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	10/01/2024-12/31/2024
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	SUD DY7Q4

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	DY5Q4

[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.

During Q4 2024, the Division of Mental Health and Addiction continued to work with providers to designate mobile crisis providers. These mobile crisis units are affiliated with community mental health centers. Currently, Indiana has enrolled 21 mobile crisis units, with others waiting for designation from DMHA.

With the expansion of mobile crisis providers, DMHA and OMPP are actively drafting a State Plan Amendment (SPA) to expand the services available at a crisis receiving and stabilization center. This expansion of services is another strategy that the State is using in trying to reduce emergency room stays. Further, OMPP is in the process of drafting a State Plan Amendment to remove the sunset date of September 30, 2025, and to make medicated-assisted treatment (MAT) services permanent to be compliant with the Consolidated Appropriations Act of 2024.

In June 2024, Indiana officials were informed that the State was chosen for the upcoming certified community behavioral health center (CCBHC) demonstrations. For the remainder of 2024, OMPP and DMHA prepared for go-live of the CCBHC demonstration in January 2025. For example, OMPP developed a new provider type and specialty for the enrollment of CCBHC providers.

In 2024, DMHA reached the legislative threshold of the allowed number of OTPs.

Finally, OMPP and DMHA have been drafting revisions to their respective Indiana Administrative Codes to reflect the ongoing changes that have been happening in behavioral health.

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	The avg. number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis, metric #3, during DY7Q4, decreased 2.14%, from 283,616 to 277,550. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the quarterly avg. number of beneficiaries for metric #3 ranged between 277,550 and 284,817.
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		Throughout 2024, DMHA and OMPP collaborated on the phase-in of the new ASAM 4.1 criteria. DMHA held sessions from May to September 2024 with providers and MCEs to discuss the new criteria and important revisions.
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 DY7Q3 and DY7Q4, the avg. number of beneficiaries receiving any SUD treatment service, facility claim, or pharmacy claim decreased 1.55%, from 46,291 to 45,575. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the avg. number of beneficiaries was 46,103. **#7:** Between DY7Q3 and DY7Q4, the avg. number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) decreased 28.92%, from 27 to 19. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the avg. number of beneficiaries was 26. **#8:** Between DY7Q3 and DY7Q4, the avg. number of beneficiaries who used outpatient services for SUD increased 2.07%, from 31,379 to 32,027. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the avg. number of beneficiaries was 31,591. **#9:** Between DY7Q3 and DY7Q4, the avg. monthly utilization for Intensive Outpatient and Partial Hospitalization services for SUD increased 3.04%, from 988 to 1018. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the avg. number of beneficiaries was 998. **#10:** Between DY7Q3 and DY7Q4, the avg. number of beneficiaries who use residential and/or inpatient services for SUD increased 1.23%., from 2,895 to 2,931. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the avg. number of beneficiaries was 2,889.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			#11: Between DY7Q3 and DY7Q4, the avg. number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) decreased 0.25%, from 2,721 to 2,714. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the avg. number of beneficiaries was 2,685. **#12:** Between DY7Q3 and DY7Q4, the avg. number of beneficiaries who have a claim for MAT for SUD decreased 1.44%, from 22,102 to 21,784. Due to the claims lag, data for Oct-Dec of 2024 is not yet available. For the remainder of CY 2024, the avg. number of beneficiaries was 22,153.
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 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)			Between October and December 2024, Indiana Medicaid and the Division of Mental Health and Addiction continued to answer policy and reimbursement questions around using G reimbursement codes for medication-assisted treatment. In addition, both divisions continue to collaborate with each other in the implementation of the certified community behavioral health centers. In addition, OMPP began drafting a SPA to make coverage and reimbursement for MAT services permanent in accordance with guidance from CMS and the Consolidated Appropriations Act of 2024. Currently, there is a sunset date for September 30, 2025, for these services.

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	X		
2.2.2	The state expects to make other program changes that may affect metrics related to Milestone 1.			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 since July 2023. The Office of Medicaid Policy and Planning received approval for the Mobile Crisis State Plan Amendment in September 2023. As of December 31, 2024, DMHA has designated 21 mobile crisis providers. Initially, Indiana allowed CMHCs to provide mobile crisis services. In April, Indiana expanded mobile crisis services by allowing non-CMHCs to be designated as a mobile crisis service provider.

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.	X	#5, #36	
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	X		
	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			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. Between October and December 2024, 4,955 users utilized Atlas with 3,712 being unique individuals. The top four substance filters are Alcohol, Methamphetamine, Cocaine and Heroin/Fentanyl. During this time 798 assessments were completed. As part of Atlas, there is an ability to directly link to 988 and 911 with 10 users utilizing 911 and 3 utilizing 988.
3.2.2	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
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			No changes to the demonstration design in CY 2024. To qualify as a residential IMD, the setting must have more than 16 beds and be enrolled as a SUD residential addiction treatment facility with Indiana Medicaid. Not all residential providers within the State are enrolled with Indiana Medicaid. The data reported below includes all residential providers and an IMD Medicaid subset. As of Dec. 2024, DMHA designated 83 facilities with a total of 3,326 beds. There were 233 ASAM 3.1 beds across 13 units, 2,749 ASAM 3.5 beds across 63 units, and 344 ASAM 3.1/3.5 combined beds across 10 units. Of the 84 facilities, 49 facilities are IMDs with 2,404 total beds. In which, for ASAM level 3.1 there was a total of 6 units with 168 beds. For ASAM level 3.5, there were 39 units with 1,962 beds. For combined ASAM 3.1/3.5 facilities, there were 7 units and 274 beds for this reporting period.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.2.1.b	Review process for residential treatment providers' compliance with qualifications.	X		
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		

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.	X	#13, #14	
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.	X		
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 rate of ED visits for SUD per 1,000 beneficiaries between July and September increased 3.96%, from 4.4 to 4.6. Due to the claims lag, data for Q4 of CY 2024 is not yet available. For the remainder of 2024, the avg. rate was 4.4.
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		
	6.2.1.b Expansion of coverage for and access to naloxone	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2.2 The state expects to make other program changes that may affect metrics related to Milestone 5.			Indiana has submitted and received approval from CMS for a state plan amendment to CMS to restructure how opioid treatment programs are currently reimbursed by Indiana Medicaid. Indiana Medicaid has completed its transition of the per diem code to the weekly G-code bundle, to 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. From October 2024 to December 2024, DMHA and Indiana Medicaid have continued to collaborate with providers, managed care entities, and outside stakeholders to provide informational sessions and bulletins on the updates to various OTP services. In addition, OMPP started drafting a SPA to eliminate the sunset date that is placed on the coverage and reimbursement of MAT services and making these services permanent in accordance with guidance from CMS and the Consolidated Appropriations Act of 2024.

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.	X	#15, #17, #25	
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.			During the SUD DY7Q4 reporting period, key activities include: 1. **October 2024 to December 2024:** a. *SUD Residential Reimbursement Rate:* Discussions around the current reimbursement rate and what is included in the reimbursement bundles. b. *Prior Authorizations*: DMHA and OMPP discussed the prior authorization process for SUD residential providers and the issues that these facilities are having with the PA/UM vendor.
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	**S.1:** Between DY7Q3 and DY7Q4, the avg. number of prescribers accessing INSPECT increased 1.48%, from 22,511 to 22,845. For the remainder of CY 2024, the number of prescribers ranged between 22,473 to 22,845. **S.2:** Between DY7Q3 and DY7Q4, the avg. number of patient requests made into INSPECT on a statewide basis increased 9.31% from 1,982,503 to 2,167,145. For the remainder of CY 2024, the avg. number of patient requests was 2,079,540. **S.3:** Between DY7Q3 and DY7Q4, the number of hospitals that have integrated INSPECT into their health care system's electronic health record remained unchanged at 154.
8.2	**Implementation update**			
8.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 8.2.1.a How health IT is being used to slow down the rate of growth of individuals identified with SUD	X		
	8.2.1.b How health IT is being used to treat effectively 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.c	How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD	X		
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.	X		
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 avg. rate of inpatient stays for SUD per 1,000 beneficiaries from July to September 2024 increased 0.13%, from 1.935 to 1.938. Data for Oct-Dec 2024 is not yet available due to the claims lag. For the remainder of CY 2024, the avg. rate was 1.92.
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	**#33**: In Q4, 7 grievances were filed related to SUD treatment services. This is a 250% increase compared to the two filed in Q3. The increase appears significant due to the small numbers. In CY 2024, grievances related to SUD ranged between 2 to 7. **#34,** The number of appeals filed related to SUD treatment services increased 12.82%. In Q4, 220 appeals were filed versus 195 appeals filed in Q3 2024. In CY 2024, appeals related to SUD ranged between 132 and 220.

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	**Metric trends**			
1.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	X	*#2*	
1.2	**Implementation update**			
1.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		
	1.2.1.a The licensure or accreditation processes for participating hospitals and residential settings			
	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		DMHA continues to review any inpatient or residential provider unannounced if the agency identifies any complaints or concerns regarding that provider.
	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		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.	X	#3, #4, #6, #7, #8, #9, #10	
2.2	**Implementation update**			
2.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		
	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		
	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		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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**			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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:** The avg. number of beneficiaries who used inpatient services related to mental health decreased 25.78% from 4,219 to 3,132 between Q3 and Q4 2024. During CY 2024, the avg. number of beneficiaries was 3,843. **#14**: The avg. number of beneficiaries in the demonstration who used intensive outpatient and/or partial hospitalization services related to mental health increased 10.75% from 372 to 412 between Q3 and Q4 2024. During CY 2024, the avg. number of beneficiaries was 386. **#15:** The avg. number of beneficiaries in the demonstration who used outpatient services related to mental health during the quarter decreased 3.65% from 47,364 to 45,633 between Q3 and Q4 2024. For CY 2024, the avg. number of beneficiaries was 47,456. **#16:** The avg. number of beneficiaries who used ED services for mental health increased by 3.83% from 444 to 461 between Q3 and Q4 2024. For CY 2024, the avg. number of beneficiaries was 458. **#17:** The avg. number of beneficiaries who used telehealth services for mental health decreased 2.19% from 15,826 to 15,480 between Q3 and Q4 2024. For CY 2024, the avg. number of beneficiaries was 15,896. **#18:** The avg. number of beneficiaries in the demonstration population who used any services related to mental health decreased 4.78% from 63,597 to 60,557 between Q3 and Q4 2024. During CY 2024, the avg. number of beneficiaries was 63,288.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.2	**Implementation update**			
3.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		
	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			
	3.2.1.b Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	X		
3.2.2	The state expects to make other program changes that may affect metrics related to Milestone 3.	X		With the current pursuit of the certified community behavioral health center demonstration, DMHA is investigating how MRO, and its assessments would be implemented into this project. This discussion was ongoing during Q4.

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:** The avg. number of beneficiaries with SMI/SED decreased 2.21% from 114,543 to 112,016 between Q3 and Q4 2024. The avg. number of beneficiaries in CY 2024 was 114,887.
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 Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)	X		DMHA is actively collaborating with community partners to develop and implement crisis receiving and stabilization services sites and designate mobile crisis teams statewide.
	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		
	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 and DMHA are currently designating mobile crisis providers across the state. As for December 31, 2024, there are 21 mobile crisis providers. More providers have submitted their applications seeking designation by DMHA to render these services. In addition, DMHA has started a Crisis Stabilization Services pilot program.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.2.1.d	Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people			OMPP submitted a state plan amendment to expand school-based services by allowing school psychologists to provide testing services. This SPA was approved in 2023. Throughout CY 2024, OMPP had discussions with the Department of Education on defining the scope of practice for an independent practice school psychologist. OMPP is working on updating the Indiana Administrative Code to define what services can be rendered by a school psychologist and who can supervise a school psychologist.
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.		Q1, Q1, Q3	**Q1:** The number of Indiana DOC facilities connected to HIE remained unchanged in CY 2024, at nine facilities. **Q2:** The count of Behavioral Health providers (Psychiatric, Pediatric Nurse Practitioner, Obstetric Nurse Practitioner, Family Nurse Practitioner, Clinical Nurse Specialist, Outpatient Mental Health Clinic, Community Mental Health Center (CMHC), Health Service Provider in Psychology (HSPP), AMHH Service Provider, CMHW Service Provider, Behavioral and Primary Healthcare Coordination (BPHC), MRO Clubhouse, ABA Therapist, Licensed Psychologist, Licensed Independent Practice School Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, Licensed Clinical Addiction Counselor, Opioid Treatment Program, SUD Residential Addiction Treatment Facility and Psychiatrist) enrolled in Medicaid increased 3.26% from 34,879 providers in Q3 2024 to 36,016 providers in Q4 2024. **Q3:** The percentage of CMHCs accessing client outcome reports decreased 40% to three in Q4 2024 compared to five in Q3. Indiana has 24 unique CMHCs and in CY 2024, between three and seven CMHCs accessed outcome reports.
5.2	**Implementation update**			

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to:	X		
5.2.1.a	The three statements of assurance made in the state's health IT plan			
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		
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		

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 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	**#36:** In Q4, like Q3, 7 grievances were filed related to SMI treatment services. In CY 2024, grievances related to SMI ranged between 2 and 7. **#37:** In Q4, 187 appeals were filed related to SMI treatment services. This is a 26.35% increase compared to the 148 filed in Q3. In CY 2024, appeals related to SMI ranged between 109 and 187. **#38:** In Q4, 396 critical incidents were filed related to SMI treatment services. This is a 24.71% decrease compared to the 526 filed in Q3. In CY 2024, critical incidents related to SMI ranged between 396 and 810.
6.2	**Implementation update**			
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**			

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.	X		In Q2 2020, the average count of beneficiaries with SMI/SED (monthly) was 94,204. As of 2024 Q1, the average monthly count of beneficiaries with SMI/SED has increased to 112,670. The count of beneficiaries with SMI/SED (annually) in 2020 was 266,256, increasing to 322,851 in 2024. (Metrics #21 and #22 were used for the analysis) In the initial provider availability assessment, the number of adult Medicaid beneficiaries with SMI 21+ was 23,936. In the 2024 assessment, the latest available, the number of adult Medicaid beneficiaries with SMI 21+ was 45,796. The assessments are ran as of January 31st of every year. The logic behind the population was modified to align with CMS' standardized definitions. Therefore, CMS should be cautious to compare the data given the logic change. An updated annual availability assessment will be submitted in 2025.
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.	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.			As of December 2024, there are 21 mobile crisis providers through various community mental health providers with more providers submitting applications to DMHA. As of December 2024, 20 of the 24 community mental health centers have received their designation, but the remainder are still offering services to Medicaid beneficiaries. In addition, DMHA and OMPP are collaborating on the upcoming implementation of the certified community behavioral health centers.
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.	X		
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		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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 processes as needed to collaborate with DMHA more closely. In Q4, to potentially increase availability, DMHA continued collaborating with CCBHC pilot sites, CMHCs, and stakeholders to survey their capacity to provide care.
	7.2.1.b Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	X		In 2024, DMHA worked with Bamboo Health to improve open beds, which provides real-time care coordination between crisis management stakeholders to help individuals access expedited behavioral health crisis assessment and treatment.

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 2024 Expenditures ($ in millions) State general funds: $255.4 State county funds: $25.4
8.2	**Narrative information**			
8.2.1	Describe and explain any reductions in the MOE dollar amount below the amount provided in the state's application materials. The state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.	X		SFY 2019 Expenditures ($ 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.

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:	X		OMPP established a provider type/specialty for mobile crisis units to able them to receive direct reimbursement by Indiana Medicaid. Mobile crisis services have been effective in Indiana since July 2023. CMS approved the Mobile Crisis Unit State Plan Amendment in September 2023. DMHA is continuing the process of designating mobile crisis unit providers. OMPP has established a provider specialty and type that allows non-CMHCs to render mobile crisis units.
	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			
	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	X		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 (CCBHC). In Q4 2023, DMHA and OMPP worked collaboratively on the financial/reimbursement aspects of the CCBHC project. In March 2024, DMHA successfully applied for the CMS 1115 Demonstration for CCBHC. In June 2024, CMS awarded Indiana the 1115 Demonstration Waiver for CCBHC. DMHA is working toward CCBHC go-live on 1/1/25.

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 budget neutrality for Q4 2024 has been updated to include actual experience for January 1, 2021, through December 31, 2024. The "Total Adjustments" tab reflects adjustments made to Schedule C expenditures that weren't previously reported from January 2021-December 2024. This adjustment is necessary as Schedule C reporting has a lag of six months. Enrollment for SUD and the two SMI MEGs is assumed to grow at 5% for DY 11. The state anticipates that institutions of mental disease (IMD) and residential treatment utilization may continue to grow as the program continues to serve members with SMI and additional providers are identified. Indiana launched the Pathways for Aging program on 7/1/2024. Encounter claims for Pathways for Aging are used for recipient summaries in this report. Note that the PMPM values have grown (especially for the SMI Managed Care MEG) as PathWays capitation payments are higher than in the other managed care programs. To address additional information requested by CMS, OMPP's actuaries are submitting figures to the actual enrollment and projected enrollment sections of the report. Recipients are those that receive IMD or residential SUD treatment and not those with SUD/SMI diagnosis receiving outpatient services
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.	X	
11.2	**Implementation update**		
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	

Prompts	State has no update to report (place an X)	State response
11.2.4 Compared to the demonstration design and operational details, the state expects to make the following changes to: 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.		By the end of Q4 2024, the SMI and SUD Independent Evaluators completed the 2021-2023 Interim Evaluations which were submitted on December 18, 2024, in PMDA
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.		SUD and SMI evaluations were submitted to CMS on December 18, 2024.
12.1.3	List anticipated evaluation-related deliverables related to this demonstration and their due dates.		The SUD and SMI 2021-2023 Interim Evaluations were submitted to CMS on December 18, 2024. Indiana also submitted the renewal application on December 20, 2024, to renew the waivers for demonstration years 2026-2030 and is pending a CMS update as of Q4 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	X	
	13.1.3.b The content or completeness of submitted monitoring reports and/or future monitoring reports	X	Indiana found that the state's data addressing the original Q3 health IT metric in the currently approved protocol was poor in quality. Due to this, in agreement with CMS, Indiana re-worked the Q3 metric and will replace the Q3 metric in the monitoring reports with a new metric moving forward. Reporting on the new Q3 metric began in Q2 2023.
13.1.4	The state identified current or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	
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.	X	

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.		On August 21, 2024, OMPP completed the 1115 Demonstration Waiver Post Award Forum. OMPP received comments specific to SUD and SMI from one MCE. The MCE submitted a letter of support and remains committed to their partnership with OMPP and providing SUD and SMI benefits for members.

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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