DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

October 19, 2023

Cora Steinmetz
Medicaid Director
Indiana Family and Social Services Administration
402 W Washington St., W374
Marion County, Indianapolis, IN 46204

Dear Director Steinmetz:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Summative Evaluation Report, which was required by the Special Terms and Conditions (STCs), specifically STC 15.7 "Summative Evaluation Report" of the "Healthy Indiana Plan (HIP)" (Project No: 11-W-00296/5). While the broader HIP demonstration was approved from February 1, 2018 through December 31, 2020, the Serious Mental Illness and Serious Emotional Disorder (SMI/SED) component of the demonstration was approved for the period of January 1, 2020 until December 31, 2020. The SMI/SED demonstration component in the HIP demonstration has since been extended through December 31, 2025. This Summative Evaluation Report covers the SMI/SED components of the demonstration between January 1, 2020 and December 31, 2020. CMS determined that the Evaluation Report submitted on June 15, 2022 is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's HIP SMI Summative Evaluation Report.

Due to the short time frame of both implementation and evaluation of the SMI/SED component of the HIP demonstration, the summative evaluation relied on quantitative analyses consisting of descriptive metric trends. The evaluation also included qualitative components using data from stakeholder interviews. The report found that emergency department utilization rates among SMI/SED beneficiaries declined in March 2020, coinciding with the start of the COVID-19 public health emergency (PHE) and then began to increase in July 2020, which is consistent with national trends of in-person health care service utilization during the PHE. The evaluation did not assess whether the demonstration reduced preventable admissions, but stakeholder interviews suggested that telehealth services, effective discharge planning, care coordination, and patient follow-up were critical for reducing preventable readmissions in acute care hospitals and residential settings. The state's preliminary data for available crisis stabilization services showed a need for improving availability of crisis services, particularly in rural areas. Stakeholder interviews revealed opportunities for integrating behavioral health care, including increasing qualified mental health provider capacity, improving transportation, and working to improve infrastructure for data sharing.

In accordance with STC 15.9, the approved Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Summative Evaluation Report on Medicaid.gov.

We look forward to our continued partnership on the Indiana HIP section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2023.10.19 11:57:19 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Mai Le-Yuen, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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Indiana 1115(a) Demonstration Evaluation

Summative Report





Prepared for: **Indiana Family and Social Services Administration**

Submitted by: **The Lewin Group, Inc.**

June 30, 2022

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I. Executive Summary

In 2018, the Indiana Family and Social Services Administration (FSSA) received authority from the Centers for Medicare & Medicaid Services (CMS) to reimburse institutions for mental diseases (IMD) for Medicaid eligible individuals ages 21-64 with substance use disorders (SUD). In 2019, FSSA received a §1115 waiver amendment to expand this authority and reimburse acute inpatient stays in IMDs for individuals diagnosed with a serious mental illness (SMI). The §1115 waiver amendment, effective on January 1, 2020 and extended through December 31, 2025 is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services for Indiana residents. Indiana's approved §1115 waiver Specific Terms and Conditions (STC) requires an independent evaluation to assess the demonstration's ability to meet its intended goals. This report aims to provide a snapshot of the demonstration's initial year.

Summary of the Goals of the Demonstration

Indiana's goals are aligned with those of CMS for the demonstration waiver. Demonstration goals include:

- Reduced utilization and length of stay (LOS) in Emergency Departments (ED) among Medicaid recipients with SMI while awaiting mental health treatment in specialized settings.
- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.
- Improved access to community-based services to address the chronic mental health care needs of recipients with SMI, including through increased integration of primary and behavioral health care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

The Impact of Coronavirus disease 2019 Public Health Emergency

The initial year of the demonstration period (2020) coincided with the Coronavirus disease 2019 (COVID-19) public health emergency (PHE), which was declared on behalf of the entire United States in January 2020.[1] The ongoing PHE caused substantial changes to Medicaid policies, service utilization and provider availability, and will have short- and long-term impacts on Indiana's health care system and specialized populations, such as SMI. Given the timing of the PHE, the State shifted many of the planned implementation activities to accommodate access to and delivery of high-quality mental health services for all Indiana residents, particularly given the social distancing and health care resource prioritization required in response to the PHE.

Summary of Summative Evaluation Methodology

Evaluation of the program goals were based on a mixed-methods approach employing quantitative and qualitative analyses to provide a snapshot of 2020 by demonstration goal. Quantitative data was compiled from various sources including administrative data, medical claims, and enrollment data.

[1] U.S. Department of Health & Human Services. (2020, January 31). *Determination that a Public Health Emergency Exists* [Press release]. https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx

Qualitative data was compiled from key informant interviews and captures provider, advocacy organization, State official, and Managed Care Entities (MCE) experiences and perspectives.

Due to the limited demonstration period (January 2020 to December 2020) and the impact of the ongoing PHE, CMS approved a revised scope for the evaluation which includes a restricted set of quantitative analyses. Consequently, and in accordance with the revised evaluation design scope, descriptive statistics (e.g., total recipients, average utilization) for selected Goals to describe ED utilization, the availability of crisis stabilization services in Indiana, and access to community-based services among Medicaid recipients with SMI were generated. **Exhibit 1.1** describes the adjusted scope of the SMI Waiver Evaluation approved by CMS.

Exhibit 1.1: Adjusted Scope of the SMI Waiver Evaluation Approved by CMS

Waiver 1115 Evaluation Scope	Adjusted Scope (May 27, 2020)
Respond to all research questions for each hypothesis, two key informant interviews (2020, 2021), perform statistical testing, do not perform cross-state comparisons	Address each hypothesis, but not each individual research question. Quantitative and qualitative analyses are limited to: • Key informant interviews conducted in 2021 • Targeted claims analysis for ED and community-based service utilization • Identification of crisis stabilization call centers, mobile crisis observation/assessment centers, coordinated community crisis response teams • No statistical testing or regression adjusted estimates will be developed • No cross-state comparisons

Data drawn during the initial demonstration year likely reflects the impact of COVID-19 related policy changes and activities, rather than the demonstration. As a result, the 2020 Summative Evaluation Report provides a snapshot of the initial demonstration year, documenting the demonstration goals and activities during 2020. Hence, information compiled for the relevant hypotheses will not draw conclusions about the impact of the demonstration.

Summative Evaluation Report Observations to Date

The §1115 waiver amendment is a crucial step for the State to reduce barriers to appropriate mental health services and shift services from less appropriate settings to hospitals and larger mental health facilities. With this waiver, the State has made a commitment to address gaps in care and enhance its existing behavioral health infrastructure. Consequently, many patients will be able to receive longer, more appropriate inpatient stays, aiding in achieving stabilization and increasing successful transitions back to their homes and communities. The impact of the waiver is expected to reduce the costs of ED visits associated with mental health conditions and psychiatric crises.

As a result of the PHE, many of the SMI demonstration activities were delayed, modified, or canceled. Additionally, emergency authorizations and policy modifications related to the PHE had broad impacts to care delivery including shifts in service delivery and utilization. For example, effective March 1, 2020 and through the duration of Indiana's PHE, an executive order authorized the Office of Medicaid Policy and Planning (OMPP) to expand the use of telehealth. These changes in policy led to a dramatic increase in the number of Medicaid claims billed for telehealth services.

Sociodemographics of the SMI Demonstration Population

The SMI demonstration target population had the following sociodemographic characteristics in 2020:

- Approximately half of SMI recipients had Medicaid Coverage for 9 months or more in a 12-month coverage year.
- 64.2% of the SMI demonstration target population were female.
- 25.7% of the SMI demonstration target population were between the ages of 31 and 40.
- 66.2% of the SMI demonstration target population were Caucasian, as compared to 11.2% Black, and 22.6% Other.
- 97.0% of the SMI demonstration target population identified as non-Hispanic versus 3.0% Hispanic.
- 76.0% of the SMI population live in metropolitan areas, followed by those (14.2%) living in a non-metropolitan area with an urban population of 2,500 to 19,999.
- 59.4% of the SMI demonstration target population were receiving the Healthy Indiana Plan (HIP) health-insurance program.

The distribution of age, gender, race, ethnicity, geographic location, and HIP enrollment of recipients with SMI has remained generally unchanged since 2018.

Summative Evaluation Report Observations By Goal

This section summarizes observations by demonstration goal. **Section VII** provides a more detailed description of these observations.

Goal 1: Reduced utilization and length of stay in EDs among Medicaid recipients with SMI while awaiting mental health treatment in specialized settings.

ED utilization rates for Medicaid recipients with SMI in January and February 2020 were comparable to rates during the same time in 2018 and 2019, however, utilization rates declined by 34% beginning in March and April 2020, coinciding with the start of PHE. Utilization rates continued to decrease through May and June and then began to rise in July. ED utilization rates were similar to national trends of in-person health care service utilization.[2,3] Findings were also consistent with provider observations, who described decreases in ED utilization during the early months of the pandemic and then noted a spike in ED utilization during the summer of 2020, especially for behavioral health related incidents (e.g., suicide; overdose).

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings.

Interviewees indicated that telehealth services, effective discharge planning, care coordination and patient follow-up are critical supporting factors in reducing preventable readmissions to acute care hospitals and residential settings.

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[2] Cox, C., Amin, K., Kamal, R. (2021, March 22). How have health spending and utilization changed during the coronavirus pandemic? Peterson-KFF Health System Tracker. Retrieved April 21, 2022, from https://www.healthsystemtracker.org/chart-collection/how-have-health care-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/

[3] Xu, S., Glenn, S., Sy, L., Qian, L., Hong, V., Ryan, D. S., & Jacobsen, S. (2021). Impact of the COVID-19 pandemic on Health Care Utilization in a large integrated health care system: Retrospective cohort study. *Journal of Medical Internet Research*, *23*(4). https://doi.org/10.2196/26558

- While interviewees noted differential population accessibility to telehealth services (i.e., technology availability for rural Indiana), most indicated that expanded telehealth services increased access to services for many which may in turn lead to reduced readmissions.
- Interviewees described the importance of effective discharge planning, care coordination and patient follow-up in reducing preventable readmissions. MCE representatives described the importance of strong relationships between inpatient and outpatient providers to address barriers prior to discharge to facilitate successful transitions, ensure that follow up appointments are completed and prevent readmissions. Interviewees described the role of care coordinators as critical in maintaining these relationships.

Goal 3: Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.

- Counts of crisis stabilization services among multiple service models were identified during the initial year of the demonstration and will be used in future demonstration years to assess improvements. Findings support the need for improvements in availability, particularly for rural areas of the state. Findings from the provider availability assessment indicate a limited number of crisis outreach and response services across the state with most services being crisis call centers. Both crisis call centers and mobile crisis units are equally distributed across urban and rural locations, while crisis observation/assessment centers and coordinated community crisis response teams are mostly located in urban areas.
    - The Division of Mental Health and Addiction (DMHA) supported two Community Mental Health Centers (CMHCs), with their Crisis Stabilization Units (CSU) pilots during 2020. Findings from the pilots informed planning for future crisis stabilization work including scope and scale of services and operational considerations like staffing requirements, model options, and provider needs.
    - While efforts to pilot Mobile Response Stabilization Services (MRSS) during 2020 were delayed due to the PHE, OMPP and DMHA continue to explore the expansion of mobile crisis services as part of a Medicaid State Plan Amendment (SPA). This amendment will enable mobile crisis teams to enroll as providers eligible to receive reimbursement directly by Indiana Medicaid.
    - Interviewees were optimistic about future CSU and MRSS implementation and spoke confidently about their ability to reduce utilization and ED LOS and readmissions among recipients with SMI while awaiting mental health treatment; however, interviewees noted that it will take close to two years to see meaningful change after implementation.

Goal 4: Increase access of recipients with SMI to community-based services to address their chronic mental health care needs including through increased integration of primary and behavioral health care.

Although the number of Medicaid recipients identified with SMI increased between 2018 and 2020, the participation rate for overall mental health-related community-based services (including Home and Community Base Services (HCBS), Long-Term Services and Supports (LTSS) and Outpatient Rehabilitation Services) decreased. Between 2018 and 2019 the participation rate for mental health-related community-based services declined by 12.7 percentage points (from 75.2 to 62.5%) and continued to decline an additional 13.5 percentage points between 2019 and 2020. Decreasing participation rates vary based on the race of recipients with Black recipients decreasing the most - from 79.6% to 46.8% between 2018 and 2020. Of the three community-based services, outpatient mental health service has

the highest participation rate, ranging from 73.9% in 2018 to 46.9% in 2020. LTSS/HCBS ranged from 7.5% in 2018 to 2.8% in 2020, and outpatient rehabilitation ranged from 37.0% in 2018 to 25.1% in 2020.

Goal 5: Improved care coordination, especially continuity of care in the community following episode of acute care in hospitals and residential treatment facilities.

Provider, advocacy organization, State official, and MCE interviewees identified several key barriers for improving integrated behavioral health care to address the needs of recipients with SMI including:

- Limited supply of qualified mental health providers
- Resource deficiencies
- Transportation limitations
- Provider engagement
- Gaps in telehealth service access
- Data sharing infrastructure

Interviewees indicated that increasing provider availability is foundational to any efforts to support coordination and integration with primary care. Interviewees also noted that the State issued order which allowed providers to authorize stays of up to seven days without a medical necessity review, resulted in patients being admitted without sufficient admission information. Interviewees described that without the appropriate patient information, discharge summaries lacked adequate information to support effective care coordination and increased the workload for care coordinators, limiting their utility.

Conclusions

Overall, availability and access to care and community-based services were identified as key areas for addressing the needs of recipients with SMI. Findings indicated that telehealth policy modifications and crisis stabilization services were critical in supporting recipients with SMI during the PHE. Although the expansion of telehealth was a positive development for increasing access to care, challenges associated with expanded telehealth and technology issues persisted and were amplified by the limited supply of qualified mental health providers.

Given the profound impact of the PHE on health care delivery, the likelihood of the PHE's confounding effect and the analytic limitations with program outcome measures, the 2020 Summative Evaluation does not draw conclusions about the impact of the SMI waiver demonstration on goal outcomes and instead provides a snapshot of the initial demonstration year. Future evaluation reports will include analytic methods to assess reductions or improvements in identified metrics.

II. General Background Information

Overview

A 2015 report to the Indiana General Assembly highlighted the need for expanded crisis services, access to inpatient psychiatric beds, and improved coordination for individuals transitioning from inpatient services back into the community. Specifically, the report cited survey results demonstrating Indiana's reliance on EDs to manage individuals in acute crisis and suggested a need for increased options for psychiatric crisis.[4]

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations in a budget neutral manner. In 2018, the FSSA received authority from the CMS to reimburse IMD for Medicaid-eligible individuals aged 21-64 years with SUD. In 2019, CMS offered new opportunities for states to receive authority to pay for short-term residential treatment services in an IMD for adults with SMI and children with serious emotional disturbance (SED). Indiana state leadership elected to focus waiver efforts on adults with SMI. The SED population was not pursued because for those 21 and under, Indiana Medicaid already paid for services if they were delivered in an IMD through the psychiatric residential treatment facility benefit for that age group (405 IAC 5-20-1).[5] Through this demonstration, Indiana will receive federal financial participation for services furnished to Medicaid recipients who are primarily receiving short-term treatment services for a SMI in facilities that meet the definition of an IMD.[6]

The FSSA §1115(a) demonstration waiver for adults with SMI was approved on December 20, 2019 and effective from January 1, 2020 through December 31, 2020. On October 26, 2020 CMS granted approval for a five-year waiver extension, permitting the waiver to remain in effect through December 31, 2025. Indiana's approved §1115 waiver STC requires an independent evaluation to assess the demonstration's ability to meet its intended goals. The State hired the Lewin Group (Lewin) to conduct the independent evaluation.[7] This report aims to provide a snapshot of the demonstration's initial year.

Exhibit 2.1: Indiana §1115(a) Demonstration

Name of Demonstration: SMI/SED Amendment Request for the HIP

Amendment Approval Date of Demonstration: December 20, 2019

Demonstration Period: January 1, 2020 - December 31, 2020

Demonstration Description

Indiana's publicly funded behavioral health (both mental health and addiction) system of care (SOC) supports access to prevention, early intervention, and recovery-oriented services and supports in all 92 counties, blending federal, state, and local funding streams to a provider network of agencies and individual practitioners. Indiana's FSSA and specifically its OMPP and DMHA partner to provide policy

4 DMHA distributed the Psychiatric and Addiction Crisis Survey in December 2014 and January 2015. Tailored surveys went out to respondent groups including mental health and addiction providers, hospital ED staff, first responders, consumer and family advocates, and probation and parole officers.

5 IAC stands for Indiana Administrative Code.

6 Reimbursement will not be extended to IMDs for residential stays; additionally, state mental health hospitals will not be classified as IMDs eligible for reimbursement under this waiver. Facilities with more than 16 beds that are certified as Private Mental Health Institution (PMHI) by the DMHA qualify as IMDs under this waiver.

7 The Lewin Group is part of Optum Serve Consulting.

oversight and primary funding of services and supports for individuals in need of behavioral health services. OMPP includes a robust continuum of behavioral health services as a benefit to enrollees in its fee-for-service and Medicaid managed care programs. DMHA leverages its block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and state appropriations to complement the Medicaid service array, with a focus on serving adults with SMI, youth with SED, and individuals with SUD of any age, and who are at or below 200% of the federal poverty level (FPL). OMPP and DMHA also partner with the Department of Child Services (DCS) and the Department of Corrections (DOC) in supporting access to and oversight of behavioral services for Indiana's most vulnerable Hoosiers.

As part of the waiver amendment application Indiana described its current behavioral health SOC, highlighting a sizeable provider network of behavioral health providers including hospitals, psychiatric residential treatment facilities (PRTF), SUD residential providers, and community-based agencies (e.g., CMHCs) and individual practitioners. Information specific to the State's current service continuum was also delineated. Refer to **Attachment I** for a complete description of Indiana's current behavioral health SOC.

Demonstration Goals. Indiana's goals are aligned with those of CMS for the demonstration waiver and are part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services. Demonstration goals include:

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

State Strategies for Addressing Waiver Milestones

Current Oversight of IMDs

To operate in the State of Indiana, all free-standing psychiatric hospitals must be licensed as a private mental health institution (PMHI) by DMHA. 440 IAC 1.5 currently requires PMHIs to be accredited by an accrediting body approved by the Division. This list only includes accrediting agencies also approved by CMS for deeming authority for Medicare requirements under 42 CFR 488.5 or 42 CFR 488.6.[8] PMHI licensure must be renewed annually. DMHA conducts annual visits to ensure requirements are being met. Prior authorization is currently required for inpatient psychiatric care under both managed care and for fee for service enrollees, and, with the implementation of the State's SMI demonstration, includes IMD admissions as well. There are currently 30 freestanding psychiatric hospitals licensed in the State of Indiana with a capacity of 1,222 beds. Only 19 of the 30 PMHIs have more than 16 beds. DMHA is in the process of reviewing the IAC related to PMHIs with attention to quality assurance and

[8] CFR stands for Code of Federal Regulations.

monitoring for these providers based on the most recent cycle of onsite reviews and compliance with the goals and milestones under Indiana's current §1115 SMI waiver authority.

Improving Integration and Care Coordination, Including Transitions to Community Based Care

Indiana has several initiatives, leveraging different authorities outside the §1115(a) waiver, to promote and expand care coordination and integrated delivery of behavioral health and primary care. These efforts focus on both youth with SED and adults with SMI and include cross-collaboration with Indiana's DMHA and Department of Health (IDOH).

Indiana's Primary Care and Behavioral Health Integration

FSSA in partnership with IDOH launched an initiative in 2012 to develop a statewide strategic plan to integrate primary and behavioral health care services in Indiana. Indiana's Primary Care and Behavioral Health Integration (PCBHI) efforts include the formation of a statewide stakeholder group, formalized definition for integration for Indiana, and the original creation of five subcommittees that spearheaded research and collaboration in the following areas that support integrated care:

- Data/Technology
- Education/Training
- Funding/Reimbursement
- Health Homes/Care Coordination
- Policy Development

In addition, FSSA applied for and was awarded the SAMHSA and National Association of State Mental Health Program Directors (NASMHPD) Transformation Transfer Initiative (TTI) Grant which allowed Indiana to complete the following initiatives toward integration:

- Eight integration educational training events in 2013
- Completion of a statewide integration survey
- Cross-training opportunities for Community Health Workers (CHW) and Certified Recovery Specialists
- Creation of an established process for state approved integrated care CHW certification
- Creation of established PCBHI Guiding Principles

FSSA and IDOH established a process by which CMHCs, Federally Qualified Health Centers (FQHC), Community Health Centers (CHC), and Rural Health Clinics (RHC) could become a state-certified, integrated care entity (ICE). ICE providers are required to provide care coordination that includes partnering with physicians, nurses, social workers, discharge planners, pharmacists, representatives in the education system, representatives of the legal system, representatives of the criminal justice system and others during any transition of care. The goals of this coordination include reducing unnecessary inpatient and emergency room use and increasing consumer and family members' ability to manage their own care and live safely in the community.

Behavioral and Primary Health Care Coordination Service Program

Conceived under a separate §1915(i) SPA, the Behavioral and Primary Health care Coordination (BPHC) program offers a service that consists of the coordination of health care services to manage the mental health/addiction and physical health care needs of eligible recipients. This includes logistical support,

advocacy and education to assist individuals in navigating the health care system, and activities that help recipients gain access necessary to manage their physical and behavioral health conditions.

BPHC service activities may include support in adhering to health regimens, scheduling and keeping medical appointments, obtaining and maintaining a primary medical provider, and facilitating communication across providers. In addition, BPHC includes direct assistance in gaining access to services; coordination of care within and across systems; oversight of the entire case; linkage to appropriate services; needs-based assessment of the eligible recipient to identify service needs; development of an individualized integrated care plan (IICP); referral and related activities to help the recipient obtain needed services; monitoring and follow-up; and evaluation.

Child Mental Health Wraparound Services

The §1915(i) Child Mental Health Wraparound (CMHW) Services Program is authorized through Medicaid state plan authority. The §1915(i) CMHW Services are outlined in 405 IAC 5- 21.7. CMHW services provide youth with SED with intensive home and community-based wraparound services provided within a SOC philosophy and consistent with wraparound principles. Services are intended to augment the youth's existing or recommended behavioral health treatment plan. The State's purpose for providing CMHW services is to serve eligible participants who have SED and enable them to benefit from receiving intensive wraparound services within their home and community with natural family/caregiver supports and provided sustainability of these services, which were originally offered under the CMS Community Alternatives to PRTF (CA-PRTF) demonstration. Under the demonstration, Indiana was able to provide a quicker and more seamless transition of youth from PRTF placement as well as prevent some youth from placement within a PRTF setting. The CMHW services available to the eligible participant include wraparound facilitation, habilitation, respite care, and training and support for the unpaid caregiver.

Increasing Access to Continuum of Care Including Crisis Stabilization Services

On March 18, 2019, CMS approved a SPA that expands crisis intervention services, intensive outpatient program services, and peer recovery services to all Indiana Medicaid programs. Previously, these services were limited to the Medicaid Rehabilitation Option (MRO) program. This change expands the potential number of providers eligible to deliver these services to Indiana enrollees. This SPA became effective July 1, 2019.

This expansion of the crisis continuum began in 2014. DMHA partnered with the National Alliance on Mental Illness of Indiana (NAMI Indiana), Mental Health America of Indiana (MHAI), the Indiana Hospital Association (IHA), Key Consumer, and the Indiana Council on CMHCs (ICCMHC) to conduct a review of Indiana's mental health and substance use crisis services. The review was in response to Indiana Senate Enrolled Act No. 248 of 2014, which mandated DMHA to conduct a psychiatric crisis intervention study ("crisis study") and report the results to the legislative council by September 2015. The crisis study included a review of psychiatric and addiction crisis services available in Indiana, a survey of professionals and individuals in Indiana who have experience with the current state of Indiana's crisis response, and a review of crisis services and models implemented by other states that could improve outcomes for individuals who experience psychiatric or addiction crises.

In response to recommendations from the report, DMHA supported two CMHCs, Centerstone Indiana and Four County, with their CSU pilots during 2020. The goals for these units are to provide an alternative to crisis evaluations within EDs and divert admissions to inpatient psychiatric units. Findings from the pilots informed planning for future crisis stabilization work including scope and scale of

services and operational considerations (e.g., staffing requirements, model options and provider needs). Additionally, OMPP and DMHA are working to increase access to care through expanded mobile crisis services. Mobile crisis response teams consist of a multidisciplinary team of trained providers who arrive and respond to behavioral health crises in the community within 60 minutes, operating 24 hours, 7 days a week. The purpose of a mobile crisis response team is to divert individuals in crisis away from hospitals, EDs, and jails to effectively eliminate the overuse and misuse of these services as well as to better service individuals in crisis and prevent fatalities from suicide, drug overdose, and other mental health and substance use emergencies. Mobile crisis response teams are intended to be immediate and short term. Crisis response teams utilize evidence-based practices to screen, assess, stabilize, and refer persons in need to CSUs, inpatient hospitals, certified respite facilities, or an individual's established provider. DMHA and OMPP will pursue a Medicaid SPA to incorporate mobile crisis teams as enrolled providers eligible to receive reimbursement directly by Indiana Medicaid in 2022.

Additionally, in accordance with 440 IAC 9-2-2, all CMHCs must provide 24/7 crisis intervention services which meet the following minimum requirements:

- Operation and promotion of a toll-free or local call crisis telephone number staffed by individual(s) trained to recognize emergencies and refer calls to the appropriate clinician or program.
- When a determination is made by the crisis telephone line that a clinician needs to be involved, a trained clinician is available to reach the consumer by telephone within 15 minutes.
- When the assessment indicates a face-to-face meeting between the clinician and consumer is necessary, an accessible safe place is available within 60 minutes driving distance of any part of the CMHC's service area, with a transportation plan for consumers without their own mode of transportation to be able to access the safe place.
- Participation in a quality assurance/quality improvement system that includes a review of individual cases and identification and resolution of systemic issues including review by supervisory or management level staff for appropriateness of disposition for each crisis case.

Some of the State's CMHCs are providing the following additional crisis services:

- Mobile crisis teams
- Assertive community treatment (ACT)
- 23-hour CSUs
- Short-term crisis residential
- Peer crisis services

Additionally, Hoosier Care Connect MCEs, who serve the State's aged, blind, and disabled Medicaid population are contractually required to ensure the availability of behavioral health crisis intervention services 24/7.

Earlier Identification and Engagement in Treatment

Indiana has expanded coverage for mental health screening, SUD screening, and referral under Medicaid. In 2014, OMPP expanded provider types eligible for reimbursement of screening and brief intervention for SUD to include mid-level licensed individuals under the supervision of a physician, including nurse practitioners (NP), health service providers in psychology (HSPP), licensed clinical social workers (LCSW), licensed mental health counselors (LMHC), and licensed marriage and family therapists (LMFT). In October 2016, OMPP began coverage for annual depression screening. Providers are expected to use validated

standardized tests for the screening. These tests include, but are not limited to, the Patient Health Questionnaire (PHQ), Beck Depression Inventory, Geriatric Depression Scale, and Edinburgh Postnatal Depression Scale (EPDS). Coverage applies to all Indiana Health Coverage programs (IHCP) under Medicaid. The State has also focused on school-based initiatives to increase behavioral health integration. Indiana Medicaid allows enrolled school corporations reimbursement for Medicaid-covered services in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Medicaid-covered IEP services include occupational, physical, speech and applied behavior analysis therapy, hearing, nursing and behavioral health evaluation and treatment services as well as IEP-required specialized transportation. In addition, CMHCs across the state work in close collaboration with Indiana schools and school districts have memorandums of understanding (MOUs) with local CMHCs for the provision of behavioral health services. Through these partnerships behavioral health staff are co-located within the schools and providing behavioral health services to youth and their families.

Additional Strategies

In addition to the latter State strategies, Indiana also highlighted the following strategies for achieving the demonstration goals as part of their implementation plan. Strategies include:

- Develop a standardized report to monitor the average length of stay (ALOS) for the entire Medicaid program
- Update the Medicaid Provider Manual to explicitly require psychiatric hospitals to have protocols in place to:
    - Assess for housing insecurity
    - Ensure contact is made by the treatment setting with each discharge beneficiary within 72 hours of discharge
- Expand the use of bed-tracking applications or platforms to include tracking of psychiatric inpatient and crisis stabilization beds
- Identify geographic shortage areas (annually) and conduct targeted outreach to non-Medicaid enrolled providers in those areas
- Pilot two CSUs
- Expand the State's model for PCBHI

The Impact of Coronavirus disease 2019 Public Health Emergency

The initial year of the demonstration period (2020) coincided with the COVID-19 PHE, which was declared on behalf of the entire United States in January 2020.[9] The ongoing PHE caused substantial changes to Medicaid policies, service utilization and provider availability, and will have short- and long-term impacts on Indiana's health care system and specialized populations, such as SMI. Given the timing of the PHE, the State shifted many of the planned implementation activities to accommodate access to and delivery of high-quality mental health services for all Indiana residents, particularly given the social distancing and health care resource prioritization required in response to the PHE. Subsequently, data drawn during this time-period (2020) likely reflects the impact of COVID-19 related policy changes and activities, rather than the demonstration. As a result, the 2020 Summative Evaluation Report provides a snapshot of the initial demonstration year, documenting the current state (2020) of the demonstration

[9] U.S. Department of Health & Human Services. (2020, January 31). *Determination that a Public Health Emergency Exists* [Press release]. https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx

goals and activities. Hence, information compiled for the relevant hypotheses will not draw conclusions about the impact of the demonstration.

Evaluation Population

This waiver includes all Medicaid recipients aged 21-64 years with a relevant SMI diagnosis, regardless of the delivery system. All enrollees continued to receive services through their delivery system and payment methodologies were consistent with those approved in the Medicaid State Plan.

Demonstration Eligibility: Individuals apply for Medicaid services through the Division of Family Resources, which determines eligibility for IHCP. If an individual is determined eligible, recipients will have access to high quality, evidence-based mental health treatment services under this demonstration. All enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and aged 21-64 years, would be eligible for acute inpatients stays in an IMD under the waiver. The eligibility groups outlined in **Exhibit 2.2** below are not eligible for stays in an IMD as they receive limited Medicaid benefits only.

Exhibit 2.2: Eligibility Groups Excluded from the Demonstration

Eligibility Group Name	Social Security Act & CFR Citation
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(10)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning	1902(a)(10)(A)(ii)(XXI)

III. Evaluation Questions and Hypotheses

This section provides the hypotheses and corresponding research questions (RQs) for each of the goals. The content aligns with the evaluation design guidance provided by CMS but is specific to Indiana's waiver demonstration which only included the SMI population.[10] Since the scope of the summative report was limited to a single year of the demonstration and overlapped with the start of the ongoing PHE, the analytic approach was designed to be descriptive in nature and aims to provide the state of service utilization, service type (e.g., crisis stabilization, community-based services), and care coordination for SMI Medicaid recipients during 2020. (See **Section IV** for additional details). We maintained the evaluation hypotheses and RQs as included in the evaluation plan and will identify within the results **Section V** the degree to which the hypotheses and RQs were analyzed.

Goal 1: Reduced utilization and length of stay in EDs among Medicaid recipients with SMI while awaiting mental health treatment in specialized settings.

The evaluation explores the impact of expanding access to high-quality, evidence-based mental health treatment services in IMDs for individuals with SMI conditions. Impact is measured by examining utilization and LOS in EDs among Medicaid recipients with SMI awaiting mental health treatment in specialized settings. Since the scope of the summative report is limited to the first year of the demonstration, findings will provide ED utilization and participation rates during 2020. **Exhibit 3.1** lists the hypothesis and RQs corresponding to this goal.

Exhibit 3.1: Hypothesis and Research Questions for Goal 1

Hypotheses	Research Questions
Hypothesis 1: The SMI demonstrations will result in reductions in utilization and LOS in EDs among Medicaid recipients with SMI while awaiting mental health treatment.	**Primary research question 1.1:** Does the SMI demonstration result in reductions in utilization and LOS in EDs among Medicaid recipients with SMI while awaiting mental health treatment? **Subsidiary research question 1.1a:** How do the SMI demonstration effects on reducing utilization and LOS in EDs among Medicaid recipients with SMI vary by geographic area or beneficiary characteristics? **Subsidiary research question 1.1b:** How do SMI demonstration activities contribute to reductions in utilization and LOS in EDs among Medicaid recipients with SMI while awaiting mental health treatment in specialized settings?

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings.

The evaluation explores the impact of expanding access to high-quality, evidence-based mental health treatment services in IMDs on reductions to preventable readmissions to acute care hospitals and residential settings. **Exhibit 3.2** lists the hypothesis and RQs corresponding to this goal.

[10] CMS SMI and SUD Evaluation Design Guidance: Attachment I. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-eval-guide-appendix-a.pdf

Exhibit 3.2: Hypothesis and Research Questions for Goal 2

Hypotheses	Research Questions
Hypothesis 2: The SMI demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	**Primary research question 2:** Does the SMI demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings (including, short-term inpatient and residential admissions to both IMDs and non-IMD acute care hospitals, critical access hospitals, and residential settings)? **Subsidiary research question 2.1:** How do the SMI demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics? **Subsidiary research question 2.2:** How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? **Subsidiary research question 2.3:** Does the SMI demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric hospital and residential setting stays and increased treatment for such conditions after discharge?

Goal 3: Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.

Since the scope of the summative report is limited to the first year of the demonstration, findings will provide an initial assessment and description of crisis stabilization services utilized across multiple service models. **Exhibit 3.3** lists the hypothesis and RQs corresponding to this goal.

Exhibit 3.3: Hypothesis and Research Questions for Goal 3

Hypotheses	Research Questions
Hypothesis 3: The SMI demonstration will result in improved availability of crisis stabilization services throughout the state.	**Primary research question 3.1:** To what extent does the SMI demonstration result in improved availability of crisis outreach and response services (including crisis call centers, mobile crisis units, crisis observation/assessment centers, and coordinated community crisis response teams) throughout the state? **Primary research question 3.2:** To what extent does the SMI demonstration result in improved availability of intensive outpatient services and partial hospitalization? **Primary research question 3.3:** To what extent does the SMI demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals; residential treatment facilities; general hospital psychiatric units; and community-based settings (such as residential crisis stabilization programs, small inpatient units in CHMCs, peer-run crisis respite programs)?

Goal 4: Improved access to community-based services to address the chronic mental health care needs of recipients with SMI including increased integration of primary and behavioral health care.

Since the scope of the summative report is limited to the first year of the demonstration, assessment is limited to describing access to community-based services which address the chronic mental health care needs of recipients with SMI. **Exhibit 3.4** lists the hypothesis and RQs corresponding to this goal.

Exhibit 3.4: Hypothesis and Research Questions for Goal 4[11]

Hypotheses	Research Questions
Hypothesis 4: Access of recipients with SMI to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	**Primary research question 4.1:** Does the demonstration result in improved access of recipients with SMI to community-based services to address their chronic mental health care needs? **Subsidiary research question 4.1a:** To what extent does the demonstration result in improved availability of specific types of community-based services needed to comprehensively address the chronic needs of recipients with SMI? **Subsidiary research question 4.1b:** To what extent does the demonstration result in improved access of SMI recipients to the specific types of community-based services that they need? **Primary research question 4.2:** Does the integration of primary and behavioral health care to address the chronic mental health care needs of recipients with SMI increase under the demonstration?

Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Since the scope of the summative report is limited to the first year of the demonstration, assessment is limited to describing care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. **Exhibit 3.5** lists the hypothesis and RQs corresponding to this goal.

Exhibit 3.5: Hypotheses and Research Questions for Goal 5[12]

Hypotheses	Research Questions
Hypothesis 5: The SMI demonstrations will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Primary research question 5.1:** Does the SMI demonstration result in improved care coordination for recipients with SMI? **Primary research question 5.2:** Does the SMI demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? **Primary research question 5.2b:** How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?

Impact of Demonstration on Health Care Spending

Due to the scope of the 2020 Demonstration as well as the pause of many demonstration activities in response to the COVID-19 pandemic during the waiver period, no separate cost analyses were performed. Milliman Inc. (the State's actuary) conducts budget neutrality assessments as part of the SMI monitoring protocol. These assessments include cost analyses to assess whether the SMI demonstration results in higher, lower, or neutral health care spending. Findings are submitted on a quarterly basis to CMS. A more robust cost analysis that adheres to CMS guidance will be conducted for a future evaluation (covers demonstration approval period: 2021 -2025).

[11] Indiana §1115(a) SMI Demonstration Evaluation Plan. Approved by CMS December 17, 2020.

[12] Indiana is not including Subsidiary Research Question 5.2a: "Does the SMI/SED demonstration result in improved discharge planning and outcomes regarding housing for recipients transitioning out of acute psychiatric care in hospitals and Residential treatment facilities?" This is because this Evaluation Plan is limited to one year of analysis and the level of effort involved in obtaining and reviewing facility records, and facility discharge records, is substantial considering the scope of this evaluation and State resources.

IV. Methodology

Evaluation of the program goals were based on a mixed-methods approach employing quantitative and qualitative analyses to provide a snapshot of 2020 by demonstration goal. Quantitative data was compiled from various sources including administrative data, medical claims / encounter, and Medicaid enrollment data. Qualitative data was compiled from key informant interviews and captures provider, advocacy organization, State official, and MCE experiences and perspectives.

Due to the limited demonstration period (January 2020 to December 2020) and the impact of the ongoing PHE (starting from March 2020), CMS approved a revised scope (See **Exhibit 1.1**) for the evaluation which includes a restricted set of quantitative analyses.[13] Consequently, and in accordance with the revised evaluation design scope, we generated descriptive statistics (e.g., total recipients, average utilization) for selected Goals to describe ED utilization, the availability of crisis stabilization services in Indiana, and access to community-based services among Medicaid recipients with SMI.

Quantitative Methods

For quantitative analyses, Lewin used data from three sources to evaluate the demonstration policy goals identified in **Section III**:

- *Member Eligibility and Enrollment Data:* This data provides monthly information on recipient Medicaid enrollment status, coverage, socio-demography.
- *Claims / Encounter Data:* The claims/encounter records provide information about the health care utilization of recipients and enrolled providers that are actively providing services.
- *Administrative Data:* Program administrative data included items such as the number of FQHCs that offer behavioral health services and the number of enrolled Medicaid providers of various types.[14]

Exhibit 4.1 provides a summary of quantitative data sources and target population by goal. Analyses using enrollment, claims, and encounter data was restricted from 2018 to 2020. Inclusion of data from the pre-demonstration period (2018 and 2019) allowed for a holistic understanding of changes in the measures of interest across time leading up to implementation and appropriate interpretation of differences between time periods. Administrative data associated with services implemented due to the waiver was restricted to 2020 (demonstration period).

[13] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-cms-appvd-smi-eval-des-12162020.pdf

[14] As required by CMS, the State completed a brief availability assessment describing the current state of provider availability in May 2020. The State used findings from a survey of providers certified by DMHA to complete the availability assessment. Lewin used data from this source to assess improved availability of crisis stabilization services (Goal 3) including counts for the number of crisis call centers, mobile crisis units, crisis observation/assessment centers, coordinated community crisis response teams.

Exhibit 4.1: Summary of Quantitative Data Sources and Populations by Goal

Goal	Populations Used for Analysis	General Analytic Approach	Data Sources
Goal 1: Reduced ED Length of stay	SMI Population	• Calculated utilization rate as the count of services (or visits) per 1,000 member years. This measurement approach reflects the frequency at which recipients access the service regardless of their length of enrollment. Only one ED visit per day is counted per recipient. The metric was calculated for yearly as well as for selected recipient cohorts. • Recipient cohorts: gender, age group, race, metro/non-metro, and whether the member is enrolled in a HIP or non-HIP program at the time of the ED visit.	Claims data - ED visits were identified using procedure codes or revenue codes – 2018-2020 **Attachment II** provides a complete list of specifications.
Goal 3: Improved availability of crisis stabilization services	Providers certified by DMHA	• The number of crisis call centers, mobile crisis units, crisis observation/assessment centers, coordinated community crisis response teams	State administrative data – Provider Availability Assessment – May 2020
Goal 4: Improved access to community based-services	SMI Population	• Calculated the number and percentage of eligible FSSA recipients who received a service in any of four categories: ○ MRO services, ○ HCBS, ○ LTSS, and ○ Outpatient mental health services. The metric was calculated for yearly as well as for selected recipient cohorts. • Recipient cohorts: gender, age group, race, metro/non-metro, and whether the member is enrolled in a HIP or non-HIP program at the time of the ED visit.	Outpatient and professional fee schedules used at FSSA – 2018-2020 Waiver program codes were used to identify the services eligible for Outpatient Rehabilitation Option and home and community-based services waiver programs **Attachment III** provides a complete list of specifications.

Developing SMI Registry (Target Population for Evaluation)

The target population for analyses was all Medicaid recipients covered by IHCP aged 21- 64 years with SMI regardless of their delivery system (e.g., managed care or fee-for-service). Based on the target population definition Lewin used the criteria listed below to identify recipients for the evaluation (referred hereto as SMI Registry).[15]

- Had at least one claim (any service utilization) with a service begin date occurring between January, 2018 and December, 2020 and having any one of the four diagnosis codes in the primary or secondary diagnosis position: F20.xx (Schizophrenia and sub codes up to 2 places), F25.xx (schizoaffective disorder and sub codes up to two places), F31.xx (Bipolar and all sub codes up to 2 places), and F33.xx (Major depression Recurrent and all sub codes up to two places).

[15] CMS has different criteria for defining the SMI population for monitoring report measures calculation. The CMS criteria provides a more stringent definition of the study population. **Attachment IV** provides a summary of findings using the CMS criteria and summarizes differences between the two populations.

- Had SMI waiver eligible Medicaid coverage during the service utilization (populations excluded are listed in **Exhibit 2.2**).

Recipients were identified for inclusion in the SMI Registry based on their first date of service received during the month with appropriate Medicaid benefit coverage containing an SMI diagnosis between 2018 and 2020. Once included in the registry, the recipient remained in the SMI registry through the end of the evaluation period (as long as the recipient received Medicaid coverage in relevant year) regardless of whether they had any additional services with an SMI diagnosis. Subsequently, the registry grew between 2018 – 2020 as a result of adding recipients that met the SMI claim diagnosis criteria over time. Hence, growth between 2018 – 2020 is an artifact of the registry construction rather than a result of an increasing SMI population. The registry does not include Medicaid recipients who had an SMI diagnosis prior to 2018 but no diagnosis in the three-year analytic time period (2018 – 2020). As the primary objective of this evaluation is to evaluate the SMI demonstration which covers 2020, a look back of two years was deemed appropriate to identify potential recipients with SMI who could be accessing the services provided by the demonstration.

Measure Development for Goal 1 and Goal 4

Lewin used claims related to services in months with eligible Medicaid coverage for individuals identified in the SMI Registry to develop utilization-based outcome measures. For Goal 1, we developed the ED visits per 1,000-member year to examine the ED utilization pattern in 2020 relative to the prior two years (pre-demonstration implementation). For Goal 4, we calculated the proportion of SMI recipients who received community-based services: MRO, HCBS, LTSS, and outpatient mental health services. Detailed specifications of both these measures are available in **Attachment II and III**.

Measure Calculation for Goal 1 and Goal 4

All-cause ED and community-based service utilization metrics (utilization rate and participation rate) were calculated for the overall SMI population and several demographic subgroups. The utilization rate metric (unadjusted for any recipient characteristics) conveys the frequency of a particular populations use of the services (utilization rate) while the participation metric calculates the percent of the population using these services (participation rate).

- *The participation rate* is the proportion of SMI recipients receiving a specific service at least once in the year. For example, of the 138,027 recipients with SMI in 2020, 65,751 recipients had an ED visit during the year, resulting in a participation rate of 48%. This metric only reflects that a recipient participated in a service; it does not reflect the frequency of service use.
- *The utilization rate* is the count of services or visits per 1,000 recipient years, which reflects the frequency at which recipients access the service regardless of their length of enrollment. For example, the ED utilization rate for recipients with SMI decreased from 2,081 visits per 1,000 recipient years in 2018 to 2,035 visits per 1,000 recipient years in 2019. This indicates that recipients with SMI were utilizing ED services less frequently in 2019 than in 2018.

The use of "recipient years" in the utilization rate reflects the number of services used per 1,000 recipients during a year and reflects the number of months of enrollment by recipients. The formula for the utilization rate is:

$$\frac{\#\ of\ services\ or\ visits\ per\ year}{member\ months}\ x\ 1{,}000\ x\ 12\ months$$

While the formula uses recipient months, a recipient year is a more tangible concept for the reader to understand and is a commonly used concept in health care utilization metrics.

Analytic Methods

Descriptive statistics (e.g., utilization rates, percent of recipients utilization services) were calculated to summarize the characteristics of Medicaid recipients with SMI across time as well as observational inference on trends. In addition to utilization over time, we calculated the measures by selected cohorts of interest to examine patterns over time: gender, age, race, metro/non-metro classification, and whether the recipients were in HIP or non-HIP programs.[16] No inferential statistics including case-mix adjusted estimates were developed for this evaluation.

Qualitative Methods

Between August and October 2021, Lewin conducted 19 key informant interviews: with FSSA officials (n=2), MCEs (n=4), advocacy organizations (n=3) and providers (n=10). **Exhibit 4.2** provides a brief description of the respondents, interview topics, and relevant goals addressed. Key informant interviews were conducted via telephone and lasted 30-60 minutes.

Lewin worked with the Indiana FSSA evaluation contract officer and support team to identify appropriate interviewees for each interview type. Each interview included one facilitator and one note taker. Prior to the interview, the interviewer requested permission to record the conversation to facilitate note taking. Findings were reported in aggregate by interview type.

Exhibit 4.2: Summary of Qualitative Data Sources

Interview Type	Description	Relevant Goals
FSSA State Officials Total: 2 interviews	• The Indiana FSSA evaluation contract officer identified State interviewees representing several roles within FSSA including officials involved in the development, planning, and administration of the SMI waiver demonstration. • Interviews lasted approximately 60 minutes. • Some interview questions were specific to each official's role. Common questions across officials covered the following topics: waiver implementation, impact of PHE, activities identified as most relevant to SMI waiver goals, challenges and successes with SMI waiver, reporting requirements and changes to data systems.	Goal 1 Goal 2 Goal 3 Goal 4 Goal 5
MCEs *Total: 4*	• The Indiana FSSA evaluation contract officer identified MCE interviewees. Interviews included executives and providers from each of the four MCEs. • Interviews lasted approximately 60 minutes. • Lewin asked MCE representatives a standardized set of questions related to experience with SMI waiver implementation, activities identified as most relevant to SMI waiver goals, impact of PHE, challenges and success with SMI waiver.	Goal 2 Goal 3 Goal 4 Goal 5

[16] HIP provides Medicaid health insurance coverage for qualified low-income, non-disabled adults ages 19 to 64. Close to 70% of Indiana Medicaid recipients ages 19-64 have coverage thru HIP (Source: https://www.in.gov/fssa/ompp/files/IHCP-Monthly-Enrollment-Report-Dec-2020.xlsx, Accessed on 03/11/2022).

Interview Type	Description	Relevant Goals
Providers *Total: 10*	• Lewin worked with the Indiana FSSA evaluation contract officer to identify provider representatives from a variety of settings including EDs, CMHCs, CSUs, and MRSS. • Interviews lasted approximately 30 minutes. • Providers included representatives from two EDs, three CMHCs, three CSUs and two MRSS. • Lewin asked providers a standardized set of questions related to strategies identified as most relevant to SMI waiver goals, impact of PHE, challenges and success with SMI waiver.	Goal 1 Goal 2 Goal 3 Goal 4 Goal 5
Advocacy Organizations *Total: 3*	• The Indiana FSSA evaluation contract officer identified MCE interviewees. Interviews included executive directors and managers from 3 advocacy organizations. • Interviews lasted approximately 30 minutes. • The Lewin team asked advocacy organization representatives a standardized set of questions related their experience with the SMI waiver including impact of the PHE and challenges and supporting factors for achieving the waiver goals.	Goal 2 Goal 3 Goal 4 Goal 5

Analysis was conducted iteratively, with team members reviewing data following each interview and using immediate findings to inform subsequent interviews. For example, if one MCE identified a novel challenge or issue, the facilitator would include additional probes for subsequent interviews to better understand the topic. Lewin used informal thematic analysis (TA) to identify themes from interviews and summarize findings by topic area. TA is a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across different interviewees.

V. Methodological Limitations

Exhibit 5.1 describes the known limitations of the evaluation for the Summative Evaluation Report and approaches used to minimize those limitations and/or acknowledgment of where limitations may preclude causal inferences about the effects of demonstration policies. The SMI Evaluation Plan used to develop this report (approved by CMS in December 2020) describes the limitations of the overall evaluation including data and methodological challenges of the analyses for subsequent reports.

The PHE, which started in March 2020, caused substantial changes to service utilization and provider availability in 2020, and will have short- and long-term impacts on Indiana's health care system. For example, due to the PHE, the State suspended policies regarding disenrollment of recipients and expanded behavioral health telehealth services.[17] Social distancing and prioritization of health care resources affected utilization of a wide variety of services during the evaluation period. Given that the program outcome measures use 2020 data only (demonstration period) and the likelihood of the PHE's significant confounding effect, the 2020 Summative Evaluation does not draw conclusions about the impact of the demonstration.

Exhibit 5.1: Summary of Summative Evaluation Report Methodological Limitations and Approach(es) Used to Minimize Limitations

Limitation	Description	Approach to Minimizing Limitations
Impact of COVID-19	The ongoing COVID-19 PHE, which started from March 2020, impacts: • Service utilization • Medicaid enrollment • Provider networks	• Provided context for interpretation of results.
Distinguishing the impacts of overlapping initiatives	Multiple policy changes were implemented concurrent to the evaluation period. As such, distinguishing the impacts of the individual initiatives becomes challenging. In addition to policies related to the PHE, non-waiver operational items have overlapping impacts, for example: • Preparation for the new 988 initiative which aims to increase coordination, capacity, funding regarding crisis intervention services	• Provided context for interpretation of results.
Self-reported qualitative data	Key informant interviews represent qualitative feedback from multiple stakeholders including State officials, MCE executives, providers and advocacy organizations. This self-reported information requires participants to recall information at a point in time (Dec-Jan 2020) and may not capture all experiences.	• Included recruitment and communication materials that emphasized the time period of interest (Dec-Jan 2020) to prepare interviewees for questions. • Tailored interview questions based on role and type of interview.
Provider response to outreach efforts	Reliability of provider contact information and provider availability made completing provider key informant interviews challenging for some interview types. For example, the evaluation team intended to include Peer Counselors within the provider interview series but were not able to connect with any of the three individuals identified.	• Included questions regarding the role of Peer Counselor in other provider interviews. • Ensured that the providers interviewed were able to speak to topics related to patient care and experience.
Impact of changes in population over time	Changes in the SMI recipient composition over time may have an impact on a variety of areas of this evaluation, including service utilization, member enrollment, and access to services.	• Provided context for interpretation of results.

[17] These policies were suspended March 17, 2020. Based on information available as of June 29, 2020.

VI. Results

The initial year of the demonstration period (2020) coincided with the PHE (which began in March 2020, refer to **Section II** for more detailed discussion). To address the ongoing PHE the State prioritized strategies which support broad access to mental health treatment and resources during this unprecedented time. In this effort, the State implemented substantial changes to Medicaid policies to support service utilization and provider availability. Given the multiple PHE-related changes to the health system and significant care delivery limitations related to social distancing and resources prioritization, the State shifted many planned demonstration activities. Due to the limited demonstration period (January 2020 to December 2020) and the restricted number of demonstration activities implemented, the State proposed a revised evaluation scope which focused on establishing a snapshot of the SMI population in 2020 as well as the behavioral health care initiatives relevant to the demonstration's goals. CMS approved the revised scope (See **Exhibit 1.1**) which restricted quantitative analyses and reflected a design that was descriptive in nature (See **Section IV**).[18]

Demonstration Activity Status During 2020

The SMI demonstration aligns with FSSA's aim to ensure a comprehensive continuum of behavioral health services. In this effort, the evaluation was designed to assess the impact of five overarching and interrelated goals (See **Section III**). Demonstration goals focus on reducing ED utilization and preventing inpatient readmission for SMI populations (Goals 1 and 2) by expanding crisis stabilization services, increasing access to community-based mental health services, and improving care coordination with special emphasis on continuity of care in the community (Goals 3, 4, and 5). Each goal is linked to key demonstration activities (See **Exhibit 6.1**) that the State planned to implement, beginning in January 2020 (prior to the PHE). Given the interdependence of goals, activities across goals overlap, and are not mutually exclusive. For example, Goal 1: Reducing ED utilization and length of stay shares four activities (e.g., Expanding use of bed tracking data platform; Increasing Network capacity; Pilot CSUs; Pilot MRSS) with Goal 3: Improved Availability of Crisis Stabilization Services.

Exhibit 6.1 describes each activity documented in the State's SMI Waiver Demonstration Implementation Plan (approved December 20, 2020), implementation status, PHE impacts, and next steps.

[18] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-cms-appvd-smi-eval-des-12162020.pdf

Exhibit 6.1: Indiana SMI Waiver Demonstration Implementation Plan Activities, Relevant Goals, Implementation Status, and Next Steps

Demonstration Activity	Goals	Implementation Status & PHE Impacts	Next Steps
To ensure that the State's utilization review process monitors recipients' access to the appropriate levels and types of care and to provide oversight on LOS, Indiana indicated that it would develop a report to monitor average LOS for all Medicaid programs with all reporting following CMS monitoring guidance.	1	At the time of the interviews, state officials indicated that they had not yet developed a report to monitor the average LOS for all Medicaid programs, however, they stated that they do internally review average LOS for all institutes of mental disease that receive federal match and the information is reported in quarterly monitoring reports as part of SMI waiver demonstration compliance. Interviewees noted that the SMI waiver requires a state-wide global average of <30 days and in 2020 the average was 27 days. Additionally, the State closely monitors ED utilization and reports to CMS on yearly basis.	DMHA leaders will continue to closely monitor the LOS and ED utilization, meeting regularly to discuss methods to continue to lower the average. State officials stated that there are no immediate plans to develop a monitoring report for average LOS for all Medicaid programs.
Expand the use of OpenBeds (i.e., a tool to help Indiana Medicaid Recipient's seeking treatment for SUD immediately connect with available inpatient or residential treatment services) beyond SUD to include tracking availability of psychiatric inpatient and crisis stabilization beds. By expanding the use of OpenBeds, EDs will be able to divert patients with behavioral health problems to the appropriate level of care.	1, 3	Social distancing and prioritization of health care resources has limited the number of beds available across the state. At the time of the interviews with state officials, expansions for including psychiatric inpatient and crisis stabilization beds in the Open Beds platform beyond SUD IP had not occurred.	MCE interviewees indicated that they used OpenBeds to track availability of psychiatric inpatient beds. However, State officials indicated challenges using the OpenBeds software for these purposes and will not be pursuing the renewal of the OpenBeds contract. Instead, the State will pursue new monitoring software as part of the 988 initiative.
Monitor provider network capacity on an annual basis and identify underserved areas for targeted provider recruitment; Identify geographic shortage areas and conduct targeted outreach to non-Medicaid enrolled providers in those areas.	1, 3	FSSA conducts an annual Provider Availability Assessment survey. Survey data enables the FSSA to map the availability of providers in all counties across the state and subsequently determine provider shortage areas. Recruiting efforts are intensified in counties that are identified as not meeting U.S. Health Resources & Services Administration provider-to-member ratio standards.	The State will continue to monitor provider network capacity on an annual basis.
Pilot two CSUs in the northern and southern parts of the state. The goals for these units are to increase access to the continuum of care by providing an alternative to crisis evaluations within EDs and diverting admissions to inpatient psychiatric units.	1, 2, 3	Two certified mental health clinics were awarded contracts to operate CSU pilots which began on July 1, 2020 and will end on June 30, 2022. Process and outcome data is currently being gathered from these pilots.	Indiana House Bill 1222 requires the DMHA to establish a plan to expand the use of certified community behavioral health clinics in Indiana as well as to consider the use of crisis hotline centers and mobile crisis teams as described in IC 12-21-8. Findings from the CSU pilot will inform future crisis stabilization services planning.

Demonstration Activity	Goals	Implementation Status & PHE Impacts	Next Steps
Explore piloting MRSS. MRSS would provide community-based crisis intervention including short term follow-up and support for the youth and family to prevent reescalation, ED utilization and/or inpatient admission.	1, 2, 3	Due to the pressures on the health care infrastructure from the PHE and uncertainties about the trajectory of the epidemic, the initial MRSS pilot was delayed indefinitely.	DMHA and OMPP will pursue a Medicaid SPA to incorporate mobile crisis teams as enrolled providers eligible to receive reimbursement directly by Indiana Medicaid. FSSA will evaluate the potential of a MRSS pilot as part of 988 and crisis system planning.
To ensure psychiatric hospitals and residential settings assess recipients' housing situations and coordinate with housing services providers when needed and available, the Indiana Medicaid Provider Manual will be updated to explicitly require psychiatric hospitals to have protocols in place to: • Assess for housing insecurity as part of the social work assessment and discharge planning processes and to refer to appropriate resources • Ensure contact is made by the treatment setting with each discharged recipient within 72 hours of discharge and follow-up care is accessed	2, 5	State officials indicated that the Indiana Medicaid Provider Manual was not updated as indicated in the implementation plan due to the reprioritization of activities and resources related to the PHE. However, state officials stated that these protocols were added to the site visit quality investigation review process to ensure facilities have appropriate processes in place to meet identified standards. Additionally, state officials indicated that IHCP maintains an expectation of a 72-hour discharge follow-up. Several MCE representatives also mentioned specific requirements for case management to follow-up with patients within 72 hours of discharge from a treatment setting.	It is unclear from the key informant interviews with State representatives if this initiative will be implemented in the future as part of the SMI waiver demonstration.
To further sustainability and expansion of the State's model for PCBHI, the State will submit an application for SAMHSA's (FY) 2020 Promoting Integrating of Primary and Behavioral Health Care (Short Title: PIPBHC) grant and will explore implementation of a Health Homes SPA in 2021.	4, 5	While the State applied for and received the PIPBHC grant, implementation of the Health Homes SPA was deprioritized in 2020 due to the PHE.	State officials indicated that leadership is reassessing priorities and will determine if Health Homes SPA will be planned for future implementation.

Non-Waiver and PHE Relevant Activities

As a result of the PHE, several unanticipated developments occurred including emergency authorizations and policy modifications as well as shifts in service delivery and utilization. Due to the PHE, the State suspended or modified several behavioral health focused policies and expanded behavioral health telehealth services.[19,20,21] Examples of emergency authorizations, policy modifications, and service utilization changes are described in the following sections and relevant qualitative findings are integrated as appropriate.

Emergency Authorizations and Policy Modifications

Telehealth. Effective March 1, 2020 and through the duration of Indiana's PHE, an executive order authorized the OMPP to expand the use of telehealth to include the following allowances: 1) voice-only modalities (e.g., telephones) could be utilized for telehealth purposes, 2) telehealth services were no longer limited to procedure codes on IHCP's Telemedicine Services Code Set, and 3) the set of providers who could use telehealth was no longer limited by licensure restrictions defined under the Indiana Professional Licensing Agency (IPLA) section of Indiana Code.

Unsurprisingly, these changes in policy led to an increase in the number of Medicaid claims billed for telehealth services. In 2019, there were only 63,844 paid claims for telehealth services, versus 2,673,241 claims in 2020, an increase of over 4000%.[22] The majority of these claims were submitted by behavioral health providers, with claims for psychotherapy services making up approximately 20% of health care services provided via telehealth.

- *Qualitative Findings***.** All interviewees discussed the impact of expanded telehealth services on the care delivery system, noting that the expansion of telehealth was a positive development for increasing access to care.[23] For example, interviewees indicated that telehealth is a good alternative for areas with high wait times for mental health providers allowing some care to occur while a patient waiting for a bed to become available. Prior to the pandemic, most CMHCs were not using telehealth, but were able to quickly pivot to remote services.

Interviewees described limitations associated with expanded telehealth services noting that not all recipients are able to effectively utilize remote services due to limited mental capacity and technology issues. Some interviewees also described initial challenges with translating some services to a telehealth format and expressed concerns regarding equivalence of efficacy of remote services compared to in-person care. To monitor the transition from in-person to virtual care, some EDs offered customer service calls to ensure that care was meeting patients' needs and held lunchtime "debriefs" to discuss client feedback with clinicians.

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19 Indiana Medicaid allows telehealth and telephone options for most health care and mental health interactions, FSSA News Release, March 19 2020, Accessed from https://www.in.gov/fssa/files/telemedicine_release_3_19_FINAL.pdf

20 Senate Bill No. 3: Telehealth Matters, Accessed from http://iga.in.gov/legislative/2021/bills/senate/3#document-742b0b09

21 These policies were suspended March 17, 2020. Based on State "Medicaid Policy Changes: re COVID-19" updated on July 28, 2020 and in discussion with State as of May 2021.

22 Baywol, Lindsay. Telehealth & the COVID 19 Public Health Emergency: Update Claim Utilization and Results. [PowerPoint Presentation]. 2021 Medicaid Advisory Committee Meeting. February 26, 2021. https://www.in.gov/fssa/ompp/files/MAC-Telehealth-presentation-Feb-2021.pdf

23 "All interviewees" is used throughout the report to refer to findings from interviewees with all participant types (e.g., State officials, providers, MCEs, and Advocates). When findings pertain to a single participant type, the report will reference the participant type in the text accordingly.

Prior Authorizations. The prior authorization process for Behavioral Health Services was modified to allow for Accessible Psychological Interventions (API) requests to be approved virtually with only basic-level patient information (Name, Date of Birth, Diagnoses, Location of Services, Type of Services) required. Additionally, the State issued an immediate order that allowed providers to authorize stays of up to seven days without a medical necessity review.

- *Qualitative Findings.* All of the MCE interviewees indicated that that the largest impact of the PHE on the waiver demonstration was the adoption of this emergency authorization related to the prior approval process. MCE interviewees described that from their perspective, the only change due to the SMI waiver was the LOS allowed for stays in IMDs, since they were already authorizing IMD stays for SMI prior to the waiver implementation. Interviewees indicated that the authorization for seven days without a medical necessity review caused delays in assessing and documenting medical necessity. Some interviewees indicated that this resulted in instances where stays were approved that otherwise would not have met medical necessity. Interviewees indicated that it will be difficult to determine the impact on LOS due to the SMI waiver demonstration as opposed to the implementation of the overarching 7-day authorization.

Enrollment of Mid-Level Providers. To increase the State's capacity of mental health Medicaid providers, the House Enrolled Act 1175 passed in the 2019 legislative session expanded access to behavioral health providers for Medicaid enrollees. Under this law, LCSWs, LMHCs, licensed clinical addiction counselors and LMFTs are eligible providers and can certify a mental health diagnosis and supervise a patient's treatment plan in outpatient mental health or substance abuse treatment settings. Prior to this legislation, mid-level behavioral health practitioners were not eligible to independently enroll in Indiana Medicaid and were required to bill under the supervision of a HSPP or psychiatrist.

With the enactment of the latter legislation, Indiana implemented infrastructure changes within their billing systems to enable mid-level provider enrollment. Enrollment was scheduled to begin in Q1 of 2021, and thus did not impact the initial year of the SMI demonstration evaluation. The enrollment of mid-level providers will allow Indiana to reimburse and monitor the full scope of providers who offer mental health services, populations served, location, and service type provided. This activity will position FSSA to better identify gaps in service and address ongoing training and support needs.

Additionally, effective July 1, 2019, in accordance with Supplier Contract Management (SCM) approval of SPA TN 18-012, Indiana Medicaid expanded crisis intervention services intensive outpatient program services and peer recovery services to all Indiana Medicaid programs. This change expanded the available provider base from the Indiana's CMHCs to all Medicaid enrolled providers meeting the applicable criteria.

- *Qualitative Findings.* All interviewees described limited provider capacity as one of the greatest challenges for achieving the goals of the demonstration. Interviewees noted that low pay and expectations of high patient load have led to provider burnout and the current shortage. Interviewees described that the provider shortage results in long patient wait times, delayed care, and increased readmissions. One interviewee said that patients will sometimes have to wait 4-6 weeks to check-in with providers. This delay in care can lead to ED visits and readmissions for those who need immediate assistance. Interviewees explained that there are simply not enough behavioral health providers in Indiana, stating that the challenge of limited provider supply is not specific to Medicaid and extends to all populations in the state. Several interviewees described the expansion of Medicaid enrollment of mid-level providers as a policy change that will ultimately have a positive impact on provider availability and patient access to care.

Changes in Utilization

Research to date indicates that in-person health care service utilization declined in the Spring of 2020 as a result of social distancing parameters, cancellations of elective care, and individuals choosing to delay medical care.[24,25] Changes in overall utilization during 2020 have considerable implications for evaluation goals 1, 2, and 4 as rates of ED visits, readmissions, and access to community-based services may be a result of the pandemic, rather than the implementation of demonstration activities.

- *Qualitative findings*. All interviewees indicated broad changes in utilization of health care services due to the PHE. Interviewees stated that utilization of health care services, particularly inpatient services, decreased, beginning Spring 2020 due to patient fear of COVID-19 exposure. Interviewees described the impact of the PHE on all levels of inpatient care, indicating that bed capacity was reduced to allow for social distancing and to establish "COVID" floors for the infected. Similarly, state officials described reduced capacity of behavioral health services, indicating that facility capacity limits slowed the intake process and further limited access to services. Initial challenges with acquiring sufficient personal protective equipment (PPE) for staff further exacerbated these capacity issues.

The details of these emergency authorizations, policy modifications and overall changes in service utilization are noted throughout this report as appropriate. Implications for the evaluation are identified by each goal and any modifications to planned analysis due the PHE are described.

Socio-Demographics of the SMI Population

For the demonstration period (2020), 138,027 Medicaid recipients who could potentially access services provided by the waiver, were identified for the SMI registry (referred henceforth as SMI recipients). The demonstration target population had the following sociodemographic characteristics (**Exhibit 6.2, 6.4**):

- Approximately half of SMI recipients had Medicaid Coverage for 9 months or more in a 12-month coverage year.
- 64.2% of the SMI demonstration target population were female.
- 25.7% of the SMI demonstration target population were between the ages of 31 and 40.
- 66.2% of the SMI demonstration target population were Caucasian, as compared to 11.2% Black, and 22.6% Other.
- 97.0% of the SMI demonstration target population identified as non-Hispanic versus 3.0% Hispanic.
- 76.0% of the SMI population live in metropolitan areas, followed by those (14.2%) living in a non-metropolitan area with an urban population of 2,500 to 19,999.
- 59.4% of the SMI demonstration target population were receiving HIP.

[24] Cox, C., Amin, K., Kamal, R. (2021, March 22). How have health spending and utilization changed during the coronavirus pandemic? Peterson-KFF Health System Tracker. Retrieved April 21, 2022, from https://www.healthsystemtracker.org/chart-collection/how-have-health care-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/

[25] Xu, S., Glenn, S., Sy, L., Qian, L., Hong, V., Ryan, D. S., & Jacobsen, S. (2021). Impact of the COVID-19 pandemic on Health Care Utilization in a large integrated health care system: Retrospective cohort study. *Journal of Medical Internet Research*, *23*(4). https://doi.org/10.2196/26558

The number of recipients covered by the SMI Waiver increased from 2018 to 2020 (as expected based on the logic used to identify the population - discussed in **Section IV**), while the distribution of age, gender, race, ethnicity, geographic location, and HIP enrollment of recipients with SMI has remained generally unchanged across the years.

Since Medicaid SMI recipients were identified based on the first observed health care service (claims / encounter) with an SMI diagnosis, the monthly percentage of Medicaid recipients with SMI increased for 2018 and 2019, starting at 6.0% in January 2018 and rising to 18.0% by December 2019 (**Exhibit 6.3**) as expected. The percentage of Medicaid recipients who could potentially receive demonstration benefits and were included in the target population for this evaluation remained stable (mostly hovering around 17.8%) throughout 2020**.** Subsequently, the inclusion of a two-year reference group likely facilitated the identification of a stable population for the study.

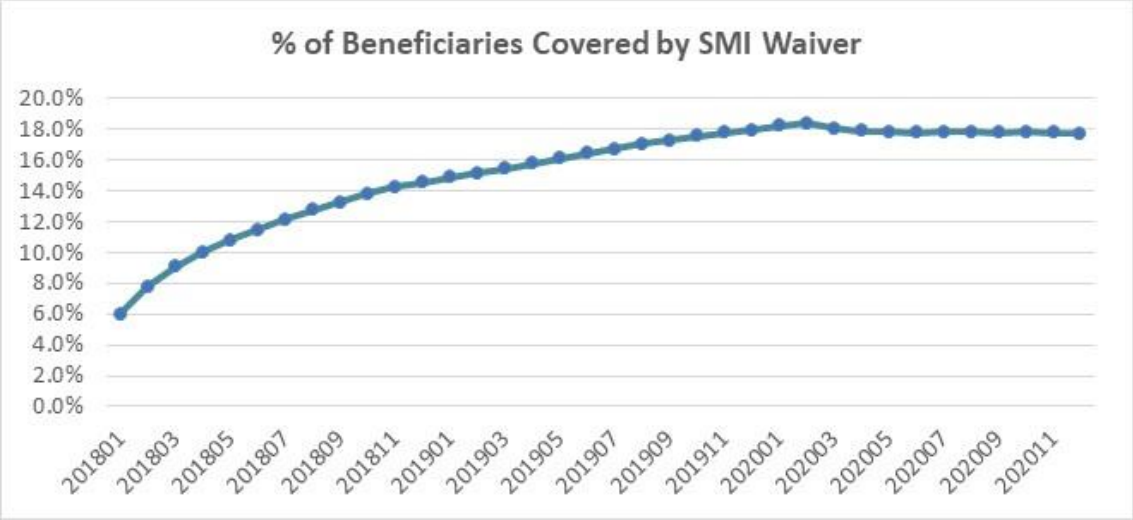
Exhibit 6.2: Medicaid and SMI Population and Distribution of Monthly Medicaid Coverage for SMI Recipients in SMI Registry (January 2018 – December 2020)

Year	# of Medicaid Recipients Age 21+ Eligible for SMI Waiver	SMI Registry Target Population	Distribution of # of months SMI Recipient had Medicaid Coverage in the Year					
			Mean	1st Pctl	25th Pctl	Median	75th Pctl	Maximum
2018	708,729	87,854	8.2	1	5	9	12	12
2019	685,243	112,788	9.2	1	6	12	12	12
2020	782,280	138,027	9.9	1	8	12	12	12

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Exhibit 6.3 displays the distribution of monthly Medicaid coverage for SMI recipients. Approximately half of SMI recipients had 9 or more months of Medicaid coverage in a 12-month period for 2018 – 2020.

Exhibit 6.3: Proportion of Medicaid Recipients identified in SMI Registry by Month (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.
Note: Since the identification of SMI recipients was based on first observed SMI diagnosis on services (claim / encounter) between 2018 and 2020, the increase in proportion of Medicaid recipients identified for SMI registry was dependent on incidence of SMI diagnosis. Stabilization in 2020 was likely due to the two-year reference period.

Exhibit 6.4 Sociodemographic Counts for Recipients with SMI provides additional detail of the SMI demonstration target population characteristics. Yearly counts (2018 – 2020) associated with gender, age, race, ethnicity, geographic location, and HIP enrollment are provided for Medicaid recipients with SMI.

Exhibit 6.4: Sociodemographic Counts for Recipients with SMI

Characteristics		# of SMI Recipients			# of Medicaid Recipients Age 21+ Eligible for SMI Waiver			% of Recipients Covered by SMI Waiver		
		Jan 2018 - Dec 2018	Jan 2019 - Dec 2019	Jan 2020 - Dec 2020	Jan 2018 - Dec 2018	Jan 2019 - Dec 2019	Jan 2020 - Dec 2020	Jan 2018 - Dec 2018	Jan 2019 - Dec 2019	Jan 2020 - Dec 2020
Total Recipients		87,854	112,788	138,027	708,729	685,243	782,280	12%	16%	18%
Gender	Female	55,856	72,032	88,545	435,433	421,785	473,202	13%	17%	19%
	Male	31,998	40,756	49,482	273,289	263,457	309,074	12%	15%	16%
Age	21-30	20,191	27,543	36,176	225,941	212,875	247,030	9%	13%	15%
	31-40	22,724	30,057	38,027	189,482	184,207	214,892	12%	16%	18%
	41-50	21,211	26,672	31,984	140,819	136,748	157,734	15%	20%	20%
	51-60	21,874	27,056	30,950	143,178	139,768	153,067	15%	19%	20%
	61-64	6,735	8,872	10,592	51,269	53,910	61,331	13%	16%	17%
Race	Caucasian	59,690	75,030	91,408	465,435	442,281	500,620	13%	17%	18%
	Black	9,960	12,927	15,464	127,094	122,004	138,661	8%	11%	11%
	Other	18,204	24,831	31,155	116,200	120,958	142,999	16%	21%	22%
Ethnicity	Hispanic	2,470	3,235	4,190	34,820	34,567	42,516	7%	9%	10%
	Non-Hispanic	85,384	109,553	133,837	673,909	650,676	739,764	13%	17%	18%
Geographic Location[26]	Metro	66,862	86,082	105,026	552,654	535,133	612,317	12%	16%	17%
	Non-Metro, Urban Population > 20K	7,863	9,926	12,159	52,254	50,232	57,092	15%	20%	21%
	Non-Metro, Urban Population 2.5K – 20K	12,334	15,755	19,615	96,705	93,042	105,395	13%	17%	19%
	Rural or Urban Population < 2.5K	695	915	1,109	6,375	6,155	6,815	11%	15%	16%
HIP/Non-HIP	HIP	48,419	64,961	81,936	524,982	501,371	577,957	19%	24%	26%
	Non-HIP	42,899	53,476	61,213	227,736	225,883	231,467	9%	13%	14%

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

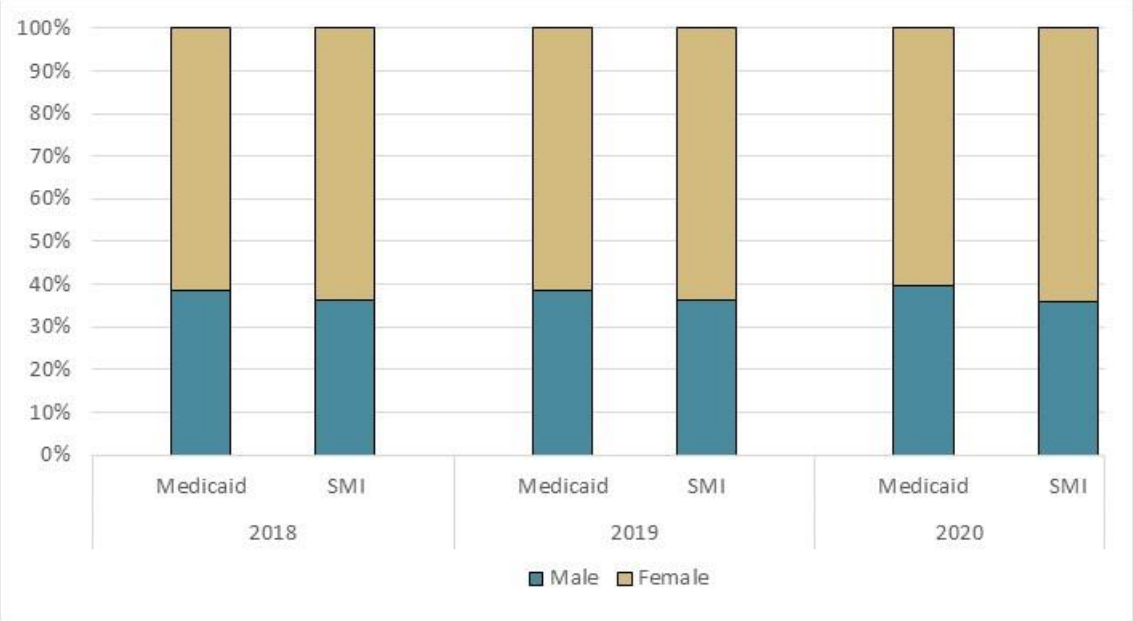
[26] United States Department of Agriculture (2022, June 9th). Rural-Urban Continuum Codes. Retrieved from https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/

Exhibits 6.5 – 6.10 provides the composition of the SMI and overall Medicaid population from 2018 – 2020. As stated in **Section IV**, recipients were initially placed in the SMI Registry based on their claim's first date of service containing an SMI diagnosis. The recipient remained in the SMI registry through the end of the evaluation period regardless of whether they had any additional claims with an SMI diagnosis. Growth between 2018 – 2020 is an artifact of the registry construction rather than a result of an increasing SMI population. Subsequently, SMI population findings focus only on the demonstration year (2020). Data from 2018-2019 was included to assess change in the SMI population composition. Changes in the SMI target population composition may be due to changes in the Medicaid recipient composition or other factors (e.g., changes in programs). Medicaid population composition was included to assess if there were changes over time in the Medicaid recipient composition. The socio-demographic composition of SMI population is similar to overall Medicaid population with some minor variations.

Gender and Age

Exhibit 6.5 provides the percent of male and females for both the total Medicaid and SMI populations by year. Almost two thirds (64.2% in 2020) of the SMI population are female. This is similar to the overall Medicaid population (60.5% in 2020).

Exhibit 6.5: Distribution of Population (SMI vs Medicaid) by Gender and Year

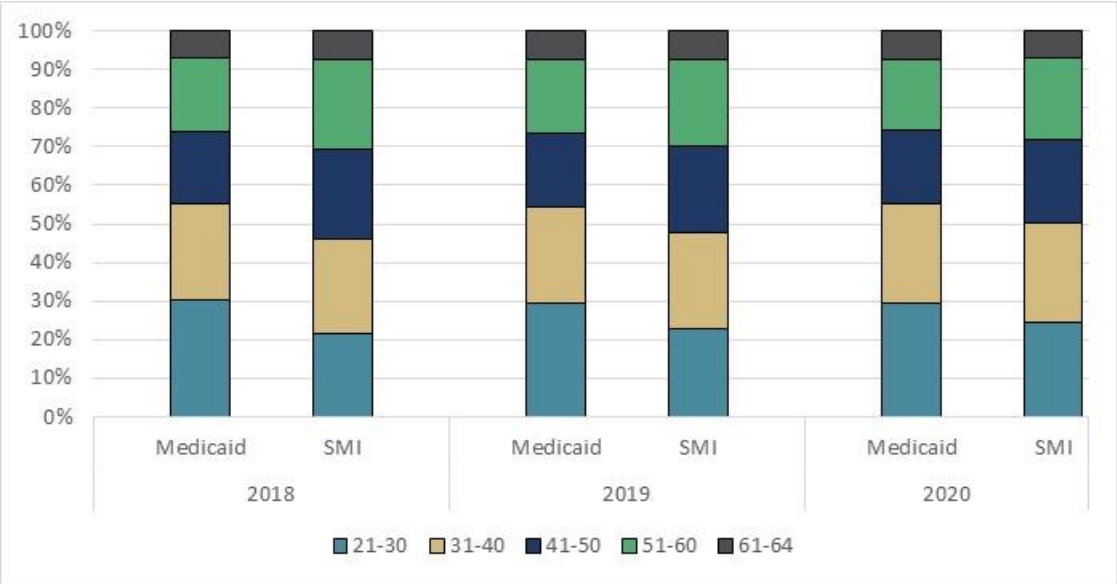


Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Exhibit 6.6 provides the age distribution for the total Medicaid and SMI populations by year. Approximately 70% of the SMI population is 50 and under (71.9% in 2020). Recipients ages 31 – 40 account for approximately a quarter (25.7%) of the waiver population in 2020. Recipients ages 61-64 accounted for the smallest cohort, having less than 10% of the total population (7.2% in 2020).

Although the majority of the Medicaid population is 50 and under, recipients ages 21-30 account for the largest proportion of the population in 2020 (i.e., approximately 30%).

Exhibit 6.6: Age Distribution by Population (SMI vs Medicaid) and Year

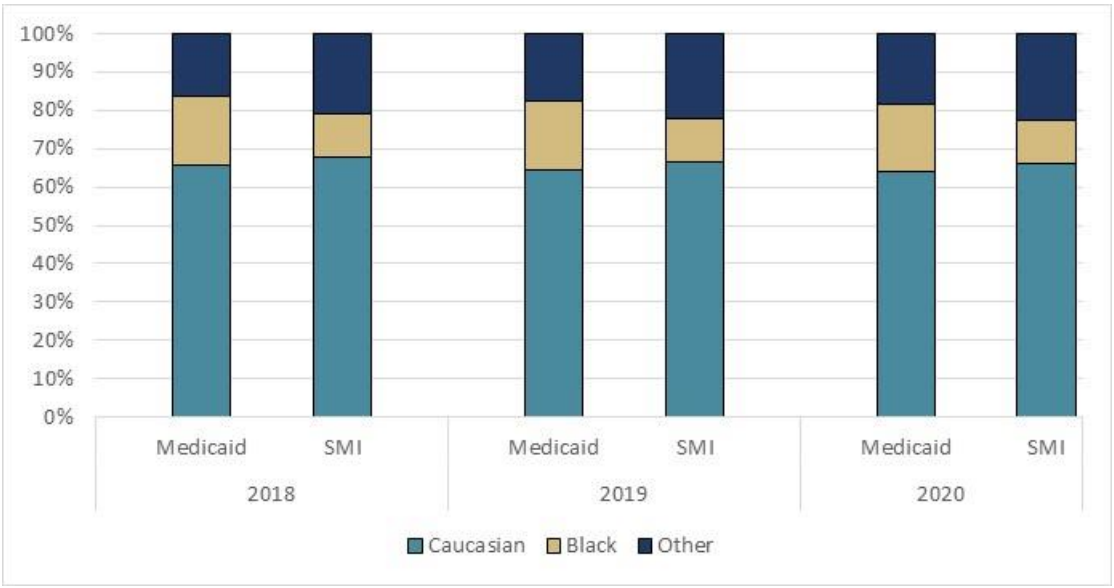


Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Race/Ethnicity

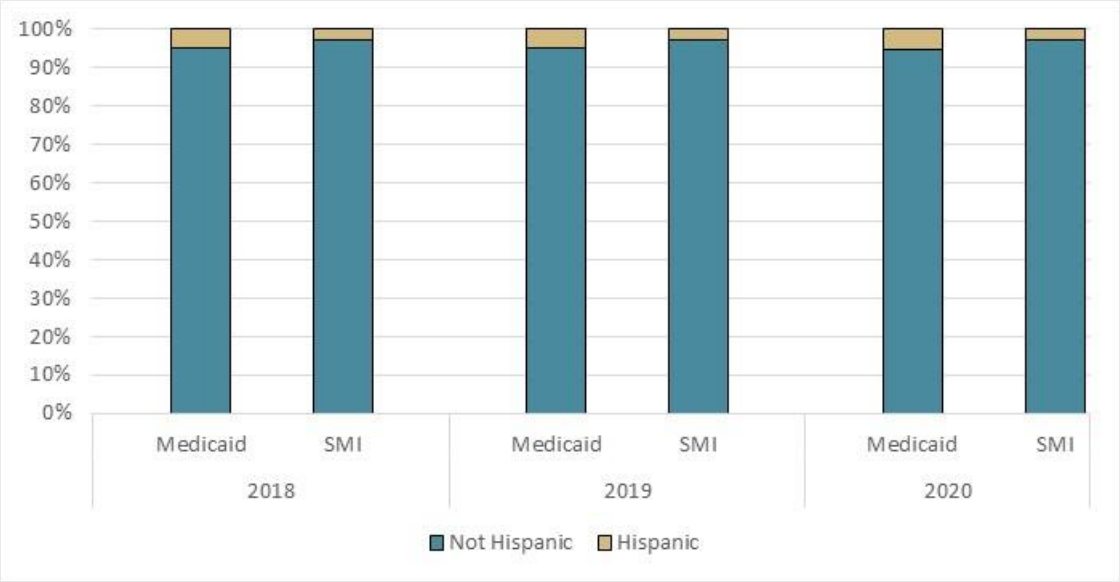
Exhibit 6.7 and 6.8 provides the distribution of total Medicaid and SMI populations by race and ethnicity and year. Approximately two thirds of the SMI and Medicaid populations are Caucasian, with almost all recipients being non-Hispanic. The SMI population includes lower proportions of Black recipients (11.2% in 2020) than overall Medicaid recipients (17.7% in 2020). Approximately 20% of SMI recipients are included in the "Other" category (see **Attachment V** for a more granular race/ethnicity breakdown).

Exhibit 6.7: Distribution of Population (SMI vs Medicaid) by Race and Year



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Exhibit 6.8: Distribution of Population (SMI vs Medicaid) by Ethnicity and Year

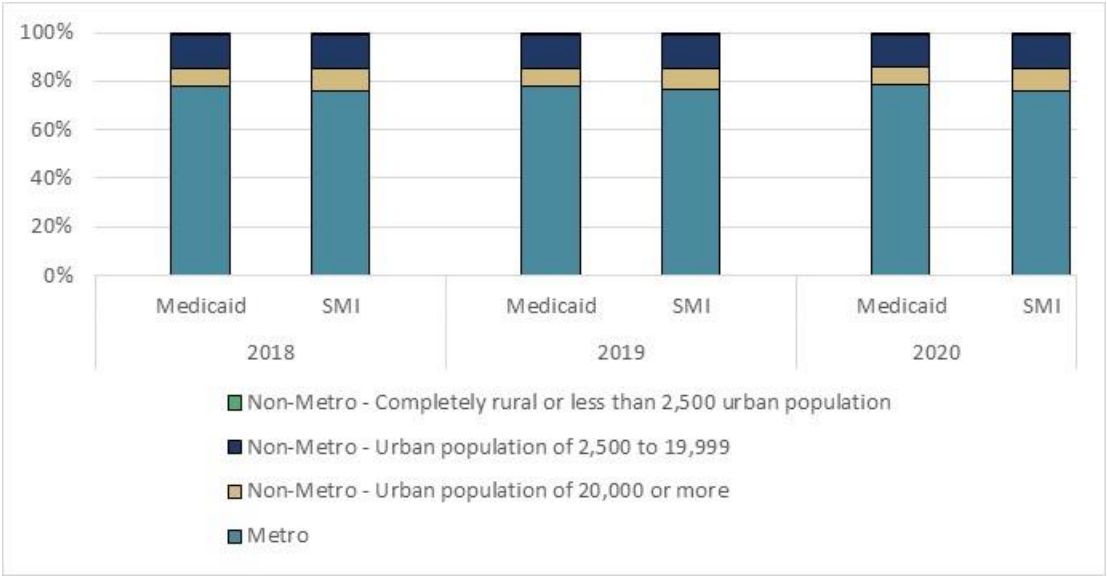


Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Metro/Non-Metro Geographical Areas

Exhibit 6.9 provides the proportion of the total Medicaid and SMI populations by metro/non-metro geographical areas. In 2020, slightly more than three quarters (76%) of the SMI population live in metropolitan areas, followed by those (14.2%) living in a non-metropolitan area with an urban population of 2,500 to 19,999. These findings indicate composition of SMI recipient by geography are similar to the overall Medicaid population.

Exhibit 6.9: Distribution of Population (SMI vs Medicaid) by Location and Year

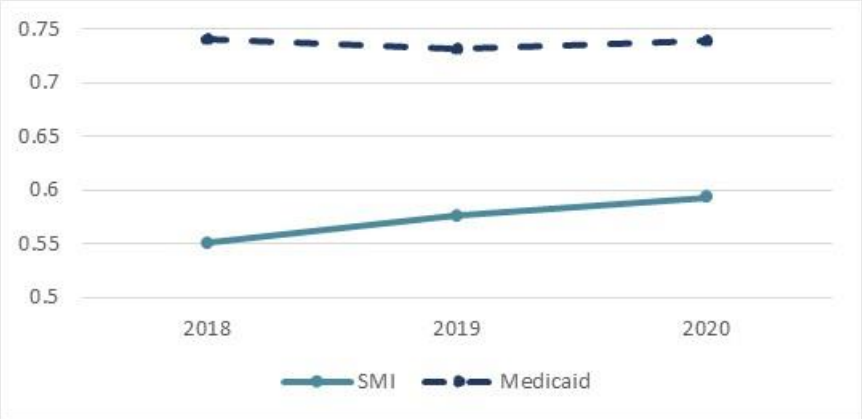


Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

HIP/Non-HIP

Exhibit 6.10 provides the proportion of the total Medicaid and SMI populations receiving HIP. More than half of the SMI population are enrolled in HIP. In 2020, 59.4% of the SMI population was enrolled in HIP while 73.9% of the overall Medicaid population was enrolled in HIP.

Exhibit 6.10: Distribution of Population (SMI vs Medicaid) Receiving HIP by Year



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Results by Demonstration Goal

This section is organized by evaluation goal. Each goal includes an exhibit that summarizes the hypothesis and associated RQs, detailing the level to which they were analyzed during the initial demonstration year. Goals 1, 3, and 4 include a combination of quantitative and qualitative analyses, while goals 2 and 5 only include qualitative analyses. Due to the limited demonstration period (January 2020 to December 2020) and the impact of the PHE (starting from March 2020), this Summative Evaluation Report was designed to be descriptive in nature and aims to provide the state of service utilization, service type (e.g., crisis stabilization, community-based services), and care coordination for SMI Medicaid recipients during 2020. (See **Section IV** for additional details).

Goal 1: Reduced utilization and length of stay in EDs among Medicaid recipients with SMI while awaiting mental health treatment in specialized settings

Although the rates of ED visits per 100,000 persons nationally have remained stable between 2009 and 2018, visits associated with mental health diagnoses continued to rise among Medicaid recipients during this time period.[27] Individuals with SMI are more likely to have higher rates of ED utilization than individuals without any mental health diagnosis.

Goal 1 for the SMI demonstration provides ED utilization data for those Medicaid recipients with SMI. ED LOS is typically calculated using data from a patient's clinical record. Given that data sources for the evaluation relied on claims and encounter data, which does not contain information specific to time spent in an ED, analyses were restricted to ED utilization only. **Exhibit 6.11** describes the hypothesis, RQs, and how the research question was assessed during the initial year of the demonstration.

[27] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Trends in the Utilization of Emergency Department Services, 2009-2018. 2021. https://aspe.hhs.gov/pdf-report/utilization-emergency-department-services

As stated in **Section V**, the ongoing PHE (which began in March 2020) has caused substantial changes to State policies, service utilization and provider availability, and will have short- and long-term impacts on Indiana's health care. Social distancing, prioritization of health care resources, and telehealth policy modifications have likely affected emergency visit utilization and demand for behavioral health care services. Given that the program outcome measures use 2020 data only (demonstration period) and the likelihood of the PHE's significant confounding effect, the 2020 Summative Evaluation does not draw conclusions about the impact of the demonstration on Goal 1 outcomes.

Exhibit 6.11: Goal 1 research questions and description of how the research questions were assessed during the initial year of the demonstration

Hypothesis: The SMI demonstrations will result in reductions in utilization and length of stay in EDs among Medicaid recipients with SMI while awaiting mental health treatment.[28]	
2020 Evaluation Plan Research Questions	**How was the Research Question assessed in 2020?**
Primary research question 1: Does the SMI demonstration result in reductions in utilization and LOS in EDs among Medicaid recipients with SMI while awaiting mental health treatment? **Subsidiary research question 1.a**: How do the SMI demonstration effects on reducing utilization and LOS in EDs among Medicaid recipients with SMI vary by geographic area or beneficiary characteristics?	Changes in overall ED utilization and participation from 2018 to 2020 is provided. Overall, ED utilization was likely impacted by COVID-19 as a result of social distancing parameters, cancellations of elective care, and individuals choosing to delay medical care.
Subsidiary research question 1.b: How do SMI demonstration activities contribute to reductions in utilization and LOS in EDs among Medicaid recipients with SMI while awaiting mental health treatment in specialized settings?	Indiana identified five activities in the Indiana SMI waiver demonstration implementation plan to achieve Goal 1. Due to the PHE, the State delayed, modified, or canceled many of the SMI demonstration activities associated with Goal 1 to prioritize behavioral health care system modifications (e.g., access to telehealth) for patient care during this unprecedented time. Subsequently, interviewees discussed the current state of ED utilization as it related to SMI populations during 2020 and described non-demonstration activities that were implemented to divert individuals experiencing behavioral health challenges from the ED.

Quantitative Analysis Approach

For this goal, we estimated the all-cause ED utilization metrics (participation rate and utilization rate) for the overall SMI population and by several demographic subgroups.

- **Utilization Rate**

  The utilization rate is the count of services or visits per 1,000 recipient years, which reflects the frequency at which recipients access the service regardless of their length of enrollment.

  The use of "recipient years" in the utilization rate reflects the number of services used per 1,000 recipients during a year and reflects the number of months of enrollment by recipients.[29]

[28] Given that the scope of the summative report was constrained to claims and administrative data, analysis of the ED LOS was not conducted. ED LOS is typically calculated using data from a patient's clinical record. The evaluation will explore accessibility to this data source in future evaluation years.

[29] The use of "recipient years" in the utilization rate reflects the number of services used per 1,000 recipients during a year and reflects the number of months of enrollment by recipients. The formula for the utilization rate is: (# of services or visits per year)/member months x 1,000 x 12 months.

- **Participation Rate**

  The participation rate is the proportion SMI recipients having an ED visit at least once in the calendar year after having SMI diagnosis. This metric only reflects that a recipient had an ED visit; it does not reflect the frequency of ED use. For example, an ED participation rate of 48% means that 48% of recipients visited the ED at least once during the year.

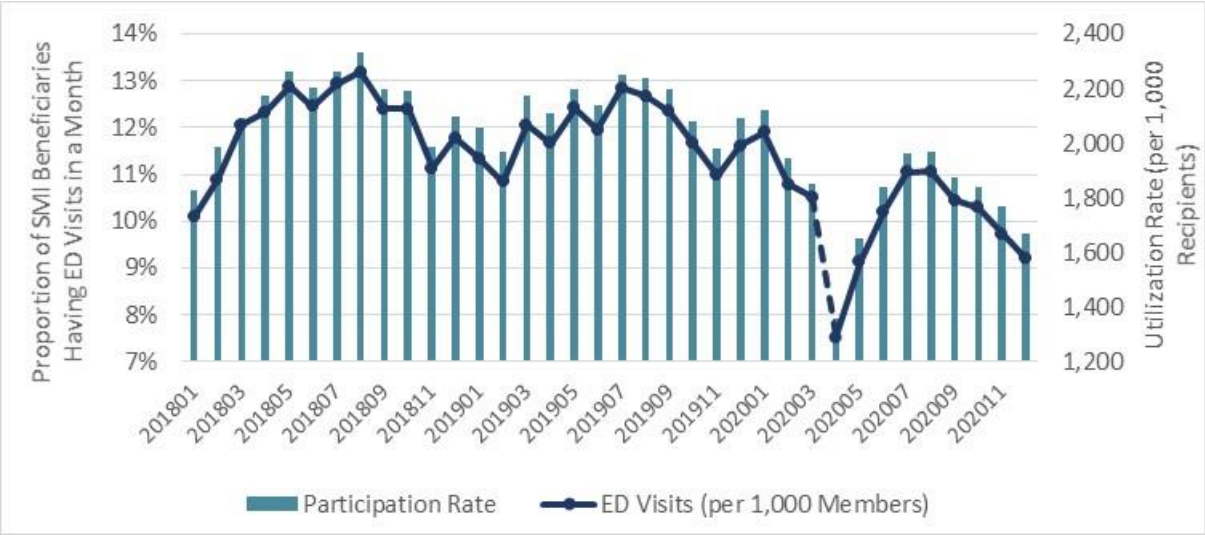
Quantitative Results

Medicaid recipients with SMI utilized the ED at a rate of 2,081 visits per 1,000 recipient per year in 2018 (**Exhibit 6.12**). ED Utilization decreased slightly in 2019 (2,035 visits per 1,000). A larger decline in utilization rate was observed in 2020 (1,736 visits per 1,000). Utilization rates in January and February 2020 were comparable to rates during same time in 2018 and 2019 (see **Exhibit 6.13**). Since the start of the PHE (March 2020), participation and utilization rates decreased over time. Utilization rates declined by 34% beginning in March and April 2020, and although there were increases during the last six months it was not at similar levels as pre PHE.

Exhibit 6.12: Emergency Department Utilization and Participation, SMI Recipients (January 2018 – December 2020)

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Exhibit 6.13: Emergency Department Utilization and Participation by month, SMI Recipients (January 2018 – December 2020)

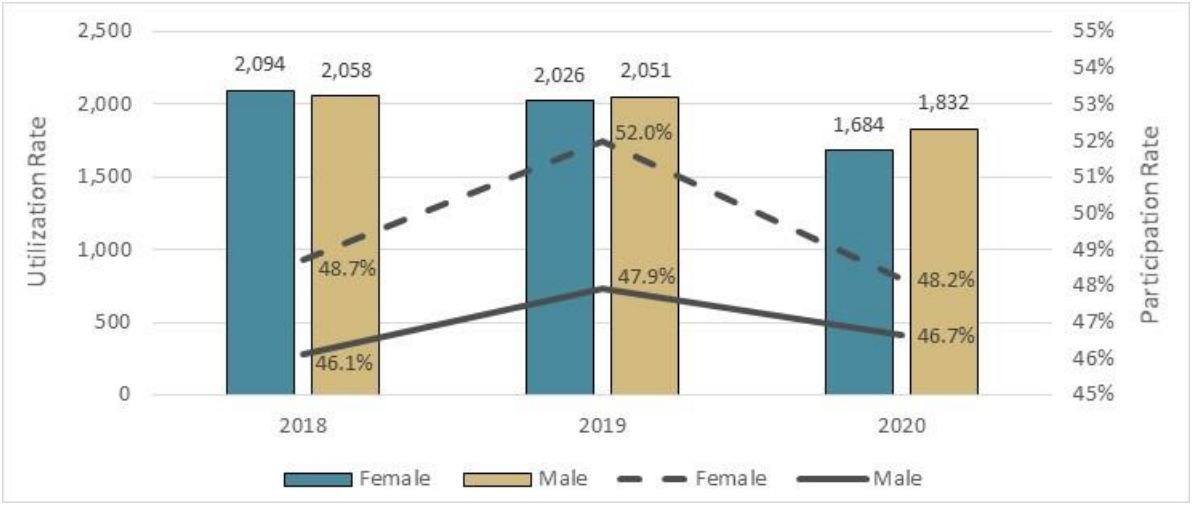


Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Female Medicaid recipients with SMI utilized the ED at a higher rate than males in 2018 then dropped below the utilization rate for males in 2019 and 2020. Between 2018 and 2020, the female ED utilization rate dropped 19.6% from 2,094 visits per 1,000 recipient years to 1,684; while the utilization rate for males dropped 11.0% from 2,058 visits per 1,000 recipient years to 1,832 in 2020.

Despite a decreasing ED utilization rate for females in 2019, their participation rate in using the ED increased from 48.7% to 52.0%. The ED participation rate for males increased as well in 2019 from 46.1% to 47.9%. In 2020, due at least in part to the PHE, the participation rate for both females and males dropped back to 48.2% and 46.7% respectively. See **Exhibit 6.14**.

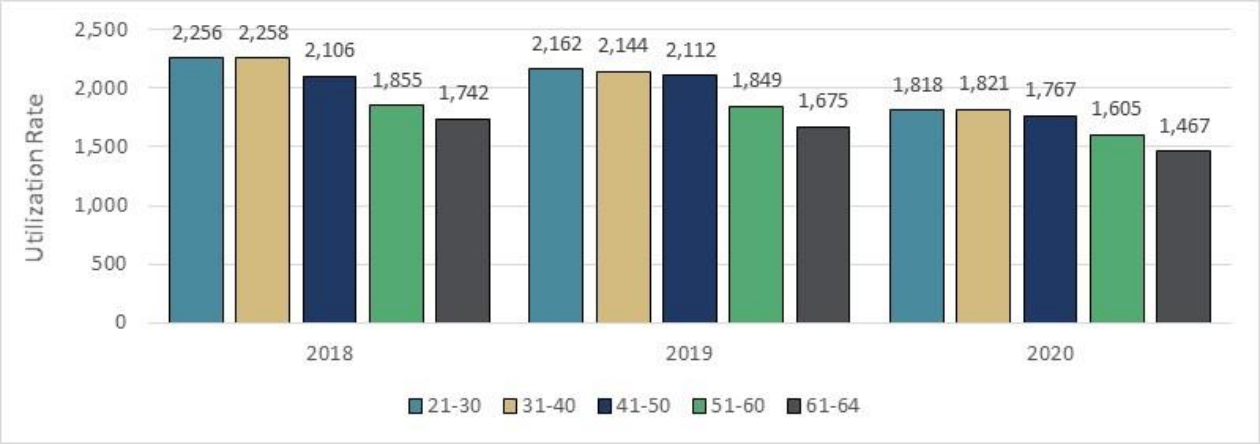
Exhibit 6.14: Emergency Department Utilization and Participation, SMI Recipients by Gender (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

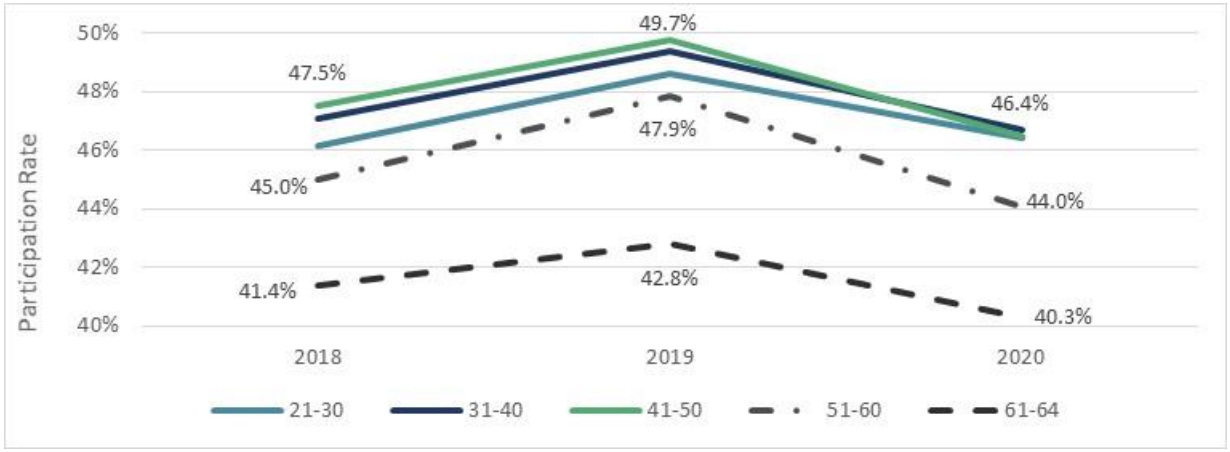
ED utilization and participation rates in using the ED are higher among recipients ages 50 and below versus those 51 years old and above across the three years studied. For example, in the ED visits per 1,000 for SMI recipients in the 21-30 age group ranged from 2,256 in 2018 to 1,818 in 2020. SMI recipients ages 61 – 64 had the lowest utilization of ED services (1,742 and 1,467; 21-25% lower than the youngest age group). See **Exhibits 6.15 and 6.16**.

Exhibit 6.15: Emergency Department Utilization, SMI Recipients by Age (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

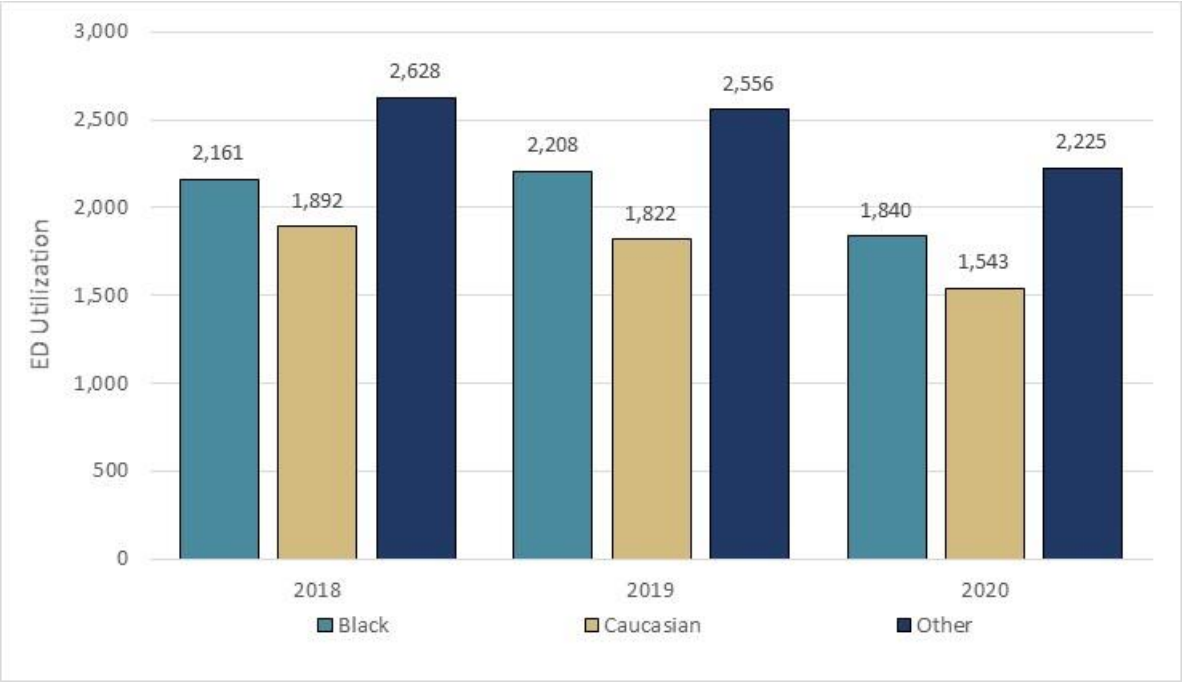
Exhibit 6.16: Emergency Department Participation Rate, SMI Recipients by Age (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

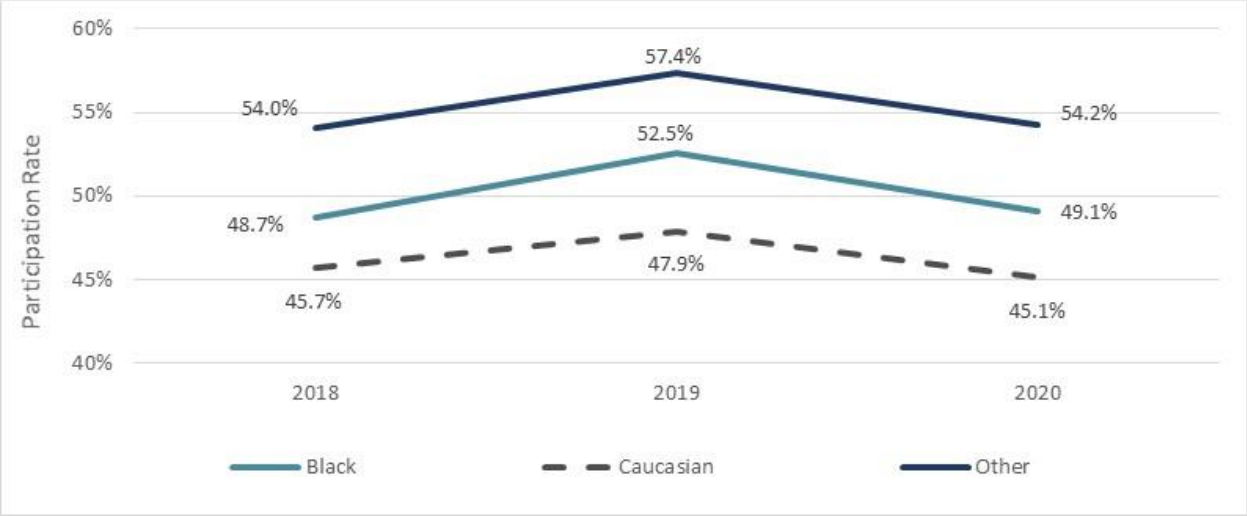
ED utilization and participation rates varied by race. For example, Black Medicaid recipients had the highest participation rates (48.7% in 2018, 52.5% in 2019, and 49.1% in 2020). Whereas Caucasian Medicaid recipients followed a similar pattern with overall lower ED participation (45.7% in 2018, 47.9% in 2019, and 45.1% in 2020). ED Visits per 1,000 recipient years exhibits a similar distribution by race. For example, Black Medicaid recipients have higher counts for this metric than those of Caucasian Medicaid recipients. It should be noted that approximately 20% of the Medicaid recipients do not have race data available. See **Exhibits 6.17 & 6.18**.

Exhibit 6.17: Emergency Department Utilization, SMI Recipients by Race (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

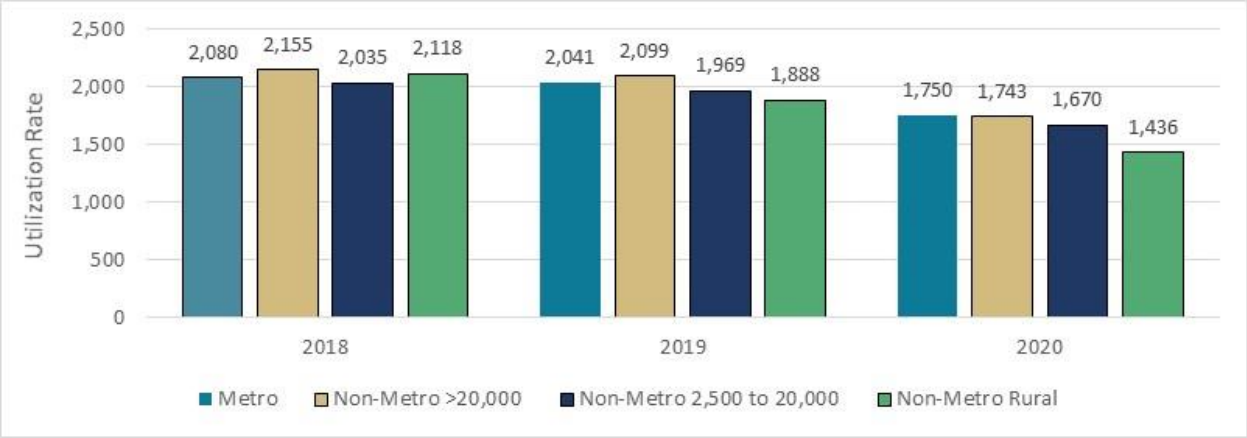
Exhibit 6.18: Emergency Department Participation Rate, SMI Recipients by Race (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

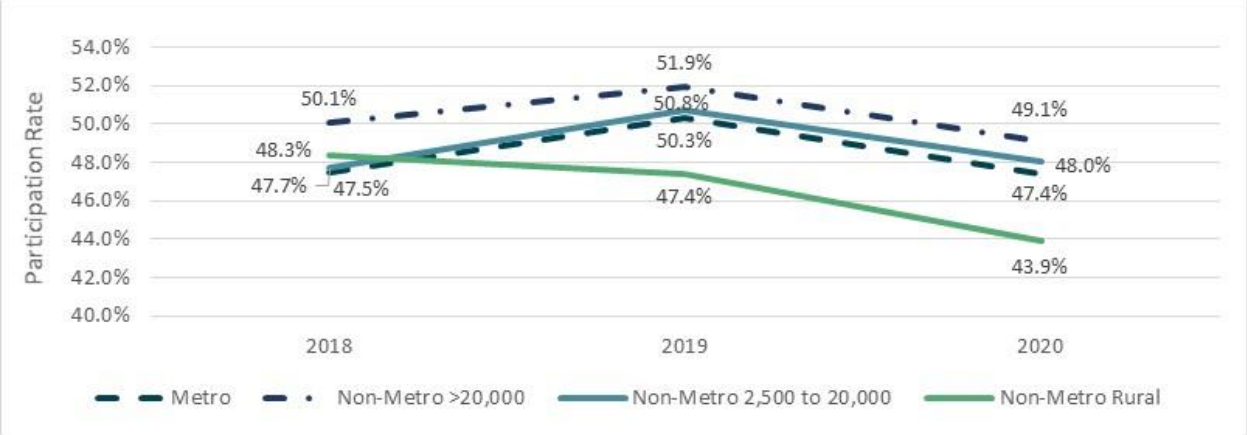
The ED utilization and participation rate varied slightly by metro/non-metro location for SMI Medicaid recipients. Medicaid recipients residing in non-metro counties with greater than 20,000 people had higher ED visit rates in 2018 and 2019 (2,155 and 2,099 visits per 1,000) than those in urban or more rural counties. Recipients in rural areas had the highest decrease in ED visit and participation in 2020: decreasing 32% from 2,118 visits per 1,000 in 2018 to 1,436 visits per 1,000 in 2020; 43.9% of recipients used ED in 2020 compared to 48.3% utilizing the ED at least once in 2018. See **Exhibits 6.19 & 6.20**.

Exhibit 6.19: Emergency Department Utilization, SMI Recipients by Metro/Non-Metro (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

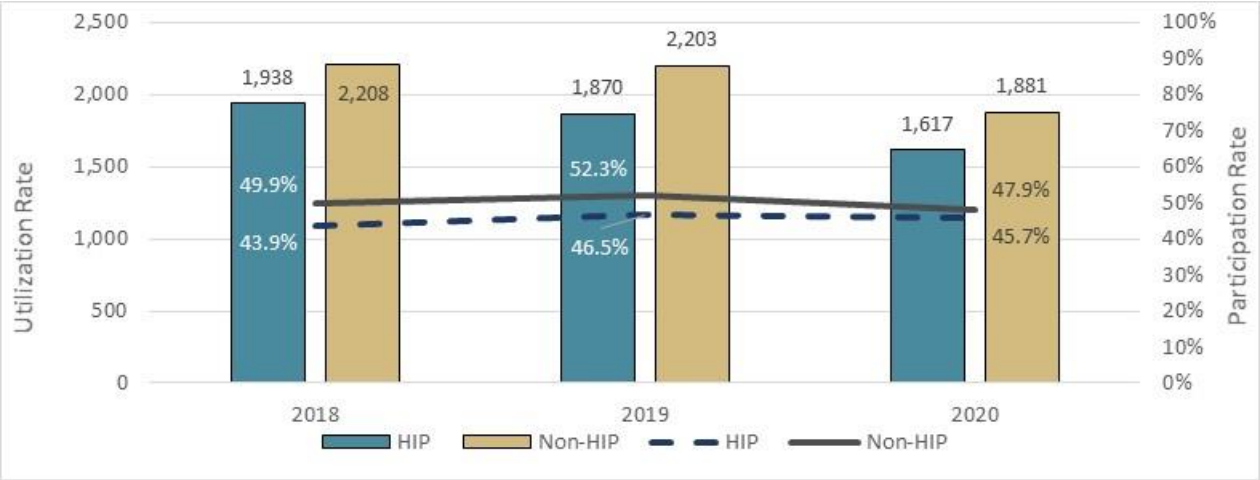
Exhibit 6.20: Emergency Department Participation Rate, SMI Recipients by Metro/Non-Metro (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Members receiving HIP coverage had different ED participation rates and utilization compared to non-HIP Medicaid recipients. Data indicates that recipients not covered by HIP use the ED at higher rates than their HIP plan counterparts, ranging from 13-16% higher between 2018 and 2020. ED participation among non-HIP recipients is also higher but the difference decreased from 6.1 percentage points in 2018 to 2.3% in 2020 (see **Exhibit 6.21**).

Exhibit 6.21: Emergency Department Utilization and Participation Rate, SMI Recipients by HIP/Non-HIP (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Qualitative Results

Indiana identified five activities in the Indiana SMI waiver demonstration implementation plan to achieve Goal 1. Due to the PHE, the State delayed, modified, or canceled many of the SMI demonstration activities associated with Goal 1 to prioritize behavioral health care system modifications (e.g., access to telehealth) for patient care during this unprecedented time. Interviewees indicated that out of five activities, one (annually identify geographic shortage areas and conduct targeted outreach to non-Medicaid enrolled providers in those areas) was fully implemented, and one (develop a report to monitor ALOS for all Medicaid programs) partially implemented during 2020.

ED Utilization Among SMI Medicaid Recipients. All the state officials and providers interviewed described how the PHE impacted implementation activities and likely confounded the impact of the waiver on ED utilization and LOS for Medicaid recipients with SMI waiting for mental health treatment. FSSA officials, MCE representatives and providers highlighted various emergency authorizations (see **Section II**) which were implemented to increase access to care by streamlining authorization and approval and decreasing wait times in prior to admission. Interviewees mentioned that these changes, particularly the API virtual approval and automatic 7-day authorization, temporarily decreased LOS in ED for many patients as they were more quickly admitted.

State officials described broad changes in utilization of health care services due to the PHE. Interviewees stated that utilization of health care services, particularly inpatient services, decreased, beginning Spring 2020 due to patient fear of COVID-19 exposure. Referencing a management performance hub dashboard with data from the Emergency Medical System (EMS) and EDs for persons with mental health conditions, one state official stated that ED visits for individuals endorsing suicidal ideations decreased from March – May 2020. However, the interviewee noted that ED utilization for individuals seeking behavioral health care "skyrocketed" starting in June 2020 to historically high levels. These findings were consistent with provider observations, who also described decreases in ED utilization during the early months of the pandemic and then noted a spike in ED utilization during the summer of 2020, especially for behavioral health related incidents (e.g., suicide; overdose). Providers also indicated that ED wait times ballooned and that there was a noticeable uptick in crime and self-harm, leading to an increase in the number of patients needing a 72-hour hold.

Although the quantitative data cited previously measures "All Cause" ED visits (i.e., not limited to behavioral health events), findings (see **Exhibit 6.13**) are consistent with State and provider observations and suggest that overall ED visits among SMI populations decreased during the early months of the pandemic and eventually increased as 2020 progressed.

Providers indicated that PHE strained overall provider capacity in the ED and across the care continuum. For example, surges in overdoses and self-harm created a "bottleneck effect" in the ED which was further amplified by reductions in inpatient bed capacity (as a result of social distancing requirements) and limited out-patient access; increasing LOS in the ED (particularly for SMI patients) until appropriate care could be coordinated. Providers stated that they struggled to get patients into out-patient treatment facilities within the seven-day post-discharge period and coordinated with local FQHCs to ensure that the SMI population was connected to primary care.

Non-Demonstration Activities. While not implemented due to the SMI waiver demonstration, interviewees described several efforts to divert individuals experiencing behavioral health related problems from the ED. For example, MCEs described efforts to identify high utilizers of ED services and connect them with appropriate disease management or care management services. MCE interviewees described identifying recipients with ED utilizations at least three standard deviations above the mean and closely monitoring these individuals to ensure they are accessing recommended services. Additionally, several interviewees described the 988 initiative which aims to create sustainable infrastructure to coordinate crisis care for mental health, substance use and suicidal crisis. This plan adopts SAMHSA's Crisis Now Model and includes statewide 24/7 call center, centrally deployed 24/7 mobile crisis services, and short-term sub-acute residential crisis stabilization programs. Once implemented, interviewees anticipate that these activities will support achievement of Goal 1.

Goal 2 – Reduced preventable readmissions to acute care hospitals and residential settings

Patients with SMI may be vulnerable to unplanned hospital readmission.[30] Unplanned hospital readmission is a common but potentially preventable health care outcome and quality indicator associated with considerable health care costs. Recent studies have indicated that 30-day hospital readmissions among Medicaid recipients with SMI are higher than rates of 30-day readmissions after medical hospitalizations than the general population.[31,32]

As stated previously, due to the limited demonstration period (January 2020 to December 2020) and impact of the ongoing PHE (starting from March 2020), CMS approved a restricted set of quantitative analyses. Based on the adjusted evaluation design (approved by CMS, See **Exhibit 1.1**), we assessed preventable readmissions to acute care hospitals and residential settings using qualitative data.

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[30] Albrecht, J. S., Hirshon, J. M., Goldberg, R., Langenberg, P., Day, H. R., Morgan, D. J., Comer, A. C., Harris, A. D., & Furuno, J. P. (2012, April 26). *Serious mental illness and acute hospital readmission in diabetic patients*. American journal of medical quality : the official journal of the American College of Medical Quality. Retrieved April 22, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3677605/

[31] Cook, J. A., Burke-Miller, J. K., Razzano, L. A., Steigman, P. J., Jonikas, J. A., & Santos, A. (2021, February 13). *Serious mental illness, other mental health disorders, and outpatient health care as predictors of 30-day readmissions following medical hospitalization*. General Hospital Psychiatry. Retrieved April 22, 2022, from https://www.sciencedirect.com/science/article/pii/S0163834321000244

[32] Cook, J. A., Burke-Miller, J. K., Jonikas, J. A., Aranda, F., & Santos, A. (2020, September). *Factors associated with 30-day readmissions following medical hospitalizations among Medicaid recipients with schizophrenia, bipolar disorder, and major depressive disorder.* American Psychological Association PsycNet. Retrieved April 22, 2022, from https://psycnet.apa.org/record/2020-66663-001

Consistent with ED utilization, social distancing, prioritization of health care resources, and telehealth policy modifications have likely affected hospital re-admissions and demand for behavioral health care services. Given that the program outcome measures use 2020 data only (demonstration period) and the likelihood of the PHE's significant confounding effect, the 2020 Summative Evaluation does not draw conclusions about the impact of the demonstration on Goal 2 outcomes.

Future evaluation reports will include quantitative analyses to assess reductions. **Exhibit 6.22** describes the hypothesis, RQs, and how the RQs were assessed during the initial year of the demonstration.

Exhibit 6.22: Goal 2 research questions and the description of how the research questions were assessed during the initial year of the demonstration

Hypothesis: The SMI demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	
2020 Evaluation Plan Research Questions	**How was the Research Question assessed in 2020?**
Primary research question 2: Does the SMI demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings (including, short-term inpatient and residential admissions to both IMDs and non-IMD acute care hospitals, critical access hospitals, and residential settings)? **Subsidiary research question 2.a:** How do the SMI demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics?	Qualitative interviews discussed waiver and non- waiver activities that impacted readmissions to acute care hospitals and residential settings. Overall (and consistent with ED utilization) re-admission rates were likely impacted by COVID-19 as a result of social distancing parameters and the limited number of available beds. Changes in overall re-admissions during 2020 have considerable implications for this research question and thus reductions were not measured as any reductions may be a result of the overarching pandemic, rather than the implementation of demonstration activities.
Subsidiary research question 2.b: How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings?	Indiana identified three activities in the Indiana SMI waiver demonstration implementation plan to achieve Goal 2. Two of these three activities were shared with Goal 1. As indicated in Goal 1, interviewees indicated that, one activity (Pilot CSUs) was implemented during 2020. As stated previously, the State delayed, modified, or canceled many of the SMI demonstration activities to prioritize behavioral health care system modifications (e.g., access to telehealth) for patient care during this unprecedented time.

Qualitative Results

Interviewees described the influence of expanded telehealth services due to the PHE as impacting several waiver goals including reduced readmission. Interviewees indicated that the expansion of telehealth increased access to services for some, noting differential population accessibility (i.e., technology availability for rural Indiana). Interviewees also described how new telehealth policies expanded the options for telehealth modalities allowing for audio-only connectivity (a first for the State of Indiana) and subsequently expanding access to care.

Although MCEs indicated that they did not see an increase in readmission rates, some MCE interviewees indicated that the 7-day automatic authorization (due to the PHE) could have influenced the number of readmissions since automatic approval may have made some providers less discerning when (re)admitting patients. Additionally, one MCE explained that due to the automatic authorization, hospital staff were collecting less information from patients at intake and MCEs were not able to use Utility Management (UM) as originally intended to track individuals, shape provider behaviors, and determine care plans. During this time, they relied more on management and CHWs to track individuals.

Several interviewees (i.e., Providers and MCEs) described the importance of effective discharge planning, care coordination, and patient follow-up in the achievement of Goal 2. MCE representatives described the importance of strong relationships between inpatient and outpatient providers to address barriers prior to discharge to facilitate successful transitions, ensure that follow up appointments are completed, and prevent readmissions. Interviewees described the role of care coordinators as critical in maintaining these relationships.

Goal 3 – Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state

Crisis response and stabilization (e.g., crisis call centers, crisis mobile team response, crises receiving and stabilization services) is a basic element of mental health care and often serves as an access point for connecting individuals to community care resources. Although evidence regarding crisis response programs is emerging, research has indicated that crisis response is associated with improved health outcomes.[33]

Goal 3 for the SMI demonstration provides a baseline measurement of the number of crisis stabilization services that were available during the initial year of the demonstration. Since the scope of the summative report is limited to the first year of the demonstration, findings are descriptive and provide a snapshot of services utilized across multiple service models. **Exhibit 6.23** describes the hypothesis, RQs, and how the RQs were assessed during the initial year of the demonstration.

Exhibit 6.23: Goal 2 research questions and how the research questions were assessed during the initial year of the demonstration

Hypothesis: The SMI demonstration will result in improved availability of crisis stabilization services throughout the state.	
2020 Evaluation Plan Research Questions	**How was the Research Question assessed in 2020?**
Primary research question 3: To what extent does the SMI demonstration result in improved availability of crisis outreach and response services (including crisis call centers, mobile crisis units, crisis observation/assessment centers, and coordinated community crisis response teams) throughout the state? **Primary research question 3.1:** To what extent does the SMI demonstration result in improved availability of intensive outpatient services and partial hospitalization?	Descriptive information is provided to describe the number of crisis outreach and response services as well as the number of intensive outpatient, partial hospitalization settings, psychiatric hospitals, psychiatric residential facilities, FQHCs, and CMHCs. Indiana identified four activities in the Indiana SMI waiver demonstration implementation plan to achieve Goal 3. All demonstration activities were shared across Goals 1 & 2, yielding no distinct activities for Goal 3. Qualitative findings focus on the status of CSUs and MRSS implementation.
Primary research question 3.2: To what extent does the SMI demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals; residential treatment facilities; general hospital psychiatric units; and community-based settings (such as residential crisis stabilization programs, small inpatient units in CMHCs, peer-run crisis respite programs, and so on)?	

[33] Vikki, W., & Natasha, C. (2021, May). *Building blocks: How Medicaid can advance mental health and substance use crisis response*. Well Being Trust. Retrieved April 22, 2022, from https://wellbeingtrust.org/wp-content/uploads/2021/05/WBT-Medicaid-MH-and-CrisisCareFINAL.pdf

Consistent with the prior goals, the Summative Evaluation does not draw conclusions about the impact of the demonstration on Goal 3 outcomes.

Quantitative Results

Exhibits 6.24 – 6.26 provide the total number of crisis response services by service type and location. Findings from the provider availability assessment indicate a limited number of crisis outreach and response services across the state with most services (n = 97) being crisis call centers. Both crisis call centers and mobile crisis units are equally split across urban and rural locations. Crisis observation/ assessment centers and coordinated community crisis response teams are mostly located in urban areas.

Exhibit 6.24: Number of Crisis Outreach and Response Services by Location

Service Type	Number of Service Type in Rural Areas	Number of Service Type in Urban Areas	Total Number Across the State
Crisis Call Centers	47	50	97
Mobile Crisis Units	3	3	6
Crisis Observation/ assessment centers	0	2	2
Coordinated community crisis response teams	1	5	6

Findings from the provider availability assessment indicated that there were 118 intensive outpatient and partial hospitalization service settings available for SMI Medicaid recipients. More than half (56%) of these services are located in urban areas.

Exhibit 6.25: Number of Intensive Outpatient/Partial Hospitalization Services by Location

Service Type	Number of Service Type in Rural Areas	Number of Service Type in Urban Areas	Total Number Across the State
Intensive Outpatient/ Partial Hospitalization	52	66	118

Findings from the provider availability assessment indicated that the largest service type for crisis stabilization services in short-term stay facilities are CMHCs (97). CMHCs are equally distributed across rural and urban areas. Fewer psychiatric hospitals, psychiatric residential facilities, and FQHCs are available in rural areas.

Exhibit 6.26: Number of Hospital and Residential Services by Location

Service Type	Number of Service Type in Rural Areas	Number of Service Type in Urban Areas	Total Number Across the State
Psychiatric Hospitals	10	24	34
Psychiatric Residential Facilities	2	9	11
FQHCs	1	22	23
CMHCs	47	50	97

Qualitative Results

State officials described efforts to pilot two CSUs across the state to provide an alternative to crisis evaluations within EDs and divert admissions to inpatient psychiatric units. As stated previously, CSUs serve as an alternative to an ED or jail for patients experiencing mental health issues. While initial implementation was delayed due to the PHE, two certified mental health clinics, Centerstone Indiana and Four County, were awarded contracts to operate CSU pilots which began on July 1, 2020 and will end on June 30, 2022. Data will be used to assess implementation and relevant outcomes (e.g., efficiency, quality of care, treatment received, repeat CSU use). Findings from the pilots will inform planning for future crisis stabilization work including scope and scale of services and operational considerations (e.g., staffing requirements, model options and provider needs).

Additionally, multiple interviewees mentioned further expansion of crisis response efforts that are not related to the SMI waiver demonstration. For example, the House Enrolled Act 1222 requires DMHA to establish a plan for the expanded use of Certified Community Behavioral Health Clinics (CCBHCs) in Indiana including the role of 988 and how initiatives will be coordinated. Although DMHA is in the planning phase, interviewees anticipated that changes will involve expanding crisis stabilization services at CCBHCs. Further, State officials described how 17 organizations (15 CCCBHCs and 2 hospitals) received 2-year SAMHSA CCBHC Expansion grants in FY18-FY21 which require participation in crisis response efforts.

Pilot MRSS are similar to an EMS or ambulance response (vehicle that can elevate the level of care) and staffed with various types of heath care providers (e.g., Peer Counselor, Licensed Professional, an Advanced Practice RN, and/or Certified Nursing Assistant). MRSS typically is for families with youth and young adults up to age 22 who are experiencing difficulties or distress, that can then receive assistance within 60 minutes after contacting the services. With MRSS, a patient calls 211 in the case of a behavioral health emergency and a Peer Counselor or Licensed Professional will attempt to mitigate the crises via a phone call. If the crisis persists, a mobile team will be dispatched to the location for in-person services. If the crisis continues to persist, the patient will transported to the CSU (23-hour acute inpatient setting) followed by the ED if deemed necessary. Consistent with CSUs, the purpose of a mobile crisis response team is to divert individuals in crisis away from hospitals, EDs, and jails to effectively eliminate the overuse and misuse of these services as well as to better service individuals in crisis and prevent fatalities from suicide, drug overdose, and other mental health and substance use emergencies. Mobile crisis response teams are intended to be immediate and short term. MRSS utilize evidence-based practices to screen, assess, stabilize, and refer persons in need to CSUs, inpatient hospitals, certified respite facilities, or an individual's established provider. Indiana initially intended to pilot a MRSS as part of the SMI waiver implantation, however, pilot efforts were postponed due to the PHE. OMPP and DMHA are working to expand mobile crisis services and are pursuing a Medicaid SPA. The amendment will enable mobile crisis teams to enroll as providers eligible to receive reimbursement directly by Indiana Medicaid.

Despite delayed efforts due to the PHE, many interviewees were optimistic about future implementation of CSU and MRSS and spoke confidently about their ability to reduce utilization and ED LOS and readmissions among recipients with SMI while awaiting mental health treatment; however, interviewees noted that it will take close to two years to see meaningful change after implementation. Interviewees described the trickle-down-effect of increased crisis response services on the behavioral health delivery system. Providers indicated that a large portion of individuals referred to CSU are individuals experiencing homelessness. Interviewees noted that one of the goals of the CSU is to take care of crisis situations so that the CMHC can focus on issues such as homelessness that "go beyond SMI

treatment." In addition to addressing behavioral health needs, CSU providers are able to assist these individuals with non-medical related needs (e.g., finding housing; connecting with community resources). Some of the CSU programming described by interviewers overlapped with the pilot for Indiana's 211 OpenBeds® Program, an innovative program in Indiana which is a partnership between "Indiana 211" and "OpenBeds®" to increase timely access to substance use disorder treatment by matching individuals to open treatment slots in the state. Interviewees described how these services stop the continuous cycling of certain individuals through law enforcement and EDs and help to appropriately triage individuals to care and services.

Non-Demonstration Activities. While not implemented as part of the SMI waiver demonstration or during the initial demonstration year (2020), several interviewees described the passage of the 988 Legislation. The 988 initiative will go live in July 2022 and features a new Suicide Hotline, spearheaded by a partnership between DMHA and the 988 coalition (including stakeholders, like law enforcement agencies, IN hospital association, CMHC association, etc.). The initiative is working to tie together the 988 hotlines with the CSU. Similarly, while not implemented due to the SMI waiver demonstration, warm-lines (alternative to hot-lines) funding was awarded to the State of Indiana by SAMHSA as part of an emergency COVID-19 mental health grant.

Interviewees indicated that these services are most needed in the southern rural areas of Indiana, yet implementation in these areas are challenging as they lack existing SMI infrastructure. Interviewees stated that the State needs to re-evaluate funding streams to identify ways to expand the number of CSUs throughout the state, especially in resource limited areas where implementation may be more intensive and challenging

Goal 4: Increase access of recipients with SMI to community-based services to address their chronic mental health care needs including through increased integration of primary and behavioral health care.

Approximately 10.4 million adults in the United States had an SMI in 2016, yet only 65 percent received mental health services during that year.[34] Individuals with SMI suffer disproportionately from physical health conditions than their non-SMI peers and are at increased risk for a range of acute and chronic diseases (e.g., diabetes, cardiovascular disease, respiratory disease, cancer, and infectious disease). In fact, life expectancy estimates for adults with SMI range from eight to 30 years lower than for the general population. Disparities have been attributed to modifiable risk factors such as substance use, poor nutrition, lack of exercise, obesity, housing instability and low socioeconomic status. Fragmentation between the general medical and behavioral health sectors is widely considered to be a significant contributor to the poor overall health outcomes associated with SMI populations.[35] Treatment options that span the entire continuum of care are needed, particularly for those individuals living with a SMI.

Goal 4 for the SMI demonstration provides the percentage of recipients with SMI who received community-based services to address their mental health needs during the initial year of the

[34] *Facilitating access to mental health services: A look at Medicaid, private insurance, and the uninsured*. Kaiser Family Foundation. (2019, March 14). Retrieved April 22, 2022, from https://www.kff.org/medicaid/fact-sheet/facilitating-access-to-mental-health-services-a-look-at-medicaid-private-insurance-and-the-uninsured/

[35] Breslau, J., Sorbero, M. J., Kusuke, D., Yu, H., Scharf, D. M., Hackbarth, N. S., & Pincus, H. A. (2019, March 28). *Primary and behavioral health care integration program: Impacts on Health Care Utilization, cost, and quality*. Office of the Assistant Secretary for Planning and Evaluation. Retrieved April 22, 2022, from https://aspe.hhs.gov/reports/primary-behavioral-health-care-integration-program-impacts-health-care-utilization-cost-quality-0

demonstration. **Exhibit 6.27** describes RQs related to this hypothesis, and how the RQs were assessed for the demonstration period (which spanned calendar year 2020).

Exhibit 6.27: Goal 4 research questions and how the research questions were assessed during the initial year of the demonstration

Hypothesis: Improved access to community-based services to address the chronic mental health care needs of recipients with SMI or SED including through increased integration of primary and behavioral health care	
2020 Evaluation Plan Research Questions	**How was the Research Question assessed in 2020?**
Primary research question 4: Does the demonstration result in improved access of recipients with SMI to community-based services to address their chronic mental health care needs? **Subsidiary research question 4.a**: To what extent does the demonstration result in improved availability of specific types of community-based services needed to comprehensively address the chronic needs of recipients with SMI? **Subsidiary research question 4.b**: To what extent does the demonstration result in improved access of SMI recipients to specific types of community-based services?	Descriptive information is provided to describe community-based service utilization and participation during 2020. Overall, community-service utilization was likely impacted by COVID-19 as a result of social distancing parameters, and individuals choosing to delay medical care. Changes in overall utilization during 2020 have considerable implications for this research question.
Primary research question 4.1: Does the integration of primary and behavioral health care to address the chronic mental health care needs of recipients with SMI increase under the demonstration?	Indiana identified two activities in the Indiana SMI waiver demonstration implementation plan to achieve Goal 4. Due to the PHE, the State delayed implementation of one initiative (Health Homes SPA) associated with Goal 4 to prioritize behavioral health care system modifications (e.g., access to telehealth) for patient care during this unprecedented time. Subsequently, interviewees discussed the status of the one initiative that was implemented and the current state of primary and behavioral health care integration to address the chronic mental health care needs of recipients with SMI.

Indiana Medicaid aims to address the chronic mental health care needs of recipients with SMI by improving access to community-based services. Consistent with Goal 1, we assessed the utilization of services (i.e., participation rate - the percent of SMI recipients who have used any community-based service) rather than the impact to provide a description of service use during the initial demonstration year. Community-based services assessed included: HCBS, LTSS, Outpatient Rehabilitation Services, and other Outpatient Mental Health Services

Quantitative Analysis Approach

The Participation Rate was used to measure the SMI population's access to community-based, mental health related services. Community-based services consist of three main components: 1) outpatient rehabilitation services provided by the MRO program and other outpatient rehabilitation services (including partial hospitalization or intensive outpatient services), 2) outpatient mental health services, 3) LTSS and HCBS services.[36,37] HCPCS and revenue codes on the claim / encounters were used to identify LTSS and HCBS services, including adult group psychotherapy, day habilitation, home health, and skilled

[36] Outpatient Rehabilitation Services align with Measure #14 found in "Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics" Version 3.0, Sept 2021

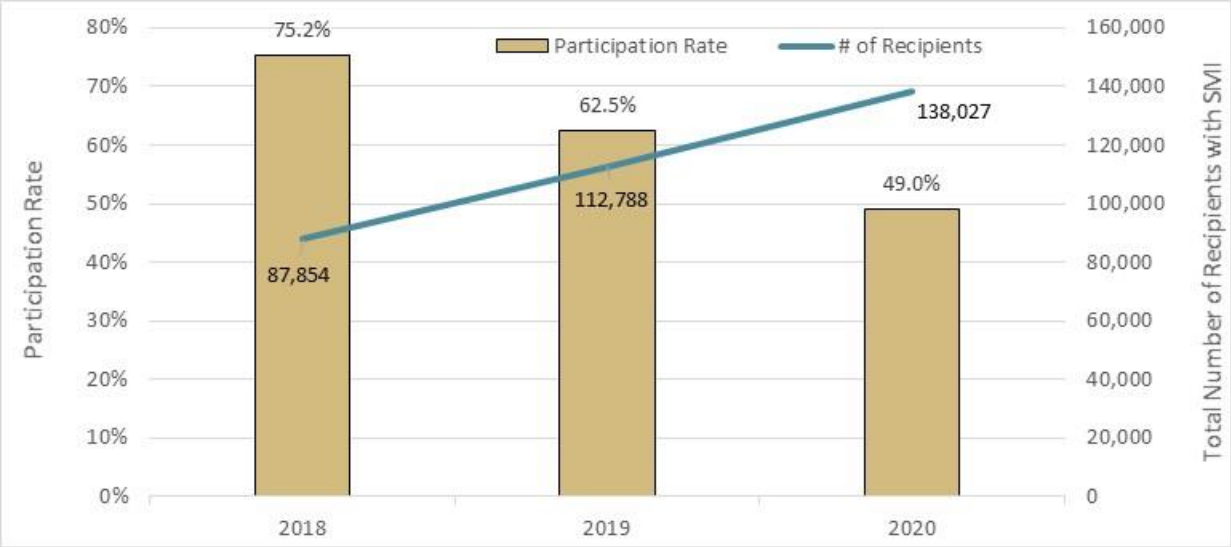
[37] Outpatient Mental Health Services align with Measure #15 found in "Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics" Version 3.0, Sept 2021

nursing. For any service identified, a corresponding mental health diagnosis code was required to be included for identifying the number of recipients who received community-based care for mental health support. The denominator for the participation rate was all SMI recipients.

Quantitative Results

The participation rate for overall mental health-related community-based services decreased across the years (**Exhibit 6.28**). Between 2018 and 2019 the participation rate for mental health-related community-based services declined by 12.7 percentage points (from 75.2 to 62.5%) and continued to decline an additional 13.5 percentage points between 2019 and 2020. By the end of 2020, less than half of the Indiana Medicaid SMI recipients were receiving a community-based service for mental health.

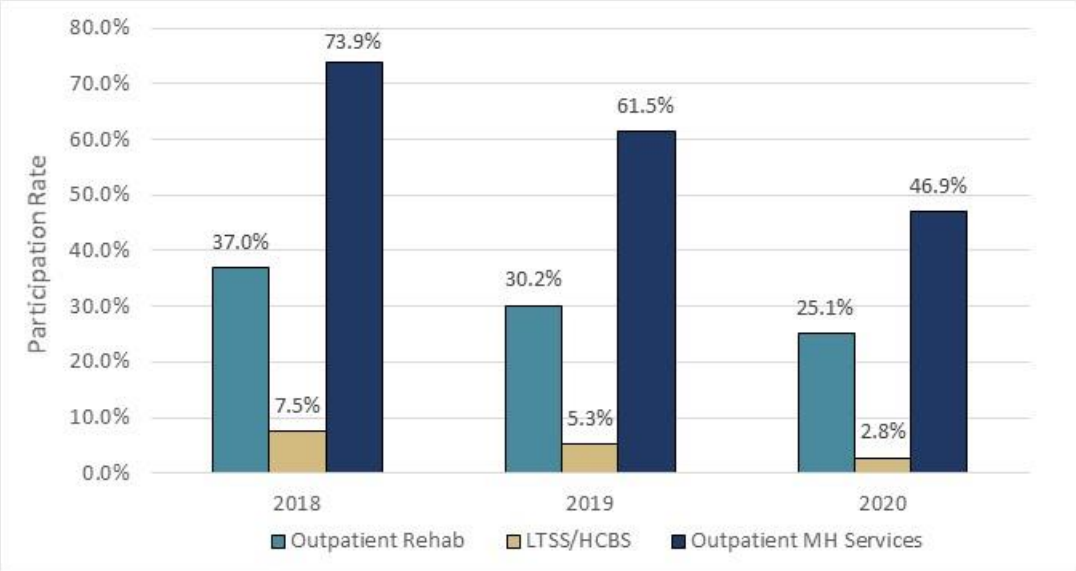
Exhibit 6.28: Participation Rate for Mental Health Related Community-Based Service by Recipients with SMI (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Of the three community-based services, outpatient mental health service has the highest participation rate, ranging from 73.9% in 2018 to 46.9% in 2020. LTSS/HCBS ranged from 7.5% in 2018 to 2.8% in 2020, and outpatient rehab ranged from 37.0% in 2018 to 25.1% in 2020. The participation rate declined in 2019 for each service type and then declined again in 2020. See **Exhibit 6.29**.

Exhibit 6.29: Participation Rate Across Types of Mental Health-Related Community-Based Service with SMI (January 2018 – December 2020)



Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Participation rates for individual between the ages of 41 and 60 were higher than recipients in the younger (ages of 21-40) and older (61-64) cohorts. Consistent with overall participation rates, rates declined for all age groups across the three years. The largest participation decline (approximately 27 percentage points) occurred in the oldest age group (61-64). See **Exhibit 6.30**.

Exhibit 6.30: Age -Mental Health Related Community-Based Service by Recipients with SMI

Age Group	Jan-2018 - Dec 2018		Jan-2019 - Dec 2019		Jan-2020 - Dec 2020	
	# of Recipients	Participation Rate	# of Recipients	Participation Rate	# of Recipients	Participation Rate
All Recipients with SMI	**87,854**	**75.6%**	**112,788**	**62.9%**	**138,027**	**49.6%**
21-30	20,191	72.5%	27,543	59.3%	36,176	47.3%
31-40	22,724	73.6%	30,057	60.5%	38,027	47.1%
41-50	21,211	76.7%	26,672	64.2%	31,984	50.0%
51-60	21,874	76.7%	27,056	64.1%	30,950	49.9%
61-64	6,735	71.1%	8,872	57.9%	10,592	44.1%

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

The participation rate for rural Medicaid recipients with SMI was consistently lower than those in more populated counties (**Exhibit 6.31**). Rural participation rates for community-based services ranged between 7 - 11 percentage points lower than counties with a population greater than 20,000. This gap between rural counties and more populated counties narrowed in 2020.

Exhibit 6.31: Urban/Non-Metro -Mental Health Related Community-Based Service by Recipients with SMI

Metro/Non-Metro	Jan-2018 - Dec 2018		Jan-2019 - Dec 2019		Jan-2020 - Dec 2020	
	# of Recipients	Participation Rate	# of Recipients	Participation Rate	# of Recipients	Participation Rate
All Recipients with SMI	**87,854**	**75.6%**	**112,788**	**62.9%**	**138,027**	**49.6%**
Metro	66,862	75.9%	86,082	63.0%	105,026	48.9%
Non-Metro >20k	7,863	75.8%	9,926	63.6%	12,159	53.0%
Non-Metro 2.5 -20k	12,334	74.2%	15,755	62.1%	19,615	51.0%
Rural	695	64.6%	915	55.2%	1,109	46.7%

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Medicaid recipients with SMI and enrolled in HIP had a lower participation rate than those not enrolled in HIP between 2018 and 2020. In 2018 Non-HIP recipients' participation rate was 80.7%, 11.7 percentage points higher than HIP recipients (69.0%). By 2020 the participation rates declined to 53.7% and 45.0% respectively. The number of recipients in a HIP plan increased at a greater rate than those not in a HIP plan, as the HIP plan recipients with SMI increased 69.2% from 2018 to 2020, while the number of non-HIP recipients with SMI increased 42.7%. See **Exhibit 6.32**.

Exhibit 6.32: HIP/Non-HIP -Mental Health Related Community-Based Service by Recipients with SMI

HIP Enrollment	Jan-2018 - Dec 2018		Jan-2019 - Dec 2019		Jan-2020 - Dec 2020	
	# of Recipients	Participation Rate	# of Recipients	Participation Rate	# of Recipients	Participation Rate
All Recipients with SMI	**87,854**	**75.6%**	**112,788**	**62.9%**	**138,027**	**49.6%**
HIP	48,419	69.0%	64,961	57.2%	81,936	45.0%
Non-HIP	42,899	80.7%	53,476	66.8%	61,213	53.7%

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Participation rates decreased over time irrespective of recipient race – although the rate of decrease varied. For example, the participation rate for all Medicaid recipients with SMI decreased 26.0 percentage points from 2018 to 2020 (75.6% to 49.6%). Comparatively, the participation rate for Black recipients, during that same time period declined 32.8 percentage points, from 79.6% to 46.8%; participation rate for Caucasian recipients and "Other" declined 26.1 and 23.1 percentage points, respectively. See **Exhibit 6.33**.

Exhibit 6.33: Race -Mental Health Related Community-Based Service by Recipients with SMI

Race	Jan-2018 - Dec 2018		Jan-2019 - Dec 2019		Jan-2020 - Dec 2020	
	# of Recipients	Participation Rate	# of Recipients	Participation Rate	# of Recipients	Participation Rate
All Recipients with SMI	**87,854**	**75.6%**	**112,788**	**62.9%**	**138,027**	**49.6%**
Black	9,960	79.6%	12,927	63.1%	15,464	46.8%
Caucasian	59,690	73.4%	75,030	60.5%	91,408	47.3%
Other	18,204	80.7%	24,831	70.1%	31,155	57.6%

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

Approach to Qualitative Analysis

Through key informant interviews, this evaluation aimed to assess Indiana's efforts to improve integration of primary and behavioral health care to address the chronic mental health care needs of recipients with SMI. FSSA officials, MCE representatives, advocacy organizations and providers provided feedback during key informant interviews about the integration of primary and behavioral health care to address mental health care needs of recipients with SMI under the demonstration.

Qualitative Results

The Indiana SMI Waiver demonstration implementation plan described two main efforts to improve the integration of primary and behavioral health care to address the chronic mental health care needs of recipients with SMI. The plan described the intent to further sustainability and expansion of the State's model for PCBHI through submission of an application for SAMHSA's (FY) 2020 PIPBHC grant as well as implementation of a Health Homes SPA.

- **PIPBHC Grant**. The purpose of the PIPBHC program is to: (1) promote full integration and collaboration in clinical practice between primary and behavioral health care; (2) support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with SMI; and (3) promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental health and SUD, and co-occurring physical health conditions and chronic diseases.
- **Health Homes**. The Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects states Health Homes providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and LTSS to treat the whole person.

The State applied for the PIPBHC grant in 2019 however the award was not granted to the State until March 2021. The implementation of the Health Homes SPA was deprioritized in 2020 due to the PHE. Interviewees described that the PHE put significant stress on the primary care and behavioral health systems and emphasized the potential for increased provider burden if new strategies were implemented. Thus, implementation of the Health Homes SPA as well as strategies related to the expansion of the State's model for primary care and behavioral health were delayed. State officials indicated that the Health Homes initiative will be explored as part of the expansion and designation of CCBHC in Indiana. According to House Enrolled Act 1222 (2022), DMHA is required to provide a report to the Indiana legislature by November 1, 2022 that will provide a plan discussing the potential expansion of CCBHCs statewide in Indiana, coordinate CCBHC expansion with 988 implementation and work to develop a PPS rate or other financial model. Health Homes is being explored as part of the CCBHC expansion.

Non-Demonstration Activities. While not implemented due to the SMI Waiver demonstration, interviewees described activities that support the achievement of goal four. Interviewees noted that a key barrier to achievement of goal four is the limited supply of qualified mental health providers. Interviewees explained that there are simply not enough behavioral health providers in Indiana, stating that the challenge of limited provider supply is not specific to Medicaid and extends to all populations in the state. These shortages tax current providers who struggle to keep up with increasing demand for services given high patient loads, pandemic-related restrictions, and burnout. Interviewees felt that addressing issues with provider supply is a necessary aspect of achieving Goal 4 and several described the importance of the House Enrolled Act 1175 which passed in the 2019 legislative session and will expand access to behavioral

health providers for Medicaid enrollees. Under this law, LCSWs, LMHCs, licensed clinical addiction counselors and LMFTs will be eligible providers for the supervision of a plan of treatment for a patient's outpatient mental health or substance abuse treatment services. Interviewees described that this change successfully expanded the pool of available behavioral health providers, which in theory will increase provider availability to participate in coordination activities with primary care. Interviewees indicated that increasing provider availability is foundational to any efforts to increase coordination and integration with primary care. However, interviewees noted that the supply of providers within Indiana is still inadequate and state officials stated that they are continuing to look for additional solutions to the provider shortage while maintaining best practices in care. FSSA has invested in several efforts, starting in 2020 to improve provider capacity assessments and identify actions that will further close the gap between demand and supply. Interviewees were optimistic about reintroducing efforts to increase integration of behavioral health and primary care once the supply of providers was adequate and stabilized.

Goal 5: Improved care coordination, especially continuity of care in the community following episode of acute care in hospitals and residential treatment facilities.

Disparities in health outcomes for individuals with SMI suggests a need for a coordinated, multifaceted approach that goes beyond conventional psychiatric care. In addition to disparities in health outcomes, people with SMI often use the mental health care system as their principal setting for access to medical and social care.[38,39,40] As such, community mental health settings are challenged to address the many demands associated with comorbid chronic medical conditions and related primary and preventive care needs.[41] A key strategy to reducing these disparities requires effective coordination and care integration.

Using findings from key informant interviews, we examined activities and factors influencing improved care coordination and continuity of care for SMI recipients during the initial demonstration year to assess Goal 5. **Exhibit 6.34** describes RQs related to this hypothesis, and how the RQs were assessed during the initial year of the demonstration.

[38] Bartels SJ (2003). Improving the system of care for older adults with mental illness in the United States: Findings and recommendations for the President's new freedom commission on mental health. *American Journal of Geriatric Psychiatry*, 11, 486–497.

[39] De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, … Leucht S (2011a). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 10, 52–77.

[40] Bao Y, Casalino LP, & Pincus HA (2013). Behavioral health and health care reform models: Patient-centered medical home, health home, and accountable care organization. *Journal of Behavioral Health Services & Research*, 40, 121–132.

[41] Bao Y, Casalino LP, & Pincus HA (2013). Behavioral health and health care reform models: Patient-centered medical home, health home, and accountable care organization. *Journal of Behavioral Health Services & Research*, 40, 121–132.

Exhibit 6.34: Goal 5 research questions and how the research questions were assessed during the initial year of the demonstration

Hypothesis: Improved access to community-based services to address the chronic mental health care needs of recipients with SMI or SED including through increased integration of primary and behavioral health care	
2020 Evaluation Plan Research Questions	**How was the Research Question assessed in 2020?**
Primary RQ 5: Does the SMI demonstration result in improved care coordination for recipients with SMI?	Interviewees did not identify any changes to the data sharing system, processes or policies due to the SMI Waiver demonstration. However, challenges and supporting factors related to care coordination and data systems are discussed.
Primary RQ 5.1: Does the SMI demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? **Subsidiary RQ 5.1a:** How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	Indiana identified three activities in the Indiana SMI waiver demonstration implementation plan to achieve Goal 5. Due to the PHE, none of the three activities were implemented as intended. Subsequently, interviewees discussed the state of care coordination efforts for the SMI populations during 2020 and described non-demonstration activities that were implemented to improve care coordination and continuity of care.

Approach to Qualitative Analysis

FSSA officials, MCE representatives, advocacy organizations and providers provided feedback during key informant interviews about the improved care coordination and continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Qualitative Findings

None of the three activities described in the Indiana SMI Waiver demonstration implementation plan for goal five were implemented as intended due to the PHE (see previous responses RE: Indiana Provider Manual, Implementation of Health Homes SPA and expansion of state's model for PCBHI). However, interviewees described ongoing efforts to improve care coordination as well as challenges and factors influencing the achievement of goal five.

Interviewees discussed several PHE-related challenges that influenced care coordination, indicating that the PHE exacerbated existing staffing and resource shortages. During the PHE, many providers (i.e., primary care or mental health providers) put a hold on accepting new patients, making it difficult for care coordinators to connect new patients to needed care. Further, many community-based services reduced capacity or closed entirely during the PHE, limiting the number of services provided in a community. Given the increased need and simultaneous decline in the supply of available resources, care coordinators scrambled to connect patients with needed services and spent more time tracking resource availability. One MCE representative described the challenge of maintaining a repository of available services given the constant changes in program operations due to the PHE. Consequently, this MCE began meeting with the ICCMHCs to stay abreast of available services, changes in intake processes, and changes in operations (hours, in-person services, etc.). The MCE would update a spreadsheet with this information to inform the care management team. Interviewees stated that rural areas were particularly affected due to more severe resource limitations (i.e., fewer providers and facilities providing care and services).

Interviewees described several challenges to the achievement of goal five including transportation limitations, provider engagement, and issues with telehealth access. Interviewees described issues with transportation as limiting care coordination efforts indicating that investments into care coordination

could be derailed by lack of transportation. One provider described that they can dedicate time, effort and resources to care coordination, but transportation issues continue to limit patient access to resources. One MCE identified provider engagement as a persistent barrier to care coordination indicating that collaboration and communication between managed care companies and providers could be improved. ED providers described how telehealth emerged as a solution for care delivery, but internet access posed challenges for care due to the lack of broadband internet connection or technology infrastructure. This was particularly challenging for rural communities.

Additionally, some MCE and providers indicated that the State issued order which allowed providers to authorize stays of up to seven days without a medical necessity review, resulted in patients being admitted without sufficient admission information. Interviewees described that without the appropriate patient data, discharge summaries lacked adequate information to support effective care coordination and increased the workload for care coordinators, limiting their utility.

Non-Demonstration Activities. While not implemented due to the SMI waiver demonstration, interviewees described several initiatives that support the achievement of goal five. For example, through the SAMHSA PIPBHC grant the State is working on creating a platform that combines individual health data from multiple sources including Medicaid claims to better track patient care needs. Once completed, the platform will include a visual alert displayed when certain items are due (or past-due), which would allow the prescribing doctor to see the mental health notes/concerns and vice-versa. Additionally, MCE interviewees mentioned strategies they have implemented to improve access to community-based services to address chronic mental health needs. Several MCE interviewees described the importance of integrated care management teams that make referrals to community programs that address issues related to social determinants of health. One interviewee described how OpenBeds software created an extension that allows users to make referrals to social services including housing resources. Other resources mentioned include My Resources and Aunt Bertha which connect recipients to local community outreach services.

VII. Conclusions

This section provides high-level observations for each goal of the Indiana SMI demonstration and highlights areas of focus for the State moving forward. **Section VI** provides additional detail by hypothesis and research question.

For Indiana and other states testing new approaches and flexibilities in their Medicaid programs through Section 1115 waiver demonstrations, evaluation allow states to build on successes and make adjustments based on lessons learned. This Summative Evaluation report provides a snapshot of the initial demonstration year (January – December 2020) and can be used to inform the State's strategy for continued implementation of policies and activities that achieve the intended goals of the waiver demonstration including increasing access to care and community-based services for recipients with SMI conditions, decreasing utilization and LOS in EDs as well as preventable readmissions to acute care hospitals and residential settings.

Overall, availability and access to care and community-based services were identified as key areas for addressing the needs of recipients with SMI. Findings indicated that telehealth policy modifications and crisis stabilization services were critical in supporting recipients with SMI during the PHE. Although the expansion of telehealth was a positive development for increasing access to care, challenges associated with expanded telehealth and technology issues persisted and were amplified by the limited supply of qualified mental health providers. Key observations include:

- The number of recipients covered by the SMI Waiver increased from 2018 to 2020, while the distribution of age, gender, race, ethnicity, geographic location, and HIP enrollment of recipients with SMI has remained similar across the three years (2018 – 2020).
- ED utilization rates for Medicaid recipients with SMI in January and February 2020 were comparable to rates during same time in 2018 and 2019, however, utilization rates declined by 34% beginning in March and April 2020, coinciding with the start of PHE. ED utilization rates followed similar trends of national in-person health care service utilization.
- While interviewees noted differential population accessibility to telehealth services (i.e., technology availability for rural Indiana), most indicated that expanded telehealth services increased access to services for many which may in turn lead to reduced readmissions.
- Findings from the provider availability assessment indicate a limited number of crisis outreach and response services across the state with the majority of services (n = 97) being crisis call centers. Both crisis call centers and mobile crisis units are equally distributed across urban and rural locations. Crisis observation/assessment centers and coordinated community crisis response teams are mostly located in urban areas.
- Participation rate in mental health-related community-based services decreased across time. Of the three community-based services, outpatient mental health service has the highest participation rate, ranging from 73.9% in 2018 to 46.9% in 2020.
- Interviewees explained that there are simply not enough behavioral health providers in Indiana, stating that the challenge of limited provider supply is not specific to Medicaid and extends to all populations in the state.

The initial year of the demonstration period (2020) coincided with the PHE, which began in March 2020. The ongoing PHE caused substantial changes to Medicaid policies, service utilization and provider availability, and delayed, modified or cancelled many of the planned implementation activities to

accommodate access to and delivery of high-quality mental health services for all Indiana residents. Given the profound impact of the PHE on health care delivery, the likelihood of the PHE's confounding effect and the analytic limitations with program outcome measures, the 2020 Summative Evaluation does not draw conclusions about the impact of the SMI waiver demonstration on goal outcomes. Future evaluation reports will include analytic methods to assess reductions or improvements in identified metrics.

Given the limited implementation of the planned demonstration activities, we recommend moving forward with activities identified in the initial implementation plan:

- Increase crisis stabilization and response services in rural areas
- Acquire software to track availability of psychiatric inpatient and crisis stabilization beds
- Continue to monitor network provider capacity and recruit new providers
- Review Health Homes SPA and determine next steps

Additionally, we recommend modifying the implementation plan to reflect the short- and long-term impacts of the PHE on Indiana's health care system and SMI populations as well as include:

- Sustain telehealth policy modifications
- Enroll mid-level providers in Medicaid as well as implement action items identified in ongoing behavioral health supply gap analyses that are relevant to SMI populations

VIII. Interpretations, Policy Implications and Interactions with Other State Initiatives

Indiana's §1115 waiver amendment enabled the State to reimburse acute inpatient stays in IMDs for individuals diagnosed with a SMI. The §1115 waiver amendment is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services for Indiana residents. As stated throughout this report, the initial year of the demonstration period (2020) coincided with the PHE, which began in March 2020. The ongoing PHE caused substantial changes to Medicaid policies, service utilization and provider availability, and will have short- and long-term impacts on Indiana's health care system and specialized populations, such as SMI. Given the timing of the PHE, the State shifted many of the planned implementation activities to accommodate access to and delivery of high-quality mental health services for all Indiana residents, particularly given the social distancing and health care resource prioritization required in response to the PHE. Additionally, program outcome measures use 2020 data only (demonstration period) and thus caution should be used when interpreting data and drawing conclusions. As such, the evaluation team did not draw conclusions about the impact of the demonstration and constructed the summative report as a snapshot of the demonstration's initial year.

During 2020, the State implemented several behavioral health initiatives that aligned with the demonstration goals and the needs of Indiana residents during the PHE. Although these initiatives were not initially codified in the implementation plan, their influence on SMI populations is expected. Key initiatives include:

- **Telehealth.** Effective March 1, 2020 and through the duration of Indiana's PHE, an executive order authorized the OMPP to expand the use of telehealth. Unsurprisingly, these changes in policy led to an increase in the number of Medicaid claims billed for telehealth services. The majority of these claims were submitted by behavioral health providers, with claims for psychotherapy services making up about 20% of health care services provided via telehealth.
- **Mental Health Workforce Capacity**. FSSA has invested in several efforts, starting in 2020 to improve provider capacity assessments and identify actions that will further close the gap between demand and supply. Interviewees were optimistic about reintroducing efforts to increase integration of behavioral health and primary care once the supply of providers was adequate and stabilized. Additionally, effective July 1, 2019, in accordance with SCM approval of SPA TN 18-012, Indiana Medicaid expanded crisis intervention services intensive outpatient program services and peer recovery services to all Indiana Medicaid programs. This change expanded the available provider base from the Indiana's CMHCs to all Medicaid enrolled providers meeting the applicable criteria.

While not implemented as part of the SMI waiver demonstration or during the initial demonstration year (2020), the following activities were in planning phases during the demonstration time period.

- **Enrollment of Mid-Level Providers.** To increase the State's capacity of mental health Medicaid providers, the House Enrolled Act 1175 passed in the 2019 legislative session expanded access to behavioral health providers (e.g., LCSWs, LMHCs, licensed clinical addiction counselors and LMFTs) for Medicaid enrollees. Enrollment was scheduled to begin in Q1 of 2021 and will allow Indiana to reimburse and monitor the full scope of providers who offer mental health services, populations served, location, and service type provided. This activity will position FSSA to better identify gaps in service and address ongoing training and support needs.
- **988 Legislation**. The 988 initiative went live in July 2022 and features a new Suicide Hotline, spearheaded by a partnership between DMHA and the 988 coalition (including stakeholders, like law enforcement agencies, IN hospital association, CMHC association, etc.). The initiative is

working to tie together the 988 hotlines with the CSU. Funding was awarded to the State of Indiana by SAMHSA as part of an emergency COVID-19 mental health grant.

Given the timing of the PHE and its likely confounding effects on the demonstration, extended timelines for activity implementation (adapting as appropriate for post pandemic needs) and evaluation is recommended to support analysis of impact and assess policy implications.

IX. Lessons Learned and Recommendations

This section describes lessons learned and recommendations from the SMI demonstration. **Exhibit 9.1** summarizes each lesson learned and recommendation(s) for the demonstration.

Exhibit 9.1: Lessons Learned and Recommendations

Lessons Learned	Recommendations
Demonstration activities require more time for implementation due to the PHE. Implementation plans should reflect PHE realities.	• Reassess the implementation plan to reflect the PHE realities. Revise Implementation plan to reflect the short- and long-term impacts of the PHE on Indiana's health care system and SMI populations. • Increase crisis stabilization and response services in rural areas. • Acquire software to track availability of psychiatric inpatient and crisis stabilization beds. • Review Health Homes SPA and determine next steps.
Increasing the behavioral health workforce capacity by implementing key policies and initiatives that will maximize availability and access to quality evidence-based care.	• Continue to monitor network provider capacity and recruit new providers. • Enroll mid-level providers in Medicaid as well as implement action items identified in ongoing behavioral health supply gap analyses that are relevant to SMI populations. • Implement relevant actions identified in behavioral health workforce gap analyses.
Social determinants of health factors limit access to behavioral health services particularly in rural areas.	• Sustain telehealth policy modifications. • Implement activities that address social determinants of health (e.g., transportation) and increase network capacity across the state.
The timing of the PHE and its likely confounding effects on the demonstration limits interpretations for the initial demonstration year.	• Extend timelines for activity implementation (adapting as appropriate for post pandemic needs) and evaluation to support analysis of impact and assess policy implications. • Consider using a different year as a reference point to understand change.

X. Attachments

Attachment I: Indiana's Current Behavioral Health System

Overview

Indiana's publicly funded behavioral health (both mental health and addiction) system of care (SOC) supports access to prevention, early intervention and recovery-oriented services and supports in all 92 counties, blending federal, state and local funding streams to a provider network of agencies and individual practitioners. Indiana's Family and Social Services Administration (FSSA) and specifically its Office of Medicaid Planning and Policy (OMPP) and Division of Mental Health and Addiction (DMHA) partner to provide policy oversight and primary funding of services and supports for individuals in need of behavioral health services. OMPP includes a robust continuum of behavioral health services as a benefit to enrollees in its fee-for service and Medicaid managed care programs. DMHA leverages its block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and state appropriations to compliment the Medicaid service array, with a focus on serving adults with Serious Mental Illness (SMI), youth with Serious Emotional Disturbance (SED), and individuals with Substance Use Disorder (SUD) of any age, and that are at or below 200% of the federal poverty level (FPL). OMPP and DMHA also partner with the Department of Child Services (DCS) and Department of Corrections (DOC) in supporting access to and oversight of behavioral services for Indiana's most vulnerable Hoosiers.

Provider Network

OMPP maintains a large network of behavioral health providers including hospitals, psychiatric residential treatment facilities (PRTF), SUD residential providers, and community-based agencies and individual practitioners. Individual practitioners are certified and/or licensed by the Indiana Professional Licensing (IPLA). While IPLA is a separate and independent agency from FSSA, both OMPP and DMHA maintain a strong collaborative relationship. DMHA is responsible for certification and licensure for SUD provider agencies, free-standing psychiatric hospitals, and community mental health centers (CMHCs). Indiana Administrative Code (IAC) outlines provider requirements that assist in assuring quality and program integrity. Addiction residential, CMHC, and Clubhouse providers participating within the Medicaid program must be certified/licensed by DMHA prior to provider enrollment with OMPP.

Community Mental Health Centers

There are currently 24 certified CMHCs in Indiana. DMHA is responsible for certification and CMHC requirements under the IAC and/or contracts include responsibility for a geographic service area that ensures coverage of a continuum of services statewide. The CMHCs are required to provide a defined continuum of care that includes:

- Individualized treatment planning
- Access to twenty-four (24) hour a day crisis intervention
- Case management
- Outpatient services, including intensive outpatient services, substance abuse services, and treatment
- Acute stabilization services including detoxification services
- Residential services
- Day treatment, partial hospitalization, or psychosocial rehabilitation

- Family support
- Medication evaluation and monitoring
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

Many of these services are part of the State plan Medicaid Rehabilitation Option (MRO) services under which service need is identified through an assessment that confirms need for services with an eligible diagnosis and level of care determination using the Child and Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA).

Current Service Continuum

Prevention/early intervention. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program services are available to Medicaid members from birth through the month of the member's 21st birthday. Members eligible for EPSDT services may be enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, or Traditional Medicaid. A psychosocial/behavioral assessment is required at each EPSDT visit. This assessment is family centered and may include an assessment of child's social-emotional health, caregiver depression, as well as social risk factors.

The Indiana Health Coverage Programs (IHCP) also provide coverage for annual depression screenings and screening and brief intervention (SBI) services. Providers are expected to use validated, standardized tests for the depression screening. These tests include, but are not limited to, the Patient Health Questionnaire (PHQ), Beck Depression Inventory, Geriatric Depression Scale, and Edinburgh Postnatal Depression Scale (EPDS). SBI identifies and intervenes with individuals who are at risk for substance abuse related problems or injuries. SBI services use established systems, such as trauma centers, emergency rooms, community clinics, and school clinics, to screen patients who are at risk for substance abuse and, if necessary, provide the patients with brief interventions or referrals to appropriate treatment.

The IHCP covers outpatient mental health services provided by a licensed medical doctor, doctor of osteopathy, psychologist endorsed as a health service provider in psychology (HSPP), psychiatric hospitals, psychiatric wings of acute care hospitals, and outpatient mental health facilities. To increase the State's capacity of mental health Medicaid providers, the House Enrolled Act 1175 passed in the 2019 legislative session expanded access to behavioral health providers for Medicaid enrollees. Under this law, licensed clinical social workers (LCSWs), licensed mental health counselors (LMHCs), licensed clinical addiction counselors and licensed marriage and family therapists (LMFTs) are eligible providers and can certify a mental health diagnosis and supervise a patient's treatment plan in outpatient mental health or substance abuse treatment settings. Prior to this legislation, mid-level behavioral health practitioners were not eligible to independently enroll in Indiana Medicaid and were required to bill under the supervision of a HSPP or psychiatrist.

Adult Mental Health Habilitation Services.

Effective November 1, 2014, Indiana implemented the §1915(i) Adult Mental Health Habilitation (AMHH) services program. The AMHH services program was adopted by Indiana to provide community-based opportunities for the care of adults with SMI who may most benefit from keeping or learning skills to maintain a healthy safe lifestyle in the community. AMHH services are provided for individuals and their families, or groups of adult persons who are living in the community and who need help on a regular basis with SMI or co-occurring mental illness and addiction disorders. AMHH services are

intended for individuals who meet all of the following core target group criteria: enrolled in Medicaid, age 19 or older, reside in a setting which meets federal setting requirements for home and community-based services (HCBS) and has an AMHH-eligible, DMHA-approved diagnosis. An eligible AMHH enrollee will be authorized to receive specific requested AMHH services, according to an individualized care plan, approved by the State Evaluation Team. The following are the AMHH services:

- Adult day services
- Home- and Community-Based Habilitation and Support Services
- Respite care
- Therapy and behavioral support services
- Addiction counseling
- Supported community engagement services
- Care coordination
- Medication training and support Initial eligibility in the program is for one year and can be extended if medical need remains.

Inpatient (acute). Prior authorization is required for all inpatient psychiatric admissions, rehabilitation, and substance abuse inpatient stays. Each Medicaid-eligible patient admitted to an acute psychiatric facility or unit must have an individually developed plan of care (POC). For members 21 and older, a POC must be developed by the attending or staff physician. For members under 21 years old, POCs must be developed by a physician and interdisciplinary team. All POCs must be developed within 14 days of the admission date, regardless of the member's age. For a patient who becomes eligible for Medicaid after admission to a facility, the POC must be prepared to cover all periods for which Medicaid coverage is claimed. The following components must be documented in each member's POC:

- Treatment objectives and goals, including an integrated program of appropriate therapies, activities, and experiences designed to meet the objectives; and
- A post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the member's community to ensure continuity of care when the patient returns to his or her family and community upon discharge.

The POC is developed as a result of a diagnostic evaluation that includes an examination of the medical, psychological, social, and behavioral aspects of the member's presenting problem and previous treatment interventions. The POC is reviewed by the attending or staff physician to ensure that appropriate services are being provided and that they continue to be medically necessary. The attending or staff physician also recommends necessary adjustments in the plan, as indicated by the member's overall adjustment as an inpatient. The POC must be in writing and must be part of the member's record.

State Hospital (longer term stays/forensic). Indiana's six state psychiatric hospitals provide intermediate and longer term inpatient psychiatric stays for adults who have co-occurring mental health and addiction issues, who are deaf or hearing impaired, and who have forensic involvement; as well as youth with SED. Individuals are admitted to a state hospital only after a screening by a CMHC. CMHCs, as the State hospital gatekeepers, are responsible for providing case management to the individual in both the hospital and their transition to the community following discharge. The State psychiatric hospitals are accredited by the Joint Commission (JC). To maintain JC accreditation, all hospitals are required to participate in a performance measurement program. This is accomplished through participation in the

National Research Institute Performance Measurement System, which provides a framework within which the State psychiatric hospitals can identify and implement consistent measures of performance and outcomes.

On March 15, 2019, Indiana opened the doors to the NeuroDiagnostic Institute (NDI) and Advanced Treatment Center located on the campus of Community East Hospital in Indianapolis. Operated in partnership with Community Health Network, NDI delivers advanced evaluation and treatment for patients with the most challenging and complex neuropsychiatric illnesses and transitions them more efficiently into the most appropriate treatment settings within the community or state operated inpatient SOC. The NDI is a key component of FSSA's initiative to modernize and reengineer Indiana's network of state-operated inpatient mental health facilities, including reducing lengths of stay. The NDI also serves as a teaching hospital by partnering with local universities for medical and nursing students, as well interns of other disciplines such as social work and psychology, gain hands-on experience helping NDI patients in their recovery.

Attachment II: ED Utilization and Participation Rates Calculation

Technical Specifications to identify Claims / Encounters and Calculate Rates

Data Sources: Enrollment, Claims / Encounter

Data Elements:
Beneficiary: recipient_ID
ICD10 Diagnosis: diagnosis_code
Date of Service: date_begin_service_header
Procedure Code: proc_code_L
Revenue Code: revenue_code
Beneficiary's Medicaid benefit coverage: recipient_aid_catgy
Indicator for whether Medicaid beneficiary coverage was only for emergency services: I_emergency_services_only

1. Identify all recipients that were between the ages of 21 and 64 during the valuation period and had a claim with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) diagnosis code in the first or second position.
    a. SMI/SED diagnosis codes are any codes that begin with "F20","F25","F31", or "F33"
2. For each recipient in Step 1, identify the oldest Date_Begin_Service_Header value with an SMI/SED diagnosis code in the first or second position.
3. Subset the claims data to claims that meet the following conditions:
    a. The Recipient_ID was one that was identified in Step 1 AND
    b. The Date_Begin_Service_Header between January 1, 2018 and December 31, 2020 AND
    c. Proc_Code_L in ('99281','99282','99283','99284','99285') or Revenue_Code in ('450', '451', '452', '456', '459', '981')
4. Remove all claims from Step 3 if the recipient's eligibility met any of the following criteria during the month/year of the Date_Begin_Service_Header field:
    a. The recipient was not between the ages of 21 and 64
    b. The Recipient_Aid_Catgy was IN ('E', 'G', 'HF', 'I', 'J', 'L', 'HA', 'PN', 'HK', 'HI', 'HP', 'HP', 'H1', 'HF') when the service was rendered
    c. I_Emergency_Services_Only = 'Y'
5. For each recipient in Step 4, remove all claims where the Date_Begin_Service_Header was before the oldest Date_Begin_Service_Header value identified in Step 2
6. For each year in the valuation period, calculate the participation rate
    a. Total unique Recipient_ID from Step 5 / Total unique Recipient_ID from Step 1
7. For each year in the valuation period, calculate the participation rate stratified by the following:
    a. Gender
    b. Age Group (21-30, 31-40, 41-50, 51-60, 60-64)
    c. Race
    d. Metro/Non-Metro
    e. Healthy Indiana Plan (HIP)/Non-HIP

Attachment III: Access to Community Based Services Participation Rates

Technical Specifications

Percent of recipients using mental health-related Outpatient rehab (MRO Services) or other Outpatient rehab services

Data Sources: Enrollment, Claims / Encounter

Data elements:
Beneficiary: recipient_ID
ICD10 Diagnosis: diagnosis_code
Date of Service: date_begin_service_header
Place of Service: place_of_service_header and place_of_service_detail
Procedure Code: proc_code_L
Revenue Code: revenue_code
Beneficiary Medicaid benefit coverage: recipient_aid_catgy
Indicator for whether Medicaid beneficiary coverage was only for emergency services: I_emergency_services_only
Provider Specialty: billing_provider_specialty, rendering_provider_specialty, and rendering_provider_specialty

1. Identify all recipients that were between the ages of 21 and 64 during the valuation period and had a claim with an Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) diagnosis code in the first or second position
    a. SMI/SED diagnosis codes are any codes that begin with "F20","F25","F31", or "F33"
2. Subset the claims data to claims that meet the following conditions:
    a. The recipient_ID is one the list of recipients with an SMI/SED diagnosis code during the valuation period AND
    b. The primary diagnosis code on the claim is a Mental Health Diagnosis value set AND
    c. The Date_Begin_Service_Header is between January 1, 2018 and December 31, 2020 AND
    d. Neither the place_of_service_header nor the place_of_service_detail are “2” or “02” (telehealth)
3. Remove all claims from Step 2 if the recipient’s eligibility met any of the following criteria during the month/year of the Date_Begin_Service_Header field:
    a. The recipient was not between the ages of 21 and 64
    b. The Recipient_Aid_Catgy was IN (‘E’, ‘G’, ‘HF’, ‘I’, ‘J’, ‘L’, ‘HA’, ‘PN’, ‘HK’, ‘HI’, ‘HP’, ‘HP’, ‘H1’, ‘HF’ when the service was rendered
    c. I_Emergency_Services_Only = ‘Y’
4. From Step 3, calculate the number of recipients with a claim that met any of the following criteria
    a. Mental health related outpatient rehabilitation (MRO) services
        i. proc_code_L in ('H0004', 'H0005', 'H0015', 'H0031', 'H0034', 'H2035', 'H0038', 'H2012', 'H2014', 'H2017', 'H2019', 'T1016', 'T2022') AND
        ii. Place_of_service_header or place_of_service_detail in ('11', '12', '23', '31', '32', '53', '99')

b. Partial Hospitalization or Intensive Outpatient
    i. proc_code_L in ('G0410', 'G0411', 'H0035', 'H2001', 'H2012', 'S0201', 'S9480', 'S9484', 'S9485') OR
    ii. revenue_code in ('0905', '0907', '0912', '0913')
c. (Mental Health Utilization (MPT) Intensive Outpatient Program (IOP)/Partial Hospitalization (PH) Group 1; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code in PH Place of Service (POS)
    i. proc_code_L in one of the following datasets:
        1. '90791', '90792', '90832', '90833', '90834', '90836', '90837', '90838', '90839', '90840', '90845', '90847', '90849', '90853', '90875', '90876'
        2. '90870'
        3. '90867', '90868', '90869'

        OR
    ii. proc_code in ('GZB0ZZZ', 'GZB1ZZZ', 'GZB2ZZZ', 'GZB3ZZZ', 'GZB4ZZZ') AND
    iii. Place_of_service_header or place_of_service_detail = ("52")
d. (MPT IOP/PH Group 1; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code in Community Mental Health Center POS
    i. proc_code_L in one of the following datasets:
        1. '90791', '90792', '90832', '90833', '90834', '90836', '90837', '90838', '90839', '90840', '90845', '90847', '90849', '90853', '90875', '90876'
        2. '90870'
        3. '90867', '90868', '90869'

        OR
    ii. proc_code in ('GZB0ZZZ', 'GZB1ZZZ', 'GZB2ZZZ', 'GZB3ZZZ', 'GZB4ZZZ') AND
    iii. Place_of_service_header or place_of_service_detail = ("53")
e. MPT IOP/PH Group 2 with a corresponding code in Partial Hospitalization POS billed by a mental health provider
    i. proc_code_L in ('90791', '90792', '90832', '90833', '90834', '90836', '90837', '90838', '90839', '90840', '90845', '90847', '90849', '90853', '90875', '90876') AND
    ii. Place_of_service_header or place_of_service_detail = ("52") AND
    iii. Billing_Provider_Specialty, Rendering_Provider_Specialty, or Rendering_Provider_Specialty_L in ('612', '615', '599', '113', 'C02', 'C12', 'C18', 'M07', 'O13', 'M08', '111', 'D08', 'M09', 'O27', '114', '618', '616', 'O71', 'M11', 'M12', 'F28', 'O41', '110', '11', '117', '339', '112', 'M14', 'O60', 'M16', 'B05'
f. MPT IOP/PH Group 2 with a corresponding code in Community Mental Health Center POS billed by a mental health provider
    i. proc_code_L in ('90791', '90792', '90832', '90833', '90834', '90836', '90837', '90838', '90839', '90840', '90845', '90847', '90849', '90853', '90875', '90876') AND

ii. Place_of_service_header or place_of_service_detail = (“53”) AND
iii. Billing_Provider_Specialty, Rendering_Provider_Specialty, or Rendering_Provider_Specialty_L in ('612', '615', '599', '113', 'C02', 'C12', 'C18', 'M07', 'O13', 'M08', '111', 'D08', 'M09', 'O27', '114', '618', '616', 'O71', 'M11', 'M12', 'F28', 'O41', '110', '11', '117', '339', '112', 'M14', 'O60', 'M16', 'B05')

5. For each year in the valuation period, calculate the participation rate
    a. Total unique recipient_ID from Step 4 / Total unique recipient_ID from Step 3
6. For each year in the valuation period, calculate the participation rate stratified by the following:
    a. Gender
    b. Age Group (21-30, 31-40, 41-50, 51-60, 60-64)
    c. Race
    d. Metro/Non-Metro
    e. Healthy Indiana Plan (HIP)/Non-HIP

Percent of recipients using mental health related Home and Community Based Services (HCBS) & Percent of recipients using mental health-related Long-Term Services and Supports (LTSS) (Tables 2 & 3 combined)

1. Identify all recipients that were between the ages of 21 and 64 during the valuation period and had a claim with an SMI/SED diagnosis code in the first or second position
    a. SMI/SED diagnosis codes are any codes that begin with "F20","F25","F31", or "F33"
2. Subset the claims data to claims that meet the following conditions:
    a. The recipient_ID was one the list of recipients with an SMI/SED diagnosis code during the valuation period AND
    b. The primary diagnosis code on the claim was a Mental Health Diagnosis value AND
    c. The Date_Begin_Service_Header between January 1, 2018 and December 31, 2020 AND
    d. Neither the place_of_service_header nor the place_of_service_detail were “2” or “02” (telehealth)
    e. There were no procedure code modifiers for telehealth (“95”, “GT”) on the claim
    f. The claim did not contain any of the following values in the revenue_code field (inpatient_stay)
        i. '0100’, ‘0101’, ‘0110’, ‘0111’, ‘0112’, ‘0113’, ‘0114’, ‘0116’, ‘0117’, ‘0118’, ‘0119’, ‘0120’, ‘0121’, ‘0122’, ‘0123’, ‘0124’, ‘0126’, ‘0127’, ‘0128’, ‘0129’, ‘0130’, ‘0131’, ‘0132’, ‘0133’, ‘0134’, ‘0136’, ‘0137’, ‘0138’, ‘0139’, ‘0140’, ‘0141’, ‘0142’, ‘0143’, ‘0144’, ‘0146’, ‘0147’, ‘0148’, ‘0149’, ‘0150’, ‘0151’, ‘0152’, ‘0153’, ‘0154’, ‘0156’, ‘0157’, ‘0158’, ‘0159’, ‘0160', '0164’, ‘0167’, ‘0169’, ‘0170’, ‘0171’, ‘0172’, ‘0173’, ‘0174’, ‘0179’, ‘0190’, ‘0191’, ‘0192’, ‘0193’, ‘0194’, ‘0199’, ‘0200’, ‘0201’, ‘0202’, ‘0203’, ‘0204’, ‘0206’, ‘0207’, ‘0208’, ‘0209’, ‘0210’, ‘0211’, ‘0212’, ‘0213’, ‘0214’, ‘0219’, ‘1000’, ‘1001’, ‘1002'
3. Remove all claims from Step 2 if the recipient’s eligibility met any of the following criteria during the month/year of the Date_Begin_Service_Header field:
    a. The recipient was not between the ages of 21 and 64
    b. The Recipient_Aid_Catgy was IN (‘E’, ‘G’, ‘HF’, ‘I’, ‘J’, ‘L’, ‘HA’, ‘PN’, ‘HK’, ‘HI’, ‘HP’, ‘HP’, ‘H1’, ‘HF’ when the service was rendered
    c. I_Emergency_Services_Only = ‘Y’

4. From Step 3, calculate the number of recipients with a claim that met any of the following criteria
    a. Aged and Disabled
        i. Procedure_code_L in (‘B4150’, ‘S5100’, ‘S5125’, ‘S5130’, ‘S5140’, ‘S5141’, ‘S5150’, ‘S5160’, ‘S5161’, ‘S5165’, ‘S5170’, ‘T1005’, ‘T1028’, ‘T2003’, ‘T2004’, ‘T2022’, ‘T2025’, ‘T2029’, ‘T2031’, ‘T2038’, ‘T2039’)
    b. Traumatic Brain Injury
        i. Procedure_code_L in (‘97535’, ‘B4150’, ‘H2023’, ‘S5100’, ‘S5125’, ‘S5130’, ‘S5141’, ‘S5150’, ‘S5160’, ‘S5161’, ‘S5165’, ‘S5170’, ‘T1005’, ‘T2003’, ‘T2004’, ‘T2021’, ‘T2022’, ‘T2025’, ‘T2029’, ‘T2031’, ‘T2038’, ‘T2039’)
    c. Family Support Waiver
        i. Procedure_code_L in (‘90846’, ‘90853’, ‘92507’, ‘G0151’, ‘G0152’, ‘H2020’, ‘H2032’, ‘S5100’, ‘S5101’, ‘S5111’, ‘S5116’, ‘S5151’, ‘S5160’, ‘S5161’, ‘T1005’, ‘T1020’, ‘T2002’, ‘T2015’, ‘T2020’, ‘T2022’, ‘T2024’, ‘T2025’, ‘T2029’, ‘T2033’, ‘T2039’)
    d. Community Integration and Habilitation
        i. Procedure_code_L in (‘90846’, ‘90853’, ‘92507’, ‘A9279’, ‘G0151’, ‘G0152’, ‘H2020’, ‘H2032’, ‘S5100’, ‘S5101’, ‘S5111’, ‘S5116’, ‘S5151’, ‘S5160’, ‘S5161’, ‘S5165’, ‘T1005’, ‘T1020’, ‘T1028’, ‘T2002’, ‘T2015’, ‘T2016’, ‘T2020’, ‘T2022’, ‘T2024’, ‘T2025’, ‘T2029’, ‘T2033’, ‘T2038’, ‘T2039’)
    e. Adult Mental Health Habilitation
        i. Procedure_code_L in (‘97537’, ‘H2035’, ‘S5101’, ‘S5150’, ‘S5151’, ‘T1016’)
    f. Behavioral & Primary Health Care
        i. Procedure_code_L = ‘T1016’
    g. Psychiatric Residential Treatment Facility
        i. Procedure_code_L in (‘H2015’, ‘H2021’, ‘S5151’, ‘T1005’, ‘T2003’, ‘T2025’, ‘T2048’)
    h. Substance Use Disorder
        i. Procedure_code_L in (‘H0010’, ‘H2034’)
    i. LTSS – Day Habilitation
        i. Procedure_Code_L in T2010’, ‘T2011’, ‘T2013’, ‘T2014’, ‘T2015’, ‘T2016’, ‘T2017’, ‘T2018’, ‘T2019’, ‘T2020’, ‘T2021
    j. LTSS – DME
        i. Procedure_Code_L in (DME Value Set) OR
        ii. revenue_code in (290’, ‘291’, ‘293’, ‘294’, ‘299)
    k. LTSS – Hospice
        i. Procedure_code_L in (‘Q5001’, ‘Q5002’, ‘Q5003’, ‘Q5004’, ‘Q5005’, ‘Q5006’, ‘Q5007’, ‘Q5008’, ‘Q5009’, ‘Q5010’, ‘T2042’, ‘T2043’, ‘T2044’, ‘T2045’, ‘T2046) OR
        ii. revenue_code in (‘115’, ‘125’, ‘135’, ‘145’, ‘155’, ‘235’, ‘650’, ‘651’, ‘652’, ‘653’, ‘654’, ‘655’, ‘656’, ‘657’, ‘658’, ‘659’)

l. LTSS – Home Health
    i. Procedure_code_L in ('G0151', 'G0152', 'G0155', 'G0156', 'G0157', 'G0158', 'G0159', 'G0161', 'G0162', 'G0153', 'S9122', 'S9124', 'S9125', 'S9126', 'S9127', 'S9128', 'S9129', 'S9131') OR
    ii. revenue_code in ('527', '570', '571', '572', '579', '580', '581', '582', '589', '590', '560', '561', '562', '569', '570', '571', '572', '579', '580', '581', '582', '583', '589', '590', '600', '601', '602', '603', '604', '609')

m. LTSS Independent Nurse
    i. Procedure_code_L in ('T1000', 'T1001', 'T1002', 'T1003')

n. LTSS – Respite Care
    i. revenue_code in ('660', '661', '662', '663', '669')

o. LTSS – Skilled Nursing
    i. Procedure_code_L in ('G0154', 'G0299', 'G0300', 'S9123') OR
    ii. revenue_code in ('524', '550', '551', '552', '559')

p. LTSS – Other LTSS
    i. Procedure_code_L = T2048', 'H0043', 'H0044', 'H0045', 'S5100', 'S5101', 'S5102', 'S5105', 'S5108', 'S5109', 'S5110', 'S5111', 'S5115', 'S5116', 'S5120', 'S5121', 'S5125', 'S5126', 'S5130', 'S5131', 'S5135', 'S5136', 'S5140', 'S5141', 'S5150', 'S5151', 'S5165', 'S5170', 'S5175', 'S5180', 'S5185', 'S5190', 'S5199

5. For each year in the evaluation period, calculate the participation rate
    a. Total unique recipient_ID from Step 4 / Total unique recipient_ID from Step 3
6. For each year in the valuation period, calculate the participation rate stratified by the following:
    a. Gender
    b. Age Group (21-30, 31-40, 41-50, 51-60, 60-64)
    c. Race
    d. Metro/Non-Metro
    e. HIP/Non-HIP

Percent using Outpatient Mental Health Services

1. Identify all recipients that were between the ages of 21 and 64 during the valuation period and had a claim with a SMI/SED diagnosis code in the first or second position
    a. SMI/SED diagnosis codes are any codes that begin with "F20","F25","F31", or "F33"
2. Subset the claims data to claims that meet the following conditions:
    a. The recipient_ID was one the list of recipients with an SMI/SED diagnosis code during the valuation period AND
    b. The primary diagnosis code on the claim was a Mental Health Diagnosis value AND
    c. The Date_Begin_Service_Header between January 1, 2018 and December 31, 2020 AND
    d. Neither the place_of_service_header nor the place_of_service_detail were "2" or "02" (telehealth)
    e. There were no procedure code modifiers for telehealth ("95", "GT") on the claim

f. The claim did not contain any of the following values in the revenue_code field (inpatient_stay)
    i. '0100', '0101', '0110', '0111', '0112', '0113', '0114', '0116', '0117', '0118', '0119', '0120', '0121', '0122', '0123', '0124', '0126', '0127', '0128', '0129', '0130', '0131', '0132', '0133', '0134', '0136', '0137', '0138', '0139', '0140', '0141', '0142', '0143', '0144', '0146', '0147', '0148', '0149', '0150', '0151', '0152', '0153', '0154', '0156', '0157', '0158', '0159', '0160', '0164', '0167', '0169', '0170', '0171', '0172', '0173', '0174', '0179', '0190', '0191', '0192', '0193', '0194', '0199', '0200', '0201', '0202', '0203', '0204', '0206', '0207', '0208', '0209', '0210', '0211', '0212', '0213', '0214', '0219', '1000', '1001', '1002'

3. Remove all claims from Step 2 if the recipient's eligibility met any of the following criteria during the month/year of the Date_Begin_Service_Header field:
    a. The recipient was not between the ages of 21 and 64
    b. The Recipient_Aid_Catgy was IN ('E', 'G', 'HF', 'I', 'J', 'L', 'HA', 'PN', 'HK', 'HI', 'HP', 'HP', 'H1', 'HF' when the service was rendered
    c. I_Emergency_Services_Only = 'Y'
4. From Step 3, calculate the number of recipients with a claim that met any of the following criteria
    a. MPT Stand Alone Outpatient Group 1
        i. proc_code_L in ('96101', '96102', '96103', '96105', '96110', '96111', '96116', '96118', '96119', '96120', '96125', '96127', 'G0155', 'G0176', 'G0177', 'G0409', 'G0451', 'H0002', 'H0004', 'H0031', 'H0034', 'H0036', 'H0037', 'H0039', 'H0040', 'H2000', 'H2010', 'H2011', 'H2013', 'H2014', 'H2015', 'H2016', 'H2017', 'H2018', 'H2019', 'H2020') OR
        ii. revenue_code in ('0513', '0900', '0902', '0903', '0904', '0911', '0914', '0915', '0916', '0917', '0918', '0919')
    b. MPT Stand Alone Outpatient Group 2 billed by a mental health provider
        i. proc_code_L in ('98960', '98961', '98962', '99078', '99201', '99202', '99203', '99204', '99205', '99211', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99381', '99382', '99383', '99384', '99385', '99386', '99387', '99391', '99392', '99393', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99411', '99412', '99483', '99510', 'G0463', 'T1015') OR
        ii. revenue_code in ('0510', '0515', '0516', '0517', '0519', '0520', '0521', '0522', '0523', '0526', '0527', '0528', '0529', '0982', '0983') AND
        iii. Billing_Provider_Specialty, Rendering_Provider_Specialty, or Rendering_Provider_Specialty_L in ('612', '615', '599', '113', 'C02', 'C12', 'C18', 'M07', 'O13', 'M08', '111', 'D08', 'M09', 'O27', '114', '618', '616', 'O71', 'M11', 'M12', 'F28', 'O41', '110', '11', '117', '339', '112', 'M14', 'O60', 'M16', 'B05')
    c. Observation billed by a mental health provider
        i. proc_code_L in ('99217', '99218', '99219', '99220') AND
        ii. Billing_Provider_Specialty, Rendering_Provider_Specialty, or Rendering_Provider_Specialty_L in ('612', '615', '599', '113', 'C02', 'C12', 'C18',

'M07', 'O13', 'M08', '111', 'D08', 'M09', 'O27', '114', '618', '616', 'O71', 'M11', 'M12', 'F28', 'O41', '110', '11', '117', '339', '112', 'M14', 'O60', 'M16', 'B05')

d. Visit Setting Unspecified; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Outpatient POS
    i. proc_code_L in one of the following datasets:
        1. '90791', '90792', '90832', '90833', '90834', '90836', '90837', '90838', '90839', '90840', '90845', '90847', '90849', '90853', '90875', '90876', '99221', '99222', '99223', '99231', '99232', '99233', '99238', '99239', '99251', '99252', '99253', '99254', '99255' '90870', '90867', '90868', '90869'
        2. '90870'
        3. '90867', '90868', '90869'

        OR
    ii. proc_code in ('GZB0ZZZ', 'GZB1ZZZ', 'GZB2ZZZ', 'GZB3ZZZ', 'GZB4ZZZ') AND
    iii. Place_of_service_header or place_of_service_detail in ('03', '05', '07', '09', '11', '12', '13', '14', '15', '16', '17', '18', '19', '20', '22', '33', '49', '50', '71', '72')

e. Visit Setting Unspecified; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Community Mental Health Center POS
    i. proc_code_L in one of the following datasets:
        1. '90791', '90792', '90832', '90833', '90834', '90836', '90837', '90838', '90839', '90840', '90845', '90847', '90849', '90853', '90875', '90876', '99221', '99222', '99223', '99231', '99232', '99233', '99238', '99239', '99251', '99252', '99253', '99254', '99255' '90870', '90867', '90868', '90869'
        2. '90870'
        3. '90867', '90868', '90869'

        OR
    ii. proc_code in ('GZB0ZZZ', 'GZB1ZZZ', 'GZB2ZZZ', 'GZB3ZZZ', 'GZB4ZZZ') AND
    iii. Place_of_service_header or place_of_service_detail = '53'

f. (Electroconvulsive Therapy or Transcranial Magnetic Stimulation) with a corresponding code from Ambulatory Surgical Center POS
    i. proc_code_L in one of the following datasets:
        1. '90870'
        2. '90867', '90868', '90869'

        OR
    ii. proc_code in ('GZB0ZZZ', 'GZB1ZZZ', 'GZB2ZZZ', 'GZB3ZZZ', 'GZB4ZZZ') AND
    iii. Place_of_service_header or place_of_service_detail = '24'

5. For each year in the valuation period, calculate the participation rate
    a. Total unique recipient_ID from Step 4 / Total unique recipient_ID from Step 3

6. For each year in the valuation period, calculate the participation rate stratified by the following:
    a. Gender
    b. Age Group (21-30, 31-40, 41-50, 51-60, 60-64)
    c. Race
    d. Metro/Non-Metro
    e. HIP/Non-HIP

Attachment IV: Detailed Race Analysis

This attachment extends the analysis of Medicaid recipients and race to include more granular categories for race (e.g., Asian or Pacific Islander; American Indian or Alaskan Native).

Methodology: Demographic information pertaining to race was compiled from monthly member enrollment files for January 2018 to December 2020. The target population for analyses was all Medicaid recipients covered by Indiana Health Coverage Programs (IHCP) aged 21- 64 years with Serious Mental Illness (SMI) regardless of their delivery system (e.g., managed care or fee-for-service). Of the total SMI Medicaid eligible population in 2020 (n = 138,027), 21.9% (n = 30,245) were missing race information.

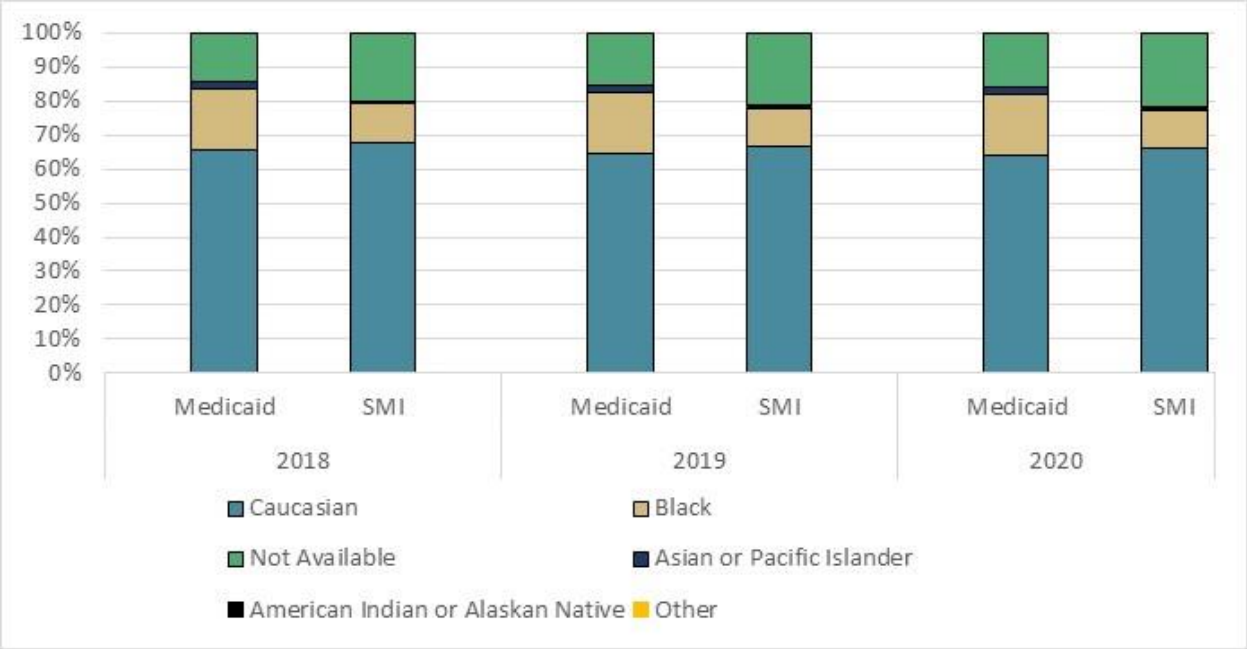
The analysis (described in **Section VI** of the summative report) used three categories ("Caucasian", "Black", and "Other") to assess race. Recipients with missing race information or who identified themselves as Asian, Pacific Islander, American Indian, or Alaskan Native were collapsed into the "Other" category. This approach was used due to the small sample sizes of the additional categories. **Exhibit IV.1** provides yearly counts (2018 – 2020) associated with race for Medicaid Recipients with SMI. The results discussed in this section does not collapse race categories.

Exhibit IV.1: Race Counts for Recipients with SMI

		# of SMI Recipients			# of Medicaid Recipients Age 21+ Eligible for SMI Waiver			% of Recipients Covered by SMI Waiver		
		Jan 2018 - Dec 2018	Jan 2019 - Dec 2019	Jan 2020 - Dec 2020	Jan 2018 - Dec 2018	Jan 2019 - Dec 2019	Jan 2020 - Dec 2020	Jan 2018 - Dec 2018	Jan 2019 - Dec 2019	Jan 2020 - Dec 2020
Total Recipients		87,854	112,788	138,027	708,729	685,243	782,280	12.4%	16.5%	17.6%
Race	Caucasian	59,690	75,030	91,408	465,435	442,281	500,620	12.8%	17.0%	18.3%
	Black	9,960	12,927	15,464	127,094	122,004	138,661	7.8%	10.6%	11.2%
	Asian or Pacific Islander	366	491	612	14,074	14,403	17,048	2.6%	3.4%	3.6%
	American Indian or Alaskan Native	185	236	296	1,441	1,394	1,676	12.8%	16.9%	17.7%
	Not Available	17,648	24,100	30,245	100,632	105,120	124,261	17.5%	22.9%	24.3%
	Other	5	4	2	53	41	14	9.4%	9.8%	14.3%

Exhibit IV.2 provides the distribution of total Medicaid and SMI populations by race. Approximately 64.0% of the Medicaid population and 66.2% of the SMI population are Caucasian. The SMI populations include few Asian or Pacific Islanders (0.4% in 2020) followed by American Indians or Alaskan Natives (0.2% in 2020). Note. Approximately 21.9% had missing information.

Exhibit IV.2: Distribution of Population (SMI vs Medicaid) by Race and Year



Attachment V: Comparing the Method for Defining the Population Used in the Demonstration Evaluation Versus the Standard CMS Method for Identifying SMI Medicaid Recipients

Background: The target population for the evaluation was all Medicaid recipients covered by Indiana Health Coverage Programs (IHCP) aged 21- 64 years with Serious Mental Illness (SMI) regardless of their delivery system (e.g., managed care or fee-for-service). Based on the target population definition, the following method was used to identify the SMI Medicaid recipients (as defined in the 2020 SMI Waiver Demonstration Evaluation Plan):

- Had at least one claim (any service utilization) with a service begin date occurring between January, 2018 and December, 2020 and having any one of the four diagnosis codes in the primary or secondary diagnosis position (F20.xx (Schizophrenia and sub codes up to 2 places), F25.xx (schizoaffective disorder and sub codes up to two places), F31.xx (Bipolar and all sub codes up to 2 places), F33.xx (Major depression Recurrent and all sub codes up to two places).
- Had SMI waiver eligible Medicaid coverage during the service utilization.

While the criteria defined above was used to construct the analytic cohort for the demonstration evaluation, Indiana has recently started using the Centers for Medicare & Medicaid Services (CMS) standard method to identify SMI Medicaid recipients in SMI monitoring reports. In this method (adapted from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)), SMI is defined as:

- At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depression, or
- At least two non-acute inpatient encounters on different days where both encounters have any diagnosis of schizophrenia or schizoaffective disorder or both encounters have any diagnosis of bipolar disorder.

Population Comparisons Using the Demonstration Evaluation Method Versus the CMS Standard Method

The demonstration evaluation approach is a broader definition, identifying a greater number of Medicaid recipients with SMI than the CMS method. **Exhibit V.1** provides a comparison of the SMI cohort using both methods for the total SMI sample as well as relevant findings for Goal 1 and Goal 4.

Exhibit V.1: Comparison of Results using the Evaluation SMI and CMS Method

Method Used		2018	2019	2020
Number of SMI Recipients	Demonstration Method	87,854	112,788	138,027
	CMS Standard Method	62,054	64,584	69,209
Goal 1 – ED Utilization - Participation Rate	Demonstration Method	47.8%	50.5%	47.6%
	CMS Standard Method	60.8%	60.4%	58.4%
Goal 1 – ED Utilization - Utilization Rate (per 1,000)	Demonstration Method	2,081	2,035	1,736
	CMS Standard Method	2,727	2,673	2,392
Goal 4 – Access to Community-based Services - Participation Rate	Demonstration Method	75.6%	62.9%	49.6%
	CMS Standard Method	60.3%	60.9%	54.7%

Source: Monthly claims/encounter and enrollment files, January 2018 – December 2020.

As expected, the CMS standard method identified fewer Medicaid recipients with SMI as it has a narrower set of criteria. Emergency department participation rates and utilization rates were higher with the CMS/NCQA method which is not surprising given the narrower set of criteria may be pooling recipients with more serious impairments. Medicaid recipients with SMI using the CMS standard method had a much lower participation rate accessing community-based services in 2018 (60.3% vs. 75.6%). However, in 2020, SMI recipients identified with the CMS method had a higher participation rate (54.7% vs 49.6%).