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	01/01/2025-12/31/2025
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 DY8Q1

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	DY6Q1

[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 Q1 2025, the Division of Mental Health and Addiction continued to work with providers to designate mobile crisis providers. Currently, Indiana has enrolled 22 mobile crisis units, with others waiting for designation from DMHA. Additionally, the CCBHC effort went live on 1/1/2025.

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 the Q4 2024 report, OMPP incorrectly reported that DMHA reached the legislative threshold of OTPs. As of Q1 2025, there were 26 OTPs and one license yet to be granted.

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			

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.		#2, #3, #4	**#2:** Between DY7Q4 and DY8Q1, the avg. number of beneficiaries with newly initiated SUD treatment/diagnosis increased 0.76%, from 20,241 to 20,395. **#3:** Between DY7Q4 and DY8Q1, the avg. number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis decreased 1.06%, from 277,550 to 274,598. **#4:** The avg. number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis in CY 2024 decreased 3.36% compared to CY 2023, from 262,405 to 253,601.
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		
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 DY7Q4 and DY8Q1, the avg. number of beneficiaries receiving any SUD treatment service, facility claim, or pharmacy claim decreased 4.41%, from 45,575 to 43,566. **#7:** Between DY7Q4 and DY8Q1, the avg. number of beneficiaries who used early intervention services did not change, remaining at 19. **#8:** Between DY7Q4 and DY8Q1, the avg. number of beneficiaries who used outpatient services for SUD decreased 3.04%, from 32,027 to 31,055. **#9:** Between DY7Q4 and DY8Q1, the avg. monthly utilization for Intensive Outpatient and Partial Hospitalization services decreased 4.49%, from 1,018 to 972. **#10:** Between DY7Q4 and DY8Q1, the avg. number of beneficiaries who utilized residential and/or inpatient services decreased 5.3%, from 2,931 to 2,775. **#11**: Between DY7Q4 and DY8Q1, the avg. number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) decreased 4.19%, from 2,714 to 2,601. **#12:** Between DY7Q4 and DY8Q1, the number of beneficiaries who had a claim for MAT for SUD decreased 3.81%, from 21,785 to 20,954.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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 January and March 2025, OMPP and the DMHA 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 CCBHCs. Lastly 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.
	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.			Mobile crisis unit response coverage has been effective since July 2023. The OMPP received approval for the Mobile Crisis State Plan Amendment in September 2023. As of March 31, 2025, DMHA has designated 22 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.		#5, #36	**#5**: The avg. number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD decreased 8.14% from 18,236 in CY 2023 to 16,751 in CY 2024. **#36**: The average length of stay rate for beneficiaries discharged from IMD inpatient/residential treatment for SUD increased 21.81% from 2.9 in CY2023 to 3.5 in CY2024.
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		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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 helps individuals seeking addiction treatment find high quality care. ATLAS successfully launched in the state in September 2023. During Q1, 5,816 users utilized Atlas with 4,243 unique individuals. The top four substance filters are Alcohol, Methamphetamine, Cocaine and Heroin/Fentanyl. During this time 804 assessments were completed. As part of Atlas, there is an ability to directly link to 988 and 911 with 15 users utilizing 911 and 30 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			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 ASAM providers within the State are enrolled with Indiana Medicaid. The data reported below includes all residential providers and an IMD subset that serves Medicaid beneficiaries. As of March 2025, DMHA designated 83 facilities with a total of 3,466 beds. There were 274 ASAM 3.1 beds across 11 units, 2,848 ASAM 3.5 beds across 65 units, and 344 ASAM 3.1/3.5 combined beds across 10 units. Of the 83 facilities, 52 facilities are IMDs with 2,734 total beds. In which, for ASAM level 3.1 there was a total of 5 providers with 138 beds. For ASAM level 3.5, there were 43 providers with 2,322 beds. For combined ASAM 3.1/3.5 facilities, there were 7 providers 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.		#13, #14	**#13:** The number of providers that were enrolled in Medicaid and qualified to deliver SUD services increased 18.07% from 6,685 in CY 2023 to 7,893 in CY 2024. **#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 decreased 21.80% from 821 in CY 2023 to 642 in CY 2024.
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:** Between DY7Q4 and DY8Q1, the avg. rate of ED visits for SUD per 1,000 beneficiaries decreased 42.88%, from 4.6 to 2.6. **#27:** The rate of overdose deaths in CY 2024 decreased 7.19% compared to CY 2023, from 0.25 to 0.23. The State modified the logic of the denominator metric 27. In accordance with the technical specifications, beneficiaries enrolled 30 days prior to the measurement period should be included. Previously, the month was excluded.
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.			OMPP submitted a SPA to CMS to restructure how opioid treatment programs are reimbursed by Indiana Medicaid. The State 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 January to March 2025, DMHA and OMPP have continued to collaborate with providers, MCEs, and stakeholders to provide informational sessions and bulletins on 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.		#15, #17, #25	**#25:** The rate of all-cause readmissions among beneficiaries with SUD increased 6.13% in CY 2024 compared to CY 2023, from 0.101 to 0.107.
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		During the SUD DY8Q1 reporting period, key activities include: 1. **January 2025 to March 2025:** 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 DY7Q4 and DY8Q1, the number of prescribers accessing INSPECT decreased 0.75%, from 22,845 to 22,674. **S.2:** Between DY7Q4 and DY8Q1, the number of patient requests made into INSPECT on a statewide basis decreased 2.29% from 2,167,145 to 2,117,623. **S.3:** Between DY7Q4 and DY8Q1, 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		
	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.		X		
9.	**Other SUD-related metrics**				
9.1	**Metric trends**				

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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, #26, #28, #29, #30, #31	**#24:** Between DY7Q4 and DY8Q1, the avg. rate of inpatient stays for SUD per 1,000 beneficiaries decreased 15.57%, from 1.94 to 1.64. **#26:** The number of overdose deaths in CY 2024 increased 9.64% compared to CY 2023, from 446 to 489. **#28:** SUD spending during CY 2024 increased 8.61% compared to CY 2023, from $498,940,550 to $541,877,865. **#29:** Total Medicaid SUD spending on inpatient/residential treatment within IMDs during CY 2024 increased 33% compared to CY 2023, from $152,872,792 to $202,717,733. Qualifying IMDs are inpatient psychiatric hospitals and SUD residential addiction treatment facilities that meet the criteria in 42 CFR 435.1010 and are licensed by the Indiana Division of Mental Health and Addiction (DMHA). **#30:** The rate of per capita SUD spending for CY 2024 increased 75.97% compared to CY 2023, from 1,901.4 to 3,345.9. **#31:** The rate of per capita SUD spending within IMDs for CY 2024 increased 44.36% from CY 2023, from 8,383 to 12,101.
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 Q1 2025, 11 grievances were filed related to SUD treatment services. This is a 57.14% increase compared to the 7 filed in Q4 2024. **#34:** The number of appeals filed related to SUD treatment services decreased 40.45%. In Q1 2025, 131 appeals were filed versus 220 appeals filed in Q4 2024.

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: 1.2.1.a The licensure or accreditation processes for participating hospitals and residential settings	X		

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

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, #19, #20	**#13:** Between Q4 and Q1, the avg. number of beneficiaries who used inpatient services related to mental health decreased 7.14% from 3,132 to 2,908. **#14**: Between Q4 and Q1, the avg. number of beneficiaries who used intensive outpatient and/or partial hospitalization services related to mental health increased 6.31% from 412 to 438. **#15:** Between Q4 and Q1, the avg. number of beneficiaries in the demonstration who used outpatient services related to mental health increased 5.80% from 45,633 to 48,278. **#16:** Between Q4 and Q1, the avg. number of beneficiaries who used ED services for mental health decreased by 5.93% from 461 to 433. **#17:** Between Q4 and Q1, the avg. number of beneficiaries who used telehealth services for mental health increased 5.97% from 15,480 to 16,404. **#18:** Between Q4 and Q1, the avg. number of beneficiaries who used any services related to mental health increased 5.21% from 60,557 to 63,714. **#19A:** The average length of stay for all IMDs and populations decreased 0.34% from 11.32 in CY 2023 to 11.28 in CY 2024. This includes State-operated psychiatric hospitals. Of these, the ALOS rate among short-term stays (less than or equal to 60 days) increased 3.84% from 7.9 in CY 2023 to 8.3 in CY 2024. The ALOS rate among long-term stays (greater than 60 days) increased 4.51 % from 314.7 in CY 2023 to 328.9 in CY 2024. **#19B**: The Average Length of Stay rate in IMDs (IMDs receiving FFP only) for all populations decreased 3.71%

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			from 8.8 in CY 2023 to 8.5 in CY 2024. The ALOS rate among short-term stays (less than or equal to 60 days) increased 4.36% from 7.9 in CY 2023 to 8.3 in CY 2024. The ALOS rate among long-term stays (greater than 60 days) decreased 64.86% from 316.9 in CY 2023 to 111.3 in CY 2024. **#20:** The avg. number of beneficiaries in the demonstration population who had a claim for inpatient or residential treatment for mental health in an IMD, metric #20, decreased by 10.1% from 7,296 in CY 2023 to 6,559 in CY 2024. CY 2023 was originally 1,387 and reported in the Q1 2024 report. After investigating further, it was identified the State underreported. For accurate reporting, the State is comparing to the rerun 2023 data.
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.	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 is ongoing, and OMPP has been involved in these conversations.

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	**#21:** The avg. number of beneficiaries with SMI/SED increased 2.66% from 112,016 to 114,994 between Q4 and Q1. **#22:** The avg. annual count of beneficiaries with SMI/SED decreased 3.91% from 322,851 in CY 2023to 310,224 in CY 2024.
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 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		DMHA is collaborating with community partners to develop and implement crisis receiving and stabilization services sites and designate mobile crisis teams statewide.
	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	X		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	X		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. OMPP is currently having 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 1.87% from 36,016 providers in Q4 2024 to 36,690 in Q1 2025. **Q3:** The state is not able to report CMHCs accessing client outcome report as the report was not operational for Q1 2025. DMHA is discontinuing the report, and a new metric will be presented to CMS in the next monthly HIP call and via email.
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.		#32, #33, #34, #35, #36, #37, #38, #39, #40	**#32:** The sum of all Medicaid spending for mental health services not in inpatient or residential settings increased by 12.02% from $476,262,410 in CY2023 to $533,493,454 in CY 2024. **#33:** The sum of all Medicaid costs for mental health services in inpatient or residential settings decreased 11.21% from $340,625,776 in CY2023 to $302,440,034 in CY 2024. **#34:** The rate of per capita costs for non-inpatient, non-residential services for mental health increased 16.58% from 1475.2 in CY 2023 to 1719.7 in CY 2024. **#35:** The rate of per capita costs for inpatient or residential services for mental health among beneficiaries decreased 7.60% from 1,055 in CY 2023 to 975 in CY 2024. **#36:** In Q1 2025, 19 grievances were filed related to SMI treatment services. This is a 171.43% increase from the 7 filed in Q4 2024. **#37:** In Q1 2025, 220 appeals were filed related to SMI treatment services. This is a 17.65% increase from the 187 filed in Q4 2024. **#38:** In Q1 2025, 1276 critical incidents were filed related to SMI treatment services. This is a 222.22% increase compared to the 396 filed in Q4 2024. The increase can be attributed to providers becoming familiar with DMHA's new reporting system that went live at the end of 2024. After go-live, DMHA has continued to emphasize reporting and utilization of the new system, further contributing to the increase. **#39:** In CY 2024, total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
				IMD increased 22.09% from $13,818,250 in CY 2023 to $16,870,358.6. CY 2023 was originally reported in the Q1 2024 report. After investigating further, it was identified the State underreported. For accurate reporting, the State is comparing to the rerun 2023 data. **#40:** The rate of per capita Medicaid costs for beneficiaries who had claims for inpatient or residential treatment for mental health in an IMD increased by 35.81% from 1,893.9 in CY 2023 to 2,572 in CY 2024.
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.			Since January 31, 2024, the previous reporting period, the number of adult beneficiaries with SMI (18-20) decreased from 2,437 to 2,407. Medicaid beneficiaries over 21, with SMI, decreased from 44,064 to 42,570. Beneficiaries with SED, between 0 and 17, also decreased from 5,458 to 5,433. It is possible the decrease across ages, except 0-17, may be attributed to decreases across enrollment. For example, the number of Medicaid beneficiaries between 18 and 20 decreased from 102,753 to 102,394 and beneficiaries over 21 decreased from 945,212 to 875,575. Enrollment for ages 0-17 is the only population that increased, from 807,836 to 809,488. The PHE unwind was ongoing during the first half of 2024, and as a result, enrollment as of January 31, 2025, was impacted. Further, annual redeterminations resumed and may be a source of influence. These numbers may not be reflective, however, of the true SMI/SED Medicaid population since it's as of a point in time, instead of a broader timeframe. In the initial provider availability assessment, the number of adult Medicaid beneficiaries with SMI 21+ was 23,936. In the 2025 assessment, the latest available, the number of adult Medicaid beneficiaries with SMI 21+ was 42,570. In 2023, the State aligned with CMS' standardized definition, previously the State definition. Therefore, CMS should be cautious to compare the data given the change.

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.			Since the initial assessment, OMPP created a new provider specialty for mobile crisis units. Further, CCBHC providers became an eligible provider. The Certified Community Behavioral Health Clinic (CCBHC) Medicaid Demonstration Program went live limited to 8 sites in Indiana on January 1, 2025. CCBHC services are carved out of managed care and are reimbursed as fee-for-service (FFS) for all eligible members. A column strictly for CCBHCs is not available in the template.

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.			Since the initial assessment, the number of inpatient mental health services has improved. At the time of the initial assessment, 34 public and private psychiatric hospitals were reported. Since then, hospitals available increased to 41. Psychiatric units within acute care hospitals have no reliable source and due to staff turnover, the source of psychiatric units in acute care hospitals in the initial assessment is unknown. Since 1/31/2024, the source is unchanged, hospitals with a primary acute specialty and secondary psychiatric specialty. Using this logic, since 1/31/2024 the number of eligible hospitals decreased from 21 to 15. Like in the initial assessment, as of January 31, 2025, the DMHA continues to certify 24 CMHCs. The CCBHC went live on January 1, 2025, and therefore was not eligible during the initial assessment. Like the initial assessment, as of January 31, 2025, every county in Indiana has access to a crisis call center. The reporting behind these centers has changed. Initially, the State reported whether a county had coverage, resulting in 97. In current reporting, the State is reporting on the primary location and clarifies their Statewide coverage in the notes. This change was made to avoid misinterpretation that every county had a call center within it. Mobile crisis unit coverage has increased significantly since the initial assessment. In 2020, six MCUs were reported and as of 1/31/2025, there are 22 MCUs, with more pending DMHA's designation. Crisis stabilization units experienced the same growth as MCUs, from six to 22. A similar pace in growth is likely occurring between these two crisis services because they share the same agencies.

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.			Since the initial assessment, there is no provider type that has ceased to exist. Instead, sources for reporting have continued to improve, making it appear that significant changes have occurred. There are providers that the current assessment does like the initial assessment. Examples include residential mental health facilities for adults, QRTPs, crisis observation centers, etc. For clarity, the State is reporting supervised group living facilities as residential mental health facilities, but they do not have a specialty with Indiana Medicaid, making their enrollment difficult to conclude. To improve accuracy, the State modified the logic behind providers who are offering intensive outpatient services. Previously, the State used SUD and SMI procedure codes. Since this assessment is intended for SMI, SUD procedure codes were removed. Previously, procedure codes H0015 & S9480 and revenue coders 905 & 906 were utilized. The 2025 report was limited to S9480 & H0035 and revenue code 905.
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	X		Throughout Q1 2025, 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			DMHA is working 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. Bamboo Health operates Indiana's unified 988 call data system for local call centers (4 Indiana 988 call centers and 1 text/chat center) aiding in monitoring key performance indicators and caller data. They plan to enhance their software to allow crisis specialists to dispatch mobile crisis teams with geolocation features for efficient service. Mobile crisis teams will access caller data to ensure consistent and safe care.

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.	X		
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		

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		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		

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 Q1 2025 has been updated to include actual experience for January 1, 2021, through March 31, 2025. Recipients included are those receiving IMD or residential SUD treatment and not those with an SUD or SMI diagnosis receiving outpatient services. The encounter claims for the newly implemented Pathways for Aging (PathWays) program) are included in the reporting.
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	Indiana Medicaid finalized a telehealth code set that was effective July 2022. It includes expanded services available via telehealth service delivery, such as expanded behavioral health treatment, and SUD treatment services (e.g., counseling, psychotherapy, MAT adherence/management services, intensive outpatient therapy, etc.). As of 2025. Indiana Medicaid will continue to cover some audio-only telehealth options in the delivery of behavioral health treatment. In February 2025, modifications were made to the telehealth code set. Indiana Medicaid has utilized a collaboration with local research universities to determine the feasibility of allowing intensive outpatient treatments to be rendered through the telehealth modality. Throughout Q1 2025 these conversations continued to take place.
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:	X	
11.2.4.a	How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service)		
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.	X	
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.	X	
12.1.3	List anticipated evaluation-related deliverables related to this demonstration and their due dates.	X	Indiana 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 Q1 2025.

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		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. The state is not able to report SMI Health IT Q3 metric in the submitted monitoring report as it was not operational for Q1 2025. DMHA is discontinuing the report, and a new metric will be presented to CMS in the next monthly HIP call and via email.
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.	X	
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.	X	

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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