the third six month payment period, provider must meet the benchmark, plus an additional 3%. For the final and fourth six month period, provider must meet the benchmark, plus an additional 5%.

To be included for a possible quality bonus payment, providers must have a denominator for each of the measures within the six month. The denominator is based on an estimate of individuals who may currently be counted in the measure. The denominators are:

| <u>Denominator</u> | <u>Measure</u> |
|--------------------|----------------|
| 50 | FUH-BH-A |
| 30 | FUH-BH-C |
| 50 | SAA-BH |
| 50 | IET-BH |
| 75 | SRA-A |
| 35 | SRA-BH-C |

The estimated percentage of QBP payment to payment made through PPS is less than 1%.

A6: Cost Report Narrative that demonstrates the rate for DY1 (Section 4.2)

CC PPS-2 includes these required elements: (1) a monthly rate to reimburse the CCBHC for services, (2) separate monthly PPS rates to reimburse CCBHCs for higher costs associated with providing all services needed to meet the needs of clinic users with certain conditions, (3) cost updates from the demonstration planning period to DY1 using the MEI and from DY1 to DY2 using the MEI or by rebasing, (4) outlier payments made in addition to PPS for participant costs in excess of a threshold defined by the state, and (5) QBP made in addition to the PPS rates.

Part 1 – Charges, Cost-to-Charge Ratio Allocation

Charges - Covered charges¹ for CCBHC services under each population group have been entered in Line 1, columns 1a-6b. Additional anticipated covered charges were entered on Line 2, columns, 1a-6b. The Total column at the far right of this table (line 3) sums the “Total Population Charges.”

Allowable Costs and Cost-to-Charge Ratio – Line 6 of the Total Column is the sum of total allowable costs (from lines 4 and 5) that is auto-populated from the Trial Balance. Line 7 computes the cost-to-charge ratio determined by dividing line 6 by line 3. Line 8 is determined by multiplying line 7 by line 3, and ties to the trial balance of total allowable costs in line 6.

Part 2 – Determination of PPS Rate

Line 9: “Total allowable CCBHC costs” is automatically populated on this line from the allowable CCBHC costs on line 8 in Part 1 (excludes outlier costs).

Line 10: “Total months patients received CCBHC services” is automatically populated on this line from the total visits in the Monthly Visits tab, line 5 for each population group. Total months have been adjusted for outlier months on the visit months tab.

Line 11: “Total allowable cost per visit,” is calculated by dividing line 9 by line 10 above, to come up with the total allowable cost per visit during the reporting period.

Line 12: The MEI trend has been entered, which trends the costs from the midpoint of the cost period to the midpoint of the rate period. (Source: Q4, 2016 and Q2, 2017)

Line 13: “CC PPS-2 rate,” which is calculated by adjusting line 11 by the factor from the column total (on the far right) on line 12 above to determine the CC PPS-2 rate payable for each population type, is automatically populated on this line.

Line 14: Outlier Pool- calculated by adding the total outlier pool amounts “b” columns, from line 9, is automatically populated on this line. The outlier amount will be paid for Medicaid beneficiaries only.

¹ . In accordance with the State’s outlier payment policy, reported charges at or below the outlier threshold were adjusted to 95% of the reported total, and charges above the threshold were calculated at 5% of the total reported. The provider in this example did not have a uniform charge master during the cost period, but the State will require an attestation that uniform charges will be used during the rate period. Charges at or below were imputed from Medicaid and uninsured payment data.

A6: Sample Completed CMHS CCBHC Cost Report (Section 4.2)

| CCBHC Cost Report | |
|--|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 1007328 |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 19028130 |
| REPORTING PERIOD: | From: 7/1/2015 To: 6/30/2016 |
| RATE PERIOD: | From: 3/1/2017 To: 2/28/2018 |
| WORKSHEET: | Provider Information |
| PPS METHODOLOGY: | CC PPS-2 |
| This box for state use only - LEAVE BLANK | |
| Select type of oversight: | <input type="checkbox"/> Audited <input type="checkbox"/> Desk Reviewed |
| Date reviewed: | |

| PART 1 - PROVIDER INFORMATION (Consolidated) | | | |
|---|--|---|-----------------------|
| 1. Name: Grand Lake Mental Health Center, Inc. | | | |
| 2. Street: 114 W Delaware Ave | | P.O. Box: | |
| 3. City: Nowata | | State: OK | |
| 4. County: Nowata | | Zip Code: 74048 | |
| 5. Medicaid ID: Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 1007328 | | | |
| 6. NPI: Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 19028130 | | | |
| 7. Location designation (see Cost Report Instructions): | | Rural | |
| 8. Organizational authority (see Cost Report Instructions): 1 | | | |
| 9. Behavioral health professionals (see Cost Report Instructions): | | | |
| | Name | NPI | |
| | 1 | 2 | |
| 9a | ALEXANDER JADA 3JSA | 1588908966 | |
| 9b | ALLGOOD NICHOLAS 4NAA | 1881969913 | |
| 9c | BRASSFIELD CHRYSTAL 4CLB | 1043592132 | |
| 9d | BRASSFIELD CHRYSTAL 4CLB | 1881842904 | |
| 9e | see additional information in the comments tab | | |
| 10. Is the CCBHC dually certified as a 1905(a)(9) clinic? no | | | |
| 11. Does the site operate as other than CCBHC? no | | | |
| 12. If line 11 is "Yes" specify the type of operation (e.g., clinic, FQHC, other): | | | |
| 13. Identify days and hours the site operates as a CCBHC by listing the time next to the applicable day: | | | |
| | Days | Hours of Operation From | Hours of Operation To |
| | | | Total Hours |
| 13a | Sunday | 12 | 24 |
| 13b | Monday | 12 | 24 |
| 13c | Tuesday | 12 | 24 |
| 13d | Wednesday | 12 | 24 |
| 13e | Thursday | 12 | 24 |
| 13f | Friday | 12 | 24 |
| 13g | Saturday | 12 | 24 |
| 14. Identify days and hours the site operates as other than a CCBHC by listing the time next to the applicable day: | | | |
| | Days | Hours of Operation From | Hours of Operation To |
| | | | Total Hours |
| 14a | Sunday | | |
| 14b | Monday | | |
| 14c | Tuesday | | |
| 14d | Wednesday | | |
| 14e | Thursday | | |
| 14f | Friday | | |
| 14g | Saturday | | |
| 15 | List any excluded satellite facilities and reasons for exclusion. Use the Comments Sheet for additional details. | | |
| 16. Is this site filing a consolidated cost report for multiple locations? If yes, see Cost Report Instructions. YES | | | |
| 17. How many sites are reported for the consolidated entity? | | 11 Remaining Provider Information tabs are hidden | |

CCBHC Cost Report

| | |
|-------------------|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 19028130 |
| REPORTING PERIOD: | From: 7/1/2015 To: 6/30/2016 |

PART 2 - PROVIDER INFORMATION FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING (For additional satellite sites, create new tab and copy and paste Part 2 for each additional site included)

| | | | | |
|--|-----------|-------------------------|-----------------------|-------------|
| Site-Specific Information | | | | |
| 1. Was this site in existence before April 1, 2014? (No payment will be made to satellite facilities of CCBHCs established after April 1, 2014). | | | | |
| 2. Name: Grand Lake Mental Health Center, Inc. | | | | |
| 3. Street: 405 E. Excelsior | | P.O. Box: | | |
| 4. City: Vinita | State: OK | Zip Code: 74301 | | |
| 5. County: Craig | | | | |
| 6. Medicaid ID: Craig 100732860F | | | | |
| 7. NPI: Craig 1710994835 | | | | |
| 8. Location designation (see Cost Report Instructions): | | Rural | | |
| 9. Organizational authority (see Cost Report Instructions): | | 1 | | |
| 10. Is the CCBHC dually certified as a 1905(a)(9) clinic? | | NO | | |
| 11. Does the site operate as other than CCBHC? | | NO | | |
| 12. If line 11 is "Yes", specify the type of operation (e.g., clinic, FQHC, other): | | | | |
| 13. Identify days and hours the site operates as a CCBHC by listing the time next to the applicable day | | | | |
| | Days | Hours of Operation From | Hours of Operation To | Total Hours |
| 13a | Sunday | 12 | 12 | 24 |
| 13b | Monday | 12 | 12 | 24 |
| 13c | Tuesday | 12 | 12 | 24 |
| 13d | Wednesday | 12 | 12 | 24 |
| 13e | Thursday | 12 | 12 | 24 |
| 13f | Friday | 12 | 12 | 24 |
| 13g | Saturday | 12 | 12 | 24 |
| 14. Identify days and hours the site operates as other than a CCBHC by listing the time next to the applicable day | | | | |
| | Days | Hours of Operation From | Hours of Operation To | Total Hours |
| 14a | Sunday | | | |
| 14b | Monday | | | |
| 14c | Tuesday | | | |
| 14d | Wednesday | | | |
| 14e | Thursday | | | |
| 14f | Friday | | | |
| 14g | Saturday | | | |

CCBHC Cost Report

| | | | |
|-------------------|---|---------------|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J, Kansa | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520102, Afton 1 | | |
| REPORTING PERIOD: | From: 7/1/2015 | To: 6/30/2016 | |
| RATE PERIOD: | From: 3/1/2017 | To: 2/28/2018 | |
| WORKSHEET: | Trial Balance | | |

PART 1 - DIRECT CCBHC EXPENSES

PART 1A - CCBHC STAFF COSTS

| Description | Compensation 1 | Other 2 | Total (Col. 1 + 2) 3 | Reclassifications 4 | Reclassified Trial Balance (Col. 3 + 4) 5 | Adjustments Increases (Decreases) 6 | Adjusted Amount (Col. 5 + 6) 7 | Adjustments for Anticipated Cost Changes 8 | Net Expenses (Col. 7 + 8) 9 |
|---|--------------------|------------|----------------------------|------------------------|--|--|---|---|--------------------------------------|
| 1. Psychiatrist | \$322,990 | | \$322,990 | | \$322,990 | \$45,219 | \$368,209 | \$0 | \$368,209 |
| 2. Psychiatric nurse | \$817,062 | | \$817,062 | | \$817,062 | \$114,389 | \$931,451 | \$669,864 | \$1,601,315 |
| 3. Child psychiatrist | | | \$0 | | \$0 | | \$0 | \$0 | \$0 |
| 4. Adolescent psychiatrist | \$0 | | \$0 | | \$0 | | \$0 | \$360,208 | \$360,208 |
| 5. Substance abuse specialist | | | \$0 | | \$0 | | \$0 | \$425,306 | \$425,306 |
| 6. Case manager | \$3,365,537 | | \$3,365,537 | | \$3,365,537 | \$471,175 | \$3,836,712 | \$0 | \$3,836,712 |
| 7. Recovery coach | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$239,400 | \$239,400 |
| 8. Peer specialist | \$750,003 | | \$750,003 | | \$750,003 | \$105,000 | \$855,003 | \$239,400 | \$1,094,403 |
| 9. Family support specialist | \$690,003 | | \$690,003 | | \$690,003 | \$96,600 | \$786,603 | \$239,400 | \$1,026,003 |
| 10. Licensed clinical social worker | \$2,015,831 | | \$2,015,831 | | \$2,015,831 | \$282,216 | \$2,298,047 | \$325,000 | \$2,623,047 |
| 11. Licensed mental health counselor | \$1,613,335 | | \$1,613,335 | | \$1,613,335 | \$225,867 | \$1,839,202 | \$325,000 | \$2,164,202 |
| 12. Mental health professional (trained and credentialed for psychological testing) | | | \$0 | | \$0 | | \$0 | \$110,000 | \$110,000 |
| 13. Licensed marriage and family therapist | | | \$0 | | \$0 | | \$0 | \$0 | \$0 |
| 14. Occupational therapist | | | \$0 | | \$0 | | \$0 | \$455,000 | \$455,000 |
| 15. Interpreter or linguistic counselor | | | \$0 | | \$0 | | \$0 | \$0 | \$0 |
| 16. General practice (performing CCBHC services) | | | \$0 | | \$0 | | \$0 | \$0 | \$0 |
| 17. Other staff costs (specify details below) | | | | | | | | | |
| 17a Psychiatric Nurse Practitioners | \$393,260 | | \$393,260 | | \$393,260 | \$55,056 | \$448,316 | -\$98,151 | \$350,165 |
| 18. Subtotal staff costs (sum of lines 1-17) | \$9,968,021 | \$0 | \$9,968,021 | \$0 | \$9,968,021 | \$1,395,522 | \$11,363,543 | \$3,290,427 | \$14,653,970 |

PART 1B - CCBHC COSTS UNDER AGREEMENT

| Description | Compensation 1 | Other 2 | Total (Col. 1 + 2) 3 | Reclassifications 4 | Reclassified Trial Balance (Col. 3 + 4) 5 | Adjustments Increases (Decreases) 6 | Adjusted Amount (Col. 5 + 6) 7 | Adjustments for Anticipated Cost Changes 8 | Net Expenses (Col. 7 + 8) 9 |
|---|-------------------|------------|----------------------------|------------------------|--|--|---|---|--------------------------------------|
| 19. CCBHC costs from DCO | | \$0 | \$0 | | \$0 | | \$0 | \$1,500,000 | \$1,500,000 |
| 20. Other CCBHC costs (specify details below) | | | | | | | | | |
| 20a | | \$0 | \$0 | | \$0 | | \$0 | \$0 | \$0 |
| 21. Subtotal costs under agreement (sum of lines 19-20) | | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$1,500,000 | \$1,500,000 |

CCBHC Cost Report

| | | | | | | | | | |
|-------------------|---|----------|-----|-----------|--|--|--|--|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J, Kansas | | | | | | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520102, Afton 1 | | | | | | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 | | | | | |

| PART 1C - OTHER DIRECT CCBHC COSTS | | | | | | | | | |
|--|--------------|-------------|-----------------------|-------------------|---|---|------------------------------------|--|---------------------------------|
| Description | Compensation | Other | Total (Col. 1 + 2) | Reclassifications | Reclassified Trial Balance (Col. 3 + 4) | Adjustments Increases (Decreases) | Adjusted Amount (Col. 5 + 6) | Adjustments for Anticipated Cost Changes | Net Expenses (Col. 7 + 8) |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 22. Medical supplies | | \$44,269 | \$44,269 | | \$44,269 | -\$2,656 | \$41,613 | \$20,876 | \$62,488 |
| 23. Transportation (health care staff) | | \$816,486 | \$816,486 | | \$816,486 | -\$48,989 | \$767,497 | \$408,739 | \$1,176,236 |
| 24. Depreciation - medical equipment | | \$169,554 | \$169,554 | | \$169,554 | -\$10,173 | \$159,381 | \$210,230 | \$369,611 |
| 25. Professional liability insurance | | \$165,732 | \$165,732 | | \$165,732 | -\$9,944 | \$155,788 | \$26,268 | \$182,056 |
| 26. Telehealth | | \$1,436,701 | \$1,436,701 | -\$69,785 | \$1,366,916 | -\$96,774 | \$1,270,142 | \$100,000 | \$1,370,142 |
| 27. Other direct costs not already included (specify details below) | | | | | | | | | |
| 27a Contracted Services | | \$1,800,000 | \$1,800,000 | \$0 | \$1,800,000 | \$0 | \$1,800,000 | \$1,500,000 | \$3,300,000 |
| 28. Subtotal other direct CCBHC costs (sum of lines 22-27) | | \$4,432,742 | \$4,432,742 | -\$69,785 | \$4,362,957 | -\$168,536 | \$4,194,420 | \$2,266,113 | \$6,460,533 |
| 29. Total cost of CCBHC services (other than overhead) (sum of lines 18, 21, and 28) | \$9,968,021 | \$4,432,742 | \$14,400,763 | -\$69,785 | \$14,330,978 | \$1,226,986 | \$15,557,963 | \$7,056,540 | \$22,614,503 |

CCBHC Cost Report

| | | | | | | | | | |
|-------------------|---|----------|-----|-----------|--|--|--|--|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J, Kansas | | | | | | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520102, Afton 1 | | | | | | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 | | | | | |

PART 2 - INDIRECT COSTS

| PART 2A - SITE COSTS | | | | | | | | | |
|---|-------------------|-------------|----------------------------|------------------------|--|--|---|---|--------------------------------------|
| Description | Compensation 1 | Other 2 | Total (Col. 1 + 2) 3 | Reclassifications 4 | Reclassified Trial Balance (Col. 3 + 4) 5 | Adjustments Increases (Decreases) 6 | Adjusted Amount (Col. 5 + 6) 7 | Adjustments for Anticipated Cost Changes 8 | Net Expenses (Col. 7 + 8) 9 |
| 30. Rent | | \$47,387 | \$47,387 | | \$47,387 | | \$47,387 | -\$25,787 | \$21,600 |
| 31. Insurance | | \$78,868 | \$78,868 | | \$78,868 | -\$4,732 | \$74,136 | \$7,887 | \$82,023 |
| 32. Interest on mortgage or loans | | \$55,032 | \$55,032 | | \$55,032 | -\$3,302 | \$51,730 | \$22,206 | \$73,936 |
| 33. Utilities | | \$189,823 | \$189,823 | | \$189,823 | -\$11,389 | \$178,434 | \$42,203 | \$220,637 |
| 34. Depreciation - buildings and fixtures | | \$470,220 | \$470,220 | | \$470,220 | | \$470,220 | \$301,041 | \$771,260 |
| 35. Depreciation - equipment | | \$53,586 | \$53,586 | | \$53,586 | -\$3,215 | \$50,371 | \$39,229 | \$89,600 |
| 36. Housekeeping and maintenance | \$228,503 | \$313,385 | \$541,889 | | \$541,889 | -\$18,803 | \$523,085 | \$167,951 | \$691,036 |
| 37. Property tax | | | \$0 | | \$0 | | \$0 | | \$0 |
| 38. Other site costs (specify details below) | | | | | | | | | |
| 38a | | | \$0 | | \$0 | | \$0 | | \$0 |
| 39. Subtotal site costs (sum of lines 30-38) | \$228,503 | \$1,208,301 | \$1,436,804 | \$0 | \$1,436,804 | -\$41,442 | \$1,395,362 | \$554,729 | \$1,950,091 |

| PART 2B - ADMINISTRATIVE COSTS | | | | | | | | | |
|---|-------------------|-------------|----------------------------|------------------------|--|--|---|---|--------------------------------------|
| Description | Compensation 1 | Other 2 | Total (Col. 1 + 2) 3 | Reclassifications 4 | Reclassified Trial Balance (Col. 3 + 4) 5 | Adjustments Increases (Decreases) 6 | Adjusted Amount (Col. 5 + 6) 7 | Adjustments for Anticipated Cost Changes 8 | Net Expenses (Col. 7 + 8) 9 |
| 40. Office salaries | \$2,568,583 | | \$2,568,583 | | \$2,568,583 | \$338,326 | \$2,906,909 | \$402,445 | \$3,309,354 |
| 41. Depreciation - office equipment | | \$53,586 | \$53,586 | | \$53,586 | -\$3,215 | \$50,371 | \$70,077 | \$120,447 |
| 42. Office supplies | | \$0 | \$0 | \$69,785 | \$69,785 | | \$69,785 | | \$69,785 |
| 43. Legal | | \$38,971 | \$38,971 | | \$38,971 | -\$2,338 | \$36,633 | \$29 | \$36,662 |
| 44. Accounting | | \$37,660 | \$37,660 | | \$37,660 | -\$2,260 | \$35,401 | \$4,840 | \$40,240 |
| 45. Insurance | | \$35,123 | \$35,123 | | \$35,123 | -\$2,107 | \$33,016 | \$3,512 | \$36,528 |
| 46. Telephone | | \$198,705 | \$198,705 | | \$198,705 | -\$11,922 | \$186,782 | \$7,869 | \$194,652 |
| 47. Other administrative costs (specify details below) | | | | | | | | | |
| 47a | \$2,283,926 | \$38,099 | \$2,322,025 | | \$2,322,025 | -\$100,465 | \$2,221,560 | \$28,113 | \$2,249,673 |
| 48. Subtotal administrative costs (sum of lines 40-47) | \$4,852,509 | \$402,145 | \$5,254,654 | \$69,785 | \$5,324,438 | \$216,018 | \$5,540,457 | \$516,884 | \$6,057,341 |
| 49. Total overhead (sum of lines 39 and 48) | \$5,081,012 | \$1,610,445 | \$6,691,458 | \$69,785 | \$6,761,242 | \$174,577 | \$6,935,819 | \$1,071,613 | \$8,007,432 |

CCBHC Cost Report

| | | | | | | | | | |
|-------------------|---|----------|-----|-----------|--|--|--|--|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J, Kansas 100732860L | | | | | | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520102, Afton 1073520102 | | | | | | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 | | | | | |

PART 3 - DIRECT COSTS FOR NON-CCBHC SERVICES

PART 3A - DIRECT COSTS FOR SERVICES OTHER THAN CCHBC SERVICES

| Description | Compensation 1 | Other 2 | Total (Col. 1 + 2) 3 | Reclassifications 4 | Reclassified Trial Balance (Col. 3 + 4) 5 | Adjustments Increases (Decreases) 6 | Adjusted Amount (Col. 5 + 6) 7 | Adjustments for Anticipated Cost Changes 8 | Net Expenses (Col. 7 + 8) 9 |
|---|-------------------|------------|----------------------------|------------------------|--|--|---|---|--------------------------------------|
| 50. Direct costs for non-CCBHC services covered by Medicaid (specify details below) | | | | | | | | | |
| 50a | \$0 | | \$0 | | \$0 | | \$0 | | \$0 |

PART 3B - NON-REIMBURSABLE COSTS

| Description | Compensation 1 | Other 2 | Total (Col. 1 + 2) 3 | Reclassifications 4 | Reclassified Trial Balance (Col. 3 + 4) 5 | Adjustments Increases (Decreases) 6 | Adjusted Amount (Col. 5 + 6) 7 | Adjustments for Anticipated Cost Changes 8 | Net Expenses (Col. 7 + 8) 9 |
|--|-------------------|-------------|----------------------------|------------------------|--|--|---|---|--------------------------------------|
| 51. Direct costs for non-CCBHC services <i>not</i> covered by Medicaid (specify details below) | | | | | | | | | |
| 51a | | | \$0 | | \$0 | | \$0 | | \$0 |
| 52. Total costs for non-CCBHC services (sum of lines 50-51) | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| 53. Total costs (sum of lines 29, 49, and 52) | \$15,049,033 | \$6,043,187 | \$21,092,220 | \$0 | \$21,092,220 | \$1,401,562 | \$22,493,782 | \$8,128,153 | \$30,621,935 |

CCBHC Cost Report

| | | | | | |
|-------------------|--|----------|-----|-----------|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, An | | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, An | | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 | |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 | |
| WORKSHEET: | Trial Balance Reclassifications | | | | |

| Explanation of Entry | Increase: | Increase: | Increase: | Decrease: | Decrease: | Decrease: |
|---|-----------------------|------------------|--------------|-----------------------|------------------|--------------|
| | Expense Category 1 | Line Number 2 | Amount* 3 | Expense Category 4 | Line Number 5 | Amount* 6 |
| 1. line 27 reduce Office supply expense by 60% for indirect costs | | | | Office Supplies | \$27 | \$ 69,784.64 |
| 2. line 40 increase Office supply expense by 60% for indirect costs | Office Supplies | | \$42 | | | \$ 69,784.64 |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
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| 9. | | | | | | |
| 10. | | | | | | |
| 11. | | | | | | |
| 12. | | | | | | |
| 13. | | | | | | |
| 14. | | | | | | |
| 15. | | | | | | |
| 16. | | | | | | |
| 17. | | | | | | |
| 18. | | | | | | |
| 19. | | | | | | |
| 20. | | | | | | |
| 21. | | | | | | |
| 22. | | | | | | |
| 23. | | | | | | |
| 24. | | | | | | |
| 25. | | | | | | |
| 26. | | | | | | |
| 27. | | | | | | |
| 28. | | | | | | |
| 29. | | | | | | |
| 30. | | | | | | |
| 31. | | | | | | |
| 32. | | | | | | |
| 33. | | | | | | |
| 34. | | | | | | |
| 35a | | | | | | |
| 36. Total reclassifications (sum of column 3 must equal sum of column 6) | | | \$ 69,784.64 | | | \$ 69,784.64 |

* Transfer to Trial Balance worksheet, column 4 as appropriate

CCBHC Cost Report

| | | | | |
|-------------------|--|----------|-----|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860D | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902810000 | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Trial Balance Adjustments | | | |

PART 1 - COMMON ADJUSTMENTS

| Description | Basis for Adjustment* | Amount** | Expense Classification*** | Line Number |
|--|-----------------------|----------|---------------------------|-------------|
| | 1 | 2 | 3 | 4 |
| 1. Investment income on commingled restricted and unrestricted funds | | | | |
| 2. Trade, quantity, and time discounts on purchases | | | | |
| 3. Rebates and refunds of expenses | | | | |
| 4. Rental of building or office space to others | FQHC Utilites | \$4,685 | | |
| 5. Home office costs | | | | |
| 6. Adjustment resulting from transactions with related organizations | | | | |
| 7. Vending machines | | | | |
| 8. Practitioner assigned by National Health Service Corps | | | | |
| 9. Depreciation - buildings and fixtures | | | | |
| 10. Depreciation - equipment | | | | |
| 11. Other common adjustments (specify details below) | | | | |
| 11a | | | | |
| 12. Subtotal of common adjustments (sum of lines 1-11) | | \$4,685 | | |

PART 2 - COSTS NOT ALLOWED (Must be removed from allowable costs)

| Description | Basis for Adjustment* | Amount** | Expense Classification*** | Line Number |
|---|-----------------------|-----------|---------------------------|-------------|
| | 1 | 2 | 3 | 4 |
| 13. Bad debts | A | \$208,972 | | |
| 14. Charitable contributions | A | | | |
| 15. Entertainment costs, including costs of alcoholic beverages | A | | | |
| 16. Federal, state, or local sanctions or fines | A | | | |
| 17. Fund-raising costs | A | | | |
| 18. Goodwill, organization costs, or other amortization | A | | | |
| 19. Legal fees related to criminal investigations | A | | | |
| 20. Lobbying costs | A | | | |
| 21. Selling and marketing costs | A | | | |
| 22. Subtotal of other costs not allowed (specify details below) | | | | |
| 22a | A | | | |
| 23. Subtotal of costs not allowed (sum of lines 13-22) | A | \$208,972 | | |
| 24. Total Adjustments (sum of lines 12 and 23) | | \$213,656 | | |

*Basis for adjustment
A. Costs - if cost (including applicable overhead) can be determined
B. Amount received - if cost cannot be determined

** Transfer to Trial Balance worksheet, column 6 as appropriate

*** Expense classification on Trial Balance worksheet from which amount is to be deducted or to which the amount is to be added

CCBHC Cost Report

| | | | | |
|-------------------|--|----------|-----|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1 | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Anticipated Costs | | | |

PART 1 - DIRECT CCBHC EXPENSES

PART 1A - CCBHC STAFF COSTS

| Description | Additional Required Full-Time Equivalent (FTE) Staff | Additional Expense Amount | Reduced Expense Amount | Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) |
|---|--|---------------------------|------------------------|--|
| | 1 | 2 | 3 | 4 |
| 1. Psychiatrist | 0 | \$0 | | \$0 |
| 2. Psychiatric nurse | 8 | \$669,864 | | \$669,864 |
| 3. Child psychiatrist | 0 | \$0 | | \$0 |
| 4. Adolescent psychiatrist | 1 | \$360,208 | | \$360,208 |
| 5. Substance abuse specialist | 7 | \$425,306 | | \$425,306 |
| 6. Case manager | | \$0 | | \$0 |
| 7. Recovery coach | 7 | \$239,400 | | \$239,400 |
| 8. Peer specialist | 8 | \$239,400 | | \$239,400 |
| 9. Family support specialist | 6 | \$239,400 | | \$239,400 |
| 10. Licensed clinical social worker | 5 | \$325,000 | | \$325,000 |
| 11. Licensed mental health counselor | 8 | \$325,000 | | \$325,000 |
| 12. Mental health professional (trained and credentialed for psychological testing) | 1 | \$110,000 | | \$110,000 |
| 13. Licensed marriage and family therapist | | \$0 | | \$0 |
| 14. Occupational therapist | 4 | \$455,000 | | \$455,000 |
| 15. Interpreters or linguistic counselor | | \$0 | | \$0 |
| 16. General practice (performing CCBHC services) | | \$0 | | \$0 |
| 17. Other staff costs (specify details below) | | | | |
| 17a Psychiatric Nurse Practitioners | | | \$98,151 | -\$98,151 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 18. Subtotal staff costs (sum of lines 1-17) | 55 | \$3,388,578 | \$98,151 | \$3,290,427 |

PART 1B - CCBHC COSTS UNDER AGREEMENT

| Description | Additional Required Full-Time Equivalent (FTE) Staff | Additional Expense Amount | Reduced Expense Amount | Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) |
|---|--|---------------------------|------------------------|--|
| | 1 | 2 | 3 | 4 |
| 19. CCBHC costs from DCO | | \$1,500,000 | | \$1,500,000 |
| 20. Other CCBHC costs (specify details below) | | | | |
| 20a | | \$0 | | \$0 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 21. Subtotal costs under agreement (sum of lines 19-20) | | \$1,500,000 | \$0 | \$1,500,000 |

CCBHC Cost Report

| | | | | |
|-------------------|--|----------|-----|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1 | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Anticipated Costs | | | |

PART 1C - OTHER DIRECT CCBHC COSTS

| Description | Additional Required Full-Time Equivalent (FTE) Staff | Additional Expense Amount | Reduced Expense Amount | Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) |
|---|--|---------------------------|------------------------|--|
| | 1 | 2 | 3 | 4 |
| 22. Medical supplies | | \$20,876 | | \$20,876 |
| 23. Transportation (health care staff) | | \$408,739 | | \$408,739 |
| 24. Depreciation - medical equipment | | \$210,230 | | \$210,230 |
| 25. Professional liability insurance | | \$26,268 | | \$26,268 |
| 26. Telehealth | | \$100,000 | | \$100,000 |
| 27. Other direct costs not already included (specify details below) | | | | |
| 27a Contracted Services | | \$1,500,000 | | \$1,500,000 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 28. Subtotal other direct CCBHC costs (sum of lines 22-27) | | \$2,266,113 | \$0 | \$2,266,113 |
| 29. Total cost of CCBHC services (other than overhead) (sum of lines 18, 21, and 28) | \$55 | \$7,154,691 | \$98,151 | \$7,056,540 |

CCBHC Cost Report

| | | | | |
|-------------------|--|----------|-----|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1 | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Anticipated Costs | | | |

PART 2 - INDIRECT COSTS

PART 2A - SITE COSTS

| Description | Additional Required Full-Time Equivalent (FTE) Staff 1 | Additional Expense Amount 2 | Reduced Expense Amount 3 | Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4 |
|--|---|--------------------------------|-----------------------------|---|
| 30. Rent | | | \$25,787 | -\$25,787 |
| 31. Insurance | | \$7,887 | | \$7,887 |
| 32. Interest on mortgage or loans | | \$22,206 | | \$22,206 |
| 33. Utilities | | \$42,203 | | \$42,203 |
| 34. Depreciation - buildings and fixtures | | \$301,041 | | \$301,041 |
| 35. Depreciation - equipment | | \$39,229 | | \$39,229 |
| 36. Housekeeping and maintenance | | \$167,951 | | \$167,951 |
| 37. Property tax | | | | \$0 |
| 38. Other site costs (specify details below) | | | | |
| 38a | | | | \$0 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 39. Subtotal site costs (sum of lines 30-38) | | \$580,516 | \$25,787 | \$554,729 |

PART 2B - ADMINISTRATIVE COSTS

| Description | Additional Required Full-Time Equivalent (FTE) Staff 1 | Additional Expense Amount 2 | Reduced Expense Amount 3 | Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4 |
|--|---|--------------------------------|-----------------------------|---|
| 40. Office salaries | | \$402,445 | | \$402,445 |
| 41. Depreciation - office equipment | | \$70,077 | | \$70,077 |
| 42. Office supplies | | | | \$0 |
| 43. Legal | | \$29 | | \$29 |
| 44. Accounting | | \$4,840 | | \$4,840 |
| 45. Insurance | | \$3,512 | | \$3,512 |
| 46. Telephone | | \$7,869 | | \$7,869 |
| 47. Other administrative costs (specify details below) | | | | |
| 47a | | \$28,113 | | \$28,113 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 48. Subtotal administrative costs (sum of lines 40-47) | | \$516,884 | \$0 | \$516,884 |
| 49. Total overhead (sum of lines 39 and 48) | | \$1,097,400 | \$25,787 | \$1,071,613 |

CCBHC Cost Report

| | | | | |
|-------------------|--|----------|-----|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1 | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Anticipated Costs | | | |

PART 3 - DIRECT COSTS FOR NON-CCBHC SERVICES

PART 3A - DIRECT COSTS FOR SERVICES OTHER THAN CCHBC SERVICES

| Description | Additional Required Full-Time Equivalent (FTE) Staff 1 | Additional Expense Amount 2 | Reduced Expense Amount 3 | Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4 |
|---|---|--------------------------------|-----------------------------|--|
| 50. Direct costs for non-CCBHC services covered by Medicaid (specify details below) | | | | |
| 50a | | | | \$0 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |

PART 3B - NON-REIMBURSABLE COSTS

| Description | Additional Required Full-Time Equivalent (FTE) Staff 1 | Additional Expense Amount 2 | Reduced Expense Amount 3 | Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4 |
|--|---|--------------------------------|-----------------------------|--|
| 51. Direct costs for non-CCBHC services <i>not</i> covered by Medicaid (specify details below) | | | | |
| 51a | | | | \$0 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 52. Subtotal costs for non-CCBHC services (sum of 50-51) | | \$0 | \$0 | \$0 |
| 53. Total costs (sum of lines 29, 49, and 52) | 55 | \$8,252,091 | \$123,938 | \$8,128,153 |

* Transfer to Trial Balance worksheet, column 8 as appropriate

CCBHC Cost Report

| | | | |
|-------------------|--|----------|---------------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rog | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Roge | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: 2/28/2018 |
| WORKSHEET: | Indirect Cost Allocation | | |

| Description | |
|---|--------------------|
| 1. Does the CCBHC have a indirect cost rate approved by a cognizant agency (see Cost Report Instructions)? If no, go to line 7. | NO |
| 2. Which cognizant agency approved the rate? | |
| 3. Describe the base rate with respect to the indirect cost rate. | |
| 4. Enter the basis amount subject to the rate agreement | |
| 5. Enter the approved rate amount | |
| 6. Calculated indirect costs allocable to CCBHC services (line 4 multiplied by line 5) | \$0 |
| 7. Does the CCBHC qualify to use the federal minimum rate and elect to use the rate for all federal awards? See instructions for qualifications. If no, go to line 11. | NO |
| 8. Direct costs for CCBHC services (Trial Balance, column 9, line 29) | \$0 |
| 9. Minimum rate | 10.0% |
| 10. Calculated indirect costs allocable to CCBHC services (line 8 multiplied by line 9) | \$0 |
| 11. Will the CCBHC allocate indirect costs proportionally by the percentage of direct costs for CCBHC services versus total allowable costs less indirect costs? If no, go to line 15. | YES |
| 12. Percentage of direct costs versus total allowable direct costs (Trial Balance, column 9, line 29 divided by the sum of Trial Balance, column 9, line 29 and Trial Balance, column 9, line 52) | 100.0% |
| 13. Indirect costs to be allocated (Trial Balance, column 9, line 49) | \$8,007,432 |
| 14. Calculated indirect costs allocable to CCBHC services (line 12 multiplied by line 13) | \$8,007,432 |
| 15. If none of the lines 1, 7, or 11 are entered as Yes, provide a thorough description of the cost allocation method used. Include attachments for descriptions and calculations. Include references to line items included in the Trial Balance tab. Enter the amount of indirect costs allocated to providing CCBHC services here. | |
| 16. Total indirect costs allocated to CCBHC services | \$8,007,432 |

CCBHC Cost Report

| | | | | |
|-------------------|---|----------|-----|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Wash | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washin | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Allocation Descriptions | | | |

PLEASE EXPLAIN METHODS USED FOR ALLOCATING RESOURCES TO DIRECT OR INDIRECT COSTS

Justification for allocation:

6% to Chapter 27 costs

CCBHC Cost Report

| | | | |
|-------------------|--|----------|---------------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, R | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Ro | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: 2/28/2018 |
| WORKSHEET: | Daily Visits | | |

PATIENT DEMOGRAPHICS CONSOLIDATED

| Include ALL visits for CCBHC services; do not limit it to those covered by Medicaid. | | Patient Visits |
|--|---|----------------|
| | | 1 |
| 1. | Number of daily visits for patients receiving CCBHC services provided directly from staff | 192,812 |
| 2. | Number of daily visits for patients receiving CCBHC services directly from DCO (not included above) | |
| 3. | Number of additional anticipated daily visits for patients receiving CCBHC services | 48,000 |
| 4. | Total daily visits for patients receiving CCBHC services (sum of lines 1-3) | 240,812 |

CCBHC Cost Report

| | | | |
|-------------------|--|---------------|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J, Kansas 100732860L, Afton 100732860W, Nowata 100 | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520102, Afton 1316954431, Kansas 1295084531, Nowata 1477 | | |
| REPORTING PERIOD: | From: 7/1/2015 | To: 6/30/2016 | |
| RATE PERIOD: | From: 3/1/2017 | To: 2/28/2018 | |
| WORKSHEET: | Monthly Visits | | |

PATIENT DEMOGRAPHICS CONSOLIDATED

Patient demographics should be analyzed to identify Certain Conditions. Because CC PPS-2 requires monthly detail, patient data must be aggregated by patient by month to determine eligibility for Certain Conditions. Months should be captured for ALL CCBHC services provided; do not limit the information to Medicaid members.

| Description | Standard Population Visit Months All 1a | Standard Population Visit Months Above the Outlier Threshold 1b | POPULATION 1: Potential costs should be based on a minimum of 3 or more hours per month CMHC | Certain Conditions 1 Visit Months Above the Outlier Threshold 2b | POPULATION 2: Potential costs should be based on a minimum of 12 or more hours of service per | Certain Conditions 2 Visit Months Above the Outlier Threshold 3b | POPULATION 3: Potential costs should be based according to the ASAM intensive outpatient | Certain Conditions 3 Visit Months Above the Outlier Threshold 4b | POPULATION 4: Potential costs should be based according to the ASAM intensive outpatient | Certain Conditions 4 Visit Months Above the Outlier Threshold 5b | POPULATION 5: Chronically homeless means: (1) A "homeless individual with a | Certain Conditions 5 Visit Months Above the Outlier Threshold 6b | Monthly Patient Visit (Sum of col. a's) Total |
|--|---|---|--|--|---|--|--|--|--|--|---|--|---|
| 1. Describe population | | | POPULATION 1: Potential costs should | | POPULATION 2: Potential costs should | | POPULATION 3: Potential costs should | | POPULATION 4: Potential costs should | | POPULATION 5: Chronically | | |
| 2. Number of months patients received CCBHC services directly from staff | 22129 | 1165 | 3885 | 3885 | 3611 | 190 | 0 | 0 | 0 | 950 | 50 | 30,575 | |
| 3. Number of months patients received CCBHC services directly from DCO (not included above) | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 | |
| 4. Number of additional anticipated months patients received CCBHC services (not included above) | 950 | 50 | 855 | 855 | 361 | 19 | 950 | 50 | 950 | 50 | 760 | 40 | 5,890 |
| 5. Total months patients received CCBHC services (sum of lines 2-4) | 23,079 | 1,215 | 4,740 | 4,740 | 3,972 | 209 | 950 | 50 | 950 | 50 | 1,710 | 90 | 36,465 |

CCBHC Cost Report

| | | | | |
|-------------------|---|----------|-----|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, R | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Services Provided | | | |

PART 1 - SERVICES PROVIDED (Consolidated)

PART 1A - CCBHC STAFF SERVICES

| Description | Number of Full-Time Equivalent (FTE) Staff | Total Number of Services Provided for CCBHC Services | Direct Cost (from Trial Balance, Col. 9) | Average Cost per Service by Position (Col. 3 divided by Col. 2) |
|---|--|--|--|---|
| | 1 | 2 | 3 | 4 |
| 1. Psychiatrist | 1.0 | 1,938 | \$ 368,208.84 | \$ 189.99 |
| 2. Psychiatric nurse | 12.0 | 23,012 | \$ 1,601,315.00 | \$ 69.59 |
| 3. Child psychiatrist | | | \$ - | \$ - |
| 4. Adolescent psychiatrist | | | \$ 360,208.00 | \$ - |
| 5. Substance abuse specialist | | | \$ 425,306.00 | \$ - |
| 6. Case manager | 83.0 | 249,000 | \$ 3,836,712.28 | \$ 15.41 |
| 7. Recovery coach | | | \$ 239,400.00 | \$ - |
| 8. Peer specialist | 23.0 | 80,000 | \$ 1,094,403.00 | \$ 13.68 |
| 9. Family support specialist | 25.0 | 62,559 | \$ 1,026,003.00 | \$ 16.40 |
| 10. Licensed clinical social worker | 37.0 | 130,521 | \$ 2,623,047.00 | \$ 20.10 |
| 11. Licensed mental health counselor | 33.0 | 111,452 | \$ 2,164,202.00 | \$ 19.42 |
| 12. Mental health professional (trained and credentialed for psychological testing) | | 0 | \$ 110,000.00 | \$ - |
| 13. Licensed marriage and family therapist | | | \$ - | \$ - |
| 14. Occupational therapist | | | \$ 455,000.00 | \$ - |
| 15. Interpreters or linguistic counselor | | | \$ - | \$ - |
| 16. General practice (performing CCBHC services) | | | \$ - | \$ - |
| 17. Other staff services (specify details below) | | | | |
| 17a Psychiatric Nurse Practitioners | 3.0 | 10,831 | \$ 350,165.00 | \$ 32.33 |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 18. Subtotal staff services (sum of lines 1-17) | 217 | 669,313 | \$ 14,653,970.12 | \$ 21.89 |

PART 1B - CCBHC SERVICES UNDER AGREEMENT

| Description | Number of Full-Time Equivalent (FTE) Staff | Total Number of Services Provided for CCBHC Services | Direct Cost (from Trial Balance, Col. 9) | Average Cost per Service by Position (Col. 3 divided by Col. 2) |
|-------------|--|--|--|---|
| | 1 | 2 | 3 | 4 |

CCBHC Cost Report

| | | | | |
|---|---|----------|------------------|-----------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, R | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 |
| WORKSHEET: | Services Provided | | | |
| 19. CCBHC services from DCO | | 70,873 | \$ 1,500,000.00 | \$ 21.16 |
| 20. Other CCBHC services (specify details below) | | | | |
| 20a | | | \$ - | \$ - |
| <i>Additional lines inserted via Trial Balance tab</i> | | | | |
| 21. Subtotal services under agreement (sum of lines 19-20) | | 70,873 | \$ 1,500,000.00 | \$ 21.16 |
| 22. Total services (sum of lines 18 and 21) | 217 | 740,186 | \$ 16,153,970.12 | \$ 21.82 |

CCBHC Cost Report

| | | | |
|-------------------|---|----------|---------------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, R | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: 2/28/2018 |
| WORKSHEET: | Services Provided | | |

PART 2 - SERVICES PROVIDED BY SITE (For additional satellite sites, create new tab and copy and paste Part 2 for each additional site included)

PART 2A - CCBHC STAFF SERVICES

| Description | Number of Full-Time Equivalent (FTE) Staff | Total Number of Services Provided for CCBHC Services |
|---|--|--|
| | 1 | 2 |
| 1. Psychiatrist | | |
| 2. Psychiatric nurse | | |
| 3. Child psychiatrist | | |
| 4. Adolescent psychiatrist | | |
| 4. Adolescent psychiatrisu | | |
| 5. Substance abuse specialist | | |
| 6. Case manager | | |
| 7. Recovery coach | | |
| 8. Peer specialist | | |
| 9. Family support specialist | | |
| 10. Licensed clinical social worker | | |
| 11. Licensed mental health counselor | | |
| 12. Mental health professional (trained and credentialed for psychological testing) | | |
| 13. Licensed marriage and family therapist | | |
| 14. Occupational therapist | | |
| 15. Interpreters or linguistic counselor | | |
| 16. General practice (performing CCBHC services) | | |
| 17. Other staff services (specify details below) | | |
| 17a Psychiatric Nurse Practitioners | | |
| <i>Additional lines inserted via Trial Balance tab</i> | | |
| 18. Subtotal staff services (sum of lines 1-17) | 0 | 0 |

PART 2B - CCBHC SERVICES UNDER AGREEMENT

CCBHC Cost Report

| | | | |
|-------------------|---|----------|---------------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, R | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: 2/28/2018 |
| WORKSHEET: | Services Provided | | |

| Description | Number of Full-Time Equivalent (FTE) Staff | Total Number of Services Provided for CCBHC Services |
|--|--|--|
| | 1 | 2 |
| 19. CCBHC services from DCO | | |
| 20. Other CCBHC services (specify details below) | | |
| 20a | | |
| <i>Additional lines inserted via Trial Balance tab</i> | | |
| 21. Subtotal services under agreement (sum of lines 19-20) | | 0 |
| 22. Total services (sum of lines 18 and 21) | 0 | 0 |
| OMB #0398-1148 CMS-10398 (#43) | | |
| End of Worksheet | | |

CCBHC Cost Report

| | |
|-------------------|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902100000 |
| REPORTING PERIOD: | From: 7/1/2015 To: 6/30/2016 |
| RATE PERIOD: | From: 3/1/2017 To: 2/28/2018 |
| WORKSHEET: | Comments |

Please explain or comment on any additional considerations that should be taken into account in determining the appropriate payment rate

| Worksheet | Line | Comment 1 | Comment 2 | Comment 3 | Comment 4 | Comment 5 | Comment 6 | Comment 7 | Comment 8 | Comment 9 |
|-----------------|------|--------------|------------|----------------|------------|-----------|------------|------------|-------------|------------|
| Provider Inform | 9 | SHOWLER F | 1881920726 | CUMMINS J | 1780083774 | | KEENER KE | 1245445485 | ROBINSON | 1902124639 |
| Provider Inform | 9 | SIBLEY-LOT | 1689902637 | DALTON ME | 1700147816 | | KENNEDY C | 1063725315 | ROGERS BA | 1437371986 |
| Provider Inform | 9 | SIMMONS D | 1962892398 | DANLEY CH | 1023238235 | | KENNEL S | 1306201116 | ROGERS CH | 1073995478 |
| Provider Inform | 9 | SMITH LAUF | 1649454836 | DEKNIGHT J | 1538533690 | | KIRCHMANN | 1700242591 | SAJULGA C | 1093170888 |
| Provider Inform | 9 | STEWART F | 1013394634 | DICKSON LI | 1972919637 | | KROLL AMY | 1144608852 | SALOM TAB | 1083024657 |
| Provider Inform | 9 | WALKER DE | 1942422183 | DILLON JAC | 1821463142 | | LAUSER VIC | 1124410592 | SALZER GR | 1194094722 |
| Provider Inform | 9 | WALKER KF | 1982096400 | DILLON LINI | 1073989174 | | LEE DOMIN | 1538525951 | SAUCIER M | 1154726297 |
| Provider Inform | 9 | WILLIS CAM | 1659824753 | DUBOSE CL | 1174871107 | | LEGGETT J | 1013218064 | SCANTLEN | 1669855524 |
| Provider Inform | 9 | WOODALL H | 1063881324 | EFFNER NA | 1174767891 | | LEVOIR RA | 1679988265 | SELIX PERF | 1275777997 |
| Provider Inform | 9 | ABBAS DYL | 1235505330 | ESTES LUC | 1033489232 | | LIKENS DA | 1952730467 | SEXTON TIM | 1144606070 |
| Provider Inform | 9 | ABRAMS KA | 1073910865 | FISCHER NU | 1164629093 | | LOCKWOOD | 1306068796 | SHELTON D | 1740444090 |
| Provider Inform | 9 | ADAMS EAL | 1043557671 | FORD BREN | 1558760348 | | LOCUST KA | 1326406109 | SMITH ANG | 1194084533 |
| Provider Inform | 9 | ALEXANDER | 1538527361 | FOSTER REBECCA | 9RLS | | LUNA KATH | 1467716209 | SMITH BRE | 1275907107 |
| Provider Inform | 9 | ALLEY DEBBIE | 9DDA | FREISBERG | 1588976179 | | LUPER SIEF | 1710315114 | SMITH ELBE | 1275909673 |
| Provider Inform | 9 | ALLS TAMM | 1851534416 | FROST WEN | 1750701108 | | MAJOR PAT | 1477936748 | SMITH JESS | 1215323613 |
| Provider Inform | 9 | ANDREWS J | 1073772752 | GANTT LAR | 1437433067 | | MALLGREN | 1841384021 | SMITH LARRY | 9LLS |
| Provider Inform | 9 | AREVALO A | 1730576539 | GEILENFELD | 1245484914 | | MANLEY PA | 1023356755 | SMITH SHEI | 1114242971 |
| Provider Inform | 9 | ARGYLE RO | 1790151710 | GLENN ALIC | 1245411396 | | MARK NICO | 1558731000 | SMOTHERM | 1528272416 |
| Provider Inform | 9 | ARNOLD KA | 1922210897 | GLENN JEN | 1295004844 | | MARTIN ELB | 1487041992 | SORAH HEI | 1194079681 |
| Provider Inform | 9 | ARNOLD ME | 1720447246 | GLOVER KA | 1275964165 | | MARTIN JEN | 1467755157 | SPENCER M | 1891030607 |
| Provider Inform | 9 | BATCHELOR | 1366815607 | GREEN-WA | 1518314749 | | MATTES TE | 1386918050 | STACY ANIT | 1720490923 |
| Provider Inform | 9 | BATES KAT | 1396116463 | GREENWOC | 1073986071 | | MATTHEWS | 1114311701 | STELMAN | 1710243829 |
| Provider Inform | 9 | BEARD ALIC | 1831427434 | GRENINGER | 1417979006 | | MCCURDEY | 1801279252 | STEPHENS | 1508159948 |
| Provider Inform | 9 | BLAINE RHO | 1578785085 | GUTIERREZ | 1770941569 | | MELTON ME | 1538542659 | STREET BE | 1700208188 |
| Provider Inform | 9 | BLASDEL R | 1124167960 | HALL AMAN | 1356688568 | | MERRITT TR | 1710370200 | SUGGS KEV | 1366779332 |
| Provider Inform | 9 | BOLTE JEAN | 1790141109 | HAMMOND | 1700184736 | | MILLER DEB | 1710920152 | TAYLOR CA | 1265889778 |
| Provider Inform | 9 | BOND LEE | 1952762403 | HAMMOND | 1821480617 | | MORAIN JAI | 1134406804 | TAYLOR SH | 1700262169 |
| Provider Inform | 9 | BOUDREAU | 1063804128 | HARLIN JEF | 1609096809 | | MORRIS AL | 1588924799 | TEEHEE KIN | 1407076615 |
| Provider Inform | 9 | BRADLEY C | 1982051322 | HARRIS DE | 1811293699 | | MORRISON | 1053648105 | THACH SHA | 1841507548 |
| Provider Inform | 9 | BRINLEE KF | 1184901159 | HAY ANGIE | 1326443235 | | MROSKO EL | 1699182865 | THOMAS CA | 1326375981 |
| Provider Inform | 9 | BRINLEE TR | 1851765796 | HAYNES PA | 1689896912 | | MURRAY-TA | 1942693346 | THOMAS DC | 1245538883 |
| Provider Inform | 9 | BRITT ANGE | 1740649862 | HAYS ANGE | 1669846598 | | MYERS BRA | 1518323294 | THOMAS JA | 1245571488 |
| Provider Inform | 9 | BROWN CH | 1760684542 | HEATON ST | 1730511684 | | MYERS JOS | 1720458268 | THOMPSON | 1457745168 |
| Provider Inform | 9 | BRYANT RA | 1356570204 | HENDERSON | 1679839617 | | NAGY VALO | 1033364286 | THOMPSON | 1225494495 |
| Provider Inform | 9 | BUCHANAN | 1134450562 | HENRY AMA | 1285045716 | | NEET AARC | 1528404902 | THOMPSON | 1093170540 |
| Provider Inform | 9 | BURNSHIRE | 1720355787 | HENSON RO | 1790905982 | | ONEILL FAY | 1568899144 | TRAMMELL | 1316283245 |
| Provider Inform | 9 | BURROUGH | 1396141271 | HESKETT D | 1528267846 | | ORTIZ CHR | 1174905970 | TREVINO M | 1417336488 |
| Provider Inform | 9 | CANBY FAI | 1922362953 | HIGGINS MA | 1316387129 | | OYER TINA | 1871982884 | TURBETT K | 1558745570 |
| Provider Inform | 9 | CANTWELL | 1184953184 | HILL KIMBE | 1962623066 | | PALMER RIC | 1588065593 | TURNER D' | 1538425574 |
| Provider Inform | 9 | CARR WEN | 1497004303 | HILL MANIA | 1750585816 | | PAPPE KAT | 1497145247 | VAN MATRE | 1881909075 |
| Provider Inform | 9 | CASELMAN | 1912306754 | HOBBS CAR | 1114237021 | | PATTERSON | 1396104030 | VASQUEZ K | 1518227008 |
| Provider Inform | 9 | CHAUDHRY | 1487052973 | HOGAN AM | 1316167513 | | PENN ANGE | 1750778817 | WALLACE M | 1366804064 |
| Provider Inform | 9 | CHAVEZ AM | 1437538352 | HOLCOMB H | 1548482698 | | PEREZ EDIE | 1699136143 | WALLS JAM | 1013316314 |
| Provider Inform | 9 | CHRISTIAN | 1619304961 | HOLENDA S | 1225444003 | | PHELPS AM | 1265757405 | WEST ELIZA | 1609183037 |
| Provider Inform | 9 | CICIO MARI | 1205207453 | HOLLAND T | 1750766218 | | PITTS-JOHN | 1710376421 | WIKEL JAM | 1679964605 |
| Provider Inform | 9 | CLAY COUF | 1164813093 | HOOPER EN | 1346547114 | | POPLIN CIN | 1760872915 | WILLIAMS C | 1124483482 |
| Provider Inform | 9 | CLEMENS V | 1821219932 | HOWARD D | 1548697386 | | POWELL BE | 1699147249 | WILLIAMS J | 1780882894 |
| Provider Inform | 9 | COOPER KA | 1215282470 | HUGHES KA | 1598987976 | | PROVOST H | 1043530827 | WILLIAMS T | 1497045454 |
| Provider Inform | 9 | CORDERO H | 1649664061 | HUMPHREY | 1235359431 | | PUTNAM DE | 1902069461 | WILMERING | 1518334689 |

| | | | | | | | | | | |
|-----------------|---------|--|--------------|-------------|--------------|--------------|------------|------------|---------------|------------|
| Provider Inform | 9 | CORONEL C | 1639542558 | JACOB CHR | 1962875880 | | RANDLE AN | 1386938660 | WILSON SHARON | 5SLW |
| Provider Inform | 9 | COWAN LA | 1548402118 | JAMES IMO | 1619227485 | | RAWLINGS | 1073913950 | WISNER CH | 1417209586 |
| Provider Inform | 9 | CRAIN ALE | 1548639826 | JAMES JAC | 1629413026 | | RAY NATAS | 1760851562 | WOOD TY | 1942443429 |
| Provider Inform | 9 | CROFFORD | 1982978045 | JAMES LISS | 1376763540 | | REUDY KAT | 1083826804 | WRIGHT MA | 1285855304 |
| Provider Inform | 9 | CROWDER | 1538457569 | JOHNSON K | 1699013052 | | RHINE MEG | 1881032597 | YIRSA MAR | 1467594044 |
| Provider Inform | 9 | CULP LINDA | 1164829529 | JOHNSON F | 1255790002 | | RICK ANISS | 1932519469 | YORK JACK | 1538466396 |
| Provider Inform | 9 | CUMMINS C | 1023401056 | JUHL DEAIR | 1659797991 | | ROBERTS M | 1841445145 | ZABEL COD | 1811375025 |
| Provider Inform | 9 | CROUCH SI | 1902299456 | | | | | | | |
| Provider Inform | 9 | DAVIS DEV | 1669843397 | | | | | | | |
| Provider Inform | 9 | GRIFFIN KA | 1619342060 | | | | | | | |
| Provider Inform | 9 | JOHNSON A | 1730546128 | | | | | | | |
| Provider Inform | 9 | LITTLE KIM | 1902277742 | | | | | | | |
| Provider Inform | 9 | LONG TIFFA | 1235471103 | | | | | | | |
| Provider Inform | 9 | MANGELS M | 1255765038 | | | | | | | |
| Provider Inform | 9 | MOSHER W | 1003037565 | | | | | | | |
| Provider Inform | 9 | PATE DEBO | 1467821017 | | | | | | | |
| Provider Inform | 9 | SHIELD MIC | 1255734752 | | | | | | | |
| | | | | | | | | | | |
| Trial Balance | | Payroll 07/01/15 to 06/30/16 | | | | | | | | |
| | line 1 | Psychiatrist | | | 322990 | | | | | |
| | line 2 | Psychiatric Nurse | | | 817062 | | | | | |
| | line 6 | Case Manager | | | 3365537 | | | | | |
| | line 8 | Peer Specialist | | | 750003 | | | | | |
| | line 9 | Family Support Specialist | | | 690003 | | | | | |
| | line 10 | LCSW | | | 2015831 | | | | | |
| | line 11 | LPC | | | 1613335 | | | | | |
| | Line 17 | Psychiatric Nurse Practitioner | | | 393260 | | | | | |
| | line 36 | Other - Maintenance | | | 228503 | | | | | |
| | line 40 | Admin | | | 2568583 | | | | | |
| | line 47 | Other - Indirect-Support | | | 2283926 | | | | | |
| | | | | | 15049033 | | | | | |
| Trial Balance | | Anticipated Payroll 03/01/17 to 02/28/18 | | | | | | | | |
| | line 1 | Psychiatrist | | | 368209 | | | | | |
| | line 2 | Psychiatric Nurse | | | 1601315 | | | | | |
| | line 4 | Adolescent psychiatrist | | | 360208 | | | | | |
| | line 5 | Substance Abuse specialist | | | 425306 | | | | | |
| | line 6 | Case Manager | | | 3836712 | | | | | |
| | line 7 | Recovery Coach | | | 239400 | | | | | |
| | line 8 | Peer Specialist | | | 1094403 | | | | | |
| | line 9 | Family Support Specialist | | | 1026003 | | | | | |
| | line 10 | LCSW | | | 2623047 | | | | | |
| | line 11 | LPC | | | 2164202 | | | | | |
| | Line 12 | MH Profesional | | | 110000 | | | | | |
| | line 14 | Occupational therapist | | | 4555000 | | | | | |
| | Line 17 | Psychiatric Nurse Practitioner | | | 393260 | | | | | |
| | line 36 | Other - Maintenance | | | 228503 | | | | | |
| | line 40 | Admin | | | 2568583 | | | | | |
| | line 47 | Other - Indirect-Support | | | 2283926 | | | | | |
| | | | | | 23878077 | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Trial Balance | | GL Account | Description | CCBHC Budg | FY 16 Actual | Difference | | | | |
| | 19 | | CCBHC cost | ##### | | | | | | |
| | 22 | 6803 | Medical Supp | \$56,388.00 | \$4,493.61 | \$51,894.39 | | | | |
| | 22 | 6804 | Testing Supp | \$6,100.00 | \$1,866.52 | \$4,233.48 | | | | |
| | 23 | 6210 | Employee Tra | ##### | ##### | ##### | | | | |
| | 23 | 7210 | Vehicle Fuel | ##### | ##### | \$55,151.85 | | | | |
| | 23 | 7220 | Vehicle Ins | ##### | ##### | \$33,405.63 | | | | |
| | 23 | 7230 | Vehicle Repa | \$61,240.00 | \$69,022.94 | (\$7,782.94) | | | | |

| | | | | | | | | | |
|-------------------|-----------|------|---|-------------|-------------|---------------|--|--|--|
| | 23 | 7240 | Tag and Regi | \$2,335.00 | \$3,817.80 | (\$1,482.80) | | | |
| | 23 | 7242 | Vehicle Admi | \$10,000.00 | \$9,102.53 | \$897.47 | | | |
| | 24 | | Depreciation | ##### | | | | | |
| | 25 | 7530 | Insurance / B | ##### | ##### | \$15,012.96 | | | |
| | 26 | | Telehealth | ##### | | | | | |
| | 27 | 6620 | Computer Eq | \$80,000.00 | \$69,000.00 | \$11,000.00 | | | |
| | 27 | 6640 | Office Equipm | \$85,800.00 | \$34,979.36 | \$50,820.64 | | | |
| | 27 | 6801 | Library Exp | \$17,600.00 | \$5,935.84 | \$11,664.16 | | | |
| | 27 | 6802 | Meals/service | ##### | ##### | ##### | | | |
| | 27 | 6807 | Computer Su | \$29,009.00 | \$48,655.71 | (\$19,646.71) | | | |
| | 27 | 6808 | Printing Supp | \$700.00 | \$2,354.08 | (\$1,654.08) | | | |
| | 27 | 6809 | EMR | ##### | \$1,701.84 | ##### | | | |
| | 27 | 6811 | Office Supplie | ##### | \$80,640.92 | \$38,359.08 | | | |
| | 27 | 6905 | LPC Supervis | ##### | \$31,203.40 | \$88,796.60 | | | |
| | 27 | 6908 | Misc. Contract | ##### | ##### | \$50,896.93 | | | |
| | 27 | 7510 | Postage | \$35,000.00 | \$13,364.18 | \$21,635.82 | | | |
| | 27 | 7520 | Recruitment | ##### | \$88,429.58 | ##### | | | |
| | 27 | 7525 | Personnel Inv | \$27,100.00 | \$15,548.94 | \$11,551.06 | | | |
| | 27 | 7550 | Transportatio | \$14,000.00 | \$5,199.59 | \$8,800.41 | | | |
| | 27 | 7570 | Advertisemen | \$700.00 | \$1,053.08 | (\$353.08) | | | |
| | 27 | 7630 | Training Regi | \$88,000.00 | \$50,325.02 | \$37,674.98 | | | |
| | 27 | 7680 | Misc | \$5,000.00 | \$8,238.24 | (\$3,238.24) | | | |
| | 27 | 7702 | Employee Me | \$40,000.00 | \$90,673.87 | (\$50,673.87) | | | |
| | 30 | 6311 | Rent | \$21,600.00 | \$ | \$21,600.00 | | | |
| | 31 | 7530 | Insurance / B | \$82,023.00 | ##### | (\$85,020.04) | | | |
| | 32 | 6312 | Interest | \$73,936.00 | \$29,402.28 | \$44,533.72 | | | |
| | 33 | 6351 | Utilities | ##### | ##### | \$20,518.59 | | | |
| | 34 | 6313 | Depreciation | ##### | ##### | ##### | | | |
| | 35 | 6710 | Depreciation | ##### | ##### | ##### | | | |
| | 36 | 6410 | Building Main | ##### | ##### | \$49,108.02 | | | |
| | 36 | 6420 | Equipment M | \$16,964.00 | \$6,863.95 | \$10,100.05 | | | |
| | 36 | 6430 | Custodial Exp | ##### | \$64,344.00 | ##### | | | |
| | 36 | 6805 | Maintenance | \$69,100.00 | \$28,936.58 | \$40,163.42 | | | |
| | 36 | 6650 | Other Equipm | \$10,600.00 | \$5,568.59 | \$5,031.41 | | | |
| | 41 | 6710 | Depreciation | ##### | ##### | ##### | | | |
| | 42 | 6811 | Office Supplie | \$69,785.00 | \$80,640.92 | (\$10,855.92) | | | |
| | 43 | 6902 | Legal Counse | \$36,662.00 | \$10,539.80 | \$26,122.20 | | | |
| | 44 | 6904 | Auditors | \$40,240.00 | \$31,138.09 | \$9,101.91 | | | |
| | 45 | 7530 | Insurance / B | \$36,528.00 | ##### | ##### | | | |
| | 46 | 7020 | Business Line | ##### | ##### | \$44,011.99 | | | |
| | 47 | 6220 | Board Travel | \$48,000.00 | \$42,000.00 | \$6,000.00 | | | |
| | 47 | 6907 | Computer An | \$25,000.00 | \$ | \$25,000.00 | | | |
| | 47 | 7540 | Professional | \$21,608.00 | \$15,257.09 | \$6,350.91 | | | |
| | 50 | | NON CCBHC | ##### | | | | | |
| | TB ADJ 13 | 7600 | Bad Debt Exp | 0 | 130972 | -130972 | | | |
| | TB ADJ 13 | 7620 | Supervision E | 0 | 9755 | -9755 | | | |
| | TB ADJ 4 | 6352 | Rt66 FQHC U | 0 | 4685 | -4685 | | | |
| | | | | 9477590 | 4677149 | 4800441 | | | |
| Services Provided | | | | | | | | | |
| | 6 | | Behavioral Health Rehab Specialists | | 57,432 | | | | |
| | 12 | | BHP - Behavioral Health Professional | | 36,121 | | | | |
| | 11 | | C24 Licensed Behavioral Health Professi | | 2,543 | | | | |
| | 2 | | C24 PRN Registered Nurse | | 60 | | | | |
| | 8 | | C24 Recovery Support Specialist | | 647 | | | | |
| | 2 | | C24 Registered Nurse | | 609 | | | | |
| | 6 | | Care Coordinator | | 6,688 | | | | |
| | 9 | | Family Support Provider | | 11,333 | | | | |
| | 10 | | LCSW | | 12,179 | | | | |

CCBHC Cost Report

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|-------------------|---|----------|---------------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100 | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750 | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: 2/28/2018 |
| WORKSHEET: | CC PPS-1 Rate | | |

PART 1 - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO THE CCBHC

| Description | Amount 1 |
|---|---------------------|
| 1. Total direct cost of CCBHC services (Trial Balance, column 9, line 29) | \$22,614,503 |
| 2. Indirect cost applicable to CCBHC services (Indirect Cost Allocation, line 16) | \$8,007,432 |
| 3. Total allowable CCBHC costs (sum of lines 1-2) | \$30,621,935 |

PART 2 - DETERMINATION OF CC PPS-1 RATE

| Description | Amount 1 |
|---|---------------------|
| 4. Total allowable CCBHC costs (line 3) | \$30,621,935 |
| 5. Total CCBHC visits* (Daily Visits, column 1, line 4) | 240,812 |
| 6. Unadjusted PPS rate (line 4 divided by line 5) | \$127 |
| 7. Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period | 0.000% |
| 8. CC PPS-1 rate (line 6 adjusted by factor from line 7) | \$127 |

* Total should reflect the total count of CCBHC visits provided and not be restricted to Medicaid visits

CCBHC Cost Report

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|-------------------|--|----------|-----|-----------|--|--|--|--|--|--|--|--|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J, Kansas 100732860L, Afton 100732860W, Nowata 100732860D | | | | | | | | | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520102, Afton 1316954431, Kansas 1295084531, Nowata 1477851756 | | | | | | | | | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 | | | | | | | | |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 | | | | | | | | |
| WORKSHEET: | CC PPS-2 Rate | | | | | | | | | | | |

PART 1 - COST-TO-CHARGE RATIO ALLOCATION

| Description | Standard Population Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 1a | Standard Population Charges and Costs for CCBHC Services: Above the Outlier Threshold 1b | POPULATION 1: Potential costs should be based on a minimum of 3 or more hours per month CMHC services and 1 hour per month of care | Certain Conditions 1 Charges and Costs for CCBHC Services: Above the Outlier Threshold 2b | POPULATION 2: Potential costs should be based on a minimum of 12 or more hours of service per month. This may be a combination | Certain Conditions 2 Charges and Costs for CCBHC Services: Above the Outlier Threshold 3b | POPULATION 3: Potential costs should be based according to the ASAM intensive outpatient placement criteria which equates to | Certain Conditions 3 Charges and Costs for CCBHC Services: Above the Outlier Threshold 4b | POPULATION 4: Potential costs should be based according to the ASAM intensive outpatient placement criteria which equates to | Certain Conditions 4 Charges and Costs for CCBHC Services: Above the Outlier Threshold 5b | SPECIAL POPULATION 5: Chronically homeless means:(1) A "homeless individual with a disability," as defined in the Act, who: | Certain Conditions 5 Charges and Costs for CCBHC Services: Above the Outlier Threshold 6b | Total Population Charges and Costs (Sum of all Columns) Total |
|--|--|--|--|---|--|---|--|---|--|---|---|---|--|
| 1. Actual charges | \$13,927,536 | \$733,028 | \$3,420,166 | \$180,009 | \$3,288,444 | \$173,076 | \$0 | \$0 | \$0 | \$1,086,113 | \$57,164 | \$22,865,536 | |
| 2. Anticipated additional charges (DY1 only) | \$1,900,000 | 100,000 | 1,425,000 | 75,000 | 1,425,000 | 75,000 | 1,187,500 | 62,500 | 1,119,334 | 58,912 | 311,745 | 16,408 | \$7,756,399 |
| 3. Total charges (sum of lines 1-2) | \$15,827,536 | \$833,028 | \$4,845,166 | \$255,009 | \$4,713,444 | \$248,076 | \$1,187,500 | \$62,500 | \$1,119,334 | \$58,912 | \$1,397,859 | \$73,572 | \$30,621,935 |
| 4. Total direct costs (Trial Balance, column 9, line 29) | | | | | | | | | | | | | \$22,614,503 |
| 5. Indirect cost applicable to CCBHC services (Indirect Cost Allocation, line 16) | | | | | | | | | | | | | \$8,007,432 |
| 6. Total allowable costs for CCBHC services (sum of lines 4-5) | | | | | | | | | | | | | \$30,621,935 |
| 7. Cost-to-charge ratio services (line 6 divided by line 3) | | | | | | | | | | | | | 100% |
| 8. Total cost of CCBHC services (line 3 times line 7) | \$15,827,536 | \$833,028 | \$4,845,166 | \$255,009 | \$4,713,444 | \$248,076 | \$1,187,500 | \$62,500 | \$1,119,334 | \$58,912 | \$1,397,859 | \$73,572 | \$30,621,935 |
| <i>Cross Check: Total costs should tie to the total direct and indirect costs applicable to CCBHC services (li</i> | | | | | | | | | | | | | \$0 |

PART 2 - DETERMINATION OF CC PPS-2 RATE

| Description | Standard Population Costs for CCBHC Services: At or Below the Outlier Threshold 1a | Standard Population Costs for CCBHC Services: Above the Outlier Threshold 1b | SPECIAL POPULATION 1: Potential costs should be based on a minimum of 3 or more hours per month CMHC services and | Certain Conditions 1 Charges and Costs for CCBHC Services: Above the Outlier Threshold 2b | SPECIAL POPULATION 2: Potential costs should be based on a minimum of 12 or more hours of service per month. This | Certain Conditions 2 Charges and Costs for CCBHC Services: Above the Outlier Threshold 3b | SPECIAL POPULATION 3: Potential costs should be based according to the ASAM intensive outpatient placement | Certain Conditions 3 Charges and Costs for CCBHC Services: Above the Outlier Threshold 4b | SPECIAL POPULATION 4: Potential costs should be based according to the ASAM intensive outpatient placement | Certain Conditions 4 Charges and Costs for CCBHC Services: Above the Outlier Threshold 5b | SPECIAL POPULATION 5: Chronically homeless means:(1) A "homeless individual with a disability," as defined in | Certain Conditions 5 Charges and Costs for CCBHC Services: Above the Outlier Threshold 6b | Total Population Costs (Sum of all Columns) Total |
|--|--|--|---|---|---|---|--|---|--|---|---|---|--|
| 9. Total allowable CCBHC costs (line 8) | \$15,827,536 | \$833,028 | \$4,845,166 | \$255,009 | \$4,713,444 | \$248,076 | \$1,187,500 | \$62,500 | \$1,119,334 | \$58,912 | \$1,397,859 | \$73,572 | \$30,621,935 |
| 10. Total months patients received CCBHC services (Monthly Visits, line 5)* | 23079 | | 4740 | | 3972 | | 950 | | 950 | | 1710 | | 36465 |
| 11. Total allowable cost per visit (line 9 divided by line 10) | \$686 | | \$1,022 | | \$1,187 | | \$1,250 | | \$1,178 | | \$817 | | \$840 |
| 12. Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period | | | | | | | | | | | | | 1.035% |

CCBHC Cost Report

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|---|--|-----------|---------|-----------|---------|-----------|---------|----------|---------|----------|-------|----------|-------------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J, Kansas 100732860L, Afton 100732860W, Nowata 100732860D | | | | | | | | | | | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520102, Afton 1316954431, Kansas 1295084531, Nowata 1477851756 | | | | | | | | | | | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: | 6/30/2016 | | | | | | | | | |
| RATE PERIOD: | From: | 3/1/2017 | To: | 2/28/2018 | | | | | | | | | |
| WORKSHEET: | CC PPS-2 Rate | | | | | | | | | | | | |
| 13. CC PPS-2 rate (line 11 adjusted by factor from column Total, line 12) | \$693 | | \$1,033 | | \$1,199 | | \$1,263 | | \$1,190 | | \$826 | | \$848 |
| 14. Outlier pool (line 9) | | \$833,028 | | \$255,009 | | \$248,076 | | \$62,500 | | \$58,912 | | \$73,572 | \$1,531,097 |

* Column "a" reflects the count for All visits. The total reflects the sum of "a" columns.

CCBHC Cost Report

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|-------------------|--|----------|---------------|
| MEDICAID ID: | Craig 100732860F, Delaware 100732860K, Mayes 100732860H, Ottawa 100732860G, Rogers 100732860E, Washington 100732860I, Annex 100732860J | | |
| NPI: | Craig 1710994835, Delaware 1063429181, Mayes 1871500900, Ottawa 1497762520, Rogers 1750398889, Washington 1902813033, Annex 1073520 | | |
| REPORTING PERIOD: | From: | 7/1/2015 | To: 6/30/2016 |
| RATE PERIOD: | From: | 3/1/2017 | To: 2/28/2018 |
| WORKSHEET: | Certification | | |

**MEDICAID COST REPORT
for Certified Community Behavioral Health Clinics**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION; FINE; AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED DIRECTLY OR INDIRECTLY THROUGH THE PAYMENT OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION; FINES; AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY OFFICER OR ADMINISTRATOR IS REQUIRED.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and that to the best of my knowledge and belief, this report and statement are true, correct, complete, and prepared from the books and records of the Provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in the cost report were provided in compliance with such laws and regulations.

| | |
|--|--|
| Signature of Officer: | |
| Title: | |
| Clinic: | |
| Medicaid ID: | |
| From Period: | |
| To Period: | |
| Preparer (if other than Officer): | |