Medicaid Section 1115 Substance Use Disorder & Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Report Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) and serious mental illness and serious emotional disturbance (SMI/SED) demonstrations or the SUD and SMI/SED components of the broader demonstration

This section collects information on the approval features of the state's section 1115 demonstration overall, followed by information for the SUD and SMI/SED components. The state completed this title page as part of its SUD and SMI/SED monitoring protocol(s). The state should complete this table using the corresponding information from its CMS-approved monitoring protocol(s) and submit this as the title page of all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

Overall section 1115 demonstration	
State	Indiana
Demonstration name	Healthy Indiana Plan (HIP)
Approval period for section 1115 demonstration	01/01/2021 – 12/31/2025
Reporting period	04/01/2020-09/30/2023
SUD demonstration	
SUD component start date[a]	02/01/2018
Implementation date of SUD component, if different from SUD component start date[b]	*N/A*

SUD-related demonstration goals and objectives	All Medicaid beneficiaries in Indiana will continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries, ages 21 through 64 will have access to expanded covered services provided while residing in an Institution for Mental Diseases (IMD) for SUD short-term residential stays. The SUD program will allow beneficiaries with SUD to access benefits that include SUD residential treatment, crisis stabilization and withdrawal management services provided in IMDs, which would otherwise be excluded from federal reimbursement. Goals include: 1. Increased rates of identification, initiation, and engagement in treatment; 2. Increased adherence to and retention in treatment; 3. Reductions in overdose deaths, particularly those due to opioids; 4. Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and 6. Improved access to care for physical health conditions among beneficiaries.
SUD demonstration year and quarter	DY3Q2-DY6Q3

SMI/SED demonstration	
SMI/SED component demonstration start date[a]	01/01/2020
Implementation date of SMI/SED component, if different from SMI/SED component start date[b]	N/A
SMI/SED-related demonstration goals and objectives	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.
SMI/SED demonstration year and quarter	DY1Q2-DY4Q3

[a] **SUD and SMI/SED demonstration components start dates:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD and SMI/SED demonstration component approvals. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD or SMI/SED demonstration component. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD and SMI/SED demonstration components:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Executive summary

The executive summary for the SUD and SMI components of the demonstration should be reported below. It is intended for summary-level information only and may be combined for all policies included in the title page. The recommended word count is 500 words or less.

Throughout 2023, OMPP has notified CMS that multiple errors have been found in the scripts that calculate the SUD and SMI metrics. To align with the feedback CMS provided to OMPP on 10/31/2022 and 10/3/2023, OMPP has resubmitted the DY3Q2-DY6Q3 SUD monitoring reports and DY1Q2-DY4Q3 SMI monitoring reports in their corresponding PMDA deliverable slots.

As of Q1 2024, all the monitoring reports have been resubmitted in their corresponding PMDA slots. The retrospective SUD DY3Q2-DY6Q3 and SMI DY1Q2-DY4Q3 reports include global and Indiana-specific changes to the monitoring metrics. The re-run results presented are based on version 4 of the CMS technical specifications. Only established quality measures were calculated using the technical specifications available during the reporting timeframe. Given that these factors resulted in meaningful changes to multiple metrics, it may not be appropriate to compare data to previous submissions. All policy or SUD/SMI initiatives submitted in previous reports remain accurate.

3. Narrative information on implementation, by milestone and reporting topic

A. SUD component

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.	**Assessment of need and qualification for SUD services**			
1.1	**Metric trends**			
1.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.		#3, #4	**#3**: Between DY3Q2-DY6Q3, the average monthly count of beneficiaries with a SUD diagnosis, increased between 3-18.44%. Every quarter had a positive change. The most significant increase, 18.44%, occurred between Q4 2022 and Q1 2023. **#4**: Between DY3Q2-DY6Q3, the number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period increased by 9.65% between 2020 and 2021 and 47.02% between 2021 and 2022.
1.2	**Implementation update**			
1.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1.a The target population(s) of the demonstration	X		
	1.2.1.b The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.2 The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.	**Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)**			
2.1	**Metric trends**			

2.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.		#6, #7, #8, #9, #10, #11, #12,	**#6:** Between DY3Q2-DY6Q3, the number of beneficiaries enrolled receiving any SUD treatment service, facility claim, or pharmacy claim changed between -0.95 and 12.04%. The most significant change occurred between Q3 and Q4 2020, increasing 12.04%. **#7:** Between DY3Q2-DY6Q3, the number of beneficiaries who used early intervention services fluctuated between -26.85 and 48.08%. A 26.5% decrease occurred between Q1 and Q2 2021. A 48.08% increase occurred between Q1 and Q2 2022. **#8:** Between DY3Q2-DY6Q3, the average monthly change for outpatient service utilization for SUD only ranged from -1.44 and 12.33%. A 12.33% increase occurred between Q3 and Q4 2020. **#9:** Between DY3Q2-DY6Q3, the average monthly change for Intensive Outpatient and Partial Hospitalization services utilization ranged from -13.22 and 48.75%. A 13.22% decrease occurred between Q2 and Q3 2020. Alternatively, a 48.75% increase occurred between Q3 and Q4 2020. **#10:** Between DY3Q2-DY6Q3, the average number of beneficiaries who use residential and/or inpatient services for SUD ranged from -0.10 and 26.39. A 26.39% change occurred between Q3 and Q4 2020. **#11**: Between DY3Q2-DY6Q3, the average number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) ranged from 0.98 and 29.19%. A 29.19% change occurred between Q3 and Q4 2020. **#12:** Between DY3Q2-DY6Q3, the change in number of beneficiaries who have a claim for MAT for SUD ranged

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			from 0.29 and 11.47%. A 11.47% change occurred between Q2 and Q3 2020.
2.2 Implementation update			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1.a Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication-assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)			In 2020, Indiana received a federal SUD planning grant to conduct a community-engaged planning process for assessing current provider capacity, improve intra- and inter-agency infrastructure for monitoring, conduct evaluation and planning, and design an action plan that will position the state to implement strategic solutions for addressing gaps in SUD provider capacity. During 2020 activities focused on completing the initial draft of the baseline capacity and planning provider survey. As part of this SUD grant, FSSA in the first quarter of 2022, began to create a data dashboard that identifies SUD Treatment, SUD Providers, and levels of ASAM within the state of Indiana via Medicaid claims data. The dashboard was available as of September 2022. In July 2023, Indiana Medicaid aligned itself with Medicare in using the G reimbursement codes for medication-assisted treatment. During the period of October 2023 and December 2023, Indiana Medicaid and the Division of Mental Health and Addiction continued to collaborate in answering policy and reimbursement questions around using G reimbursement codes for MAT. In addition, both divisions continue to collaborate with each other in the implementation of the certified community behavioral health centers.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1.b	SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication-assisted treatment services provided to individual IMDs			In July 2023, Indiana began to use the G reimbursement codes for medication-assisted treatment. This new alignment with Medicare will allow great access for members to various services including to allow them to have take-home supplies of the medication-assisted treatment.

2.2.2 The state expects to make other program changes that may affect metrics related to Milestone 1.			In 2020, FSSA assessed movement from Telemedicine opportunities implemented in response to COVID-19 to determine the best options for Telehealth in a post-COVID-19 environment. In 2021, Indiana Medicaid worked on developing a finalized telehealth code set to be used after the public health emergency. This code set includes expanded services available via telehealth service delivery, such as expanded behavioral health treatment, and substance use disorder treatment services. (e.g., counseling, psychotherapy, MAT adherence/management services, intensive outpatient therapy, etc.) Indiana Medicaid is also exploring audio-only telehealth options in the delivery of behavioral health treatment. The proposed 2022 Telehealth and Virtual Services code set was published December 30th, 2021. Indiana Medicaid's new Telehealth and Virtual Services Code set went into effect July 21, 2022. Indiana Medicaid will also continue to offer audio-only telehealth options in the delivery of behavioral health treatment. The implementation of this code set ensures that Indiana Medicaid can continue to provide a full continuum of behavioral health services in the post-PHE environment. In coordination with the Division of Mental Health and Addiction, the Office of Medicaid Policy and Planning developed several service parameters for when telehealth delivery satisfies the "face-to-face" contact required for several behavioral health services. An innovative solution was to allow skills training and development to be rendered through telehealth and establishing those services parameters accordingly. Additionally, Indiana

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			continues to offer audio-only telehealth options by expanding the types of services reimbursable when rendered via audio-only telehealth. The Indiana Division of Mental Health and Addiction coordinated with the Office of Medicaid Policy and Planning to implement the statewide 9-8-8 Crisis Hotline services. The Division of Mental Health and Addiction is currently designating different organizations to render mobile crisis services. Mobile crisis unit response coverage has been effective July 2023. The Office of Medicaid Policy and Planning received approval for the Mobile Crisis State Plan Amendment in September 2023. Indiana Medicaid provided a clarification on the specific codes and how to become a designated mobile crisis unit.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.	**Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)**			
3.1	**Metric trends**			
3.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.		#5, #36	Metric #5, the number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD increased every year, from 7,061 in 2020 to 13,281 in 2021 to 16,781 in 2022. Metric #36, the average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD increased 14.69% in 2021 and decreased by 7.14% in 2022.
3.2	**Implementation update**			
3.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1.a Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria			As of Q3 2023, DMHA is looking at how the new revision of the ASAM criteria (ASAM 4.1) will impact provider expectations and quality control.
	3.2.1.b Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings			During Q4 of 2023, the Division of Mental Health and Addiction continued discussions relating to 3.7 ASAM level designations for our SUD residential providers.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.2.2 The state expects to make other program changes that may affect metrics related to Milestone 2.			OMPP and DMHA collaborated with Next Level Recovery to launch ATLAS (Addiction Treatment Locator, Assessment, and Standards platform) as the state's addiction treatment locator. This effort will help individuals seeking addiction treatment find high quality care. ATLAS successfully launched in the state in September 2023. For the period of October-December 2023, 16,371 users utilized ATLAS with 13,791 being unique individuals. The top three substance filters are Heroin/Fentanyl, Alcohol, and Cocaine. The treatment ATLAS assessment is being completed by 67.9% of users.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.	**Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)**			
4.1	**Metric trends**			
4.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3. Note: There are no CMS-provided metrics related to Milestone 3. If the state did not identify any metrics for reporting this milestone, the state should indicate it has no update to report.	X		
4.2	**Implementation update**			
4.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 4.2.1.a Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards			As reported previously, DMHA began providing ASAM designations for the State's residential providers on March 1, 2018. In Q3 2020, there were 16 ASAM 3.1 providers, totaling 330 beds. There were 39 ASAM 3.5 providers, totaling 1212 beds. By September 2023, for ASAM level 3.1 there was a total of 14 providers with 244 beds. For ASAM level 3.5, there was a total of 61 providers with 2556 beds. For combined ASAM 3.1 and 3.5 facilities, there were 3 providers and 125 beds for this reporting period.
	4.2.1.b Review process for residential treatment providers' compliance with qualifications.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.2.1.c Availability of medication-assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site	X		
4.2.2 The state expects to make other program changes that may affect metrics related to Milestone 3.	X		During 2020, Indiana continued to work with providers to expand access to all evidence-based treatments and promoting the use of MAT for SUD treatment. During 2021, Indiana continued work on the implementation of combined ASAM 3.1 & 3.5 facilities to allow greater flexibility/capacity for our SUD providers, and greater access to SUD care for members. In 2021, Indiana per HEA 1468 submitted a state plan amendment so that individuals within a ASAM 3.1 SUD residential facility can receive Medicaid Rehabilitation Option services while in a residential facility. This change allows for skills training/development to be provided by a CMHC and the MRO-eligible member is residing within a 3.1 SUD residential facility. CMS approved this SPA on December 27th, 2021 and the changes were effective January 1st, 2022.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.	**Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)**			
5.1	**Metric trends**			
5.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.		#13, #14	Metric #13, the number of providers who were enrolled in Medicaid and qualified to deliver SUD services increased 44.60% in 2021 and 19.27% in 2022. Metric #14, the number of providers who were enrolled in Medicaid and qualified to deliver SUD services and who meet the standards to provide buprenorphine or methadone as part of MAT increased by 1.63% (n=809) in 2021 and 1.48% (n=821) in 2022.
5.2	**Implementation update**			
5.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients across the continuum of SUD care.			Effective October 1, 2020, Indiana added midlevel practitioners to those who qualify to bill for services rendered in an FQHC or RHC under the PPS system. During 2020, Indiana has worked to develop new OTP sites. Two of the three planned new OTP sites opened during 2020. On August 7, 2020, Governor Eric J. Holcomb announced partnership between the Indiana Division of Mental Health and Addiction and Mental Health America of Indiana to expand access to trained peer support recovery professionals through the Indiana Recovery Network. This expanded peer recovery options for Hoosiers with mental health and substance use disorders.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.2 The state expects to make other program changes that may affect metrics related to Milestone 4.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.	**Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)**			
6.1	**Metric trends**			
6.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.		#23 #27	**#23:** The number of emergency department visits for SUD per 1,000 beneficiaries changed quarterly between -18.18 and 20.10%. The most significant change, 20.10%, occurred between Q2 and Q3 2020. **#27:** The rate of overdose deaths among adult Medicaid beneficiaries living in a geographic area covered by the demonstration decreased by 39.08% in 2021 to 0.000467 and increased by 16% in 2022 to 0.000541.
6.2	**Implementation update**			
6.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 6.2.1.a Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2.1.b Expansion of coverage for and access to naloxone			Indiana implemented a sustainable reimbursement system for emergency responders who utilize naloxone – the first in the nation. The Emergency Medical Transportation Services (EMS) Project for Naloxone Coverage was effective July 1, 2020. During July 2020, Indiana held four live webinar trainings for EMS provider agencies about the new naloxone reimbursement policy. Effective November 10, 2020, the Department of Corrections (DOC) will provide a supply of naloxone to every offender with a history of substance use disorder upon release.
6.2.2 The state expects to make other program changes that may affect metrics related to Milestone 5.			In 2021, Indiana worked on submitting a state plan amendment to CMS to restructure how opioid treatment programs are reimbursed by Indiana Medicaid. Indiana Medicaid updated the per diem bundle, in order incorporate other forms of MAT treatment besides methadone (e.g. buprenorphine, naltrexone) and to include mechanisms for take-home MAT dispensing. This SPA received approval from the Indiana State Budget Committee in July 2022, and OMPP submitted these SPA pages to CMS in Q1of 2023. CMS approved the state amendment pages in June 2023, and these changes became effective in July 2023. Indiana Medicaid further aligned with Medicare by implementing the OTP G-codes that would allow for more services on a weekly basis including the ability to allow take-home supplies.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
7.	**Improved Care Coordination and Transitions between Levels of Care (Milestone 6)**			
7.1	**Metric trends**			

7.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.		#15, #17, #25	**#15:** Percentage of beneficiaries aged 18 and older who received the following: Initiation of AOD Treatment - Alcohol abuse or dependence increased in 2021 by 5.28% (rate=0.25) and increased 4.09% in 2022 (rate=0.26). Initiation of AOD Treatment - Opioid abuse or dependence increased 23.37% in 2021 (rate=0.27) and increased 5.02% in 2022 (rate=0.28). Initiation of AOD Treatment - Other drug abuse or dependence increased 13.39% in 2021 (rate=0.22) and increased 3.29% in 2022 (rate=0.23). Initiation of AOD Treatment - Total AOD abuse of dependence increased 16.06% in 2021(rate=0.32) and increased 3.38% in 2022 (rate=0.33). Engagement of AOD Treatment - Alcohol abuse or dependence increased 16.30% in 2021 (rate=0.008) and increased 8.67% in 2022 (rate=0.009). Engagement of AOD Treatment - Opioid abuse or dependence decreased 16.35% in 2021 (rate=0.057) and increased 12.23% in 2022 (rate=0.064). Engagement of AOD Treatment - Other drug abuse or dependence decreased 0.09% in 2021 (rate=0.017) and decreased 3.22% in 2022 (rate=0.0169). Engagement of AOD Treatment - Total AOD abuse of dependence decreased 4.04% in 2021 (rate=0.0317) and decreased 0.42% in 2022 (rate=0.0315). **#17:** The percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit decreased 0.55% in 2021 (rate=0.34) and decreased 4.76% in 2022 (rate=0.33).

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
				The percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit increased 0.21% in 2021 (rate=0.43) and decreased 1.31% in 2022 (rate=0.42). The percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit decreased 9.12% in 2021 (rate=0.19) and decreased 7.40% in 2022 (rate=0.17). The percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit decreased 6.04% in 2021 (rate=0.28) and decreased 5.29% in 2022 (rate=0.26). **#25**: The rate of all-cause readmissions during the measurement period among beneficiaries with SUD decreased 1.20% in 2021 (rate=0.0987) and decreased 1.04% in 2022 (rate=0.0977).
7.2	**Implementation update**			
7.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.	X		
7.2.2	The state expects to make other program changes that may affect metrics related to Milestone 6.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
8.	**SUD health information technology (health IT)**			
8.1	**Metric trends**			
8.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its SUD health IT metrics.		S.1, S.2, S.3	**S1**: The count of prescribers accessing INSPECT on a statewide basis, during DY3Q2-DY6Q3, changed between -0.93 and 9.38%. The most significant change, 9.38%, occurred between Q4 2022 (n=19782) and Q1 2023 (n=21638). **S2**: The number of patient requests made into INSPECT on a statewide basis, during DY3Q2-DY6Q3, changed between -5.15 and 4.13%. The most significant change, a 5.15% decrease, occurred between Q1 (n=2,063,622) and Q2 2023 (1,957,347).
8.2	**Implementation update**			
8.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		
	8.2.1.a How health IT is being used to slow down the rate of growth of individuals identified with SUD			
	8.2.1.b How health IT is being used to treat effectively individuals identified with SUD	X		
	8.2.1.c How health IT is being used to effectively monitor “recovery” supports and services for individuals identified with SUD	X		

Prompt			State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
	8.2.1.d	Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels	X		
	8.2.1.e	Other aspects of the state's health IT implementation milestones	X		
	8.2.1.f	The timeline for achieving health IT implementation milestones	X		
	8.2.1.g	Planned activities to increase use and functionality of the state's prescription drug monitoring program	X		
8.2.2	The state expects to make other program changes that may affect SUD metrics related to health IT.				Effective December 31, 2020 and pursuant to Senate Enrolled Act 176, the State of Indiana has mandated that all prescriptions for a controlled substance be issued through an electronic format and transmission (E-prescribing). In addition, Indiana has provided funding to ensure that all practices are in compliance with the December 31, 2020 deadline.
9.	**Other SUD-related metrics**				
9.1	**Metric trends**				
9.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.			#24	The number of inpatient stays for SUD per 1,000 beneficiaries, during DY3Q2-DY6Q3, changed between -13.19 and 10.72%. The 10.72% increase occurred between Q2 and Q3 2020 and the -13.19% change occurred between Q4 2020 and Q1 2021.
9.2	**Implementation update**				

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
9.2.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.		#33, #34	Between Q2 2020 and Q4 2020, Indiana was incorrectly capturing appeals and grievance data for SUD. The state collects data for this metric from the MCEs, which at the time were reporting grievances received and resolved in the quarter. To align with the metric, the state updated the reporting requirement and began to collect appeals and grievances received in the quarter regardless of resolution. Due to this, Q2-Q4 2020 data will not be considered trend purposes. **#33:** Between Q1 2021- Q3 2023, the number of grievances filed during the measurement period that are related to SUD treatment services ranged from two to seven. The most significant change occurred between Q1 and Q2 2022, with grievances increasing from two to six, a 200% increase. **#34**: Between Q1 2021-Q3 2023, the number of appeals filed during the measurement period that are related to SUD treatment services ranged between 12 and 330. The most significant change between Q3 and Q4 2022, with appeals increasing from 12 to 197, a 1542% increase.

B. SMI/SED component

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.	**Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)**			
1.1	**Metric trends**			
1.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.		*#2*	The percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment increased 9.83% in 2021 compared to 2020 and decreased 3.73% in 2022 compared to 2021. 2020 rate: 0.550 2021 rate: 0.604 2022 rate: 0.581
1.2	**Implementation update**			
1.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1.a The licensure or accreditation processes for participating hospitals and residential settings	X		
	1.2.1.b The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1.c	The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	X		
1.2.1.d	The program integrity requirements and compliance assurance process	X		
1.2.1.e	The state requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	X		
1.2.1.f	Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	X		
1.2.2	The state expects to make other program changes that may affect metrics related to Milestone 1.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.	**Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)**			
2.1	**Metric trends**			

2.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.		#3, #4, #6, #7, #8, #9, #10	#4: The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease decreased 0.39% in 2021 compared to 2020 and increased 3.76% in 2022 compared to 2021. The 2020 rate was 0.251, the 2021 rate was 0.250 and the 2022 rate was 0.259. #6: The number of psychiatric patients admitted to an IPF for MDD, schizophrenia, or bipolar disorder that filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge increased 6.19% in 2021 compared to 2020 and increased 1.26% in 2022 compared to 2021. The 2020 rate was 0.547, the 2021 rate was 0.581 and the 2022 rate was 0.588. #7: The percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge, increased 8.51% in 2021 compared to 2020 and by 0.09% in 2022 compared to 2021. The 2020 rate was 0.604, the 2021 rate was 0.656 and the 2022 rate was 0.656. The percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days after discharge increased 12.50% in 2021 and decreased 12.89% in 2022. The 2020 rate was 0.387, the 2021 rate was 0.435, and the 2022 rate was 0.379. #8: The percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health

			practitioner within 30 days after discharge increased 21.24% in 2021 and decreased 9.70% in 2022. The 2020 rate was 0.406, the 2021 rate was 0.492, and the 2022 rate was 0.444. The percentage of discharges for beneficiaries aged 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner within 7 days after discharge increased 36.08% in 2021 and decreased 13.17% in 2022. The 2020 rate was 0.249, the 2021 rate was 0.339, and the 2022 rate was 0.294. #9: Percentage of (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit increased 1.18% in 2021 and 66.62% in 2022. The 2020 rate was 0.234, the 2021 rate was 0.237, and the 2022 rate was 0.394. The percentage of (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence within 7 days of the ED visit increased 3.21% in 2021 and 67.76% in 2022. The 2020 rate was 0.159, the 2021 rate was 0.165, and the 2022 rate was 0.276. #10: Percentage of (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within 30 days of the ED visit increased 0.19% in 2021 and decreased 4.09% in 2022. The 2020

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			rate was 0.505, the 2021 rate was 0.506 and the 2022 rate was 0.485. The percentage of (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within 7 days of the ED visit decreased 0.23% in 2021 and 8.41% in 2022. The 2020 rate was 0.362, the 2021 rate was 0.361, and the 2022 rate was 0.331.
2.2 Implementation update			
2.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1.a Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	X		
2.2.1.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1.c	State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge	X		
2.2.1.d	Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)	X		
2.2.1.e	Other state requirements/policies to improve care coordination and connections to community-based care)	X		
2.2.2	The state expects to make other program changes that may affect metrics related to Milestone 2.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3. Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.1 Metric trends			

3.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.		#13, #14, #15, #16, #17, #18	**#13:** Between DY1Q2-DY4Q3, the average monthly inpatient utilization for mental health changed between -15.94 and 7.78%. A 15.94% decrease occurred between Q4 2022 and Q1 2023, with the avg. decreasing from 5306 to 4460. A 7.78% increase occurred between Q2 and Q3 2021, with the avg. increasing from 5114 to 5512. **#14**: Between DY1Q2-DY4Q3, the average number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during changed between -29.29 and 65.36%. A 29.29% decrease occurred between Q2 and Q3 2020, with the avg. decreasing from 132 to 93. A 65.36% increase occurred between Q3 and Q4 2020, with the avg. increasing from 93 to 154. **#15:** Between DY1Q2-DY4Q3, the average monthly utilization of outpatient services for mental health changed between -59.50 and 54.89. A 59.50% decrease occurred between Q2 and Q3 2020, with the avg. decreasing from 41,439 to 16,781. A 54.89% increase occurred between Q3 and Q4 2020, with the avg. increasing from 16,781 to 25,992. **#16:** Between DY1Q2-DY4Q3, the average monthly utilization of ED services for mental health changed between -18.50 and 36.07%. An 18.50% decrease occurred between Q3 and Q4 2021, with the avg. decreasing from 654 to 533. A 36.07% increase occurred between Q3 and Q4 2020, with the avg. increasing from 426 to 579. **#17:** Between DY1Q2-DY4Q3, the average monthly utilization of telehealth services for mental health changed between -27.47 and 504.77%. A 505% increase occurred between Q2 and Q3 2020 due to the telehealth services made available to beneficiaries due to the

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			COVID 19 PHE. Between Q3 and Q4 2021, telehealth utilization decreased 27%. **#18:** Between DY1Q2-DY4Q3, the average monthly utilization of all mental health changed between -6.19 and 11.66%. A 6.19% decrease occurred between Q3 and Q4 2021. An 11.66% increase occurred between Q1 and Q2 2023. .
3.2 Implementation update			
3.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1.a State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay	X		
3.2.1.b Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.2.2 The state expects to make other program changes that may affect metrics related to Milestone 3.			Indiana's Division of Mental Health and Addiction (DMHA) is working to establish updates to intake assessments, particularly by replacing/updating CANS/ANSA criteria that are required for certain packages under Indiana Health Coverage Programs (e.g. the Medicaid Rehabilitation Option). These discussions are ongoing, and no decision has been made yet on how to proceed with the project. As of Q3 2023, these discussions have been occurring on an ongoing basis. With the current pursuit of the certified community behavioral health center demonstration, DMHA is looking how MRO, and these assessments would be implemented into this project.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.	**Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)**			
4.1	**Metric trends**			

4.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.		#21, #22, #23, #26, #29, #30	**#21:** Between DY1Q2-DY4Q3, the average monthly count of beneficiaries with SMI/SED changed between -4.05 and 9.39%. A 4.05% decrease in beneficiaries occurred between Q3 and Q4 2021. A 9.39% beneficiary increase occurred between Q1 and Q2 2023. **#22:** The number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period increased from 266,256 in 2020 to 300,734 in 2021, a 12.95% increase. In 2022, the population increased to 306,730, a 1.99% increase. **#23:** The rate of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level >9.0% was 0.983 in 2020. In 2021, the rate decreased 0.76% to 0.976. In 2022, the rate decreased 2.18% to 0.954. **#26**: The rate of Medicaid beneficiaries aged 18 years or older with SMI who had an ambulatory or preventive care visit in 2020 was 0.90 and increased 5.60% in 2021 to 0.95. In 2022, the rate increased 0.41% to 0.954. **#29:** The rate of children and adolescents on antipsychotics who received blood glucose testing in 2020 was 0.44. In 2021, the rate increased 2.88% to 0.45. In 2022, the rate increased 3.05% to 0.46. The rate of children and adolescents on antipsychotics who received cholesterol testing in 2020 was 0.27. In 2021, the rate increased 2.28% to 0.28. In 2022, the rate decreased 0.38% to 0.27. The rate of children and adolescents on antipsychotics who received blood glucose and cholesterol testing was 0.26 in 2020 and increased 2.30% in 2021 to 0.27. In 2022, the rate decreased 0.43% to 0.26.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			#30: The rate of Medicaid beneficiaries aged 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication was 0.784 in 2020. In 2021, the rate decreased 0.78% to 0.778. In 2022, the rate decreased 3.04% to 0.754.
4.2 Implementation update			
4.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		
4.2.1.a Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)			
4.2.1.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.2.1.c	Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED			OMPP is currently in the process of developing a state plan amendment for Mobile Crisis Intervention Services. The proposed budget for this state plan amendment was reviewed by the State Budget Committee December 2022 with a goal effective date set for July 2023. During late 2023, the Division of Mental Health and Addiction created a designation plan, that will be used to identify these providers within the state. OMPP has been involved in the development of this designation process, that will ultimately be used to build a new provider enrollment specialty within our program. OMPP has submitted the state amendment pages to CMS in June 2023 for approval. CMS approved the Mobile Crisis SPA in September 2023. OMPP and DMHA are currently in the beginning stages of implementing Crisis Stabilization Services. DMHA has started a Crisis Stabilization Services pilot program.
4.2.1.d	Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	X		
4.2.2	The state expects to make other program changes that may affect metrics related to Milestone 4.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.	**SMI/SED health information technology (health IT)**			
5.1	**Metric trends**			

5.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its SMI/SED health IT metrics.			As approved in the monitoring protocol, Q1, Q2, and Q3 were due to phase in during DY3Q1. Indiana was not able to find a reliable data source for the original health IT metrics in the monitoring protocol. As a result, Indiana proposed new Health IT metrics. Q1 and Q2 were approved by CMS in March 2023. Q3 was approved by CMS in August 2023. Q1 was originally meant to capture the number of jails/criminal justice systems connected to HIE. Moving forward, after modifications, Indiana will report the number of Indiana Department of Correction facilities connected to HIE. Q2 was originally meant to capture the number of providers and resources managed in provider/resource directory. Moving forward, after modifications, Indiana will report the number of behavioral health providers. Q3 was originally meant to capture the number of clinicians with a list of community resources that individuals can be referred to in an e-directory. Moving forward, after modifications, Indiana will report the percentage of Community Mental Health Centers in Indiana that are monitoring their clients' outcomes via the Data Assessment Registry Mental Health & Addiction (DARMHA). **Q1:** Indiana was not able to report this metric until DY4Q1.Since Q1 2023, the number of Indiana DOC facilities connected to HIE has remained the same. As of Q3 2023, there are nine of 21 facilities connected to health information exchange. **Q2:** Indiana was not able to report this metric until DY4Q1. The count of behavioral health providers increased every quarter in the reporting period, Q1 2023-Q2 2023. In Q1 2023, there were 28,560 providers. In Q2 2023, there was a 3.35% increase, resulting in 29,518

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
				providers. In Q3 2023, there was a 3.44% increase, resulting in 30,532 providers. **Q3:** Indiana was able to capture retrospective data for Q2 2022- Q3 2023. During this timeframe, the number of CMHCs monitoring outcomes ranged from five to seven. There are 24 unique CMHCs in Indiana.
5.2	**Implementation update**			
5.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 5.2.1.a The three statements of assurance made in the state's health IT plan	X		
	5.2.1.b Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports	X		
	5.2.1.c Electronic care plans and medical records	X		
	5.2.1.d Individual consent being electronically captured and made accessible to patients and all members of the care team	X		
	5.2.1.e Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1.f	Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care	X		
5.2.1.g	Alerting/analytics	X		
5.2.1.h	Identity management	X		
5.2.2	The state expects to make other program changes that may affect SMI/SED metrics related to health IT.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.	**Other SMI/SED-related metrics**			
6.1	**Metric trends**			
6.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SMI/SED-related metrics.		#36, #37, #38	Between Q2 2020 and Q4 2020, Indiana was incorrectly capturing appeal and grievance data for SMI. The state collects data for this metric from the MCEs, which at the time were reporting grievances received and resolved in the quarter. To align with the metric, the state updated the reporting requirement and began to collect appeals and grievances received in the quarter regardless of resolution. Due to this, Q2-Q4 2020 data will not be considered for trend purposes. **#36:** Between Q1 2021 and Q3 2023, the number of grievances filed has ranged from zero to eight. **#37:** Between Q1 2021 and Q3 2023, the number of appeals filed has ranged from 14 to 125. The most significant change occurred between Q3 and Q4 2022, with a 407% change from 14 appeals to 71. **#38:** Critical incident data is not available for DY1Q2-DY1Q3.Between DY1Q4-DY4Q3, critical incidents ranged from 651 to 1230. The most significant decrease occurred between Q1 and Q2 2022, 36.26%, from 1230 to 784. The most significant increase occurred between Q4 2022 and Q1 2023, 38.22%, from 662 to 915.
6.2	**Implementation update**			

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2.1	The state expects to make the following program changes that may affect other SMI/SED-related metrics.	X		
7.	**Annual Assessment of Availability of Mental Health Services (Annual Availability Assessment)**			
7.1	**Description of changes to baseline conditions and practices**			
7.1.1	Describe and explain any changes in the mental health service needs of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of the Availability of Mental Health Services (for example, prevalence and distribution of SMI/SED). Recommended word count is 500 words or less.			In the initial provider availability assessment, the number of adult Medicaid beneficiaries with SMI 21+ was 23,936. In the 2023 assessment, the latest available, the number of adult Medicaid beneficiaries with SMI 21+ was 22,485. The assessments are run as of January 31st of every year. Throughout the assessments, that state has continued to improve data collection. As a result, the data sources for a few settings have changed between the assessments. Accurate comparison of assessments will begin in Q1 2024.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
7.1.2 Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.			Indiana Medicaid continues to not offer residential treatment for SMI, which results in this provider type having low counts within both the initial assessment and the current assessment for 2021. Additionally, the state of Indiana only identifies IMDs when these IMDs are enrolled with Indiana Medicaid, therefore our number of IMDs identified in this assessment is low. Lastly, Indiana Medicaid currently does not have a way of identifying QRTPs that are IMDs within our system, which why this section of the assessment is intentionally left blank. The Office of Medicaid Policy and Planning is currently working on an identification strategy to identify these facilities as part of compliance with the Family First Act.
7.1.3 Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of the Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.			In July 2023, the mobile crisis units became effective. In September 2023, CMS approved the SPA for the mobile crisis units. Also, there is current cross-collaboration between the Division of Mental Health and Addiction and OMPP to designate these mobile crisis units. In addition, DMHA and OMPP are collaborating on the upcoming implementation of the certified community behavioral health centers. Significant changes in the availability of mental health services include mobile crisis units, increasing from 6 in the 2020 assessment to 16 in the 2023 assessment. Crisis observation centers have also increased, from 2 in the original assessment to 3 in 2023. Community mental health centers increased from 97 in 2020 to 231 in 2023.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
7.1.4	Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Annual Availability Assessment compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.			As of 2021, we now directly enroll behavioral health practitioners (licensed clinical addiction counselors, licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, etc.) which means we are better able to identify behavioral health practitioners rendering services under our program.
7.1.5	Describe and explain whether any changes in the availability of mental health services have impacted the state's maintenance of effort (MOE) on funding outpatient community-based mental health services. Recommended word count is 500 words or less.	X		
7.2	**Implementation update**			
7.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 7.2.1.a The state's strategy to conduct annual assessments of the availability of mental health services across the state and updates on steps taken to increase availability			Throughout the assessments, that state has continued to improve data collection. As a result, the data sources for a few settings have changed between the assessments. Given that the Division of Mental Health and Addiction is the licensing authority for multiple settings in the assessment, OMPP has continued to update strategies as needed to collaborate with DMHA more closely.
	7.2.1.b Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
8.	**Maintenance of effort (MOE) on funding outpatient community-based mental health services**			
8.1	**MOE dollar amount**			
8.1.1	Provide as a dollar amount the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year.			SFY 2023 MOE data will be reported in the 2024Q1 monitoring report. Currently, 2022 MOE is available. SFY 2022 Expenditures ($ in millions) State general funds: $174.2 State county funds: $27.2
8.2	**Narrative information**			
8.2.1	Describe and explain any reductions in the MOE dollar amount below the amount provided in the state's application materials. The state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.			SFY 2019 Expenditures ($ in millions) included in the application: State general funds: $118.1 State county funds: $27.8 Indiana confirms that the state did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services. Differences in MOE amounts are mainly due to the enhanced federal funding (extra 6.2% FMAP) that was effective January 2020 (in the middle of the SFY 2020) due to the Public Health Emergency

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
9.	**SMI/SED financing plan**			
9.1	**Implementation update**			
9.1.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 9.1.1.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders			In 2022, the State established a 9-8-8 Implementation Coalition after the passing of the national 988 legislation. The Office of Medicaid Policy and Planning (OMPP) is collaborating with the Division of Mental Health and Addiction (DMHA) to work with behavioral health providers, law enforcement agencies, and community partners to prepare the Indiana Behavioral Health System for the launch of the crisis hotline. This project is being led by DMHA. OMPP continues to work collaboratively with DMHA to establish mobile crisis units as a provider type/specialty able to receive direct reimbursement by Indiana Medicaid. OMPP submitted the state amendment pages to CMS in June, 2023. Mobile crisis services have been effective in Indiana since July 2023. CMS approved the Mobile Crisis Unit State Plan Amendment in September 2023. DMHA has begun the process of designating mobile crisis unit providers. OMPP is working with an outside vendor to set up new provider specialty for the mobile crisis units.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
9.1.1.b	Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model			Currently, Indiana uses the community mental health center (CMHC) to deliver accessible behavioral health care to the residents of Indiana. DMHA has started the planning stages of implementing the designation process of certified community behavioral health center. Both DMHA and OMPP are working on the planning stages of submitting a 1115 Demonstration Waiver for the CCBHC project. In Q4 2023, DMHA and OMPP have been working collaboratively on the financial/reimbursement aspects of the CCBHC project. Furthermore, the certification standards for the CCBHCs are in the final stages.

4. Narrative information on other reporting topics applicable to both SUD and SMI/SED components

Prompts		State has no update to report (place an X)	State response
10.	**Budget neutrality**		
10.1	**Current status and analysis**		
10.1.1	Describe the current status of budget neutrality and an analysis of the budget neutrality to date. If the SUD and SMI/SED components are part of a broader demonstration, the state should provide an analysis of the SUD- and SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole.		The SUD and SMI/SED budget neutrality components are part of the 1115 HIP budget neutrality report. The "Total Adjustments" tab reflects adjustments made to Schedule C expenditures that are now being reported for Demonstration Year (DY) 7 and 8 to reflect the actual experience for CY 2021 and CY 2022. This adjustment is necessary as Schedule C reporting has a lag of six months. As of Q3 2023, enrollment for SUD and SMI Managed Care MEGs is assumed to grow at 5% for DY 10 and DY 11. Enrollment for the SMI FFS MEG for DY 10 through DY 11 is assumed to grow by 1% per year PMPMs for each MEG for DY 10 through DY 11 are assumed to grow by the presidential budget trend for each MEG (4.9% for SUG MEG and 4.6% for SMI FFS and SMI Managed Care MEGs). The state anticipates that institution of mental disease (IMD) utilization may continue to grow as the program continues to serve members with SMI and additional providers are identified.
10.2	**Implementation update**		
10.2.1	The state expects to make other program changes that may affect budget neutrality.	X	

Prompts		State has no update to report (place an X)	State response
11.	**SUD- and SMI/SED-related demonstration operations and policy**		
11.1	**Considerations**		
11.1.1	The state should highlight significant SUD and SMI/SED (or if broader demonstration, then SUD- and SMI/SED-related) demonstration components' operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD and SMI/SED demonstration components approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.		During the Public Health Emergency (PHE), Governor Eric Holcomb gave the Family & Social Services Administration the legislative authority to expand telehealth policies. This expansion of telehealth resulted in an increased adherence to treatment plans and appointments. Seeing how telehealth expansion had a positive impact during the PHE, the Indiana Legislature passed Senate Bill 3 in 2021 which allows FSSA to make some of the expansions permanent. Further expansions in telehealth were granted by the legislature via Senate Bill 284, passed in April of 2022. Indiana Medicaid has finalized a telehealth code set that was effective July 2022. This code set includes expanded services available via telehealth service delivery, such as expanded behavioral health treatment, and substance use disorder treatment services (e.g., counseling, psychotherapy, MAT adherence/management services, intensive outpatient therapy, etc.). In addition, Indiana Medicaid will also continue to cover audio-only telehealth options in the delivery of behavioral health treatment. In coordination with the Indiana Division of Mental and Health Addiction, the Office of Medicaid Policy and Planning has allowed coverage for skills training and development through telehealth certain criteria has been met. The updated code set for telehealth services will remain in place in 2022 and 2023. At the end of 2023, Indiana Medicaid will reevaluate these codes. Currently, there are discussions being held among OMPP and FSSA leadership to discuss the re-evaluation of the telehealth codes.
11.2	**Implementation update**		

Prompts	State has no update to report (place an X)	State response
11.2.1 The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.	X	
11.2.2 The state is working on other initiatives related to SUD, OUD and/or SMI/SED.	X	
11.2.3 The initiatives described above are related to the SUD and/or SMI/SED demonstration components. (The state should note similarities and differences from the SUD and SMI/SED demonstration components).	X	
11.2.4 Compared to the demonstration design and operational details, the state expects to make the following changes to:	X	
11.2.4.a How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service)	X	
11.2.4.b Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes)	X	
11.2.4.c Partners involved in service delivery	X	
11.2.4.d ***SMI/SED-specific:*** The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency	X	

Prompts		State has no update to report (place an X)	State response
12.	**SUD and SMI/SED demonstration evaluation update**		
12.1	**Narrative information**		
12.1.1	Provide updates on SUD and SMI/SED evaluation work and timeline. The appropriate content will depend on when this monitoring report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual reports. See Monitoring Report Instructions for more details.		As of Q3 2023, Indiana Medicaid and the independent evaluators continued working on the mid-point evaluations due to CMS no later than 60 days after December 31, 2023. Throughout Q3, the evaluators and the state completed several rounds of data validation for the SUD and SMI critical metrics outlined in the Midpoint TA CMS guidance. During Q3, the SUD began the provider and member surveys outlined in the evaluation design, while the SMI evaluator primarily focused on data validation. As of submission of the retrospective report, Indiana has submitted the SUD and SMI mid-point assessments and has begun work on the interim evaluations.
12.1.2	Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.		Indiana submitted the 2021-2022 SUD Mid-Point Assessment to CMS December 31, 2023, as agreed in the STCs. The 2021-2022 SMI Mid-Point Assessment was granted an extension due to the re-run of monitoring reports, a data source of the assessment. As a result, CMS extended the due date to February 29, 2024, to grant the evaluator additional time to appropriately analyze the Part A data.
12.1.3	List anticipated evaluation-related deliverables related to this demonstration and their due dates.		Indiana submitted the 2021-2022 SUD Mid-Point Assessment to CMS December 31, 2023, as agreed in the STCs. The 2021-2022 SMI Mid-Point Assessment was granted an extension due to the re-run of monitoring reports, a data source of the assessment. As a result, CMS extended the due date to February 29, 2024.

Prompts		State has no update to report (place an X)	State response
13.	**Other demonstration reporting**		
13.1	**General reporting requirements**		
13.1.1	The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.	X	
13.1.2	The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	X	
13.1.3	Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.3.a The schedule for completing and submitting monitoring reports		Throughout 2023, OMPP has notified CMS that multiple issues have been found in the scripts that calculate the SUD and SMI metrics. To align with the feedback CMS has provided to OMPP on 10/31/2022 and 10/3/2023, OMPP will resubmit the DY2Q2-DY6Q3 SUD monitoring reports and DY1Q2-DY4Q3 SMI monitoring reports. During a bi-weekly touchpoint with CMS, OMPP and CMS agreed to resubmit the retrospective reports no later than May 2024. As of Q1 2024, all the monitoring reports have been resubmitted in their corresponding PMDA slots.
	13.1.3.b The content or completeness of submitted monitoring reports and/or future monitoring reports		Indiana found that the state's data to address the original health IT metric in the currently approved protocol was poor in quality. Due to this, in agreement with CMS, Indiana re-worked the Health IT metrics.
13.1.4	The state identified current or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	

Prompts	State has no update to report (place an X)	State response
13.1.5 Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR § 431.428(a)5.		No satisfaction surveys were completed during the reporting timeframe by the state. However, for the Midpoint Assessments, the independent evaluators have conducted beneficiary satisfaction surveys. The results of these surveys will be shared with CMS in the SUD and SMI Midpoint assessments.

Prompts	State has no update to report (place an X)	State response
13.2 Post-award public forum		

13.2.2 If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.		**2020:** The 1115 demonstration waiver post-award forum was held on July 30, 2020 during a special meeting of the Medicaid Advisory Committee and was open to the public. Due to the ongoing nature of the COVID-19 PHE, this meeting was held virtually. The state presented on HIP eligibility and enrollment and gave an update of the operational status. In addition, updates were provided for the Serious Mental Illness (SMI) waiver, the Substance Use Disorders (SUD) waiver, and the Maternal Opioid Misuse Indiana Initiative (MOMII) waiver. Due to the virtual nature of this year's public comment, the four managed care entities (MCEs) provided written comments in support of the HIP, SMI, and SUD waivers. An MCE commented that the SMI waiver has expanded access to crisis intervention services, inpatient psychiatric beds, and most importantly improved the coordination and navigation of community-based services for this population. The SMI waiver has also helped improve access to services along the continuum of care and to assist individuals by offering access in the least restrictive setting possible. They continued that, having these waiver services in place has assisted with access during this COVID health crisis as research has shown that there will continue to be a surge in mental health, SUD and SMI needs as we come out of the pandemic. These sentiments were echoed across all the MCEs. In addition, all four of the MCEs were supportive about the continued expansion of crisis services based in the community. **2021:** The 1115 demonstration waiver post award forum was held on August 31, 2021 during a special meeting of the Medicaid Advisory Committee and was open to the public. Due to the ongoing nature of the COVID-19 PHE, this meeting was held virtually. The state presented on HIP eligibility and enrollment and gave an update of the operational status. In addition, updates were provided for the Serious Mental Illness (SMI) waiver, the Substance Use Disorders (SUD) waiver, and the Maternal Opioid Misuse Indiana Initiative (MOMII) waiver.

		Due to the virtual nature of this year's public comment, the four managed care entities (MCEs) provided written comments in support of the HIP, SMI, and SUD waivers. SUD Metric data reported each quarter/annually to CMS was presented during the forum for public comment. As the meeting was held virtually, there were connectivity issues, disrupting oral comments. Most commenters had to paste their comments into the "chat box" feature of the virtual meeting as a result. They then forwarded their comments to the HIP and Medicaid Directors via email. Most questions received were in the "chat box" feature of the virtual meeting where guests of the meeting could type in questions and a moderator would repeat the question to the presenters. Questions were related to understanding HIP eligibility, POWER Accounts, results regarding the disparities found in the Interim HIP Evaluation, and ongoing operational and policy updates in response to COVID-19. **2022:** The post-award public forum for both the SUD/SMI waivers was presented at the Indiana Medicaid Advisory Committee on 7.27.2022. As highlighted in that presentation, there are over double the number of SUD residential beds available for our members as of June of 2022 in comparison to February 2020 and also almost 20 new facilities that have enrolled with Indiana Medicaid as SUD residential treatment providers. Additionally for 2021, the rates of emergency service utilization for substance use disorders per 1,000 Medicaid members was significantly lower when comparing rates from 2019 and 2020. Our SUD evaluators found this difference to be statistically significant for ED use when comparing pre versus post waiver implementation utilization. Our SMI evaluators also found ED use decreased between pre and post waiver implementation for our SMI population, however no statistical significance testing was performed due to the PHE most likely being a confounding factor.

Prompts		State has no update to report (place an X)	State response
14.	**Notable state achievements and/or innovations**		
14.1	**Narrative information**		
14.1.1	Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD and SMI/SED (or if broader demonstration, then SUD- or SMI/SED-related) demonstration components or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms (e.g., number of impacted beneficiaries).	X	

*The state should remove all example text from the table prior to submission.

Note: Licensee and states must prominently display the following notice on any display of Measure rates:
SUD measures IET-AD, FUA-AD, FUM-AD, and AAP [Metrics #15, 17(1), 17(2), and 32] and SMI/SED measures MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, and APM measures (#13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29) *are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.*
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