**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**

December 16, 2020

Allison Taylor
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461, MS25
Indianapolis, IN 46204

Dear Ms. Taylor:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for the Serious Mental Illness (SMI) component of Indiana's section 1115(a) demonstration entitled, "Healthy Indiana Plan (HIP)" (Project No. 11-W-00296/5), and effective through December 31, 2020. This approval of the evaluation design is for the SMI demonstration period of performance from January 1, 2020 through December 31, 2020, which was approved as an amendment to the HIP demonstration on December 20, 2019. We sincerely appreciate the state's commitment to a comprehensive evaluation of your SMI demonstration.

CMS has added the approved evaluation design to the demonstration's Special Terms and Conditions (STC) as Attachment I. A copy of the STCs, which includes the new attachment, is enclosed with this letter. The approved evaluation design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

A draft of the summative evaluation report, consistent with this approved design, is due to CMS by June 30, 2022—that is, 18 months after the end of the demonstration approval period on December 31, 2020. Indiana is also expected to develop a more expansive and rigorous evaluation design, inclusive of a robust cost analysis, for the next SMI demonstration approval period (2021- 2025) following CMS's guidance, including an appropriate logic model, hypotheses, research questions, and causal analytic approaches. In addition, Indiana will assess, through sensitivity analyses, if the COVID-19 pandemic changes the feasibility of including calendar year 2020 data into the new demonstration period evaluation of the SMI component.

We look forward to our continued partnership with you and your staff on the HIP demonstration. If you have any questions, please contact your CMS project officer, Ms. Rachel Nichols, at Rachel.Nichols@cms.hhs.gov.

Sincerely,

Danielle Daly -S Digitally signed by Danielle Daly -S Date: 2020.12.16 12:22:21 -05'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

Andrea J. Casart -S Digitally signed by Andrea J. Casart -S Date: 2020.12.16 14:48:46 -05'00'

Andrea J. Casart
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Demonstrations

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

# Indiana Family and Social Services Administration

## Serious Mental Illness/Serious Emotional Disturbance
## Updated Evaluation Plan

***Updated Evaluation Plan for CMS Review***

***December 17, 2020***

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# A. General Background Information

The Centers for Medicare & Medicaid Services (CMS) approved the Indiana Family and Social Services Administration's (FSSA) §1115(a) demonstration waiver for adults with serious mental illness (SMI) for one year, from January 1, 2020 through December 31, 2020.

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 indicated that there is a need for increased options for individuals in psychiatric crises, with survey results suggesting that Indiana residents rely heavily on general hospital emergency rooms to handle individuals in acute crisis[1]. In 2018, the FSSA received authority from the CMS to reimburse institutions for mental diseases (IMDs) for Medicaid-eligible individuals aged 21-64 years with substance use disorders (SUDs). In 2019, Indiana sought to expand this authority to reimburse for acute inpatient stays in IMDs for individuals diagnosed with SMI.[2]

Through the §1115(a) demonstrations and waiver authorities in the Social Security Act, states can test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner. Indiana's approved §1115 waiver Specific Terms and Conditions (STCs) to implement the SMI waiver require an evaluation of this program's ability to meet its intended goals. This Evaluation Plan will guide the federally required, independent evaluation of this program, and is organized as follows:

- Section A: General Background Information
- Section B: Evaluation Questions and Hypotheses
- Section C: Methodology
- Section D: Methodological Limitations
- Section E: Attachments
    - Attachment E.1: Summary of Independent Evaluator Approach
    - Attachment E.2: Evaluation Budget
    - Attachment E.3: Timeline and Major Milestones
- Section F: Analytic Plans by Goal

[1] 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 emergency department staff, first responders, consumer and family advocates, and probation and parole officers.

[2] 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 Division of Mental Health and Addiction qualify as IMDs under this waiver.

# 1. Demonstration Goals

In an effort to ensure a comprehensive continuum of behavioral health services, the State will monitor the new approaches and flexibilities in Indiana's Medicaid program to reimburse for acute inpatient stays in IMDs for Medicaid enrollees with SMI. Over the current demonstration period (January 1, 2020 through December 31, 2020), the State seeks to achieve several demonstration goals (**Exhibit A.1**). These goals inform the State's evaluation of the SMI demonstration and include, but are not limited to, the following:

**Exhibit A.1: Indiana §1115(a) Demonstration**

**Name of Demonstration:**
SMI/SED Amendment Request for the Healthy Indiana Plan (HIP)

**Amendment Approval Date of Demonstration:**
December 20, 2019

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

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

The above goals address key milestones of §1115(a) demonstrations outlined in **Exhibit A.2**.

**Exhibit A.2: SMI/SED Demonstration Milestones**

| Milestones | |
|---|---|
| **Milestone 1** | Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings |
| **Milestone 2** | Improving care coordination and transitioning to community-based care |
| **Milestone 3** | Increasing access to the continuum of care, including crisis stabilization services |
| **Milestone 4** | Earlier identification and engagement in treatment, including through increased integration |

## 2. Description of the Demonstration and Implementation Plan

In 2018, the FSSA received authority from the CMS to reimburse for inpatient and residential stays in institutions for mental diseases (IMDs) for Medicaid eligible individuals ages 21-64 with substance use disorders (SUD). In 2019, Indiana sought to expand this authority to reimburse for acute inpatient stays in IMDs for individuals diagnosed with SMI.[3] The SMI demonstration was approved by the CMS on December 20, 2019 and became effective January 1, 2020. Under this demonstration, beneficiaries have access to high-quality, evidence-based mental health treatment services. These services range in intensity from short-term acute care in settings that qualify as an IMD to ongoing chronic care for such conditions in cost-effective community-based settings. Indiana must achieve a statewide average length of stay of no more than 30 days in inpatient treatment settings and will be continuously monitored.

### *Overview of Indiana's Behavioral Health System of Care*

Indiana's publicly funded behavioral health (both mental health and addiction) system of care 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 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 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.

#### 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 Agency (IPLA). While IPLA is separate and independent from FSSA, both OMPP and DMHA maintain a strong collaborative relationship with the agency. DMHA is responsible for certification and licensure for SUD provider agencies, freestanding psychiatric hospitals, community mental health centers (CMHCs). Indiana Administrative Code (IAC) outlines provider requirements that assist in assuring quality and program integrity. Addiction, residential, CMHCs, and Clubhouse providers participating within the Medicaid program must be certified/licensed by DMHA prior to provider enrollment with OMPP.

[3] 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 certified as PMHI by the DMHA with more than 16 beds qualify as IMDs under this waiver.

### *Community Mental Health Centers*

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

- Individualized treatment planning;
- Access to 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; and
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.

Many of these services are part of Medicaid Rehabilitation Option (MRO) state plan services, under which, an assessment confirms a 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*

Prevention/early intervention occur through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. These 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 the Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC), Hoosier Healthwise (HHW), or Traditional Medicaid. A psychosocial/behavioral assessment is required at each EPDST visit. This assessment is family-centered and may include an assessment of a 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 screening 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 departments, 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.

### *Outpatient Mental Health Services*

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. Reimbursement is also available for services provided by mid-level practitioners when a physician or an HSPP supervises those services. The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and supervising the treatment plan.

### *Adult Mental Health Habilitation Services*

Effective November 1, 2014, Indiana implemented the §1915(i) Adult Mental Health Habilitation (AMHH) services program. Indiana adopted AMHH services 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 intended for individuals who meet all of the following core target group criteria: 1) enrolled in Medicaid; 2) aged 19 years or older; 3) reside in a setting which meets federal setting requirements for home and community-based services (HCBS); and 4) has an AMHH-eligible, DMHA-approved diagnosis.[4] Once approved by the State Evaluation Team, an eligible AMHH enrollee is able to receive an AMHH service package, according to an individualized care plan. All services covered under the AMHH program are applicable for an additional prior authorization (PA) option. This will allow additional units to be authorized above the initial listed limit. Additional units can be requested via the Data Assessment Registry Mental Health and Addiction (DARMHA) system. The State Evaluation Team (SET) will review all PA requests and approve or deny additional units requested. Initial eligibility in the program is for one year and can be extended if medical need remains. 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

### *Inpatient/Acute Care*

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 aged 22 years and older, a POC must be developed by the attending or staff physician. For members aged 21 years old and younger,

[4] Indiana recently amended its AMHH SPA, which became effective April 1, 2020. The modifications are intended to make the program more accessible for members and remove administrative burden for providers. Specific changes are as follows:

- Eligibility age was changed from 35 years and older to 19 years and older;
- The required Adult Needs and Strengths Assessment (ANSA) score was changed from 4 and above to 3 and above; and
- Each AMHH service will no longer require an individual justification. Instead, an individual service package will be assigned.

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:

1. Treatment objectives and goals, including an integrated program of appropriate therapies, activities, and experiences designed to meet the objectives; and
2. 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 their 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 attending or staff physician reviews the POC to ensure that appropriate services are 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 while an inpatient. The POC must be in writing and must be part of the member's record.

### *State Hospitals*

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 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 its 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 to a state-operated inpatient system of care. 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 as social work and psychology interns, which affords them hands-on experience helping NDI patients in their recovery.

## *State Strategies for Addressing Waiver Milestones*

### Current Oversight of Institutions for Mental Disease (IMDs)

In order 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. PMHI licensure must be renewed annually. DMHA conducts annual visits to ensure requirements are being met. In SFY 2019, all PMHI renewal site visits were unannounced. DMHA utilizes a site visit checklist that crosswalks with licensure requirements. The site visit checklist includes confirmation that individuals receive a physical within 24 hours of admission as well as an initial emotional, behavioral, social and legal assessment per IAC requirements. This includes screening for chronic health conditions and substance use disorders. 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 28 freestanding psychiatric hospitals licensed in the state of Indiana with a capacity of 1,010 beds. Only 13 of the 28 PMHIs have more than 16 beds. DMHA is in the process of reviewing the IAC related to PMHIs with attention to quality assurance and 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 State Department of Health (ISDH).

#### *Indiana's Primary Care and Behavioral Health Integration*

FSSA in partnership with ISDH 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 (NASHMHPD) 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; and
- Creation of established PCBHI Guiding Principles.

FSSA and ISDH established a process by which CMHCs, Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs), and Rural Health Clinics (RHCs) 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. OMPP is considering submitting a state plan amendment in 2021 to transition the ICE model to a health home program.

### *Behavioral and Primary Health care Coordination Service Program*

Conceived under a separate §1915(i) state plan amendment, the Behavioral and Primary Healthcare 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 (CMHW) 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 system of care (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 Psychiatric Residential Treatment Facilities (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 state plan amendment 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 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 specifically 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 Community Mental Health Centers (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 plans to pilot two Crisis Stabilization Units (CSU) in the northern and southern parts of the state. The goals for these units are to provide an alternative to crisis evaluations within emergency departments and divert admissions to inpatient psychiatric units. The state initially proposes to fund these services with Mental Health Block Grant funding. In addition to the CSUs, FSSA's OMPP, DMHA, and Division of Disability and Rehabilitative Services (DDRS) partner with the Department of Child 14 Services (DCS) and Juvenile Justice agencies to explore piloting mobile response stabilization services (MRSS), adapting a model utilized in New Jersey. MRSS would provide community based crisis intervention including short-term follow-up and support for the youth and family to prevent reescalation, emergency department utilization and/or inpatient admission.

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; and

- 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 crisis stabilization units
- Short-term crisis residential
- Peer crisis services

Additionally, Hoosier Care Connect MCOs, 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 midlevel licensed individuals under the supervision of a physician, including nurse practitioners (NP), health service providers in 15 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 IHCP programs 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. Currently 85% of school districts have partnerships with the CMHC in their area. Through these partnerships behavioral health staff are co-located within the schools and providing behavioral health services to youth and their families.

# 3. Population Groups Impacted by the Demonstration

Indiana will evaluate whether the SMI demonstration has the intended effects on the target population. This waiver of the IMD exclusion for all Medicaid beneficiaries aged 21-64 years, regardless of the delivery system. All enrollees will continue to receive services through their current delivery system and payment methodologies will be 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 Indiana Health Coverage Programs. If an individual is determined eligible, beneficiaries 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 A.3** below are not eligible for stays in an IMD as they receive limited Medicaid benefits only.

**Exhibit A.3: 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)<br>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)<br>1905(s) |
| Family Planning | 1902(a)(10)(A)(ii)(XXI) |

# B. Evaluation Questions and Hypotheses

The evaluation will focus on the demonstration policy goals described in **Section A**. This section provides the hypotheses and research questions (RQs) that correspond to each of the goals. Since this Evaluation Plan is limited to one year, logic models are not provided and the proposed analyses are descriptive in nature and aim to provide a baseline of the demonstration. Indiana had to carefully consider the scope of the 2020 Summative Evaluation Report given the limited period it encompasses (one year) and the Mid-Point Assessment due that same year. In addition to the limited waiver period (2020 only), COVID-19's disruption to Indiana's health care system in 2020 (starting from March 2020), also creates significant difficulty in assessing the impact of the demonstration in 2020. This is further discussed in **Section C**.

## 1. Goal One: Reduced utilization and length of stay in emergency departments (EDs) among Medicaid beneficiaries with SMI/SED 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 on utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings. **Exhibit B.1** below lists the hypothesis and research questions corresponding to this goal.

**Exhibit B.1: Hypothesis and Research Questions for Goal 1**

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

## 2. Goal Two: 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 B.2** below lists the hypothesis and research questions corresponding to this goal.

**Exhibit B.2: Hypothesis and Research Questions for Goal 2**

| Hypotheses | Research Questions |
|---|---|
| **Hypothesis 2:** The SMI/SED demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings. | **Primary research question 2:** Does the SMI/SED 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)?<br>**Subsidiary research question 2.1:** How do the SMI/SED demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics?<br>**Subsidiary research question 2.2:** How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings?<br>**Subsidiary research question 2.3:** Does the SMI/SED 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? |

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

Since this Evaluation Plan is limited to one year of the approved demonstration, Indiana will determine a baseline assessment and describe the availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state. **Exhibit B.3** below lists the hypotheses and research questions corresponding to this goal.

**Exhibit B.3: Hypothesis and Research Questions for Goal 3**

| Hypotheses | Research Questions |
|---|---|
| **Hypothesis 3:** The SMI/SED demonstration will result in improved availability of crisis stabilization services1 throughout the state. | **Primary research question 3.1:** To what extent does the SMI/SED 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?<br>**Primary research question 3.2:** To what extent does the SMI/SED demonstration result in improved availability of intensive outpatient services and partial hospitalization?<br>**Primary research question 3.3:** To what extent does the SMI/SED 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 community mental health centers, peer-run crisis respite programs, and so on)? |

## 4. Goal Four: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.

Since this Evaluation Plan is limited to one year of the approved demonstration, Indiana will describe the access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care. **Exhibit B.4** below lists the hypotheses and research questions corresponding to this goal.

**Exhibit B.4: Hypothesis and Research Questions for Goal 4**[5]

| Hypotheses | Research Questions |
|---|---|
| **Hypothesis 4:** Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care. | **Primary research question 4.1:** Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs?<br>**Subsidiary research question 4.1a:** To what extent does the demonstration result in improved availability of specific types2 of community-based services needed to comprehensively address the chronic needs of beneficiaries with SMI/SED?<br>**Subsidiary research question 4.1b:** To what extent does the demonstration result in improved access of SMI/SED beneficiaries to the specific types of community-based services that they need?<br>**Primary research question 4.2:** Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED increase under the demonstration? |

[5] Indiana is not including Subsidiary Research Question 4.1c in this Evaluation Plan: "How do the SMI/SED demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics?" The provider type summaries seen in Goal 3 can address this subsidiary RQ and streamline evaluation efforts and State resources.

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

Since this Evaluation Plan is limited to one year of the approved demonstration, Indiana will describe the care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. **Exhibit B.5** below lists the hypotheses and research questions corresponding to this goal.

**Exhibit B.5: Hypotheses and Research Questions for Goal 5**[6]

| Hypotheses | Research Questions |
|---|---|
| **Hypothesis 5:** The SMI/SED 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/SED demonstration result in improved care coordination for beneficiaries with SMI/SED?<br>**Primary research question 5.2:** Does the SMI/SED demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?<br>**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? |

[6] Indiana is not including Subsidiary Research Question 5.2a: "Does the SMI/SED demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries 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.

# C. Methodology

This section provides a summary of Indiana's evaluation design, including data sources, target populations, evaluation period, and analytic methods. This Evaluation Plan aims to provide a baseline of the demonstration through descriptive quantitative analyses and qualitative data collection and analysis to reflect all five of the program goals and to incorporate CMS' §1115(a) SMI/SED and SUD Evaluation Guidance[7].

This Evaluation Plan is limited to one year of the SMI Demonstration. Observations will be provided in the **2020 Summative Evaluation Report** and will be submitted to CMS in June 2022. The observation period for the evaluation will be calendar years (CYs) 2018 to 2020. This period includes two years before the SMI/SED amendment took effect on January 1, 2020 through December 31, 2020.

The ongoing coronavirus disease 2019 (COVID-19) public health emergency (PHE), which started in March 2020, is anticipated to cause substantial changes to service utilization and provider availability in 2020, and will have short- and long-term impacts on Indiana's health care system. Due to COVID-19, the State suspended policies regarding disenrollment of members and expanded behavioral health telemedicine services.[8] Social distancing and prioritization of health care resources are anticipated to affect utilization of a wide variety of services in the immediate future, even as telehealth services increase. Additionally, Medicaid enrollment will likely grow due to loss of income and some health care providers are anticipated to experience financial stress due to the short-term loss of income, and potential changes in payer mix as individuals lose employer-based coverage and Medicaid enrollment and the number of uninsured increases. The ability to use CY 2020 data to analyze the impact of the SMI waiver from 2018 to 2020 will require careful consideration and be dependent on multiple factors including the policies and the economic impact of COVID-19 which have been in effect from March and extended thru December. For example, mental health-related ED use in 2020 may be reduced due to concerns about acquiring the COVID-19 virus at the hospital; access to community-based services will be restricted due to temporary provider closures and/or limited hours and the use of telehealth; and initiatives to integrate physical and behavioral health may be delayed.

As the program outcome measures are based only on 2020 (demonstration period) and ongoing PHE can have significant confounding effect, the 2020 Summative Evaluation will not provide conclusions about the impact of the SMI/SED program. The evaluation will include descriptive analyses of changes in the composition of the enrolled population and the evaluator will consider any findings from this analysis when interpreting the results of the analyses described in the Evaluation Plan.

**Section F** includes the analytic design tables for each goal, detailing the relevant hypotheses, research questions, data sources, outcome measures, analytic methods, and comparison group(s) (if applicable). These tables also specify the years of data to be used for individual research questions and how they will be addressed in the 2020 Summative Evaluation Report.

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7 CMS. 1115 Demonstration State Monitoring & Evaluation Resources. Released and Accessed May 25, 2020 at https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html

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

## 1. Data Sources and Collection

The evaluator will compile data from claims/encounter and enrollment data. The evaluator will also capture qualitative data via key informant interviews (i.e., State officials, MCEs, and providers). **Exhibit C.1** summarizes the data sources anticipated to be used to evaluate each goal ("X" indicates relevant sources for each goal), followed by detailed descriptions of key data sources. **Section F** provides specific information regarding how these data sources will be used in the evaluation.

**Exhibit C.1: Data Sources by Goal**

| Type | Data Sources | Goal 1 Utilization and LOS | Goal 2 Preventable Readmissions | Goal 3 Crisis Stabilization | Goal 4 Community-based Services | Goal 5 Care Coordination |
|---|---|---|---|---|---|---|
| **Indiana– Quantitative** | 1. Member Eligibility, Application, and Enrollment Data *Note: Enrollment data will be used to draw member survey samples that are applicable across goals.* | X | X | - | X | X |
| | 2. Claims Data | X | X | - | X | X |
| | 3. State administrative data—for example, enrolled providers, psychiatric hospitals, crisis stabilization units, etc. [9] | - | - | X | X | - |
| **Indiana – Qualitative** | 1. Key Informant Interviews with State Officials | X | X | X | X | X |
| | 2. Key Informant Interviews with MCEs | - | X | X | X | X |
| | 3. Key Informant Interviews with Other Stakeholders (including consumer advocates) | - | X | X | X | X |
| | 4. Key Informant Interviews with Providers | X | X | X | X | X |

Note: The table indicates data sources that can be used for calculating outcome measures for each Goal. All data sources will not be used for the 2020 Summative Evaluation due to limited scope of the evaluation. Refer Section F for specific data sources that will be used for the 2020 Summative Evaluation.

[9] Other sources of State administrative data may be leveraged as available.

## *Internal Data Source Descriptions – Quantitative*

Other applicable data sources may be included as available and validated. Current sources include:

- *Member Eligibility, Application, and Enrollment Data:* Member application and enrollment data provide information on the size, location, and socio-demographic makeup of SMI/SED enrollees.
- *Claims Data:* The claims records (encounter data) that the MCEs submit to the State provide information about the health care utilization patterns of SMI/SED enrollees and identifies enrolled providers that are actively providing services.
- State Administrative Data: Program administrative data will include items related to the number of FQHCs that offer behavioral health services or the number of enrolled Medicaid providers.

Data acquisition process will include identifying the data elements of interest (e.g. coverage information, beneficiary demographic characteristics, claims / encounter data including at least first two diagnosis codes) and appropriate data sources or data tables. Different data are captured in different systems and for appropriate interpretation and use of data, supporting data dictionaries from the data owners will be used. Enrollment and claims data will be used in conjunction to identify the SMI population. The population total will be benchmarked to State reports to ensure accurate identification of the target SMI population. Claims associated with individuals identified as having SMI and covered under the waiver will be used to develop utilization based outcome measures (example ED visits in a year). Administrative data like summary information of number of crisis call centers, mobile centers will be studied for anomalies (e.g. very large or small numbers, benchmark to published reports).

## *Internal Data Source Descriptions – Qualitative*

In addition to quantitative data collection and analysis, Indiana will conduct key informant interviews to capture State Official, MCE, provider, and other stakeholder experience and evaluate other outcomes related to each goal. All the key informant Interviews will take place in 2021. **Exhibit C.2** describes the targeted number of interviewees and potential topics.

**Exhibit C.2: Summary of Indiana-Specific Qualitative Data Collection – Key Informant Interviews by Type, to be performed in 2021**

| Type | Potential Topics | Targeted Number of Interviewees | Approach to Selecting Participants |
|---|---|---|---|
| **State Officials** (60 minute interviews) | • Demonstration activities most effective in:<br>o Reducing utilization and lengths of stays in EDs<br>o Reducing preventable readmissions to acute care hospitals and residential settings<br>• Identify any obstacles as hindering the effectiveness of the demonstration in:<br>o Reducing utilization and lengths of stays in EDs<br>o Reducing preventable readmissions to acute care hospitals and residential settings<br>• Changes made through the demonstration to data sharing systems, processes, or policies | Five semi-structured interviews (including group interviews) | The evaluator will identify key state officials involved in the development, planning and administrative of the SMI/SED waiver. |
| **MCEs** (30-60 minute interviews) | • Demonstration activities most effective in:<br>o Reducing preventable readmissions to acute care hospitals and residential settings<br>o Data sharing systems, processes, or policies that staff identify as most effective for improving care coordination<br>• Identify any obstacles as hindering the effectiveness of the demonstration in:<br>o Reducing preventable readmissions to acute care hospitals and residential settings<br>o Data sharing systems, processes, or policies aimed at improving care coordination | Four semi-structured interviews with representatives from the four MCEs each year | Evaluator will interview staff from each contracted MCE involved in supporting the SMI/SED waiver |
| **Providers** (15-30 minute interviews – individual providers 30-60 minute interviews – provider associations | • Demonstration activities most effective in:<br>o Reducing utilization and lengths of stays in EDs<br>o Reducing preventable readmissions to acute care hospitals and residential settings<br>o Data sharing systems, processes, or policies that staff identify as most effective for improving care coordination<br>• Identify any obstacles as hindering the effectiveness of the demonstration in:<br>o Reducing utilization and lengths of stays in EDs<br>o Reducing preventable readmissions to acute care hospitals and residential settings<br>o Data-sharing systems, processes, or policies aimed at improving care coordination | *A total of ten provider/provider association interviews will be performed and inform all hypotheses Interviews will include provider associations and certified navigators* | Evaluator will identify key provider associations serving this population (e.g. Indiana Hospital Association) |

| Type | Potential Topics | Targeted Number of Interviewees | Approach to Selecting Participants |
|---|---|---|---|
| **Other Stakeholders** | • Demonstration activities regarding data-sharing systems, processes, or policies that staff identify as most effective for improving care coordination<br>• Obstacles that staff identify as hindering the effectiveness of demonstration activities regarding data sharing systems, processes, or policies aimed at improving care coordination | *A total of three interviews will be conducted. The interviewee will be determined based on stakeholder availability.* | 30-60 minutes |

## 2. Target and Comparison Populations

The target population for analyses are all Medicaid beneficiaries covered by an IHCP program aged 21-64 years with SMI regardless of their delivery system (e.g. managed care or fee-for-service). The SMI population are identified using 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)). Individuals not included in this target population are outlined in **Exhibit A.3**. IHCP programs include HIP members who are low-income, non-disabled adults ages 19 to 64; other adults eligible for Medicaid in Indiana include individuals who are 65 and older, blind, or disabled and who are also not eligible for Medicare, or low-income adults who can receive home and community-based services or who are in nursing homes and other facilities.

During the development of strategies for comparative analyses, both within-state and other-state comparison groups who are similar to IHCP members but not subject to the policies being evaluated were analyzed. Indiana had to carefully consider the scope of the 2020 Summative Evaluation Report given the limited period it encompasses (one year) and the Mid-Point Assessment due that same year. These factors, in addition COVID-19's disruption to Indiana's health care system in 2020 also creates significant difficulty in assessing the impact of the demonstration in 2020.

## 3. Analytic Methods

A modified evaluation approach for the purposes of the 2020 Summative Evaluation Report will be utilized given the limited demonstration period it encompasses (one year) and the Mid-Point Assessment due the same year. Indiana will use a mixed-methods approach, employing both quantitative and qualitative analyses to answer the research questions in this Evaluation Plan. Qualitative analyses will support an understanding of stakeholders' perspectives related to context, implementation, and outcomes, and will identify contextual factors that help to explain outcomes. Quantitative analyses will ascertain baseline data and describe the SMI/SED population's utilization of the ED, the availability of crisis stabilization services in Indiana, access to community-based services, and care coordination. Quantitative and qualitative analyses will reinforce each other and contribute to understanding context, implementation, impact, and variation.

The evaluation will employ a convergent approach incorporating mixed methods. With a convergent approach, qualitative data and analysis may inform the collection, analysis, and interpretation of quantitative data, and quantitative data and analysis can inform the collection, analysis, and interpretation of qualitative data. For example, key informant interviews will provide important contextual information that may help to explain the results of claims analysis; and the claims analyses may inform the development of survey and interview protocols. Both quantitative and qualitative data will be used throughout the course of the evaluation.

***Qualitative Analyses:*** Qualitative data collected through key informant interviews will be analyzed using thematic analysis, a systematic data coding and analysis process during which information is categorized with codes developed iteratively to reflect themes or patterns within the data.

***Quantitative Descriptive and Trend Analyses:*** Descriptive statistics (e.g., total, average, proportion) will be calculated to summarize the characteristics of Medicaid members with SMI/SED (across time where necessary) as well as observational inference on trends in outcomes of interest. No inferential statistics including case-mix adjusted estimates will be developed for this evaluation.

***Subgroup Analysis:*** These analyses will be conducted as part of descriptive analyses as listed in **Section F**. The type and number of subgroup analyses will be determined by appropriateness for the research question, and as data allow. To inform the selection of characteristics that will define subgroups, information gathered through interviews as well as through the descriptive analysis will be considered. The key informant interviews will provide perspective on potential subgroups for analysis, e.g., differences in care between geographic areas, historically marginalized populations, and individuals receiving services through the Medicaid Rehabilitation Option. The evaluator will use Medicaid administrative and enrollment data to identify these populations (e.g., based on zip code of residence, reported race/ethnicity, dual eligibility, receiving Medicaid Rehabilitation Option services via fee-for-service) for analysis.

# D. Methodological Limitations

**Exhibit D.1** describes the known limitations of the evaluation and anticipated approaches to minimizing those limitations and/or acknowledges where limitations might preclude casual inferences about the effects of demonstration policies. **Section C** contained information on limitations regarding identifying comparison groups and the potential impact of the COVID-19 public emergency on the use of 2020 data for evaluation purposes. The 2020 Summative Evaluation Report will describe in detail the limitations of the evaluation, which may include data and methodological challenges and other limitations identified during the evaluation process that are not described below. These reports will acknowledge approaches taken by the independent evaluator and necessary modifications made to the Evaluation Plan to address these challenges and limitations.

**Exhibit D.1: Summary of Methodological Limitations and Approach to Minimizing Limitations**

| Area | Issue | Description | Anticipated Approaches to Minimizing Limitations |
|---|---|---|---|
| **Overall issues** | Impact of COVID-19 | The ongoing COVID-19 public health emergency, which started from March 2020, is anticipated to cause substantial changes to:<br>• Service utilization<br>• Medicaid enrollment<br>• Provider networks | • Use and inclusion of CY 2020 data to analyze impact of policies will require careful analyses, and be dependent on multiple factors including the period for reinstatement of policies and COVID-19's economic impact.<br>• Provided context for interpretation of results. |
| | Quality of provider contact information for key informant interviews | Reliability of provider contact information made completing provider key informant interviews challenging. For example, provider email addresses and phone numbers listed in the MCE provider list often provided only generic office email addresses. | • Obtain support from key provider associations to identify providers for key informant interview purposes.<br>• Use interviews with key provider associations in lieu of individual providers as necessary. |
| | Impact of changes in population over time | Changes in the SMI/SED case mix 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. |

# E. Attachments

# Attachment E.1. Summary of Independent Evaluator Approach

Due to the COVID-19 PHE issued in Indiana, and the impact of COVID-19 on the State's budget, an independent evaluator was not procured in time for the initial Evaluation Design submission. The State, however, has granted FSSA's request to enter a contract with The Lewin Group, Inc to provide independent evaluation services for the SMI waiver. The contract is in its early stages of development and the State will provide detailed progress updates via monitoring reports until the contract is finalized. The State is committed securing an independent evaluator in a timely fashion to work through iterations of this Plan with CMS. Indiana will ensure that there are no conflicts of interest to report as stated in Section XVI, Paragraph 1 of CMS's STCs for this Waiver Evaluation.

In order to ensure an independent evaluation, the evaluation process will be independent of any process involving program policy making, management, or activity implementation of the waiver demonstration. The State's responsibility towards an independent evaluation is the assurance of quality data to the evaluator, support in understanding program context of any data anomalies, and identifying the program components that are important for the evaluation.

CMS recommended inclusion of cost analysis to understand how the demonstration affected health care spending. Analyses developed by State's actuary, Milliman Inc., will be included for this portion of the evaluation.

# Attachment E.2. Evaluation Budget

The State will provide a detailed evaluation budget upon finalization of the independent evaluator contract. Although not fully approved as of this report submission, the State is forecasting a proposed project budget of approximately $735,000. The budget should be approved by the next monitoring report and will be provided upon the contract finalization. The state will leverage its existing contract with Milliman Inc. for the required cost analysis.

# Attachment E.3. Timeline and Major Milestones

### Exhibit E.4: Timeline and Milestones

| | Key SMI/SED Deliverables and Reporting Activities | CY 2020 | CY 2021 | | | | CY 2022 | | | | CY 2023 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| Task 1 | **Conduct Project Kick-off and Project Management and Monitoring Activities** | | | | | | | | | | | |
| | Kickoff Meeting *(Deliverable 1.1)* | | | | | | | | | | | |
| | Updated work plan *(Deliverable 1.2)* | | | | | | | | | | | |
| | Status meetings (agendas, materials, meeting notes) *(Deliverable 1.3)* | | | | | | | | | | | |
| | Monthly progress reports *(Deliverable 1.4)* | | | | | | | | | | | |
| Task 2 | **Provide Input on FSSA's Draft Evaluation Plan** | | | | | | | | | | | |
| | Review the draft evaluation plan prepared by FSSA | | | | | | | | | | | |
| | Provide feedback and recommendations for the draft evaluation plan | | | | | | | | | | | |
| Task 3 | **Finalize Evaluation Plan based on CMS Feedback** | | | | | | | | | | | |
| | Review CMS feedback and discuss with FSSA and CMS | | | | | | | | | | | |
| | Develop summary table listing any recommended changes and proposed response *(Deliverable 3.1)* | | | | | | | | | | | |
| | Develop Revised Evaluation Plan for FSSA review *(Deliverable 3.2)* | | | | | | | | | | | |
| | Develop Revised Evaluation Plan (post-CMS review) *(Deliverable 3.3)* | | | | | | | | | | | |
| | Develop Final Evaluation Plan for submission to CMS *(Deliverable 3.4)* | | | | | | | | | | | |
| Task 4 | **Develop 2020 Summative Evaluation Report** | | | | | | | | | | | |
| | Collect quantitative data and prepare for analysis<br>-- Claims data request *(Deliverable 4.1)* | | | | | | | | | | | |
| | Develop quantitative analyses | | | | | | | | | | | |
| | Collect qualitative data and prepare for analysis<br>-- 2021 Key Informant Interview Summaries *(Deliverable 4.2)* | | | | | | | | | | | |
| | Develop qualitative analysis | | | | | | | | | | | |
| | Develop 2020 Summative Evaluation Report outline *(Deliverable 4.3)* | | | | | 12/15 | | | | | | |
| | Develop Draft 2020 Summative Evaluation Report for FSSA review *(Deliverable 4.4)* | | | | | | 2/11 | | | | | |
| | Develop Revised 2020 Summative Evaluation Report for public comment *(Deliverable 4.5)* | | | | | | 4/1 | | | | | |
| | Develop 2020 Summative Evaluation Report incorporating public comments and submit to FSSA *(Deliverable 4.6)* | | | | | | | 6/15 | | | | |
| | FSSA submits 2020 Summative Evaluation Report to CMS | | | | | | | 6/30 | | | | |
| | Respond to CMS feedback and submit Final 2020 Summative Evaluation Report *(Deliverable 4.7)* | | | | | | | | | | | |
| Task 5 | **Develop Mid-Point Assessment Report** | | | | | | | | | | | |
| | Develop Mid-Point Assessment outline *(Deliverable 5.1)* | | | | | | | | 8/19 | | | |
| | Collect qualitative data and prepare for analysis<br>-- 2022 Key Informant Interview Summaries *(Deliverable 5.2)* | | | | | | | | | | | |
| | Submit Mid-Point Assessment data/information request *(Deliverable 5.3)* | | | | | | | | | | | |
| | Develop Draft Mid-Point Assessment *(Deliverable 5.4)* | | | | | | | | 9/30 | | | |
| | Develop Final Mid-Point Assessment *(Deliverable 5.5)* | | | | | | | | | 11/16 | | |
| | FSSA submits Mid-Point Assessment Report to CMS | | | | | | | | | 12/31 | | |
| | Support FSSA during CMS briefing with briefing materials *(Deliverable 5.6)* | | | | | | | | | | | |
| Task 6 | **Support FSSA in Presenting Findings and Recommendations** | | | | | | | | | | | |
| | Develop presentations for the four main reports *(Deliverables 6.1-6.2)* | | | | | | | | | | | |
| Task 7 | **Develop Ad Hoc Analyses** | | | | | | | | | | | |
| | *TBD: Subtasks will vary by specific request for this task* | | | | | | | | | | | |

# F. Analytic Tables

## Goal 1: Reduced utilization and length of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings

**Exhibit F.1: Goal 1**

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.1:** The SMI/SED demonstrations will result in reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment. | **Primary RQ 1.1:** Does the SMI/SED demonstration result in reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment? | • Number of all-cause ED visits per 1,000 beneficiary-months among adult Medicaid beneficiaries age 18 and older who met the eligibility criteria of beneficiaries with SMI *Measure steward, endorsement: Milestone 2 monitoring metric* | • Claims/encounter data (2018-2020)<br>• Enrollment data (2018-2020) | Descriptive quantitative analysis of trends over time during the demonstration | n.a. |
| **H.1, continued** | | | | | |

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| | **Subsidiary RQ 1.2:** How do SMI/SED demonstration activities contribute to reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings? | • Demonstration activities or their components or characteristics that stakeholders identify as most effective in reducing utilization and lengths of stays in EDs among Medicaid beneficiaries with SMI or SED<br>• Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in reducing utilization and lengths of stays in EDs | Key informant interviews with State staff and ED providers (2021) | Descriptive qualitative analysis of demonstration activities most effective, and obstacles that stakeholders identify, in reducing utilization and lengths of stays in EDs | n.a. |

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

**Exhibit F.2: Goal 2, Hypothesis 2**

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.2:** The SMI/SED demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings. | **Primary RQ 2:** Does the SMI/SED 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)? | • Demonstration activities or their components or characteristics that stakeholders identify as most effective in reducing preventable readmissions to acute care hospitals and residential settings<br><br>• Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in reducing preventable readmissions to acute care hospitals and residential settings | Key informant interviews with State staff, MCOs, ED providers, and other stakeholders (including consumer advocates), 2021 | Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for reducing preventable readmissions to acute care hospitals and residential settings | n.a. |
| | **Subsidiary RQ 2.1:** How do the SMI/SED demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics? | | | | |
| | **Subsidiary RQ 2.2:** How do demonstration activities contribute to reductions in preventable readmissions to acute-care hospitals and residential settings? | | | | |

# Goal 3: The SMI/SED demonstration will result in improved availability of crisis stabilization services throughout the state

**Exhibit F.6: Goal 3**

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.3:** The SMI/SED demonstration will result in improved availability of crisis stabilization services throughout the state.<br>**H.3, continued** | **Primary RQ 3.1:** To what extent does the SMI/SED 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? | • Number of crisis call centers<br>• Number of mobile crisis units<br>• Number of crisis observation/assessment centers<br>• Number of coordinated community crisis response teams | State administrative data (2018-2020) | Descriptive quantitative analysis of trends over time during the demonstration | Baseline assessment at the start of the demonstration |
| | **Primary RQ 3.2:** To what extent does the SMI/SED demonstration result in improved availability of intensive outpatient services and partial hospitalization? | • Demonstration activities or their components or characteristics that stakeholders identify as most effective in improved availability of intensive outpatient services and partial hospitalization<br>• Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in improved availability of intensive outpatient services and partial hospitalization | Key informant interviews with State staff, MCOs, ED providers, and other stakeholders (including consumer advocates), 2021 | Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for improved availability of intensive outpatient services and partial hospitalization | n.a. |

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.3, continued** | **Primary RQ 3.3:** To what extent does the SMI/SED 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 community mental health centers, peer-run crisis respite programs, and so on)? | Number of:<br>• Crisis call centers<br>• Mobile crisis units<br>• Crisis observation/assessment centers<br>• Coordinated community crisis response teams | State administrative data (2018-2020) | Descriptive quantitative analysis of trends over time during the demonstration | Baseline assessment at the start of the demonstration |

# Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care

**Exhibit F.7: Goal 4**[10]

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.4:** Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care. | **Primary RQ 4.1:** Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs? | Proportion of beneficiaries with SMI/SED who use mental-health-related (1) outpatient, rehabilitation, and targeted case management services; (2) home and community-based services; and (3) long-term services and supports<br>Measure steward for (1): Milestone 3 monitoring metric for outpatient mental health services utilization divided by Milestone 4 monitoring metric for count of beneficiaries with SMI/SED | • Enrollment data (2018-2020)<br>• Claims/encounter data (2018-2020)<br>  • Institutional<br>  • Non-institutional<br>  • Pharmacy | Descriptive quantitative analysis of trends over time during the demonstration | n.a. |

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.4, continued** | **Subsidiary RQ 4.1a** - To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED? | Proportion of beneficiaries with SMI/SED who use mental-health-related (1) outpatient, rehabilitation, and targeted case management services; (2) home and community-based services; and (3) long-term services and supports | • Enrollment data (2018-2020)<br>• Claims/encounter data (2018-2020)<br>  • Institutional<br>  • Non-institutional<br>  • Pharmacy | Descriptive quantitative analysis of trends over time by type of service during the demonstration | n.a. |
| | **Subsidiary RQ 4.1b:** To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services? | | | | |

[10] Indiana is not including Subsidiary Research Question 4.1c: "How do the SMI/SED demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics?" in this Evaluation Plan. The outcome measures from Goal 3, the summaries of provider types, address this question. Furthermore, this Evaluation Plan is limited to one year of the demonstration and because this is a subsidiary research question.

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| | **Primary RQ 4.2:** Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED improve under the demonstration? | • Demonstration activities or their components or characteristics that stakeholders identify as most effective in the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED<br>• Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED | Key informant interviews with State staff, MCOs, ED providers, and other stakeholders (including consumer advocates), 2021 | Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED | n.a. |

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

**Exhibit F.9: Goal 5**[11]

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.5:** The SMI/SED demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. | **Primary RQ 5.1:** Does the SMI/SED demonstration result in improved care coordination for beneficiaries with SMI/SED? | • Changes made through the demonstration to data-sharing systems, processes, or policies<br>• Demonstration activities regarding data-sharing systems, processes, or policies that staff identify as most effective for improving care coordination<br>• Obstacles that staff identify as hindering the effectiveness of demonstration activities regarding data sharing systems, processes, or policies aimed at improving care coordination | • Key informant interviews with State staff, MCOs, Inpatient/residential and outpatient provider staff, and other stakeholders (including consumer advocates), 2021 | Qualitative analysis to identify themes associated with the effectiveness of demonstration activities to improve data sharing systems, processes, and policies to support care coordination | n.a. |

[11] Indiana is not including Subsidiary Research Question 5.2a: "Does the SMI/SED demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries 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 especially considering Indiana's budget and the impact of COVID-19.

| Hypothesis | Research Question | Outcome Measure(s) | Data Sources | Analytic Approach | Comparison Strategy |
|---|---|---|---|---|---|
| **H.5, continued** | **Primary RQ 5.2:** Does the SMI/SED demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? | • Demonstration activities or their components or characteristics that stakeholders identify as most effective in improving continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities<br>• Obstacles that stakeholders identify as hindering the effectiveness of the demonstration in improving continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities | Key informant interviews with State staff, MCOs, Inpatient/residential and outpatient provider staff, and other stakeholders (including consumer advocates), 2021 | Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for improving continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities | n.a. |
| | **Subsidiary RQ 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? | | | | |

# G. Impact of Demonstration on Health Care Spending

Milliman will provide the cost analyses to assess whether the SMI demonstration results in higher, lower, or neutral health care spending. They will follow the guidance found in the SMI/SED and SUD Evaluation Design Guidance: Appendix C[12]. Milliman's analyses will be included in this section.

12 https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf