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Indiana 1115(a) Demonstration Evaluation

Mid-Point Assessment

HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND ANALYTICS — WITH REAL-WORLD PERSPECTIVE.

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

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

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Abbreviations List

Abbreviation	Meaning	Abbreviation	Meaning
ALOS	Average length of stay	LCSW	Licensed clinical social worker
ANSA	Adult Needs and Strengths Assessment	LGBTQ+	Lesbian, gay, bisexual, transgender, and queer
BIPOC	Black, indigenous, and people of color	LMFT	Licensed marriage and family therapist
CAHPS	Consumer assessment of healthcare providers and systems	LMHC	Licensed MH counselor
CANS	Child and Adolescent Needs and Strength	LOS	Length of stay
CCBHC	Certified Community Behavioral Health Clinics	MCE	Managed Care Entities
CFR	Code of Federal Regulations	MCG	Milliman Care Guidelines
CMHC	Community mental health centers	MCO	Managed care organizations
CMS	Centers of Medicare & Medicaid Services	MH	Mental health
COVI-19	Coronavirus disease 2019	MHIN	Michiana Health Information Network
CPT CAT	Current procedural terminology category	MHSIP	Mental Health Statistical Improvement Project
CSU	Crisis stabilization units	MRO	Medicaid rehabilitation option
DCS	Department of Child Services	MRSS	Mobile response stabilization services
DMHA	Division of Mental Health and Addiction	MU	Meaningful use
DOC	Department of Corrections	NCQA	National Committee for Quality Assurance
DOH	Department of Health	OMPP	Office of Medicaid Policy and Planning
ED	Emergency department	PA	Prior authorization
EHR	Electronic health record	PCBHI	Primary Care and Behavioral Health Integration
EPDS	Edinburgh Postnatal Depression Scale	PHE	Public health emergency
FFP	Federal financial participation	PHQ	Patient heath questionnaire
FFS	Fee-for-service	PIPBHC	Promoting Integrating of Primary and Behavioral Health Care
FPL	Federal poverty level	PMHI	Private Mental Health Institution
FQHC	Federally qualified health center	PPO	Preferred Provider Organization
FSSA	Family Social Services Administration	PRFT	Psychiatric residential treatment facilities
HEDIS	Healthcare Effectiveness Data and Information Set	QDWI	Qualified Disabled Working Individual
HHS	Health and Human Services	QI	Qualified individual
HIE	Health Information Exchange	QMB	Qualified Medicare beneficiaries
HIO	Health Information Organizations	RMHT	Rural mental health treatment
HIP	Healthy Indiana Plan	SAMHSA	Substance Abuse and Mental Health Services Administration
HIT	Health Information Technology	SBHC	School-based health centers
HMO	Health maintenance organization	SE	Supported employment
HSPP	Health services provider in psychology	SED	Serious emotional disturbance
IAC	Indiana Administrative Code	SLMB	Specified Low Income Medicare Beneficiaries
ICE	Integrated care entity	SMHP	State Medicaid Health Information Technology Plan
IDOH	Indiana Department of Health	SMI	Serious mental illness
IEP	Individualized Education Program	SOC	System of care
IHCP	Indiana Health Coverage Programs	SPA	State plan amendment
IHIE	Indiana Health Information Exchange	STC	Specific terms and conditions
IMD	Institutions for mental disease	SUD	Substance use disorder
IN	Indiana	TA	Thematic analysis
ISA	Interoperability Standards Advisory	UM	Utilization management
IPLA	Indiana Professional Licensing Agency	VRS	Vocational rehabilitation services

Executive Summary

A. Background

In 2018, the Indiana and Family Social Services Administration (FSSA) received authority from the Centers of Medicare & Medicaid Services (CMS) to reimburse institutions for mental diseases (IMD) for Medicaid eligible individuals ages 21-64 with substance use disorders (SUD). In 2019, FSSA received a §1115 waiver amendment to expand this authority and reimburse acute inpatient stays in IMDs for individuals diagnosed with a serious mental illness (SMI). The §1115 waiver amendment, effective on January 1, 2020, and extended through December 31, 2025 is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services for Indiana residents. Indiana's approved §1115 waiver's Specific Terms and Conditions (STC) requires an independent evaluation to assess the demonstration's ability to meet its intended milestones. As part of the evaluation, the state is required to conduct a Mid-Point Assessment that examines: (1) whether the state is making sufficient progress towards meeting its milestones as outlined in Indiana's approved Section 1115 SMI/ Serious Emotional Disturbance (SED) Demonstration Implementation Plan, (2) factors that influenced achievement of milestones (3) factors that may affect milestones in the future, and (4) whether the state is on track to meet budget neutrality. This report aims to summarize Mid-Point Assessment findings, providing recommendations for adjustments (when appropriate).

B. Summary of the Milestones

As described in Indiana's approved Section 1115 SMI/SED Demonstration Implementation Plan, the state's approach to achieving the demonstration goals involves implementing action items to accomplish four key milestones:

- **Milestone 1**: Ensuring quality of care in psychiatric hospitals and residential settings.
- **Milestone 2**: Improving care coordination and transitioning to community-based care.
- **Milestone 3**: Increasing access to the continuum of care, including crisis stabilization services.
- **Milestone 4**: Earlier identification and engagement in treatment, including through increased integration.

C. The Impact of the Coronavirus disease 2019 Public Health Emergency

The initial three years of the demonstration period (2020-2022) coincided with the Coronavirus disease 2019 (COVID-19) public health emergency (PHE), which was determined in January 2020.[1] The ongoing PHE caused substantial changes to Medicaid policies, service utilization, and provider availability, and will have short- and long-term impacts on Indiana's health care system and specialized populations, such as SMI. Given the timing of the PHE, the

[1] U.S. Department of Health & Human Services. (2020, January 31). Determination that a Public Health Emergency Exists. [Press release]. Determination that a Public Health Emergency Exists (hhs.gov)

state shifted many of the planned implementation activities to accommodate access to and delivery of high-quality mental health (MH) services for all Indiana residents, particularly given the social distancing and health care resource prioritization required in response to the PHE.

D. Summary of Mid-Point Assessment Methodology

Evaluation of the program milestones was based on a mixed-methods approach employing quantitative and qualitative analyses to assess the first two years (2021 and 2022) of the waiver covering 2021-2025 (Note. Data from 2020 [pre-waiver] was used to make baseline comparisons when appropriate). Quantitative data was compiled from various sources including monitoring report data, Provider Availability Assessment data, and MH Statistical Improvement Project (MHSIP) survey reports. Qualitative data was compiled from key informant interviews and captures provider, advocacy organization, FSSA state officials, Managed Care Entities (MCE), and member experiences and perspectives.

Progress for achieving demonstration goals was impacted by COVID-19 related policy changes and activities.[2] Therefore, data drawn during this time period likely reflects both the impact of COVID-19 related policy changes and activities as well as demonstration impacts. Consequently, any observed changes should be interpreted with caution as findings may be confounded by the impact of the PHE.

E. Implementation Action Items Completed Between January 2020 and December 2022

Indiana identified 23 action item specific activities in its SMI Implementation Plan. These action items are organized by milestones 1-4 (**ES.B**). Between the Mid-Point Assessment time frame, 20 of the 23 action items were completed. Implementation action items completed during the time frame include conducting annual consumer assessment of health care providers and systems (CAHPS); monitoring provider network capacity including identifying underserved/geographic shortage areas and conducting targeted outreach to non-Medicaid enrolled providers in those areas; increasing access and availability of non-hospital, non-residential crisis stabilization services via crisis stabilization units (CSUs); and submitting an application and receiving the Substance Abuse and MH Services Administration's (SAMHSA) 2020 Promoting Integrating of Primary and Behavioral Health Care (PIPBHC) grant.

Action items that are in progress include developing a report to monitor average length of stay (ALOS) for all Medicaid programs and updating the Medicaid Provider Manual to include protocols that assess beneficiary housing access.

[2] Indiana 1115(a) Demonstration Evaluation Summative Report (https://secure.in.gov/fssa/hip/files/IN-SMI-Summative-Evaluation-Report.pdf)

F. Assessment of the State's Progress in Achieving Milestones

In alignment with CMS guidance, the Mid-Point Assessment requires an assessment of the state's progress in achieving milestones. Lewin assessed the state's overall risk for not meeting each of the four milestones based on the state's completion of relevant action items (documented in the IN SMI Implementation Plan), the percentage of monitoring metric goals met, themes from stakeholder feedback, and potential risks for impacting success in achieving milestones. A risk level of "low", "medium" or "high" was assigned. Lewin reviewed the risk assessment with the state who concurred with the findings. **Exhibit ES.1** presents a high-level summary of the risk assessment.

Exhibit ES.1: Risk Assessment - Actions Completed, Monitoring Metrics Met, Stakeholder Feedback, Potential Risks for Achieving Success, and Risk Level for Achieving Milestones

Milestone	Actions Complete	Monitoring Metric Goals Met	Stakeholder Feedback Themes	Potential Risks Impacting Success	Risk Level
1	100%	N/A	• Policies and procedures focused on quality care. • Access to care perspectives varied. • Telehealth was a good alternative. • Comprehensive screening protocols in place	• Access to care and provider capacity • Inadequate monitoring metrics • Telehealth limitations	**LOW**
2	100%	25%	• Case management services were provided during the time frame. • Challenges in treatment and discharge planning collaboration. • Limited provider capacity as an overarching challenge. • Processes for identifying high emergency department (ED) utilizers.	• Limited communication during discharge planning and care transitions.	**MEDIUM**
3	67%	100%	• Utilization of Child and Adolescent Needs and Strengths (CANS)/ Adult Needs and Strengths Assessment (ANSA). • Behavioral health provider capacity is monitored annually. • Challenges with the OpenBeds software. • Mobile response stabilization services (MRSS) pilot delayed indefinitely.	• Length of CANS/ANSA • CSU findings were limited. • Suspension of implementation activities • Unavailable methodology to assess provider availability and validate data.	**MEDIUM**

Milestone	Actions Complete	Monitoring Metric Goals Met	Stakeholder Feedback Themes	Potential Risks Impacting Success	Risk Level
4	67%	67%	• Strategies to identify beneficiaries with SMI in treatment sooner including relationships with Schol-based health centers (SBHCs) and providing vocational rehabilitation services (VRS) and supportive employment (SE) services. • Limited awareness of state strategies to engage SMI beneficiaries sooner. • Challenges with treating SMI beneficiaries with co-occurring conditions.	• Stigma reducing efforts began after time frame. • Challenges in screening for co-occurring conditions. • Limited metrics that measure integration of primary and behavioral health	**MEDIUM**

G. Prioritized Recommendations for Adjustments to Implementation Plan

Lewin developed 25 recommendations to support the state in achieving its' milestones. The state prioritized 12 recommendations (bolded) and determined whether modifications to the Implementation Plan or other state activities are needed. **Exhibits ES.2** and **ES.3** list the recommendations and notates potential adjustments to the Implementation Plan or additional activities being conducted via another Indiana initiative.

Exhibit ES.2: Recommendations by Milestone for Potential Modifications to Implementation Plan or Other State Activities

Milestone	Recommendations for Potential Modifications to Implementation Plan or Other State Activities	Implementation Plan*	Other State Activities**
1	1. Conduct studies that focus on access to care and unmet needs on inpatient care or crisis stabilization to better identify gaps and develop strategies for minimizing those gaps.		
	2. Identify metrics that assess access and care quality among beneficiaries who have received care in psychiatric hospitals and residential settings. Incorporate these metrics into the state's monitoring plan.		
	3. Build provider capacity (e.g., more beds, more staff, more crisis stabilization services, CSU) and increase investments in workforce initiatives, level of care assessments, and provider quality training across the state.		
	4. Provide technical assistance support for both providers and patients to increase effective use of remote services **and identify best practices for patient engagement**.	X	
	5. Minimize costs associated with patient use of telehealth services (e.g., increase reimbursement rate, provide increased access to technology).		

Milestone	Recommendations for Potential Modifications to Implementation Plan or Other State Activities	Implementation Plan*	Other State Activities**
2	**6. Increase interactions (e.g., meetings, communications), provide consistent messaging for treatment and discharge expectations, and adopt tools (e.g., user-friendly portals) to support collaboration between MCE and provider groups.**	X	
	7. Encourage frequent and intentional provider to provider communication and collaboration during key care transition phases (e.g., treatment planning and discharge).	X	
	8. Identify strategies to increase workforce capacity (e.g., investments in care coordinators) and increase quality interactions (e.g., decrease case manager workloads) for members with SMI.	X	
3	**9. Revisit the use of the CANS/ANSA and determine if a shorter assessment tool could be used to inform individualized treatment planning and level of care decision making.**	X	
	10. Conduct additional CSU pilots that include evaluation and monitoring protocols to assess the impact of CSUs on increasing access to care across the care continuum and associated health improvements. Insights derived will support potential expansion strategies that can be scaled state-wide.		
	11. Update the Implementation Plan to account for actions that the state is no longer executing as well as add additional actions (if any) that the state is pursuing to increase access to care, including crisis stabilization.	X	
	12. Meet with providers, advocates, and state agencies (e.g. Department of Health [DOH]; Department of Corrections [DOC]) to identify strategies for increasing collaboration and minimizing barriers for accessing treatment services.	X	
	13. Develop processes to document methodology to assess provider availability and systematically collect data across time.		
4	**14. Improve communication specific to stigma reducing efforts between state officials and advocacy organizations.**		X
	15. Examine the impact of the state's stigma reducing efforts on engagement.		
	16. Address barriers to behavioral health integration (e.g., enhance infrastructures to support care coordination, identify strategies to improve communications between providers and support information sharing).		X
	17. Provide trainings and technical support opportunities in evidence-based screening and interventions and building referral networks.		X
	18. Update the monitoring protocol to include metrics that align more closely with behavioral integration.		
	19. Prioritize processes to capture Current Procedural Terminology category (CPT CAT) II codes CPT CAT II codes will provide additional information specific to provider screening and assessment efforts via claims.		
	20. Review the findings of the PIPBHC grant and identify action items that could be added to the implementation plan.		

Milestone	Recommendations for Potential Modifications to Implementation Plan or Other State Activities	Implementation Plan*	Other State Activities**
	21. Re-visit the Health Homes state plan amendment (SPA).		

*Note: Any recommendations indicated for the implementation plan are subject to the approval of a committee before changes to the plan can be enacted.
**Note: Recommendations are either addressed via another Indiana initiative, implementation, or funding source outside of the IN SMI waiver.

Exhibit ES.3: Overarching Recommendations for Potential Modifications to Implementation Plan or Other State Activities

Milestone	Recommendations for Potential Modifications to Implementation Plan or Other State Activities	Implementation Plan*	Other State Activities**
Across Milestones 1-4	**1. Continued diligence for data entry, compilation, and reporting. Increase data quality checks when appropriate.**		X
	2. When possible, use the SMI population definition for reporting metrics.		
	3. Identify and report additional supplemental metrics that better align with actions and goals.		
	4. Update the implementation plan with current actions aimed at improving care among the SMI population.	X	

*Any recommendations indicated for the implementation plan are subject to the approval of a committee before changes to the plan can be enacted.
**Recommendations are either addressed via another Indiana initiative, implementation, or funding source outside of the IN SMI waiver.

I. General Background Information

A. Overview

A 2015 report to the Indiana General Assembly highlighted the need for expanded crisis services, access to inpatient psychiatric beds, and improved coordination for individuals transitioning from inpatient services back into the community. Specifically, the report cited survey results demonstrating Indiana's reliance on EDs to manage individuals in acute crisis and suggested a need for increased options for psychiatric crisis.[3]

Demonstration Name: Healthy Indiana Plan - Project Number 11-W-00296/5
Approval Date: 12/20/19
Study Time Frame: 2021-2022 (with 2020 as the baseline)
Target Population: Beneficiaries with SMI

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations is to establish and evaluate state-specific policy approaches to better serve Medicaid populations in a budget neutral manner. In 2018, the FSSA received authority from the CMS to reimburse IMD for Medicaid-eligible individuals aged 21-64 years with SUD. In 2019, CMS allowed states to receive authority to pay for short-term acute stays in an IMD for adults with SMI and children with SED. Indiana state leadership elected to focus waiver efforts on adults with SMI. The SED population was not pursued because for those 21 and under, Indiana Medicaid already paid for services if they were delivered in an IMD through the psychiatric residential treatment facility benefit for that age group (405 Indiana Administrative Code (IAC) 5-20-1). Through this demonstration, Indiana will receive federal financial participation (FFP) for services furnished to Medicaid recipients who are primarily receiving short-term treatment services for an SMI in facilities that meet the definition of an IMD. [4]

The FSSA §1115(a) demonstration waiver for adults with SMI was approved on December 20, 2019, and effective from January 1, 2020 - December 31, 2020. On October 26, 2020, CMS granted approval for a five-year waiver extension, permitting the waiver to remain in effect through December 31, 2025.

B. Demonstration Description and State Agency Collaboration

Indiana's publicly funded behavioral health (both MH and SUD) system of care (SOC) supports access to prevention, early intervention, and recovery-oriented services and supports in all 92 counties, blending federal, state, and local funding streams to a provider network of agencies and individual practitioners. Indiana's FSSA and specifically its Office of Medicaid Policy and

[3] Division of Mental Health and Addiction (DMHA) distributed the Psychiatric and Addiction Crisis Survey in December 2014 and January 2015. Tailored surveys went out to respondent groups including MH and addiction providers, hospital ED staff, first responders, consumer and family advocates, and probation and parole officers.

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

Planning (OMPP) and Division of MH and Addiction (DMHA) partners provide policy oversight and primary funding of services and supports for individuals in need of behavioral health services. OMPP includes a robust continuum of behavioral health services as a benefit to enrollees in its fee-for-service (FFS) and Medicaid managed care programs. DMHA leverages its block grant funding from SAMHSA and state appropriations to complement the Medicaid service array, with a focus on providing SUD/SMI services to all fully eligible beneficiaries of any age, and who are at or below 350% of the federal poverty level (FPL). OMPP and DMHA also partner with the Department of Child Services (DCS), DOC, and county jails in supporting access to and oversight of behavioral services for Indiana's most vulnerable individuals.

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

C. Demonstration Goals and Milestones

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

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

As described in Indiana's approved Section 1115 SMI/SED Demonstration Implementation Plan, the state's approach to achieving the demonstration goals involves implementing action items to accomplish four key milestones:

- **Milestone 1**: Ensuring quality of care in psychiatric hospitals and residential settings.
- **Milestone 2**: Improving care coordination and transitioning to community-based care.

- **Milestone 3**: Increasing access to the continuum of care, including crisis stabilization services.
- **Milestone 4**: Earlier identification and engagement in treatment, including through increased integration.

Milestones are interrelated and action items identified in Indiana's Section 1115 SMI/SED Demonstration Implementation Plan overlap. Consequently, a distinct action item could be aligned to multiple milestones. Refer to **Sections I.E** and **IV.D** for additional details delineating action items which repeat across multiple milestones. Indiana's approved IN SMI Implementation Plan also includes a financing and Health Information Technology (HIT) plan. Refer to **Sections I.F** and **I.G** for additional details.

D. Mid-Point Assessment Scope and Timeline

Indiana's approved §1115 waiver STC requires the Mid-Point Assessment to be conducted by an independent evaluator. The state hired the Lewin Group (Lewin) to conduct the independent evaluation.[5] See **Attachment A** for the Lewin Group's "No Conflict of Interest" Statement. The scope and timeline of the assessment is described in the following sections.

1. Scope

Per STC 5 in the SMI component (Page 44, Section 3.XI) of the State Medicaid Director Letters for the section 1115 Medicaid demonstration, the state is required to conduct a Mid-Point Assessment by December 31, 2023[6] that examines: (1) whether the state is making sufficient progress towards meeting its milestones as outlined in Indiana's approved Section 1115 SMI/SED Demonstration Implementation Plan, (2) factors that influenced achievement of milestones (3) factors that may affect milestones in the future, and (4) whether the state is on track to meet budget neutrality. Additionally, the STC also specifies that the Mid-Point Assessment includes recommendations for adjustments, specifically for milestones that were assessed to be at medium to high risk of not being met.

Per CMS guidance[7], monitoring report data (calculated and reported by the State as detailed in the Monitoring Protocol [STC 4; page 44 Section 3.XI and Attachment G]) was used to inform the Mid-Point Assessment. CMS guidance also recommends using other available information including, but not limited to, the state's progress towards completion of implementation action items, feedback from key stakeholders, and other state-specific data to assess its risk of not achieving milestones. Together monitoring report metrics and other available data will be used by

[5] The Lewin Group is part of Optum Serve Consulting.

[6] Data discrepancies required the state to re-issue monitoring reports and provider capacity assessment data, causing schedule shifts in the Mid-Point Assessment timeline. Consequently, FSSA requested and received approval to extend the timeline to February 28, 2024.

[7] Centers of Medicare & Medicaid Services. (2021, October). *Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations: Mid-Point Assessment Technical Assistance.* 1115 SUD and SMI/SED Mid-Point Assessment Technical Assistance Version 1.0 (medicaid.gov)

the state to inform future demonstration planning and quality improvement efforts as well as highlight successful approaches for consideration across the broader Medicaid population.

2. Timeline

Indiana's approved §1115 waiver STC specifies that the state must conduct the Mid-Point Assessment between years two and three of the demonstration and the report should cover the first half of the demonstration approval period (i.e., 2.5 years). Given data availability (e.g., claim run off; annual data collection for most metrics) and report timeline; a two-year timeframe (2021-2022 for the waiver covering 2021-2025) with 2020 as the baseline (pre- waiver) was selected as the study timeframe. The state received CMS agreement for the study timeframe on June 30, 2023.

E. Key Elements of the SMI Demonstration Implementation Plan

The FSSA submitted its Section 1115 SMI/SED Demonstration Implementation Plan to CMS on August 30, 2019. As stated previously, FSSA received initial approval for the first year of the demonstration on December 20, 2019. On October 26, 2020, CMS granted a five-year waiver extension, permitting the waiver to remain in effect through December 31, 2025. The demonstration implementation plan includes:

- Oversight of IMDs (**Milestone 1**).
- Improved integration and care coordination, including transitions of care (**Milestones 2 and 3**).
- Improved primary care and behavioral health integration (**Milestones 2 and 3**).
- Behavioral and primary health care coordination service programming (**Milestone 2**).
- Implementation of child (MH) wraparound services (**Milestones 3 and 4**).
- Increased access to continuum of care including crisis stabilization services (**Milestone 3**).
- Expanded coverage for early identification (**Milestone 4**).
- Increased partnerships for engaging individuals into care (**Milestone 4**).

FSSA identified 23 distinct action items in its Implementation Plan. Action items are aligned to milestones and some action items are included in multiple milestones. For example, the action- Monitoring provider network capacity to identify underserved/geographic shortage areas and conduct targeted outreach to non-Medicaid enrolled providers in those areas - was aligned to both milestones 2 & 3. **Section II** of this report summarizes the action items in the Section 1115 SMI/SED Demonstration Implementation Plan. **Section IV** of this report describes the state's progress for achieving these action items.

F. Key Elements of the SMI Demonstration Finance Plan

The state's financing plan describes state efforts for increasing the availability of nonhospital, non-residential crisis services and community-based MH providers for Medicaid beneficiaries. State efforts include:

- Providing mobile crisis teams (16) in addition to the CMHCs mandated 24/7 crisis services.
- Annually monitoring access to non-residential crisis stabilization services through completion of the CMS Template – "Overview of the Assessment of the Availability of MH Services."
- Piloting two CSUs in the northern and southern parts of the state.
- Piloting MRSS.
- Effective July 1, 2019, in accordance with the CMS approval of SPA TN 18-102, Indiana Medicaid expanded crisis intervention services, intensive outpatient program services, and peer recovery services to all Indiana Medicaid programs, not only the Medicaid rehabilitation option (MRO).

The state's financing plan also describes a comprehensive continuum of community-based services. The state monitors access to community-based services through an agreed upon methodology. The state specifically monitors any changes to non-CMHC providers and the impact on access to intensive outpatient, peer support, and crisis intervention services. Additionally, the state monitors provider enrollment, identifies geographic shortage areas, and conducts targeted outreach to non-Medicaid enrolled providers in those areas.

G. Key Elements of the SMI Demonstration Health Information Technology Plan

As outlined in Indiana's State Medicaid Health Information Technology Plan (SMHP), Indiana's HIT environment is active with multi-faceted efforts to support provider HIT capacity and foster the sharing of clinical and administrative data to improve health care and support system improvements. The state has taken an active role through its state health agencies and Medicaid program to promote HIT adoption and Health Information Exchange (HIE) development, building upon its private health care marketplace. As outlined in **Exhibit I.1**, the state has four well-established HIE networks operated by Health Information Organizations (HIOs), each functioning in different capacities for community partners.

Exhibit I.1: Status of Regional Health Information Organizations

Regional HIO	Current Status
HealthBridge (includes greater Cincinnati tristate area)**	Utilization of the Health Collaborative's HealthBridge Suite (hb/suite): • 58 hospitals • 8,901 providers • 160 million clinical results processed • 15 million monthly messages

Regional HIO	Current Status
HealthLINC**	• Delivers more than 175,000 medical results per month among hospitals, office and clinic practices and under-served clinics • Health service directory that includes more than 350 physicians and other providers
Indiana Health Information Exchange (IHIE)*	• Connection to 123 hospitals representing 38 health systems • Over 19,000 practices • Over 54,500 providers • Over 20,000,000 patients • Over 16,000,000,000 clinical data elements
Michiana Health Information Network (MHIN)**	• Over 576 data sources • 3.9 million transactions inbound per month • 44,582 providers connected

*Historical data covering the study time period for IHIE is unavailable. Consequently, data listed in column 2 of Exhibit I.1 for IHIE reflects status as of October 2023.

**Data listed in column 2 of Exhibit I.1 for Health Bridge, HealthLINC, and MHIN reflects status for 2021 and 2022. Health Bridge, HealthLINC, and MHIN data have not changed since the development of the Implementation Plan.

Indiana's HIT plan identifies the following actions:

- Drive improvements for increased electronic documentation and standardization among settings and providers not previously addressed through Meaningful Use (MU), including behavioral health.
- Update the broader State Medicaid HIT Plan and align areas of prioritization with waiver milestones as appropriate.
- Review the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 Code of Federal Regulations (CFR) 170 Subpart B for potential inclusion into our contracts.
- Conduct a provider survey to identify the volume of providers utilizing closed loop referrals and e-referrals.
- Determine required steps and timeline for compliance with the CMS Interoperability and Patient Access Final Rule.[8]
- Explore submitting the health homes SPA which will include leveraging HIT for enhanced integration and coordination.
- Survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.

[8] The CMS Interoperability and Patient Access final rule is intended to move the health care ecosystem in the direction of interoperability by improving the quality and accessibility of information that patients need in order to make informed health care decisions, including data about health care prices and outcomes, while minimizing reporting burdens on impacted providers and payers. (https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and)

- Modernize the electronic health record (EHR) system used collectively by all state psychiatric hospitals.
- Continued operation of managing consent/privacy in a multitude of mechanisms across the Medicaid Health Information Sharing Enterprise.
- Continued utilization of the Relias ProAct Tool.
- Continued operation of the Indiana Telehealth Network and Project ECHO (Extension for Community Healthcare Outcomes).

H. Population

Although the expenditure authority for the demonstration is specific to IMDs, the waiver provides high quality, evidence-based MH treatment services to all Medicaid recipients with a relevant SMI diagnosis. Consequently, all Medicaid enrollees[9] (**Exhibit I.2** summarizes eligibility groups excluded) received services regardless of the delivery system and payment methodologies (consistent with those approved in the Medicaid State Plan) during the 2021-2022 timeframe. Indiana defined five populations depending on the metrics calculated for monitoring and oversight: (1) demonstration population - MH diagnosis at primary position, (2) demonstration population – MH diagnosis at any position, (3) state-specific SMI, (4) state-specific SMI/SED and (5) standardized (National Committee for Quality Assurance (NCQA) definition). The specifications for the population are summarized in **Exhibit I.3**.

Exhibit I.2: Eligibility Groups Excluded from the Demonstration[10]

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

The majority of the monitoring protocol metrics are calculated for the demonstration population. The IN SMI Evaluation Plan (2021-2025) (approved March 21, 2023) limits the waiver population to all Medicaid recipients, aged 21-64 years in eligibility groups that are eligible for

[9] Several eligibility groups were excluded from the analytic population as Medicaid coverage for these groups does not include IMDs.

[10] Eligibility identified using multiple data elements captured in enrollment data. Emergency Only Services based on I_Emergency = "Y", Family Planning Services (recipient_aid_catgy = E), PE Family Planning Services (recipient_aid_catgy = HF), Pregnancy (recipient_aid_catgy = PN), QMB only (recipient_aid_catgy = L and I_dual_aid =Y), SLMB only(recipient_aid_catgy=J and I_dual_aid =Y), Qualified Disabled Working Individual (QDWI) only (recipient_aid_catgy=G and I_dual_aid =Y), Qualifying Medicare individuals (QI) only (recipient_aid_catgy=I and I_dual_aid =Y).

stays in an IMD. The evaluation analytic population was constructed to better reflect the demonstration target population.

Exhibit I.3: Population Definition and Specifications: Demonstration, State Specific (Evaluation), NCQA Standardized[11]

Identification Criteria	Demonstration (1 & 2)	State Specific (SMI) */ Evaluation (3 & 4)	Standardized (5)
International Classification of Disease (ICD) 10 Diagnosis on claims[12]	MH diagnosis from the Healthcare Effectiveness Data and Information Set (HEDIS) Measurement Year 2022 MH Diagnosis value set	F20.xx, F25.xx, F31.xx, F33.xx	F20.xx, F25.xx, F30.xx, F31.xx, F32.xx, F33.xx
Diagnosis Position	Primary (except for selected metrics which use all positions)	Primary or Secondary	Any position
Care Setting	No restriction on care settings	No restriction on care settings	• Inpatient: At least one admission with any diagnosis listed • Outpatient: At least two visits with bipolar (F30xx, F31xx) or schizophrenia (F20xx, F25xx) diagnosis
Payment Exclusions	Include on Paid claims; Exclude claims paid by third-party	Include on Paid claims; Exclude claims paid by third-party	Include on Paid claims; Exclude claims paid by third-party
Medicaid Eligibility**	Exclude individuals receiving Emergency Only Services, Family Planning Services, Presumptive Eligibility (PE) Family Planning, Pregnant, QMB only, SLMB only, QDWI, and Medicare QI	Exclude individuals receiving Emergency Only Services, Family Planning Services, PE Family Planning, Pregnant, QMB only, SLMB only, QDWI, and Medicare QI	Exclude individuals receiving Emergency Only Services, Family Planning Services, PE Family Planning, Pregnant, QMB only, SLMB only, QDWI, and Medicare QI
Age Group	No age restriction	No restriction (Analytic population for Evaluation is restricted to age 21 to 64)	No age restriction
SMI/SED	SMI/SED	Non-SED	Non-SED

* FSSA also monitors state-specific (SMI/SED) population. This population is identified using similar criteria as the state-specific (SMI) except for the type of diagnosis. For the state-specific (SMI/SED), Indiana uses the four ICD10 codes associated with SMI (listed above) as well as ICD10 associated with SED.

** Eligibility is based on indicator of emergency services only (I_Emergency_Services_Only), recipient aid categories (Recipient_Aid_Catgy) and dual aid categories (MSIS dual aid) in the member enrollment data. Recipients are considered ineligible and excluded if one had I_Emergency_Services_Only that takes value of "Y", Recipient_Aid_Catgy with the values of "E"(family

[11] For the monitoring protocol, Indiana defined five populations for monitoring and oversight. Column 2 provides the specifications for populations 1 (demonstration population - MH diagnosis at primary position) and 2 (demonstration population – MH diagnosis at any position). Column 3 provides the specifications for populations 3 (state-specific SMI) and 4 (state-specific SMI/SED). Column 4 provides the specifications for the standardized (NCQA definition) population.

[12] For HEDIS MY 2022 MH value set, refer to HEDIS Measures and Technical Resources - NCQA . F20.xx [Schizophrenia and sub codes up to 2 places], F25.xx [Schizoaffective Disorder and sub codes up to two places], F31.xx [Bipolar and all sub codes up to 2 places], F33.xx [Major depression Recurrent and all sub codes up to two places], F30.xx [Manic episode and all sub codes up to 2 places], F32.xx [Major depressive disorder single episode or other]

planning), "HF"(PE family planning), "PN"(PE for pregnancy) or T-MSIS dual aid with the values of "01"(QMB only), "03"(SLMB only), "05"(QDWI), or "06"(Medicare QI).

I. Measures Collected in the SMI Monitoring Protocol

CMS completed its review of the SMI Monitoring Protocol, which is required by the STC, specifically, STCs IX.4 and X.4, of Indiana's section 1115 demonstration, "Healthy Indiana Plan (HIP)" (Project No: 11-W00296/5). **Exhibits II.2, II.4, II.6,** and **II.8** in **Section II** lists the metrics that Indiana reports to CMS in the quarterly and annual demonstration reporting template. Note: Indiana reports sub-population data for utilization metrics 13 – 18 and metrics 21 and 22.

J. Budget Neutrality

Milliman Inc. (Indiana's actuary) conducts budget neutrality assessments as part of the SMI monitoring protocol. These assessments include cost analyses to assess whether the SMI demonstration results in higher, lower, or neutral health care spending. Findings are submitted on a quarterly basis to CMS. Consistent with CMS guidance, a separate budget neutrality assessment was not included in the Mid-Point Assessment. A more robust cost analysis that adheres to CMS guidance will be conducted for a future evaluation (covers demonstration approval period: 2021 -2025).

K. Impact of COVID-19 PHE

The initial three years of the demonstration (2020 - 2022) coincided with the COVID-19 PHE, which was determined in January 2020.[13] The PHE caused substantial changes to Medicaid policies, service utilization and provider availability, and will have short- and long-term impacts on Indiana's health care system and specialized populations, such as SMI. Given the timing of the PHE, the state shifted many of the planned implementation action items to accommodate access to and delivery of high-quality MH services for all Indiana residents, particularly given the social distancing and health care resource prioritization required in response to the PHE. Subsequently, progress for achieving demonstration goals was impacted by COVID-19 related policy changes and activities.[14] Therefore, data drawn during this time-period likely reflects both the impact of COVID-19 related policy changes and activities as well as demonstration impacts. Consequently, any observed changes should be interpreted with caution as findings may be confounded by the impact of the PHE.

[13] U.S. Department of Health & Human Services. (2020, January 31). *Determination that a Public Health Emergency Exists* [Press release]. Determination that a Public Health Emergency Exists (hhs.gov)

[14] Indiana 1115(a) Demonstration Evaluation Summative Report (https://secure.in.gov/fssa/hip/files/IN-SMI-Summative-Evaluation-Report.pdf)

II. Implementation Plan Milestones: Action Items, Relevant Assessment Questions, Monitoring Metrics, and Data Sources

This section provides the underlying assessment questions and corresponding action items for each milestone. The content aligns with Indiana's Section 1115 SMI/SED Demonstration Implementation Plan and maps the relevant data sources used to assess Indiana's progress for achieving the demonstration's intended goals. As stated in **Section I.C**, milestones are interrelated, and action items identified in Indiana's Section 1115 SMI/SED Demonstration Implementation Plan overlap. Consequently, a distinct action item could be aligned to multiple milestones. Refer to **Sections I.E** and **IV.D** for additional details delineating how some action items are repeated across multiple milestones.

Measures collected in the SMI Monitoring Protocol are catalogued by milestone. Additionally, where available and appropriate, Lewin used other data sources (e.g., key informant interviews, enrollment data, and claims data) to assess progress. **Section III** provides further details on these data sources. Progress towards completing action items and assessment of overall risk is summarized in **Section IV**.

A. Milestone 1: Ensuring quality of care in psychiatric hospitals and residential settings

Quality of care for individuals with SMI is suboptimal, including a lack of follow-up care after a MH hospitalization, gaps in access to care, and receipt of MH services. For example, in the U.S., only one third of those in need of MH care received adequate MH care. [15,16] Milestone 1 focuses on quality of care and examines the demonstration's impact on maintaining appropriate standards, providing access to appropriate levels and types of care, and requiring inpatient and residential facilities to screen for co-morbid conditions. Both quantitative and qualitative data were used to assess the impact of milestone 1. **Exhibit II.1** summarizes relevant assessment questions, implementation action items, and data sources for milestone 1. **Exhibit II.2** catalogues the monitoring measures used to assess milestone 1.

[15] Kilbourne, A.M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'Brien, R.W., Tomoyasu, N. and Pincus, H.A. (2018), Measuring and improving the quality of MH care: a global perspective. World Psychiatry, 17: 30-38. https://doi.org/10.1002/wps.20482.

[16] Philip S. Wang, Olga Demler, and Ronald C. Kessler, 2002: Adequacy of Treatment for Serious Mental Illness in the United States. *American Journal of Public Health* **92**, 92_98, https://doi.org/10.2105/AJPH.92.1.92

Exhibit II.1: Milestone 1 Assessment Questions, Action Items, and Data Sources

Assessment Question	Implementation Plan - General Description	Action Item(s) – Specific Description	Data Source / Monitoring Report Metric
Did participating psychiatric hospitals and residential settings maintain appropriate standards to ensure quality of care?	Assure that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide MH treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.	Continued maintenance of licensure among Private Mental Health Institution (PMHI) (1a).	Key Informant Interviews
	Provide oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements.	Conduct annual unannounced site visits of each PMHI (1b).	Key Informant Interviews
	Implement requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	Conduct the MHSIP for individuals served by DMHA contracted providers.; Conduct annual CAHPS surveys.; Use findings from MHSIP and CAHPS surveys for quality assurance and improvement activities as needed (1g).	• Annual MHSIP Survey Reports • Key Informant Interviews
Has access to appropriate levels and types of care changed during the demonstration period?	Utilization review process to ensure beneficiaries have access to the appropriate levels, types of care and lengths of stay.	Develop a report to monitor ALOS for all Medicaid programs; Review timeline requirements for submission of the 1261A form; Managed care organizations (MCOs) and State's FFS prior authorization (PA) entity conduct medical necessity reviews; MCOs to use Milliman Care Guidelines (MCG) to complete medical necessity reviews and determine the appropriate level of care/LOS for behavioral health diagnosis; OMPP reviews MCOs' utilization management (UM) practices (1c.).	• Key Informant Interviews • ALOS (calculated using enrollment, claims) • Metric #2
	Ensure IMDs comply with program integrity requirements and state compliance assurance process.	Screen and revalidate the IMDs to permit them to contract with Indiana Medicaid (1d).	Key Informant Interviews

Assessment Question	Implementation Plan - General Description	Action Item(s) – Specific Description	Data Source / Monitoring Report Metric
Did psychiatric hospitals and residential settings incorporate protocols for co-morbid condition screening during the demonstration period?	Require psychiatric hospitals and residential settings to screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.	Review hospital compliance with required policies and procedures for intake and assessment processes as part of annual unannounced site visits and recertification (1e).	Key Informant Interviews

Exhibit II.2: Milestone 1 Monitoring Metrics Reported by Indiana

Metric #	Metric Name	Indiana Reporting	Demonstration	Standardized	State-Specific SMI
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings	N	N	N	N
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Y	Y	N	N

B. Milestone 2: Improving care coordination and transitions to community-based care

Disparities in health outcomes for individuals with SMI (e.g., greater comorbidities, decreased lifespan, increased prevalence of numerous diseases, pregnancy complications, etc.[17]) suggests a need for a coordinated, multifaceted approach that transcends conventional psychiatric care. In addition to disparities in health outcomes, people with SMI often use the MH care system as their principal setting for access to medical and social care.[18,19,20] As such, community MH settings are challenged to address the many demands associated with comorbid chronic medical conditions and

[17] DE Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Detraux J, Gautam S, Möller HJ, Ndetei DM, Newcomer JW, Uwakwe R, Leucht S. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 2011 Feb;10(1):52-77. doi: 10.1002/j.2051-5545.2011.tb00014.x. PMID: 21379357; PMCID: PMC3048500.

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

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

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

related primary and preventive care needs.[21] A key strategy to reducing these disparities requires effective coordination and care integration.

Milestone 2 focuses on pre-discharge planning and care coordination, examining the impact of the demonstration on ED utilization, re-admission, and hospital follow-up. Both quantitative and qualitative data were used to assess the impact of milestone 2. **Exhibit II.3** summarizes relevant assessment questions, implementation action items, and data sources for milestone 2. **Exhibit II.4** catalogues the monitoring measures used to assess milestone 2.

Exhibit II.3: Milestone 2 Assessment Questions, Action Items, and Data Sources

Assessment Question	Implementation Plan – General Description	Action Item (s) – Specific Description	Data Source(s) / Monitoring Report Metric
Do psychiatric hospitals and residential settings have pre-discharge planning for care coordination to enable transition to community-based care post discharge?	Ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available; Ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible (e.g., email, text, or phone call within 72 hours post discharge).	Update the Medicaid Provider Manual to include protocols that assess housing insecurity (as part of the social work assessment and discharge planning processes and to refer to appropriate resources) and ensure contact is made by the treatment setting with each discharged recipient within 72 hours of discharge and follow-up care is accessed; Communicate updates to providers as needed (2b, 2c).	Key Informant Interviews
Do psychiatric hospitals and residential settings have established processes for follow-ups post discharge to ensure members have access to and are receiving community-based care?	Ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	Require hospitals to initiate discharge planning at admission; Involve CMHCs in discharge planning; Provide case management services for any member discharged from an inpatient psychiatric or substance abuse hospitalization for at least 90 calendar days following discharge (2a).	• Key Informant Interviews • Metric #6 • Metric #7 • Metric #8
Do beneficiaries discharged from ED receive follow-ups for care coordination?	Implement strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI prior to admission.	Increase access and availability of non-hospital, non-residential crisis stabilization services by implementing CSUs (2d).	• Key Informant Interviews • Metric #9 • Metric #10

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

Assessment Question	Implementation Plan – General Description	Action Item (s) – Specific Description	Data Source(s) / Monitoring Report Metric
Does the demonstration help reduce preventable readmissions to acute care hospitals and residential settings?	N/A	N/A	Metric #4

Exhibit II.4: Milestone 2 Monitoring Metrics Reported by Indiana

Metric #	Metric Name	Indiana Reporting	Demonstration	Standardized	State-Specific SMI
3*	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care	N	N	N	N
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	Y	Y	N	N
6**	Medication Continuation Following Inpatient Psychiatric Discharge	Y	Y	N	N
7	Follow-up After Hospitalization for Mental Illness: Ages 6–17	Y	Y	N	N
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older	Y	Y	N	N
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse	Y	Y	N	N
10	Follow-up After Emergency Department Visit for Mental Illness	Y	Y	N	N

*This metric was removed by CMS from the monitoring report indefinitely.

** The metric is not listed for the milestone in the CMS Guidance but included to address transition from inpatient psychiatric discharge to community-based care

C. Milestone 3: Increasing access to continuum of care including crisis stabilization services

The continuum of care for those with SMI encompasses treatment modalities across a spectrum including early intervention, emergency services, inpatient treatment, residential programs, outpatient services, community support, clubhouse programs, supportive employment (SE), peer support, etc.[22] Access to the continuum of care for those with SMI is of paramount importance, as those with SMI may experience recurring episodes of crisis and could benefit from ongoing

[22] Manning, S., & Van Pelt, M. (2005). The Challenges of Dual Relationships and the Continuum of Care in Rural MH. Council on Social Work Education, Inc. https://maryvanpelt.com/books/Rural_Mental_Health.pdf

support.[23,24] Crisis response and stabilization (e.g., crisis call centers, crisis mobile team response, crises receiving, and stabilization services) is a basic element of MH care and often serves as an access point for connecting individuals to community care resources. Although evidence regarding crisis response programs is emerging, research has indicated that crisis response is associated with improved health outcomes.[25]

Milestone 3 focuses on crisis stabilization and examines the impact of the demonstration on increasing access to care across the care continuum. Both quantitative and qualitative data were used to assess the impact of milestone 3. **Exhibit II.5** summarizes relevant assessment questions, implementation action items, and data sources for milestone 3. **Exhibit II.6** catalogues the monitoring measures used to assess milestone 3.

Exhibit II.5: Milestone 3 Assessment Questions, Action Items, and Data Sources

Assessment Question	Implementation Plan – General Description	Action Item (s) – Specific Description	Data Source / Monitoring Report Metric
Do contracted providers use a widely recognized, publicly available assessment tool to determine level of care and LOS?	Utilize a widely recognized, publicly available patient assessment tool to determine level of care and LOS.	Ensure every individual served by a DMHA contracted provider receives a CANS/ANSA. (3d).	Key Informant Interviews
Do demonstration action items contribute to increased access to the continuum of care?	Conduct annual assessments of the availability of MH providers.	Monitor provider network capacity, identify underserved/ geographic shortage areas and conduct targeted outreach to non-Medicaid enrolled providers in those areas (2d, 3a).	Annual Provider Availability Assessment
	Implement strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI prior to admission.	Increase access and availability of non-hospital, non-residential crisis stabilization services by implementing CSUs (2d, 3a, 4c).	• Key Informant Interviews • Annual Provider Availability Assessment • Claims (for crisis stabilization services provider)

[23] Eide, S. & Gorman, C. (September 2022). The Continuum of Care: A Vision for MH Reform. The Manhattan Institute. Retrieved September 21, 2023, from https://media4.manhattan-institute.org/sites/default/files/the-continuum-of-care-vision-for-mental-health-reform.pdf

[24] Coombs NC, Meriwether WE, Caringi J, Newcomer SR. Barriers to healthcare access among U.S. adults with MH challenges: A population-based study. SSM Popul Health. 2021 Jun 15;15:100847. doi: 10.1016/j.ssmph.2021.100847. PMID: 34179332; PMCID: PMC8214217.

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

Assessment Question	Implementation Plan – General Description	Action Item (s) – Specific Description	Data Source / Monitoring Report Metric
	Implement strategies to expand access to behavioral health providers for Medicaid beneficiaries.	Implement legislation and policies (House Enrolled Act 1175 and SPA TB 18-103) to address expanded access to behavioral health providers for Medicaid beneficiaries (3a).	Key Informant Interviews
Do demonstration action items contribute to increased access to crisis stabilization services?	Implement strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI prior to admission; Establish specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI.	Review timeline for a potential MRSS pilot (2d, 3a, 4c).	Key Informant Interviews
	Implement strategies to improve state tracking of availability of inpatient and crisis stabilization beds.	Expand OpenBeds contract to include psychiatric bed capacity (3c).	Key Informant Interviews
Do SMI beneficiaries have short-term stays and is LOS being tracked?	N/A	N/A	• Metric #19 • Metric #20

Exhibit II.6: Milestone 3 Monitoring Metrics Reported by Indiana

Metric #	Metric Name	Indiana Reporting	Demonstration	Standardized	State-Specific SMI
19 (a & b)	Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs)	Y	Y	N	N
20*	Beneficiaries With SMI/SED Treated in an IMD for MH	Y	Y	N	N

Note: 19a- All Average Length of Stay in IMDs for all IMDs; 19b- All Average Length of Stay in IMDs receiving FFP only
* The metric is not listed for the milestone in the CMS Guidance but included to address length of stay.

D. Milestone 4: Earlier identification and engagement in treatment, including through increased integration

The average delay between the onset of a mental illness and treatment is 11 years.[26] Therefore, early identification of SMI and engagement in treatment across the continuum of care is crucial to improving MH outcomes and enhancing the overall well-being and quality of life of those affected

[26] Wang PS, Berglund PA, Olfson M, Kessler RC. Delays in initial treatment contact after first onset of a mental disorder. Health Serv Res. 2004 Apr;39(2):393-415. doi: 10.1111/j.1475-6773.2004.00234.x. PMID: 15032961; PMCID: PMC1361014.

by SMI.[27] Treatment engagement strategies vary and are an emerging area for study. One example of an evidence-based treatment strategy for SMI populations is SE services. Research has suggested that individuals receiving SE services are more likely to have improvements in MH status and symptom control, as well as reduced inpatient hospital use.[28, 29,30] Additionally, integrated care (primary care and behavioral health) and multidisciplinary services increase touchpoints for intervention and referral to treatment.[31]

Milestone 4 focuses on identifying and engaging individuals at risk of SMI into treatment and examines the impact of the demonstration on increasing the number of individuals covered by waiver services as well as increased primary and behavioral health integration. Both quantitative and qualitative data were used to assess the impact of milestone 4. **Exhibit II.7** summarizes relevant assessment questions, implementation action items, and data sources for milestone 4. **Exhibit II.8** catalogues the monitoring measures used to assess milestone 4.

Exhibit II.7: Milestone 4 Assessment Questions, Action Items, and Data Sources

Assessment Question	Implementation Plan – General Description	Action Item(s) – Specific Description	Data Source / Monitoring Report Metric
Does the demonstration result in earlier identification and engagement of treatment for beneficiaries?	Identify strategies for engaging beneficiaries at risk of SMI in treatment sooner, e.g., with supported education and employment.	Engage beneficiaries at risk of SMI in VRS (e.g., SE) (4a).	• Key Informant Interviews • Metrics 21 & 22
Was there any increase in care integration between primary and behavioral health during demonstration period?	Increase integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment.	Ensure financial sustainability of a physical health and behavioral health integration model following the end of the current grant funding (4b).	• Key Informant Interviews • Metrics: 26, 29 & 30

[27] Dixon LB, Holoshitz Y, Nossel I. Treatment engagement of individuals experiencing mental illness: review and update. World Psychiatry. 2016 Feb;15(1):13-20. doi: 10.1002/wps.20306. Erratum in: World Psychiatry. 2016 Jun;15(2):189. PMID: 26833597; PMCID: PMC4780300.

[28] Marshall T, Goldberg R, Braude L, Dougherty R, Daniels A, Ghose S, George P, Delphin-Rittmon M, Ph.D. Supported employment: Assessing the evidence. Psychiatry Services. 1 Jan 2014. Volume 65, Issue 1. https://doi.org/10.1176/appi.ps.201300262.

[29] Drake RE, Xie H, Bond GR, et al. Early psychosis and employment. *Schizophr Res.* 2013;146:111–117. A prospective study of FEP and the importance of employment or education for recovery.

[30] Killackey EJ, Jackson HJ, Gleeson J, et al. Exciting career opportunity beckons! Early intervention and vocational rehabilitation in first-episode psychosis: employing cautious optimism. *Aust N Z J Psychiatry.* 2006;40:951–962.

[31] Colizzi M, Lasalvia A, Ruggeri M. Prevention and early intervention in youth MH: is it time for a multidisciplinary and trans-diagnostic model for care? Int J Ment Health Syst. 2020 Mar 24;14:23. doi: 10.1186/s13033-020-00356-9. PMID: 32226481; PMCID: PMC7092613.

Assessment Question	Implementation Plan – General Description	Action Item(s) – Specific Description	Data Source / Monitoring Report Metric
Do beneficiaries with SMI receive screening or monitoring for co-morbid conditions during the demonstration period	Require psychiatric hospitals and residential settings to screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.	Review hospital compliance with required policies and procedures for intake and assessment processes as part of annual unannounced site visits and recertification (1e).	• Metric #23

Exhibit II.8: Milestone 4 Monitoring Metrics Reported by Indiana

Metric #	Metric Name	Indiana Reporting	Demonstration	Standardized	State-Specific SMI
21*	Monthly Count of Beneficiaries With SMI	Y	Y (state-specific SMI/SED population)	Y	Y
22*	Annual Count of Beneficiaries With SMI	Y	Y (state-specific SMI/SED population)	Y	Y
23**	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Y	Y	N	N
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	Y	Y	N	N
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Y	Y	N	N
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Y	Y	N	N

* The metrics are not listed for the milestone in the CMS Guidance but included to address identification of SMI population in treatment.

** The state opted to use metric #23 to demonstrate progress toward Milestone 4 (rather than Milestone 1) for the Mid-Point Assessment.

III. Methodology

Evaluation of the program milestones was based on a mixed-methods approach employing qualitative and quantitative analyses to provide a snapshot of the first two years of the demonstration. Qualitative data was compiled from key informant interviews and captures provider, advocacy organization, FSSA state official, MCE, and member experiences and perspectives. Quantitative data was compiled from various sources including monitoring report data, Provider Availability Assessment data, and MHSIP survey reports.

A. Qualitative Methods

Between April and October 2023, Lewin conducted 50 key informant interviews with FSSA state officials (n= 8), MCEs (n=5), advocacy organizations (n=3), providers (n=9), and members (n=25). **Exhibit III.1** provides a brief description of the respondents, interview topics, and relevant milestones addressed. Key informant interviews were conducted virtually and lasted 15-60 minutes (depending on interview type).

Lewin worked with the Indiana FSSA federal reporting team to identify appropriate interviewees for FSSA state official, MCE, advocacy organization, and provider interviews. For member interviews, a random sample of 500 members was selected from SMI beneficiaries (state-specific definition) aged 21-64 who had at least one SMI related paid claim between October 2022 – December 2022 and was eligible to receive Medicaid benefits in December 2022 stratified by gender, race, and age group. Although the sample derived was stratified to generate a representative cohort, the respondent pool was skewed. (i.e., predominately female, Caucasian, not Hispanic or Latino, aged 43 years old, and located in an urban setting) and subsequently not representative of the Medicaid SMI population (see **Attachment D** for additional details). Consequently, findings derived from the member interviews should be interpreted with caution.

FSSA state officials, MCE, advocacy organization, and provider interviews included one facilitator and one note taker. Member interviews included one facilitator who also took notes. Prior to the interview, the interviewer requested permission to record the conversation to facilitate note taking for FSSA state official, MCE, provider, and advocacy organization interviews. Findings were reported in aggregate by interview type. Facilitators used a structured interview (see **Attachment C** for data collection protocols) to gather information.

Exhibit III.1: Summary of Qualitative Data Sources

Interview Type	Description	Relevant Goals
FSSA state officials ***Total: 8 interviews***	• The Indiana FSSA federal reporting team identified FSSA state official interviewees representing several roles within FSSA including officials involved in the development, planning, administration, and/or implementation of the SMI waiver demonstration. • Interviews lasted approximately 60 minutes. • Most interview questions were specific to each official's role and/or experience regarding the IN SMI waiver. Common questions across officials covered the following topics: experience with waiver development and implementation, impact of PHE, and challenges and successes with implementation action items during the timeframe.	• Milestone 1 • Milestone 2 • Milestone 3 • Milestone 4 • Topic 5: Financial Plan • Topic 6: Health IT Plan
MCEs ***Total: 5 interviews***	• The Indiana FSSA MCE Contract Officers identified MCE interviewees. Interviews included executives and providers from each of the five MCEs. • Interviews lasted approximately 60 minutes. • Lewin asked MCE representatives a standardized set of questions related to their awareness of IN SMI waiver related action items, role in the implementation action items, observations on the impact of the IN SMI waiver, and observations on the impact of PHE, as well as tailored follow-up questions related to responses from the 2020 Summative Report key informant interviews.	• Milestone 1 • Milestone 2 • Milestone 3 • Milestone 4 • Topic 6: Health IT Plan
Providers ***Total: 9 interviews***	• Lewin worked with the Indiana FSSA Coverage and Benefits Team to identify provider representatives from a variety of settings including CMHCs, Inpatient, Outpatient, and CSU. • Interviews lasted approximately 30 minutes. • Providers included representatives from three Inpatient facilities, three CMHCs, one CSU, and two Outpatient programs. • Most interview questions were specific to each provider type. Common questions related to expanded services made available to SMI beneficiaries with SMI, provider role in implementation action items, impact of PHE, challenges or barriers SMI beneficiaries faced during the timeframe.	• Milestone 1 • Milestone 2 • Milestone 3 • Milestone 4
Advocacy Organizations ***Total: 3 interviews***	• The Indiana FSSA Federal reporting team identified advocacy organization representatives. Interviews included executive directors and managers from 3 advocacy organizations. • Interviews lasted approximately 30 minutes. • The Lewin team asked advocacy organization representatives a standardized set of questions related to their perspective on the expanded services made available due to the IN SMI waiver, their role in the implementation of waiver action items, impact of the PHE, and any challenges or barriers SMI beneficiaries faced during the timeframe.	• Milestone 1 • Milestone 2 • Milestone 3 • Milestone 4

Interview Type	Description	Relevant Goals
Members ***Total: 25 interviews***	• Lewin worked with the Indiana FSSA Federal reporting team and support team to develop the SMI population for the waiver. Lewin selected a random sample of SMI beneficiaries to contact for interviews. • Interviews lasted approximately 15 minutes. • Members were asked a standardized set of questions related to their experiences of SMI services during the timeframe.	• Milestone 1 • Milestone 2 • Milestone 3 • Milestone 4

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

B. Quantitative Methods

1. Data Sources

For quantitative analyses, Lewin used data from five sources to evaluate the demonstration milestones identified in **Section I.C.**

- **Monitoring Report Data**: This data provides monthly, quarterly, and annual data for all metrics identified in the state's SMI Monitoring Protocol. See **Exhibits II.2, II.4, II.6,** and **II.8** for the critical and supplemental metrics evaluated in the Mid-Point Assessment.
- **Member Eligibility and Enrollment Data**: This data provides monthly information on recipient Medicaid enrollment status, coverage, and socio-demography.
- **Claims/Encounter Data**: The claims/encounter records provide information about the health care utilization of recipients and enrolled providers that are actively providing services.
- **MHSIP Survey Reports**: The annual MHSIP survey captures perceptions on health services received at community MH settings (e.g., CMHCs) among individuals with a MH condition. Lewin used the summarized report prepared by the MHSIP survey vendor.
- **Administrative Data**: Program administrative data included items such as the number of Medicaid-enrolled providers (e.g., psychiatrists or practitioners, CMHCs) that offered behavioral health services and ratio of beneficiaries served to available providers. As required by CMS (annually) the state also conducts point-in-time assessment of provider availability. For this report, Lewin used the Provider Availability Assessment data collected as part of this point-in-time assessment.

Analyses were restricted from CY2021 to CY2022. Inclusion of data from the baseline time-period (CY2020) allowed for a holistic understanding of changes in measures of interest across the demonstration time-period.

2. Demonstration and Analytic Populations

As discussed in **Section I.H**, Indiana has defined multiple population definitions for relevant monitoring and oversight. The state uses the demonstration analytic population to calculate all CMS constructed monitoring metrics (**Exhibits II.2, II.4, II.6,** and **II.8**) defined in the SMI Monitoring Protocol (submitted on March 25, 2021; Revised on June 17, 2021; Revised July 27, 2021). Monitoring metrics are submitted to CMS quarterly via a reporting template. The Mid-Point Assessment report compiled the monitoring metrics reported to CMS and used this data to assess the state's progress. For metrics not included in the quarterly monitoring reports, such as ALOS for all inpatient admissions or ED visits for members aged 21-64, the state-specific SMI (or evaluation) analytic population was used for calculations. See **Attachment D f**or details specific to the calculation of these measures. The approach used for the Mid-Point Assessment report differs from other evaluation activities (e.g., Interim, Summative) which require the evaluator to independently calculate metrics using claims data. Consequently, there may be some inconsistencies between the Mid-Point Assessment report findings and prior or future report findings when similar metrics are used (e.g., ED utilization).

The Mid-Point Assessment report will specifically indicate when the state-specific SMI (or evaluation analytic) population was used. In all other instances (except for the Provider Availability Assessment), the reader should assume that the demonstration population was used. For data examining provider capacity, the state-specific SMI/SED population was used. **Exhibit III.2** summarizes the population definitions and associated quantitative metrics for the three populations included in the Mid-Point Assessment report.

Exhibit III.2: Population Definitions and Associated Quantitative Metrics

Population	Population Definition	Quantitative Metrics
Demonstration Population	All Medicaid eligible recipients who received health care services (inpatient and/or outpatient) with at least one claim that was not paid by third-party and having any MH related diagnosis in the primary position regardless of their delivery system (e.g., managed care or FFS).	• All CMS constructed utilization metrics in monitoring report (13-18, 19a, 19b, 20, 21, 22)

Population for Established Quality Measures	• Metrics 2, 29, and 30 are based on claims for antipsychotic medications. • Metric 4 uses a list of psychiatric disorders and dementia diagnoses. • Metric 6 uses a principal diagnosis of major depressive disorder, schizophrenia, or bipolar disorder. • Metrics 7, 8, and 10 are based on claims with principal diagnoses of mental illness and intentional self-harm. • Metric 9 uses alcohol use disorder abuse or dependence diagnoses. • Metric 23 uses the NCQA SMI definition. • Metric 26 uses any diagnosis placement of a MH diagnosis.	• 2, 4, 6-10, 23, 26, 29, 30
State-Specific SMI Population	All Medicaid eligible recipients who received health care services (inpatient and/or outpatient) with at least one claim that was not paid by third-party and having any of the four SMI related diagnosis in the primary or secondary position regardless of their delivery system (e.g., managed care or FFS).	• Monitoring Report Utilization metrics (13-18, 21, 22) state-specific subpopulation • ALOS for all inpatient, ED visits (with and without age 21-64 restriction)
State-Specific SMI/SED Population	All Medicaid eligible recipients who received health care services (inpatient and/or outpatient) with at least one claim that was not paid by third-party and having any SMI/SED diagnosis in the primary and secondary position regardless of their delivery system (e.g., managed care or FFS).	• Provider Availability Assessment • Monitoring Report Utilization metric (21, 22) demonstration populations & subpopulations

Recipients were identified for inclusion in the analytic population based on their date of service received during the month with appropriate Medicaid benefit coverage containing an SMI diagnosis between 2021 and 2022. The target population for metric calculation was based on the measurement period. For metrics calculated quarterly (or annually), the analytic population consisted of all individuals who had relevant claims (with MH or SMI/SED or other) diagnosis in the measurement quarter (or year) and were eligible for Medicaid benefits relevant to the SMI waiver.

3. Analytic Approach

a. Population Description and Utilization of Health Care Services

Descriptive statistics (e.g., total count, average) for utilization metrics reported in the monitoring report (**Exhibit III.3**) were used to determine the volume of the population covered by the waiver during the analytic time frame. Additionally, trend charts were used to visualize study changes over time (monthly or annual).

Exhibit III.3: List of Monitoring Report Utilization Metrics

Metric #	Metric Name	Indiana Reporting	Demonstration	Standardized	State-Specific
13	MH Services Utilization – Inpatient	Y	Y	Y	Y

14	MH Services Utilization – Intensive Outpatient and Partial Hospitalization	Y	Y	Y	Y
15	MH Services Utilization – Outpatient	Y	Y	Y	Y
16	MH Services Utilization – ED	Y	Y	Y	Y
17	MH Services Utilization – Telehealth	Y	Y	Y	Y
18	MH Services Utilization – Any Services	Y	Y	Y	Y

b. State's Capacity to Provide SMI/SED Services

FSSA conducts an annual Provider Availability Assessment to determine provider shortages. When provider shortages are identified, Indiana intensifies recruiting efforts to increase workforce capacity within counties and across the state. Recruiting efforts are intensified in counties that are identified as having shortages. Annual Provider Availability Assessment data was used to examine provider capacity.[32] For each provider type, the count of Medicaid-enrolled providers for 2020, 2021, and 2022 were identified. However, several provider types had discrepant or unavailable data for a given year (or multiple years). Only data that was validated by the state was included in the analysis. **Exhibit III.4** presents the provider type, assessment unit, and any relevant data limitations.

Exhibit III.4. Provider Type, Assessment Unit and Data Limitations

Type of Provider	Assessment Unit	Data Limitations
Practitioners	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications.	Data was not available for all three years.
	Other Practitioners Certified and Licensed to Independently Treat Mental Illness.	Data was not available for all three years.
CMHCs	Sites/locations providing outpatient mental health services, 24-hour emergency care services, day treatment, screenings, and consultation and educational services, as defined at 42 CFR §410.2.	None.
Intensive Outpatient Services	Distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting.	None.
Residential MH Treatment	Residential MH Treatment Facilities.	Data was not available for 2020.
Inpatient	Public and Private Psychiatric Hospitals.	None.
	Psychiatric Units at general hospital that provides inpatient MH services and has specifically allocated staff and space (beds) for the treatment of persons with mental illness, as defined for SAMHSA's National Mental Health Services Survey (N-MHSS).	Data was not available for all three years.

[32] The Provider Availability Assessment data is compiled at the county level and does not account for an individual provider delivering care across multiple counties.

Type of Provider	Assessment Unit	Data Limitations
	Psychiatric Beds: defined by state licensure requirements.	Only the 2022 counts could be validated by Indiana Department of Health (IDOH). Did not report data for 2020 and 2021.
IMDs	Residential Treatment Facilities That Qualify as IMDs.	There were no residential treatment facilities that qualify as IMDs in the state.
	Psychiatric Hospitals That Qualify as IMDs.	None.
Crisis Stabilization Services	• Crisis Call Centers • Mobile Crisis Units • Crisis Observation/Assessment Centers • CSUs • Number of Providers providing crisis stabilization services (based on H2011 procedure code)	• Validated data was not available for crisis call centers (2020, 2021) and crisis observation/assessment centers (2021). • Data was aggregated for the two-year waiver period (2021, 2022). Hence, any change of the capacity could not be examined.
Federally Qualified Health Centers (FQHC)	Entities that have entered into an agreement with CMS to meet Medicare program requirements under 42 CFR §405.2434 and 42 CFR §405.2401, typically serving underserved area (or population) providing comprehensive on-site (or by arrangement with another provider) services (e.g., preventative health, dental, mental health, substance abuse, and transportation)	None.

c. Supplemental Analyses

Access, quality, and satisfaction of MH care was also examined using MHSIP Survey Report findings. The MHSIP survey captures beneficiary responses across seven performance domains: patient satisfaction, access to services, service quality, health outcomes, treatment planning, individual functioning, and social connectedness. Each domain included multiple questions with a 5-level Likert scale response option (Strongly Agree = 1, Agree = 2, Neither Agree or Disagree = 3, Disagree = 4, Strongly Disagree = 5). Responses across multiple questions were summarized into single composite score for each domain. A mean score of less than 2.5 was defined as a positive score. For each domain, the percentage of respondents with a positive response (or satisfied) was calculated as the proportion of respondents with a composite score less than 2.5 among those with a complete response. The report included results for five years (2018 to 2022). For the Mid-Point Assessment, summary findings for each domain were extracted from the prepared report for the three years (2020-2022).

C. Risk Assessment

To assess the states' progress in achieving demonstration milestones, monitoring metrics were used to calculate the absolute and percent change between the baseline (CY2020) and mid-point (CY2022) reporting periods for each metric. The formulas used to calculate absolute and percent change are as follows:

$$Absolute\ Change = \text{Value of metric in CY2022} - \text{Value of metric in CY2020}$$

$$Percent\ Change = \frac{\text{Value of metric in CY2022} - \text{Value of metric in CY2020}}{\text{Value of metric in CY2020}}$$

The approach delineated below (based on CMS guidance) was applied to examine change over time (and directionality of change):

- **Step 1**: Calculated the change between CY2020 and CY2022 (absolute and percent) for each metric. Calculated the annual averages for metrics calculated monthly or quarterly.
- **Step 2**: Created a flag to determine the change in direction:
    - Increase: If the percent change in a metric was 2% and above.
    - Neutral: If the percent change was less than 2% and more than between –2% and 2%.
    - Decrease: If the percent change was –2% and below.
- **Step 3**: Compared observed change to the expected change (determined by state in the monitoring protocol).
- **Step 4**: Calculated the proportion of monitoring metric goals met (i.e., change in the expected direction) to assess risk. **Exhibit III.5** summarizes the critical monitoring metrics used to calculate Indiana's risk for achieving metric goals. Only metrics that focused on Medicaid beneficiaries between the ages of 21 and 64 were included in the risk assessment to ensure consistency with the IN SMI Evaluation Plan. Additionally, metric # 9 was excluded from the risk assessment calculation as its metric specifications focused on individuals with a primary condition of SUD rather than SMI. FSSA confirmed this approach with CMS on January 10, 2024. All annual metrics reported were analyzed.

Exhibit III.5. Metrics Included in the Mid-Point Assessment Report Versus the Metrics Included in the Risk Assessment Calculation

Milestone	Metrics Included in the Mid-Point Assessment	Critical Metrics Included in the Risk Assessment
1	2	N/A
2	4, 6, 7, 8, 9, 10	4, 8. 7-day rate*, 10. 7-day rate, 10. 30-day rate**
3	19a, 19b, 20	19b. average length of stay in IMDs (IMDs receiving FFP only) ***
4	21****, 22, 23, 26, 29, 30	23, 26, 30

*Metric 8: Although the state implementation plan emphasizes a 72-hour follow-up after hospitalization for mental illness, Metric 8 assesses 7-day follow up after hospitalization for mental illness (in alignment with the standardized HEDIS measure definition).

**Metric 10: Both 7-day and 30-day follow-up after ED visit for mental illness was included to examine metric #10.

***Metric #19b is ALOS in IMDs that receive FFP and were covered by the waiver, while Metric #19a is ALOS for all IMDs. Therefore, #19b is used for risk assessment.

****Metric 21 is a monthly metric, and its annual average was used in the analysis.

- **Step 5**: Determined overall risk. State progress (i.e., moving in the expected direction relative to its annual goals for each milestone) was calculated using the percent of critical metrics (See Step 4) in combination with the percent of action items completed, stakeholder themes, and potential risks for impacting success in achieving milestones. The criteria listed below (in alignment with CMS guidance) were used to make final determinations for overall risk for each milestone.
    - **Low** - For all or nearly all the critical metrics (e.g., 75 percent or more), the state is moving in the direction expected according to its annual goals and overall demonstration targets. The state has fully completed most/all associated action items as scheduled to date. Few stakeholders identified risks related to meeting the milestone, and the risks identified can easily be addressed within the planned timeframe.
    - **Medium** - The state is moving in the expected direction relative to its annual goals and overall demonstration targets for some (e.g., 25-75 percent) of the critical metrics and additional monitoring metrics that the state reported for additional context. The state fully completed some of the associated action items as scheduled. Multiple stakeholders identified risks that could cause challenges in meeting the milestone.
    - **High** - The state is moving in the expected direction relative to its annual goals and overall demonstration targets for few (e.g., less than 25 percent) of the critical metrics and additional monitoring metrics that the state reported for additional context. The state fully completed few or none of the associated action items as scheduled. Stakeholders identified significant risks to meeting the milestone.

D. Limitations

The 2021-2025 SMI Evaluation Plan describes the limitations of the overall evaluation including data and methodological challenges of the analyses for subsequent reports. The PHE caused substantial changes to service utilization and provider availability in 2020 as well as the study time-period (CY2021 – CY2022) and will have short- and long-term impacts on Indiana's health care system. For example, due to the PHE, Indiana suspended policies regarding disenrollment of recipients and expanded behavioral health telehealth services.[33] Additionally, social distancing and prioritization of health care resources affected utilization of a wide variety of services during the evaluation period.

Exhibit III.6 describes the known limitations of the Mid-Point Assessment and approaches to minimize those limitations and/or acknowledgement of where limitations may preclude casual inferences about the effects of the demonstration.

Exhibit III.6: Methodological Limitations and Approach(es) Used to Minimize Limitations

Issue	Description	Approach to Minimizing Limitations
Impact of COVID-19 PHE	The assessment examines the impact of Indiana's Section 1115 SMI/SED Demonstration Implementation Plan and compares pre-waiver (i.e., baseline) to mid-point. Pre-waiver (CY 2020) coincides with the start of the COVID-19 PHE. The PHE was in place for the entire waiver Mid-Point Assessment study period (CY2021 – CY2023) and impacts: service utilization, Medicaid enrollment, and provider networks.	Provided context for interpretation of results.
Distinguishing the impacts of overlapping initiatives	Multiple policy changes were implemented concurrent to the evaluation period. As such, distinguishing the impacts of the individual action items becomes challenging.	Provided context for interpretation of results.
Limited number of quantitative measures to assess risk for implementation plan activities	Metrics to measure progress over time are available for a limited number of action items identified in Indiana's Section 1115 SMI/SED Demonstration Implementation Plan.	Reported all available and relevant metrics. Where feasible, identified additional data sources (e.g., MHSIP survey for milestone 1, number of providers providing crisis stabilization services using claims data, qualitative interviews) to supplement metrics and assess risk for implementation action items.
Risk assessment does not reflect all impact and changes due to the SMI waiver on the population covered by the waiver	State leverages HEDIS and other standardized measures (e.g., Follow-Up After Emergency Department Visit for Mental Illness [FUM]) where feasible. Depending on measure specifications, the population covered varies across the calculated metrics (e.g., FUM metrics are calculated for Medicaid beneficiaries aged 18 or older and with mental illness, ALOS metrics calculated for beneficiaries with SMI).	Included measure details in findings section for ease of interpretation.

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

Issue	Description	Approach to Minimizing Limitations
Self-reported qualitative data	Key informant interviews represent qualitative feedback from multiple stakeholders including FSSA state officials, MCE executives, providers, advocacy organizations, and members. This self-reported information requires participants to recall information at a point in time (CY2021 – CY2022) and may not capture all experiences.	• Tailored interview questions based on role and type of interview. • Emphasized the time period in both stakeholder communication materials of interview instructions to help interviewees prepare for interviews.
Impact of changes in population over time	Changes in the SMI recipient composition over time may have an impact on a variety of areas of this assessment, including service utilization, member enrollment, and access to services.	Provided context for interpretation of results.
Identification of population for assessment	Technical specifications for monitoring metrics defined the population using the diagnosis captured during beneficiary utilization of health care service(s). Consequently, Medicaid beneficiaries who did not have a health care service but may have a MH condition and need MH services are not captured in the analyses.	For population and monitoring metrics, used the annual demonstration population that is identified based on 12 months of claims and prevalence of any MH diagnosis for at least one claim during the time frame.
Availability of data elements to calculate measure specifications	Calculation and analyses of metric 23 is restricted due to unavailability of required data elements (systemic use of CAT II codes in claims) for the measure.	Provided context for interpretation and use of the measure.
Comprehensive assessment of provider availability and changes over time	Provider availability data was not available across all years for all provider types identified as key for this assessment. Additionally, parameters in how providers were counted varied across the years.	Reported all available and state validated data. Identified gaps and recommendations for future monitoring.

IV. Findings

This section presents the integrated qualitative and quantitative findings. This section is organized as follows:

A. Population Description and Utilization

B. Progress Towards Completing Milestone Action Items in the Implementation Protocol

C. Progress Towards Completing HIT Action Items in the Implementation Protocol

D. Progress in Achieving Milestones

E. State's Capacity to Provide SMI Services

A. Population Description and Utilization

Metrics #21 (monthly) and 22 (annual) provide the count of beneficiaries from 2020 to 2022 (baseline to waiver midpoint). The beneficiaries were identified based on prevalence of relevant MH diagnosis from claims (or utilization) data (refer to **Attachment D** for details). To examine utilization trends, CMS guidance identified 6 metrics (metric #13: MH Services Utilization – Inpatient, metric #14: MH Services Utilization – Intensive Outpatient and Partial Hospitalization, metric #15: MH Services Utilization – Outpatient, metric #16: MH Services Utilization – ED, Metric #17: MH Services Utilization – Telehealth, metric #18: MH Services Utilization – Any Services). Claims and enrollment data were used to calculate the number (and average length) of inpatient stays and the number of beneficiaries having ED visits (for any reason) to further supplement and contextualize utilization. The population size is presented for three different populations (discussed in **Exhibit III.2** and **Exhibit I.3**): demonstration, SMI/SED, and state-specific SMI. Monitoring metrics used for this assessment are primarily based on a sub-population of the demonstration population (varying based metric). This is in contrast with the analytic population defined by the 2021-2025 Evaluation Plan which is the state-specific SMI population age 21-64. Consequently, analyses focused on utilization of mental health services among demonstration and state-specific SMI population (monitoring report does not include data for state-specific SMI age 21-64).

1. Population

The number of beneficiaries increased from baseline (2020) to the waiver mid-point (**Exhibits IV.1** and **IV.2**) for the demonstration and state-specific SMI populations (refer to **Exhibit I.3** for detailed specification). Relative to baseline (2020), the average annual and monthly populations were higher during the waiver period (annual: 15% higher in 2022 for demonstration, 23% higher for state-specific SMI). Although there was a gradual increase across the months, the rate of growth in population between 2021 and 2022 was lower relative to growth between 2020 and 2021. In 2020 (baseline year), the number of beneficiaries decreased between January and April and then steadily increased starting in May. During 2021-2022, the number of beneficiaries was highest in March and lowest in July. Given that the demonstration and state-specific definition restrict to individuals with a health service claim, findings also reflect health care service

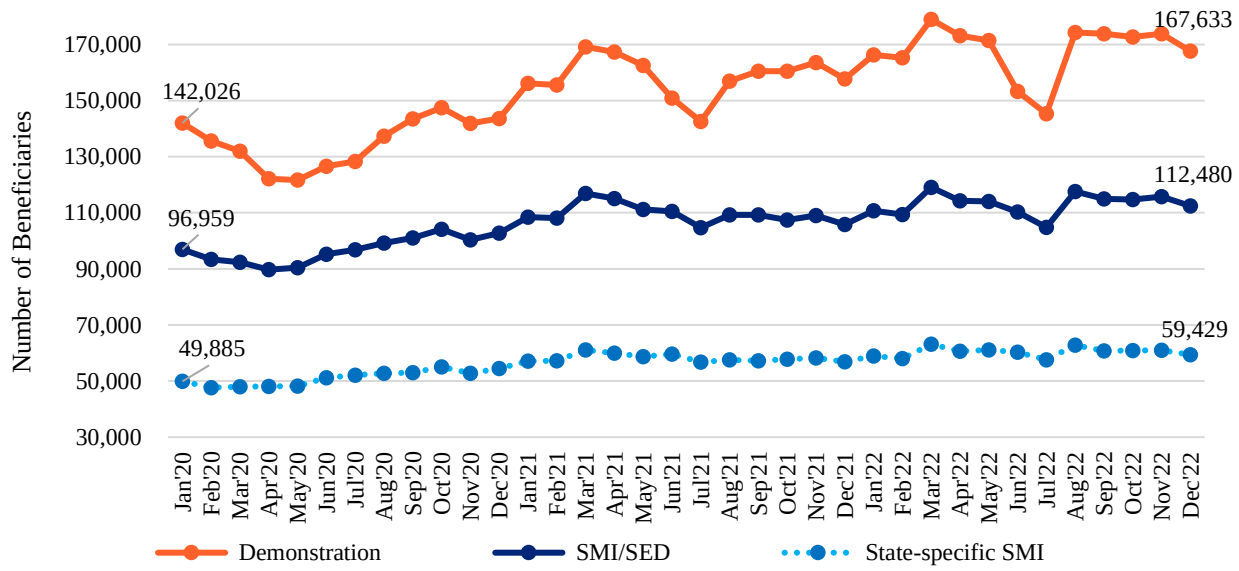
utilization and suggest that the population growth aligns with an increase in access to care (consistent with the state's goal). However, it should be noted that given the social distancing and health care resource prioritization required in response to the PHE, health care service access and utilization was low in 2020. Consequently, the observed growth between 2020 and 2021 may be a result of PHE restrictions being relaxed rather than state implementation actions.

Exhibit IV.1 Annual Count of Beneficiaries, 2020-2022 (Metric # 22)

Year	Population			Percent Change (Relative to 2020)		
	Demonstration	SMI/SED	State-Specific SMI	Demonstration	SMI / SED	State-Specific SMI
2020	361,720	266,256	136,335			
2021	417,286	300,734	157,769	15.4%	12.9%	15.7%
2022	444,028	306,730	168,546	22.8%	15.2%	23.6%

Source: Monitoring Report Data for Demonstration and state-specific SMI population.

Exhibit IV.2 Monthly Count of Beneficiaries in the Demonstration, SMI/SED and State-Specific SMI Population, 2020-2022 (Metric # 21)



Notes: **Demonstration**: All Medicaid eligible recipients who received health care services (inpatient and/or outpatient) with at least one claim that was not paid by third-party and having any MH related diagnosis in the primary position regardless of their delivery system (e.g., managed care or FFS). Monitoring report metric 21 reports state-specific SMI/SED population for the demonstration population. Lewin calculated the demonstration population using the definition outlined in Exhibits I.3 and III.2 and claims and enrollment data. **State-Specific SMI**: All Medicaid eligible recipients who received health care services (inpatient and/or outpatient) with at least one claim that was not paid by third-party and having any of the four SMI related diagnosis in the primary or secondary position regardless of their delivery system (e.g., managed care or FFS).

2. MH Service Utilization

Monitoring metrics 13-17 were used to examine health care utilization among beneficiaries who used inpatient, intensive outpatient, outpatient, ED services provided by MH provider, telehealth services, and/or had partial hospitalization related to a MH condition during the measurement period (refer to **Attachment D** for metric specifications). Metric 18 presents the number of

beneficiaries who had at least one of the services identified by metrics 13-17. Data for these metrics were available and examined at the monthly level.

Between 2020 (baseline) and 2021 (first year of current waiver assessment period) the average count of beneficiaries using MH services in a month increased by approximately 12% among the demonstration population and 6% among the state-specific SMI (**Exhibits IV.3**). In 2022, the proportion of beneficiaries utilizing MH services remained relatively stable for the demonstration population (0.2% increase between 2021 and 2022) while it decreased slightly for the state-specific SMI population.

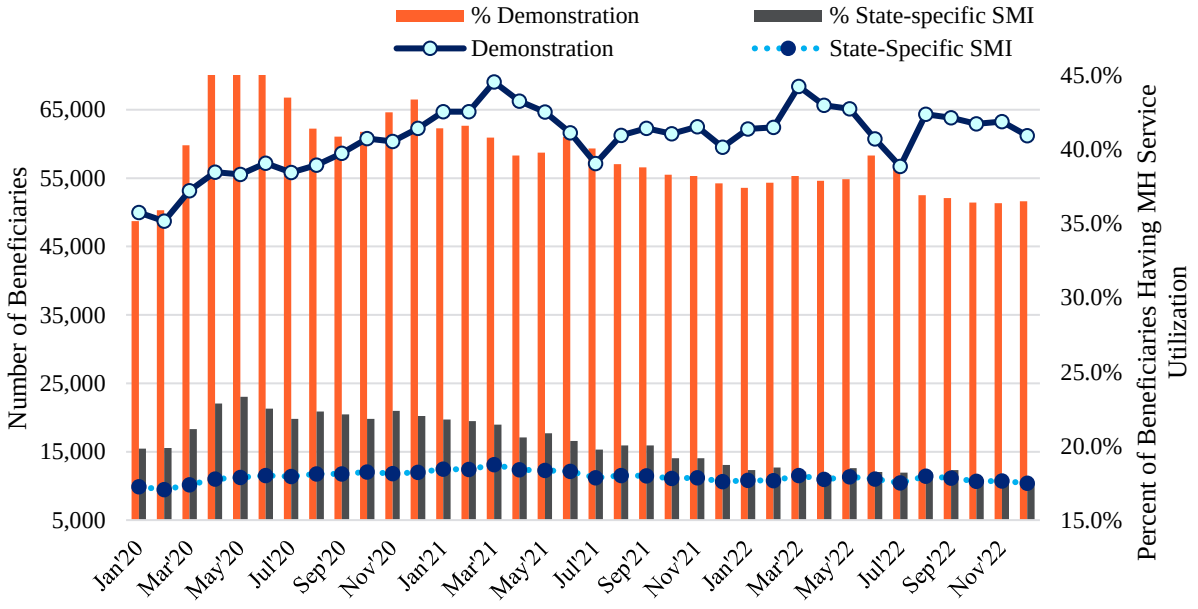
Exhibit IV.3 Average Count of Beneficiaries per Month in the Demonstration and State-Specific SMI Populations Who Used any Services Related to MH, Annual, 2020-2022 (Derived from Metric #18)

Year	Number of Beneficiaries (% of Population)		Percent Growth (Relative to 2020)	
	Demonstration	State-Specific SMI	Demonstration	State-Specific SMI
2020	56,274 (15.6%)	11,163		
2021	62,938 (15.1%)	11,812	11.8%	5.8%
2022	63,067 (14.2%)	10,936	12.1%	-2.0%

Source: Monitoring Report Data.

Monthly, between 35% - 45% of the demonstration population and 17% - 25% of the state-specific SMI population utilized any of the identified services (metric #18, **Exhibit IV.4**). In 2020, the number of beneficiaries utilizing services increased significantly (approximately 20% higher in December compared to January). This increase is likely explained by the expansion of telehealth (**Section IV.D**) as a strategy to increase access to care during the PHE. Between 2021 and 2022, the number of beneficiaries utilizing identified MH services varied across months (between 57,000 to 69,000 for demonstration population and 11,000 – 13,000 for state-specific SMI population) with the highest counts in March and lowest counts in July. This trend differs from the population trend in which the highest population counts for 2021 and 2022 were in July of each year. The difference in trends suggests that although the number of beneficiaries with MH diagnoses was higher in July, fewer used MH services during that time period.

Exhibit IV.4 Count and Percent of Beneficiaries in the Demonstration and State-Specific SMI Populations Who Used any Services Related to MH, by Month, 2020-2022 (Metric # 18)



Source: Monitoring Report Data. Percent was calculated as metric 18 counts divided by count for the relevant population.

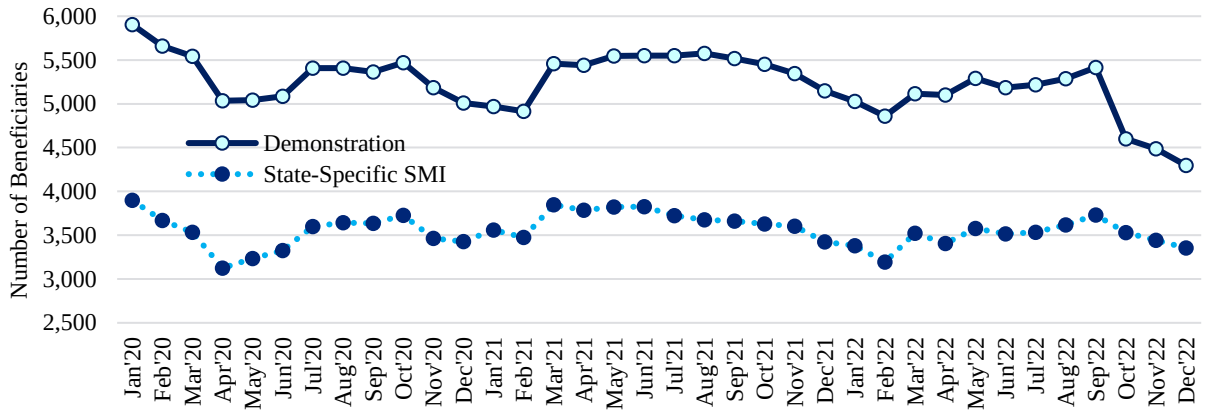
The trends in service utilization varied by type of services. **Exhibits IV.5** to **IV.11** present monthly counts of beneficiaries by the identified service types.

Inpatient (Metric #13, Exhibits IV.5 and **IV.6)**: The number (and proportion) of beneficiaries with a MH related inpatient stay decreased between 2020 (baseline) and 2022 for the demonstration and slightly for state-specific SMI population. For the demonstration population, the average number of beneficiaries who had a MH related inpatient stay in a month decreased by 6.6% (from 5,343 in 2020 to 4,990 in 2022) and 1.1% for state-specific SMI population (from 3,524 in 2020 to 3,484 in 2022). At the start of the baseline (2020) on average 4.2% of the demonstration and 7.8% of state-specific SMI population in a month had a MH related inpatient stay. The proportion of beneficiaries having a MH related inpatient stay continued to decline across months through the last quarter of 2022 (2.6% for demonstration population, 5.8% for state-specific SMI). Declines in the proportion of MH related inpatient stays can be explained by both an increased population size and decrease in service use.

Lewin calculated the number of stays and ALOS using claims and enrollment data to further supplement findings (**Exhibit IV.6**). For each population, inpatient utilization was identified based on claim type, and inpatient stays related to MH was identified based on prevalence of a MH diagnosis for an inpatient stay (refer to **Attachment D** for additional details on calculating the ALOS). The number of patients with an inpatient stay and the number of inpatient stays (both for any type of inpatient stay and related to MH) increased between 2020 and 2021, and then decreased in 2022. The lower counts in 2020 may be explained by the PHE related restrictions and subsequent increase related to the relaxation of those same restrictions in 2021 (expanding access

to care). For any inpatient stay ALOS increased slightly across the years while for inpatient stays related to MH, the ALOS decreased (refer **Exhibit IV.6** for details).

Exhibit IV.5 Number of Beneficiaries Who Used Inpatient Services Related to MH, by Month, 2020-2022 (Metric # 13)



Source: Monitoring Report Data.

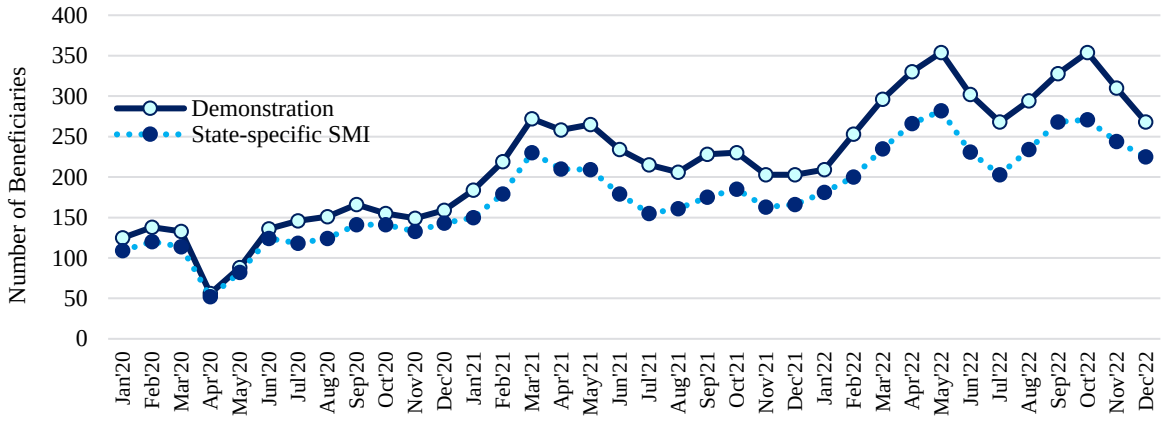
Exhibit IV.6 Number of Inpatient Stays and Average Length of Stay (ALOS), Annual, 2020-2022

Population	Type of Inpatient Stay	# of Beneficiaries			# of Stays			Average Length of Stay		
		2020	2021	2022	2020	2021	2022	2020	2021	2022
Demonstration	Any	31,788	35,773	30,360	46,598	52,760	44,843	7.4	7.5	7.7
	Related to mental health	14,215	15,405	13,519	19,122	20,949	18,701	8.7	8.7	8.7
State-Specific SMI	Any	21,619	23,982	20,615	32,253	37,376	32,001	7.6	7.6	7.7
	Related to mental health	12,031	13,249	11,769	16,688	18,551	16,753	8.7	8.6	8.5

Source: Enrollment and Claims Data.
Note: Refer to **Exhibits IV.1** and **IV.2** for each population size. During a measurement period (calendar year for this exhibit), beneficiaries can have only outpatient visits related to mental health and no inpatient stays or inpatient stays without any mental health diagnosis.

Outpatient and/or partial hospitalization services (Metric #14, Exhibit IV.7): Monthly, few beneficiaries (n = < 500 beneficiaries; less than 1% of the population) received intensive outpatient services or had partial hospitalization services. Although the total counts (and proportion) were small, the number of beneficiaries receiving these services increased over time. In 2021 and 2022, approximately twice the number of beneficiaries (monthly average 226 and 297 respectively for demonstration population) utilized these services compared to 2020 (monthly average - 130).

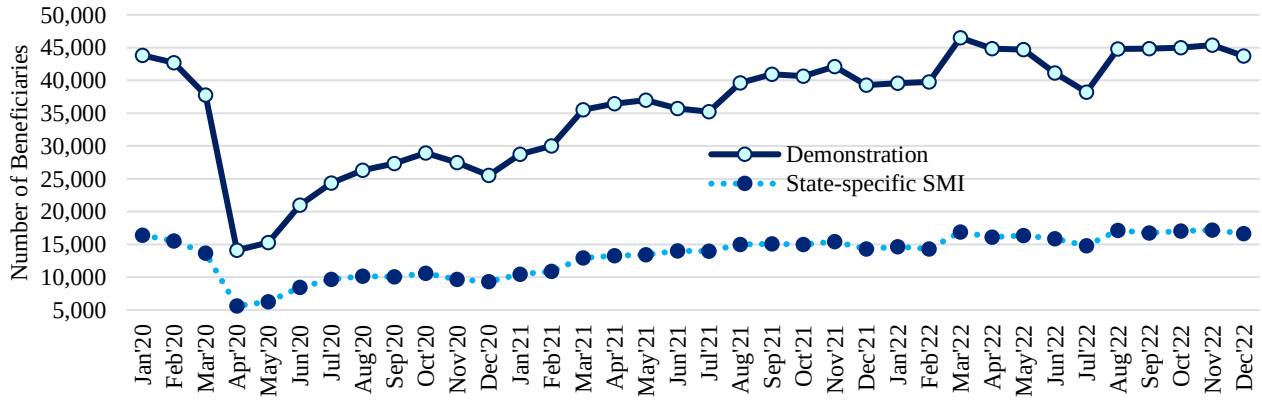
Exhibit IV.7 Number of Beneficiaries Who Used Intensive Outpatient and/or Partial Hospitalization Services Related to MH, by Month, 2020-2022 (Metric # 14)



Source: Monitoring Report Data.

Outpatient services (Metric #15, Exhibit IV.8): Monthly, the number of beneficiaries receiving outpatient services decreased significantly in April 2020 (as expected) as it coincided with onset of social distancing restrictions and health care resource prioritization in response to the PHE. However, over time, the number of beneficiaries receiving outpatient services increased and in 2022 were at similar counts to pre-pandemic levels.

Exhibit IV.8 Number of Beneficiaries Who used Outpatient Services Related to MH, by Month, 2020-2022 (Metric #15)



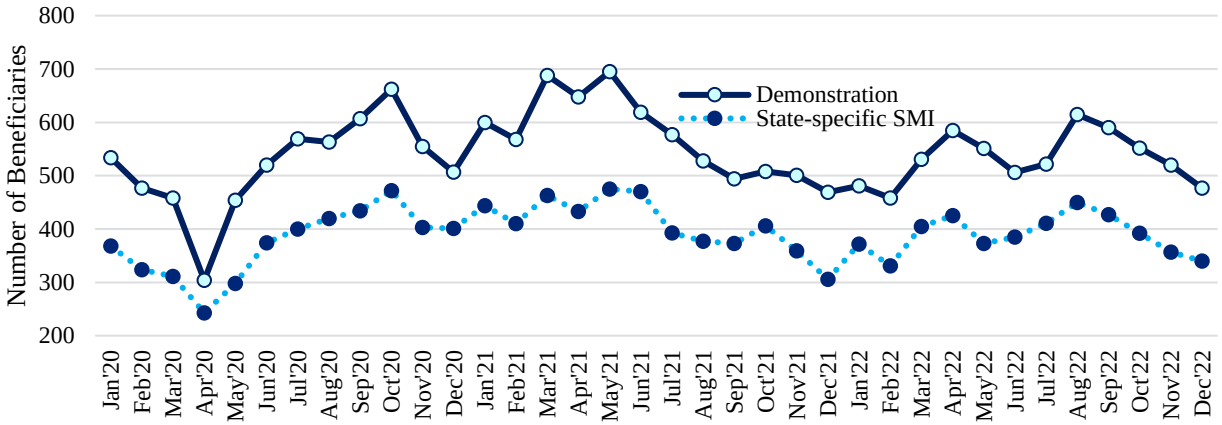
Source: Monitoring Report Data.

MH related ED services[34] (Metric #16, Exhibit IV.9): Based on the monthly average, less than 1% of beneficiaries (less than 1,000 among demonstration population beneficiaries and less than 500 among state-specific SMI population) used ED services for a MH condition. The number of

[34] Metric #16 calculates ED visits based on three types of claims: 1) for claims with ED visit setting, identify claims billed by a MH provider, 2) for claims with unspecified setting, use ED place of service, and 3) for CMHC place of service, identify ED visits based on procedure code H2011.

beneficiaries who used ED services increased between May 2020 and May 2021. Starting in June 2021, ED use declined and returned to pre-pandemic levels.

Exhibit IV.9 Number of Beneficiaries Who Used ED Services Related to MH conditions, by Month, 2020-2022 (Metric # 16)



Source: Monitoring Report Data.

Utilization of ED services (All Cause, Exhibit IV.10): One of the goals of the waiver is to reduce utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED. For this report, the number of beneficiaries with an ED visit(s) (due to any reason) as well as the total number of visits were calculated for the two populations: demonstration and state-specific SMI (refer **Exhibit IV.1** and **IV.2** for population size and **Attachment D** for specifications on calculation). For the demonstration population, the number of beneficiaries and the proportion of the population who used ED services increased across the years (from 149,000 beneficiaries (41.3%) in 2020 to 196,000 beneficiaries (44.2%) in 2022). Although the ED visits per beneficiary was higher in 2022 relative to 2020, it was lower compared to 2021 (2020: 1,127; 2021: 1,174; 2022: 1,152). For the state-specific SMI population, the number of beneficiaries using ED services increased over time. However, the percentage of the population fluctuated – increased from 2020 to 2021 (52.9% to 54.3%) and then decreased in 2022 (53.5%). The number of ED visits per beneficiary decreased over time (from 1,738 per '1000 in 2020 to 1,659 per '1000 in 2022). This trajectory is in alignment with state goals.

Exhibit IV.10 Number of Beneficiaries Who Used ED Services (All Cause), Annual, 2020-2022

Population	Metric	Year		
		2020	2021	2022
Demonstration	# of Beneficiaries who used ED services	149,323	181,899	196,205
	# of ED visits	383,240	473,317	498,231
	ED visits per 1,000	1,127	1,174	1,152
State-Specific SMI	# of Beneficiaries who used ED services	72,155	85,642	90,173
	# of ED visits	219,416	261,938	270,545

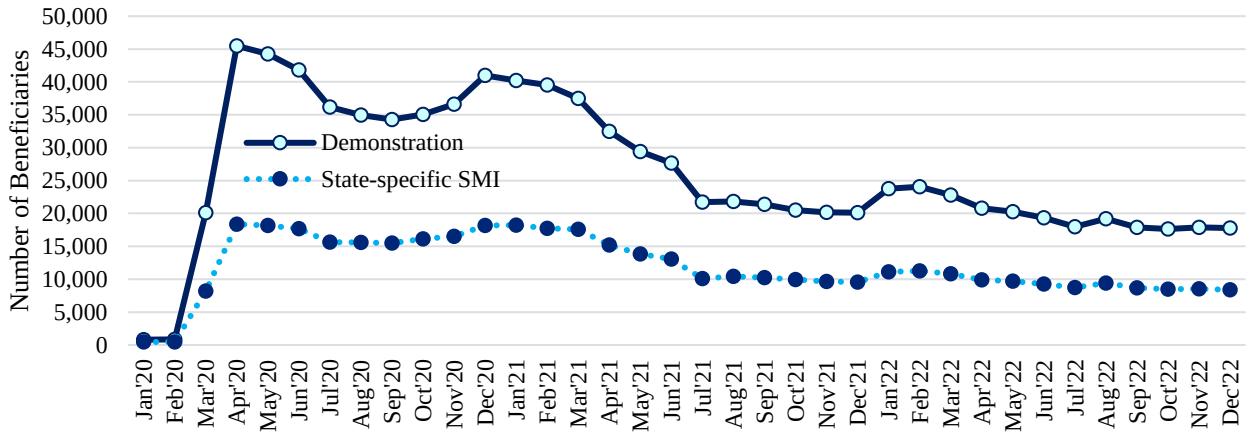
Population	Metric	Year		
		2020	2021	2022
	ED visits per 1,000	1,738	1,731	1,659

Source: Enrollment and Claims.

Note: This table captures utilization of ED services among the three different populations - irrespective of the type of provider or the reason for the visit (i.e., it also identifies use of ED for non-MH related services).

Telehealth services (Metric #17, Exhibit IV.11): Less than 1,000 beneficiaries used telehealth services prior to the COVID-19 pandemic. However, during the early months of the PHE (2020), utilization of telehealth services increased dramatically (March - approximately 20,000 or 22% of demonstration population; April - approximately 45,000 or 51% of the demonstration population). As social distancing restrictions relaxed and in-person service options increased, the number of beneficiaries who utilized MH related telehealth services decreased. However, it should be noted that telehealth continues to be used by almost a quarter of the population (approximately 22%) in 2022. See **Section IV.D** for additional findings on telehealth.

Exhibit IV.11 Number of Beneficiaries Who Used Telehealth Services Related to MH, by Month, 2020-2022 (Metric # 17)



Source: Monitoring Report Data.

Comparing across the different services, the effect of the PHE (restrictions on access and availability of in person services) likely explains the trends, with individuals use of in-person services decreasing during the early months of 2020 while telehealth services increased. In contrast, as restrictions relaxed, in-person services began to increase while telehealth services started to decrease.

B. Progress Towards Completing Milestone Action Items in the Implementation Protocol

Indiana identified 23 action items in its SMI implementation plan for milestones 1-4. Overall, the state implemented 20 of the 23 action items (Note. Action items are counted as complete if a distinct action was completed either prior to the demonstration, during the assessment time frame, post assessment time frame, or partially completed). This section describes the state's progress in

implementing the action items. Action items were defined as partially completed, if either the action was started during the Mid-Point Assessment time frame or components of the action were completed.

- **Milestone 1** (Ensuring quality of care in psychiatric hospitals and residential settings) has 10 distinct actions. Of these, 7 were completed prior to the demonstration, 1 was completed during the assessment time frame, 1 was completed post assessment time frame, 1 was partially completed, and 0 were suspended.
- **Milestone 2** (Improving care coordination and transitioning to community-based care) has 4 distinct actions. Of these, 1 was completed prior to the demonstration, 0 were completed during the assessment time frame, 2 were completed post assessment time frame, 1 was partially completed, and 0 were suspended.
- **Milestone 3** (Increasing access to the continuum of care, including crisis stabilization services) has 3 distinct actions. Of these, 2 were completed prior to the demonstration, 0 were completed during the assessment time frame, 0 were completed post assessment time frame, 0 were partially completed, and 1 was suspended.
- **Milestone 4** (Earlier identification and engagement in treatment, including through increased integration) has 3 distinct actions. Of these, 1 was completed prior to the demonstration, 1 was completed during the assessment time frame, 0 were completed post assessment time frame, 0 were partially completed, and 1 was suspended.
- 3 action items overlap milestones. Of these, 0 were completed prior to the demonstration, 2 were completed during the assessment time frame, 0 were partially completed, 0 were completed post assessment time frame, and 1 was suspended.

Exhibit IV.12 provides a summary of the action items completed to date as well as next steps envisioned for the larger demonstration time-period (i.e., through 2025).

Exhibit IV.12: Indiana SMI Demonstration Implementation Plan: Status of Action Items Completed Across Milestones 1 - 4

Milestone(s)	Implementation Plan - General Description	Action Item - Specific Description	Implementation Date	Current Status	Next Steps
1	Assure that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide MH treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.	Continued maintenance of licensure among PMHI.	N/A	Completed, Prior to Demonstration Time-Period	State to continue operations.
	Provide oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements.	Conduct annual unannounced site visits of each PMHI.	N/A	Completed, Prior to Demonstration Time-Period. (Note: During the PHE, the site visit protocols were modified to only focus on open Corrective Action Plan (CAP) items)	State to continue operations.
	Utilize review process to ensure beneficiaries have access to the appropriate levels, types of care and lengths of stay.	Develop a report to monitor ALOS for all Medicaid programs.	Jan-2020	Completed, Partially	Since 2020, MCEs have reported ALOS, as it is required in their contracts, as well as quarterly reports with LOS data. Although state officials indicated that they had not yet developed a report to monitor the average LOS for all Medicaid programs, they stated that they internally review average LOS for all IMDs that receive federal match and report this information in quarterly SMI waiver demonstration monitoring reports. In 2023, the state released a new version of the ALOS report for inclusion in the MCE quarterly reports to more accurately collect the data as specified by the STCs.

Milestone(s)	Implementation Plan - General Description	Action Item - Specific Description	Implementation Date	Current Status	Next Steps
1 (continued)	Utilize review process to ensure beneficiaries have access to the appropriate levels, types of care and lengths of stay. (continued)	Review timeline requirements for submission of the 1261A form.	N/A	Completed, Prior to Demonstration Time-Period	The state discontinued the use of the 1261A form due to administrative burden. Moving forward, the state will use a plan of care instead of the 1261A form.
		OMPP reviews the MCO's UM practices; MCOs to continue to use MCG to complete medical necessity reviews and determine the appropriate level of care/LOS for behavioral health diagnosis.	N/A	Completed, Prior to Demonstration Time-Period	State to continue operations.
	Ensure IMDs comply with program integrity requirements and state compliance assurance process.	Screen and revalidate the IMDs to permit them to contract with Indiana Medicaid.	N/A	Completed, Prior to Demonstration Time-Period	Screening and re-validation occurs every five years.
	Require psychiatric hospitals and residential settings to screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.	Review hospital compliance with required policies and procedures for intake and assessment processes as part of annual unannounced site visits and recertification.	N/A	Completed, Prior to Demonstration Time-Period	Ongoing.
	Implement requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	Conduct the MHSIP for individuals served by DMHA contracted providers.	Jul-2018	Completed, Prior to Demonstration Time-Period	MHSIP conducted annually.
		Conduct annual CAHPS surveys.	Jul-2021	Completed, On-time	CAHPS are conducted annually by the MCEs.

Milestone(s)	Implementation Plan - General Description	Action Item - Specific Description	Implementation Date	Current Status	Next Steps
1 (continued)	Implement requirements/policies to ensure good quality of care in inpatient and residential treatment settings. (continued)	Use findings from MHSIP and CAHPS surveys for quality assurance and improvement activities as needed.	April-2021	Completed, Post Mid-Point Assessment Time Frame	MHSIP findings are reviewed annually.
2	Ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available; Ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge.	Update the Medicaid Provider Manual to include protocols that assess housing insecurity (as part of the social work assessment and discharge planning processes and to refer to appropriate resources; compliance will be monitored via the annual unannounced site visits as part of recertification) and ensure contact is made by the treatment setting with each discharged recipient within 72 hours of discharge and follow-up care is accessed; Communicate updates to providers as needed.	Nov-2019	Completed, Partially	Provider Manual modules are updated on a rolling basis and communicated via bulletins. The next full update will incorporate all requirements outlined in the implementation plan is targeted to occur in CY2024 as part of the Behavioral Health Services module.

Milestone(s)	Implementation Plan - General Description	Action Item - Specific Description	Implementation Date	Current Status	Next Steps
2 (continued)	Ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	Require hospitals to initiate discharge planning at admission.	July 1, 2023	Completed, Post-Mid-Point Assessment	Site visits are conducted annually and assess requirement.
		Involve CMHCs in discharge planning.	July 1, 2023	Completed, Post-Mid-Point Assessment	CMHCs and psychiatric hospitals both participate in the community care rules (CCR) process whenever it is invoked.
		Provide case management services for any member discharged from an inpatient psychiatric or substance abuse hospitalization for at least 90 calendar days following discharge.	2018	Completed, Prior to Demonstration Time-Period	Site visits are conducted annually to assess requirements. Additionally, the state assesses requirements via random onsite visits. The state will update reporting requirements in 2024.
2 & 3	Implement strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI prior to admission; Conduct annual assessments of the availability of MH providers.	Monitor provider network capacity, identify underserved/geographic shortage areas and conduct targeted outreach to non-Medicaid enrolled providers in those areas.	Dec-2021	Completed, On-time	Provider network capacity is monitored annually and used to identify provider deficiencies and build provider recruitment plans.
2, 3, & 4	Implement strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI prior to admission; Conduct annual assessments of the availability of MH providers; Utilize a widely	Increase access and availability of non-hospital, non-residential crisis stabilization services by implementing CSUs.	Jul-2020	Completed, On-time	CSU pilot was completed on June 30, 2022.

Milestone(s)	Implementation Plan - General Description	Action Item - Specific Description	Implementation Date	Current Status	Next Steps
	recognized, publicly available patient assessment tool to determine level of care and LOS: Establish specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI.	Review timeline for a potential MRSS pilot.	N/A	Suspended	The MRSS pilot has been delayed indefinitely, as other initiatives have taken focus.
3	Utilize a widely recognized, publicly available patient assessment tool to determine level of care and LOS.	Ensure every individual served by a DMHA contracted provider receives a CANS/ANSA	N/A	Completed, Prior to Demonstration Time-Period	Ongoing.
	Implement strategies to improve state tracking of availability of inpatient and crisis stabilization beds.	Expand Openbeds contract to include psychiatric bed capacity	Sep-2019	Suspended	State Officials indicated challenges using the OpenBeds software and did not pursue contract renewal in the Fall of 2019.
	Implement strategies to expand Medicaid beneficiary access to behavioral health providers.	Passed House Enrolled Act 1175 and implemented SPA TB 18-103. substance use treatment services.	July-2019	Completed, Prior to Demonstration Time-Period	

Milestone(s)	Implementation Plan - General Description	Action Item - Specific Description	Implementation Date	Current Status	Next Steps
4	Identify strategies for engaging beneficiaries at risk of SMI in treatment sooner, e.g., with supported education and employment.	Engage beneficiaries at risk of SMI in VRS (e.g., SE).	N/A	Completed, Prior to Demonstration Time-Period	VRS, including SE, are available statewide. State to continue operations and expand SE via CMHC vendors.
	Increase integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment.	Ensure financial sustainability of a physical health and behavioral health integration model following the end of the current grant funding.	Dec-19	Suspended	The state did not pursue a health homes SPA and instead focused efforts for behavioral health integration on the roll out of Certified Community Behavioral Health Clinics (CCBHC).
		Submit an application for SAMHSA's (FY) 2020 PIPBHC grant to further sustainability and expansion of the State's model for primary care and behavioral health integration (PCBHI).	March 23, 2021	Completed, on-time	The state applied for and received the PIPBHC grant.

C. Progress Towards Completing HIT Action Items in the Implementation Protocol

Exhibit IV.13 provides a summary of the HIT action items completed to date as well as actions in progress through the demonstration time-period (i.e., through 2025).

Exhibit IV.13: Indiana SMI Demonstration Implementation Plan Status of HIT Action Items Completed

HIT Implementation Actions	Actions In Progress/Completed
Drive improvements for increased electronic documentation and standardization among settings and providers not previously addressed through MU, including behavioral health.	FSSA continues to work toward achievement of the HIT for Economic and Clinical Health goals and objectives under the Medicaid MU.
Update the broader State Medicaid Health IT Plan and align areas of prioritization with waiver milestones as appropriate.	The Implementation Advance Planning Document and SMHP progress on initiatives include: • Continued administration and expansion of HIT- Enabled Community-Wide Approach to Opioid Treatment and the Quality Care for Indiana Medicaid Long-Term Care Patients. • Completed an HIE Assessment/Maturity Model analysis to establish current and target HIE states. • Continued collaboration with Purdue Healthcare Advisors at Purdue University to guide Medicaid eligible, Indiana health care providers toward the promoting interoperability (PI) standards associated with EHR systems. • Continued collaboration with the Indiana DOC to implement HIE and enhance coordination of care for offenders entering and exiting the correction system for the health and success of the person, decreasing duplication of services, and creating efficiency with the Medicaid MCEs.
Review the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B for potential inclusion into our MCO contracts.	The following interoperability standards are included in the MCO contracts: 42 CFR 438.242, 42 CFR 457.1233; 42 CFR 457.760, 42 CFR 438.62, and 42 CFR 438.10, 42 CFR 438.242(b)(5) and 42 CFR 457.1233(d)(2), 42 CFR 438.242(b)(3)(i)-(iii).
Conduct a provider survey to identify the volume of providers utilizing closed loop referrals and e-referrals.	Information for this action item is not currently available.
Determine required steps and timeline for compliance with the CMS Interoperability and Patient Access Final Rule.[35]	Implementation of Patient Access and Provider Directory Application Programming Interface for FFS per the CMS Interoperability and Patient Access Final Rule was completed in 2022. The state will include any remaining requirements from the interoperability and patient access final rule in the next contract amendments.

[35] The CMS Interoperability and Patient Access final rule is intended to move the health care ecosystem in the direction of interoperability by improving the quality and accessibility of information that patients need in order to make informed health care decisions, including data about health care prices and outcomes, while minimizing reporting burdens on impacted providers and payers. (https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and)

HIT Implementation Actions	Actions In Progress/Completed
Submit the health homes SPA which will include leveraging HIT for enhanced integration and coordination.	Although the health homes SPA was suspended indefinitely, the state is leveraging HIT for enhanced integration and coordination via the CCBHC initiative. For example, DMHA collaborated with the Indiana Council of CMHCs to independently review business requirements of the Population Health Management Platform in the context of CCBHC and has aligned the platform with the updated CCBHC clinic and state required quality measures.
Survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.	Information for this action item is not currently available.
Modernize the EHR system used collectively by all state psychiatric hospitals.	Adopted Cerner's Information Technology platform to improve Indiana's network of state psychiatric hospitals and connect other MH providers in the state. Initiated interface development and implementation across the six State Psychiatric Hospitals in 2021.
Continued operation of managing consent/privacy in a multitude of mechanisms across the Medicaid Health Information Sharing Enterprise.	Information for this action item is not currently available.
Continued utilization of the Relias ProAct Tool.	Information for this action item is not currently available.
Continued operation of the Extension for Community Healthcare Outcomes.	Continued to progress

D. Progress in Achieving Milestones

This section integrates the quantitative and qualitative findings for each milestone. Assessment questions provide a framework for contextualizing Indiana's overall progress during CY2021 - CY2022.

1. Milestone 1: Ensuring quality of care in psychiatric hospitals and residential settings

CMS guidance identified two critical SMI monitoring metrics (metric #1: SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Settings and metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics). Indiana does not report metric #1 and consequently it is not included in the Mid-Point Assessment. Metric #2 is included in the Mid-Point Assessment and provides information on the state's progress in meeting its' demonstration target. However, since the scope of the waiver evaluation focuses on adults, ages 21-64, metric #2 was not included in the milestone risk assessment as it exclusively examines a child and adolescent population. In addition to metric #2, milestone 1 Mid-Point Assessment questions draw findings from stakeholder interviews and the MHSIP survey.

Did participating psychiatric hospitals and residential settings maintain appropriate standards of care to ensure quality of care? (Qualitative and MHSIP Findings)

In accordance with Indiana Administrative Code (440 IAC 1.5), all free-standing psychiatric hospitals must be licensed as a PMHI by the Indiana DMHA and renewed annually[36,37]. Additionally, all entities must be accredited by an agency approved by DMHA. State officials confirmed continued maintenance of licensure requirements for PMHIs during CY2021 and CY2022. Additionally, state officials confirmed that annual unannounced site visits for each PMHI are conducted. These visits ensure that PMHIs are compliant with licensure requirements.

In addition to state official interviews, MCEs were asked to discuss strategies for ensuring quality care at inpatient and residential facilities. All MCEs noted policies and procedures focused on quality of care relevant to SMI beneficiaries. Policies and procedures addressed a variety of services across the care continuum and applied to both IMD and non-IMD settings. Examples included:

- Requirements for regularly tracking and assessing quality of care (e.g., bi-monthly care reviews, tools for flagging providers of concern) as well as opportunities for members to report concerns.
- Internal workflows and defined roles/responsibilities for staff (e.g., care management) to facilitate safe discharge planning.
- Provider education focused on care standards.
- Verification of provider licensures and accreditation to ensure adequate provider networks who provide quality care.
- Inclusion of IMD policy that requires pay for stays.

In addition to stakeholder feedback, findings from reports developed by DMHA based on data collected from the MHSIP survey were also examined.[38] The MHSIP survey is fielded annually to a sample of adults receiving services at each of the 24 CMHCs and 7 additional contracted providers in Indiana. The survey instrument captures patient perceptions of MH care received at the CMHCs using 36 questions (each question utilizes a Likert scale of possible responses from (1) Strongly Agree to (5) Strongly Disagree) grouped into 7 quality of care related performance domains – general satisfaction, access to services, quality of services, participation in treatment planning, treatment outcomes, functioning, and social connectedness. Refer to **Attachment D** for additional details on MHSIP survey convenience sampling methodology, instrument questions, and calculation of percentage of respondents reporting satisfaction for each domain.

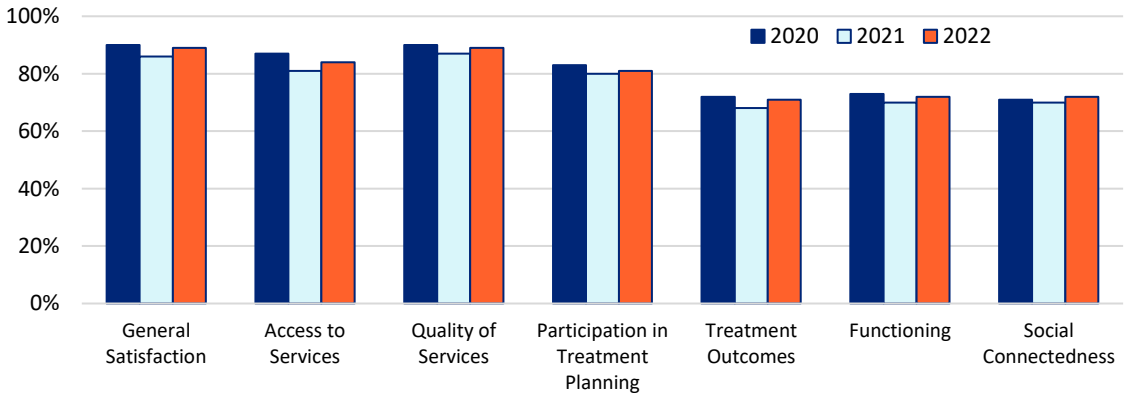
[36] DMHA will not license a PMHI if the hospital does not have an approved design plan from IDOH. IDOH is required to review and approve the physical setting prior to license approval.

[37] Due to the PHE, during the timeframe (CY2021 and CY2022), DMHA was only performing critical unannounced site visits.

[38] Current status for implementation action item "1.g Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings" identified "*DMHA conducts the MHSIP Survey for Adults and Youth), an annual consumer satisfaction surveys for all individuals who have been served by DMHA contracted providers."*

The Mid-Point Assessment used findings from the 2022 survey report.[39] The majority of respondents were White/Caucasian (80%), indicated ethnicity as not Hispanic (64%), identified as women (55%) and had received in-person care (87%). Respondent age varied, with most respondents ages 30 and older (69%). Approximately two thirds (63%) of respondents reported receiving services related to MH only, while half (48%) reported receiving treatment for 1 year or less. Across the study period, findings (**Exhibit IV.14)** indicated that more than 80% of respondents reported being satisfied with care received, had access to care, and received quality care. Additionally, 85% of respondents indicated "I was able to get all the services I thought I needed" and 72% indicated "being able to see a psychiatrist when I wanted to." Findings were stable across the years studied and compared to the baseline year (2020).

Exhibit IV.14: Percentage of MHSIP Respondents Reporting Satisfaction with Quality of Care Measured Across 7 Domains: Satisfaction, Access to Care, Quality of Care, Treatment Planning, Outcomes, Functioning and Social Connectedness



Has access to appropriate levels and types of care changed during the demonstration period? (Qualitative and Quantitative Findings)

Findings specific to this assessment question aligned to four thematic topics: Medical Necessity Reviews, Seven-Day Instant Authorization, Access to Care, Telehealth, and Use of First-Line Psychosocial Care.

Medical Necessity Reviews. In accordance with 405 IAC 5-3-13, all inpatient psychiatric, SUD, and rehabilitation admissions require prior authorization to ensure the appropriate level of care. Medical necessity reviews are completed by Indiana's MCOs and the state's FFS PA entity, based on the individual's enrollment. All MCEs (n = 5) stated that they completed medical necessity reviews during CY2021 and CY2022 and used guidelines as the foundation of their processes. Three MCEs reported using MCG, with one MCE highlighting its benefits (i.e., clearly delineates what is expected to meet medical necessity for higher levels of care such as residential treatment centers or inpatient) and challenges (i.e., insufficient criteria for lower levels driving clinicians to

[39] "Adult Individual Served Perception of Care MHSIP Survey 2022", prepared by InteCare, Inc. for IN FSSA DMHA.

make determinations for medical necessity). Two MCEs reported utilizing InterQual as an alternative and stated that InterQual criteria aligns better across health plans and markets.

Seven-Day Instant Authorization. All MCEs indicated that, at some point, the 7-day instant authorization was active during CY2021 and CY2022. Of the three inpatient providers interviewed, two providers indicated that the 7-day instant authorization impacted the inpatient IMD and SMI beneficiaries positively, promoting quicker and more efficient care as well as providing greater access to care. In contrast the third inpatient provider indicated that the 7-day instant authorization impacted individuals negatively and did not provide sufficient time to treat SMI members, particularly those with schizophrenia or schizoaffective disorder.

Access to Care. All advocacy organizations (n = 3) indicated that access to care had worsened compared to years prior and attributed declines during CY2021 and CY2022 to the PHE. Two of the three advocacy organizations asserted that COVID impacted access to care by limiting facility operational capacity (e.g., restrictions on number of beds or appointment availability) and magnifying staff shortages. COVID also impacted the ability for beneficiaries to connect with community-based support (i.e., scheduling timely CMHC appointments which consequently delayed hospital admissions). An additional challenge (unrelated to the PHE) was identified by the third advocacy organization. The latter organization stated that Indiana changed how care is reimbursed in a way that disincentivized some providers from providing teams or providing long term residential supportive housing and subsequently reducing care options.

Advocacy organizations suggested several strategies for improving access to care among SMI beneficiaries including:

- Making larger investments in community-based services, level of care assessments, and provider quality.
- Building provider capacity (e.g., more beds, more staff, more CSUs) across the state.
- Increasing reimbursement rates to reflect the level of care needed for SMI beneficiaries.
- Accelerating the process to prioritize severe cases of individuals for hospitalization, and to lessen the frequency of provider turnover.

Despite assertions that access to care worsened, 96% of members (24/25) indicated that they received MH or SUD care services between CY2021 and CY2022 (Note. These findings are consistent with the MHSIP findings, indicating that more than 80% of respondents indicated access to care across the years studied). The majority of respondents received outpatient care. Of the four respondents who reported a stay in an inpatient facility, the average LOS was 5 days. Note, none of the respondents indicated receiving care at an IMD[40.]

[40] 83% of member survey respondents were not familiar with the term IMD. When IMD was defined, all respondents indicated that they did not receive care at an IMD.

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

Unsurprisingly, these changes in policy led to an increase in the number of Medicaid claims billed for telehealth services during the first year of the PHE. In 2019, there were only 63,844 paid claims for telehealth services, versus 2,673,241 claims in 2020, an increase of over 4000%.[41] However, as access for in-person appointments increased, telehealth service utilization began to decline. For example, in 2021, there were 2,014,048 paid claims for telehealth services, versus 1,226,905 claims in 2022, a decrease of 39%. The majority of these claims were submitted by behavioral health providers, with claims for psychotherapy sessions (45 minutes) accounting for approximately 28% in 2021 and 23% in 2022 of health care services provided via telehealth.

All interviewees (MCEs, advocacy organizations, providers, and members) discussed the impact of expanded telehealth services on the care delivery system, noting that the modality increased access to care. Consistent with findings from the Summative Report, interviewees indicated that telehealth is a good alternative for SMI beneficiaries who had difficulties accessing transportation or lived in areas with high wait times for MH providers. Both MCEs and providers reported using telehealth services during CY2021 and CY2022. Approximately two thirds of members (67%) reported receiving MH or SUD care via the computer or phone during CY2021 and CY2022. Most members found telehealth to be convenient, with some members stating that the modality was equal in quality to in-person sessions. Additionally, some members credit telehealth visits with maintaining their accountability and continue to use the modality post PHE.

Interviewees described limitations associated with expanded telehealth services. Consistent with findings from the Summative Report, interviewees noted that not all recipients are able to effectively utilize remote services due to limited mental capacity and technology issues (e.g., limited bandwidth, access to the Internet). Additionally, advocacy organizations asserted that some beneficiaries struggle with building rapport with providers via virtual modalities and subsequently may prefer in-person interactions. Member interviews confirmed advocacy organization assertions and added that insurance did not always cover telehealth services.

Use of First-Line Psychosocial Care. Children and adolescents are frequently prescribed antipsychotic medications for non-psychotic conditions (e.g., attention deficit disorder, conduct disorder). Safer first line psychosocial interventions, such as behavioral and psychological

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

therapies) are often underutilized even though recommended for children and adolescents diagnosed with non-psychotic conditions.[42] Although the state's implementation plan did not document action items specific to increasing the use of first-line psychosocial care for children and adolescents (Note. The waiver evaluation focused on beneficiaries between the ages of 21 and 64), findings indicate that between baseline and waiver mid-point (CY2022), the proportion of beneficiaries receiving first-line psychosocial care increased - in alignment with State's demonstration target (**Exhibit IV.15**). This finding further supports the state's progress for improving access to appropriate levels of care.

Exhibit IV.15. Trend in Milestone 1 Related Monitoring Metrics Reported by FSSA (Between Baseline and Mid-Point)

Metric #	Metric Name	DY 2020	DY 2022	Absolute Change	Percent Change	State's Demonstration Target	Change Directionality at Mid-Point	In Desired Direction
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	55.0%	58.2%	3.15%	5.73%	Increase	Increase	**Yes**

Note: DY = Demonstration Year. Baseline: DY 2020, Mid-Point: DY 2022.

Did psychiatric hospitals and residential settings incorporate protocols for co-morbid condition screening during the demonstration period? (Qualitative Findings)

All inpatient providers (n = 3) reported having a comprehensive screening protocol (inclusive of a COVID-19 screening) in place during CY2021 and CY2022. In general screening protocols across inpatient providers were similar and included a full medical history that covered physical health, MH, comorbid/co-occurring conditions, medication use, and treatments. If a patient endorses a physical or co-morbid condition that requires immediate attention, all three inpatient providers indicated that medical providers are "on staff and ready to treat," in addition to their other MH services. Two of the three inpatient providers highlighted that patients with co-occurring conditions were positively impacted by discharge planning and care coordination. These providers emphasized that applying a wholistic/integrated approach was essential for positive outcomes.

2. Milestone 2: Improving care coordination and transitions to community-based care

CMS guidance identified six critical SMI metrics (metric #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care [PMH-20], metric #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric facility [IPF], metric #7: Follow-

[42] "Use of First-Line Psychological Care for Children and Adolescents on Antipsychotics (APP)." NCQA. January 16, 2024. https://www.ncqa.org/hedis/measures/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-anti-psychotics/.

up After Hospitalization for Mental Illness: Ages 6–17 [FUH-CH], metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older [FUH-AD], metric #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse [FUA-AD], and, metric #10: Follow-up After Emergency Department Visit for Mental Illness [FUM-AD]). Metric #3 is not included in the risk assessment as the state does not calculate this metric for the demonstration or other populations. Metrics #7 and # 9 are included in the Mid-Point Assessment and provide information on the state's progress in meeting its' demonstration target. However, since the scope of the waiver evaluation focuses on adults, ages 21-64 with a primary diagnosis of SMI, metrics #7 and # 9[43] were not included in the milestone risk-assessment.

Metric #6: Medication Continuation Following Inpatient Psychiatric Discharge is not a critical metric and was not included in the milestone risk assessment; however, it was calculated as an additional measure to examine and address the transition from inpatient psychiatric care to community-based care. In addition to the monitoring metrics, milestone 2 Mid-Point Assessment questions draw findings from stakeholder interviews.

Do psychiatric hospitals and residential settings have pre-discharge planning for care coordination to enable transition to community-based care post discharge? (Qualitative Only)

Findings specific to this assessment question aligned to two thematic topics: Case Management Services and Provider Capacity.

Case Management Services. Indiana Administrative Code (440 IAC 1.5-3-10) outlines minimum requirements for discharge planning. Hospitals are required to initiate discharge planning at admission that facilitates the provision of follow-up care and transfers or refers consumers to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care. Additionally, in accordance with the Indiana Medicaid Medical Policy Manual, all plans of care must document a post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the member's community to ensure continuity of care when the patient returns to his or her family and community upon discharge. CMHCs are required, as codified in Indiana Administrative Code (440 IAC 9-2-4), to be involved in the planning of treatment for and the discharge of consumers during the time a consumer is in inpatient care, to maintain continuity of care. CMHCs are also required, in accordance with IAC 440 IAC 9-2-10, as a component of case management, to provide advocacy and referrals including helping individuals access entitlement and other services, such as Medicaid, housing, food stamps, educational services, recovery groups, and vocational services.

MCEs are contractually required to provide case management services for any member at risk for or discharged from an inpatient psychiatric or SUD hospitalization, and to members discharged from an inpatient psychiatric or SUD hospitalization for no fewer than 90 calendar days following

[43] Metric #9 restricts the population to those individuals with a primary diagnosis of alcohol or other drug abuse dependence irrespective of whether the Medicaid beneficiary had a diagnosis of a MH condition.

discharge. Given these requirements, it was not surprising that all MCEs confirmed providing case management services during CY2021 and CY2022 to all members discharged from an inpatient psychiatric or substance abuse hospitalization. MCEs stated that case management services were available for at least 90 calendar days post discharge and included:

- Outreach to members while in an inpatient facility.
- Comprehensive assessments and screening for other conditions, which supported development of care plans for the member upon discharge.
- Coordination with the member's primary care provider and behavioral health provider upon member discharge.
- Peer engagement (Note. COVID-19 hindered the number of peers during CY2021 and CY2022).

All MCEs stated that case management was provided to members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization. In general, MCEs were alerted when a patient needed case management and engaged with members during their inpatient stay to identify appropriate community-based discharge services. Although two of the inpatient providers interviewed reported positive experiences with MCEs; the third inpatient provider noted that MCEs do not always provide the necessary service coverage for SMI members and consequently discharge patients who are not fully stabilized. Inpatient providers described a variety of challenges for MCE collaboration including, the use of non-user-friendly portals, expectations for treating and discharging patients quickly despite need, and inconsistent messaging or communications specific to prior authorization. Inpatient providers emphasized the need for improved collaboration with MCEs and suggested increasing interactions as a strategy for nurturing relationships.

Discharge planning between inpatient providers and CMHCs were also explored. CMHCs (n = 3) stated that their case managers provide a myriad of services (i.e., housing services, skills development, appointment coordination, and referrals) and are delivered by certified recovery specialists or individual with at minimum an associate or bachelor level degree. Of the three inpatient providers interviewed, two indicated that CMHCs were not involved in SMI member treatment planning and the discharge process. One CMHC assisted beneficiaries with accessing supportive housing services including determining eligibility. Another CMHC assisted with connecting beneficiaries to nutritional support, physical health education via an evidence-based practice called "In-Shape," and accessing vocational services.

Advocacy organizations reinforced the importance of providing case management services following inpatient discharge and noted several improvements that if executed may benefit SMI members. Improvements included:

- Focusing on individualized processes (employment support, housing, connection to VR, food security, etc.).

- CMHCs increasing capacity to better serve members with SMI.
- Decreasing case manager workload to ensure quality interactions and ability to devote undivided attention to SMI members.

Provider Capacity. Consistent with the findings in the 2020 Summative Report, all interviews described limited provider capacity as an overarching system challenge and specified its' negative impact on care planning and coordination. Most MCEs reported that staffing challenges (e.g., large caseloads, provider shortages, lengthy appointment wait times) continued to impact facilities providing care to SMI beneficiaries during CY2021 and CY2022 and emphasized difficulties with care coordination and connecting beneficiaries to community-based care. Member findings also emphasized limited availability for care coordination appointments. Of the 24 members interviewed, only 7 (29.2%) reported having a professional (such as a nurse or care manager) provide care coordination services.

Inpatient, CMHC, and outpatient providers also highlighted provider shortages. Although inpatient providers emphasized nursing shortages, other provider types indicated that the provider shortage was more widespread. When asked to describe strategies for minimizing the impact of provider shortages, some providers indicated that setting caps on the number of patients treated while others emphasized implementation of financial incentives (e.g., changing rates, raising wages, offering bonuses).

Do psychiatric hospitals and residential settings have established processes for follow-ups post discharge to ensure members have access to and are receiving community-based care? (Quantitative and Qualitative)

The IN SMI waiver Implementation Plan includes the following action item: Update the Medicaid Provider Manual to ensure contact is made by the treatment setting with each discharged recipient within 72 hours of discharge and follow-up care is accessed. Monitoring metric #7 (critical), metric#8 (critical) and metric #6 (supplemental) were used to assess the state's achievement of short-term follow-up. Metric #7 calculates the percent of Medicaid beneficiaries ages 6-17 who were hospitalized (non-acute inpatient stay) for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a MH provider within 7 days after discharge. Metric #8 calculates the percent of Medicaid beneficiaries aged 18 and older who were hospitalized (non-acute inpatient stay) for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a MH provider within 7 days after discharge.[44] Since the state does not calculate a metric for 72 hour follow up, the 7 day follow up metrics (#7 and #8) were used as proxy measures to assess progress for the state's relevant action item. Metric #6 calculates the proportion of psychiatric patients admitted to an inpatient psychiatric facility

[44] The denominator for metrics 7&8 is a subset of the state demonstration population restricted to only beneficiaries with a diagnosis of mental illness (a subset of MH diagnosis value set) who had a non-acute inpatient stay. For metric 7, approximately 560 patients (annually) were identified who met the measure specifications criteria. For metric 8, approximately 1,500 patients (annually) were identified who met the measure specifications criteria.

(IPF) for major depressive disorder, schizophrenia, or bipolar disorder and filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. This metric also provides information indicative of members access to care as it is expected that a large proportion of SMI beneficiaries will be prescribed a medication at discharge (Note. Approximately 96% of members interviewed (n-24) reported being prescribed a medication for a MH or SUD condition).

Findings indicate that between baseline and waiver mid-point (CY2022), the proportion of beneficiaries 18 and older receiving follow-up care increased - in alignment with state's demonstration target (**Exhibit IV.16**) while the proportion of beneficiaries 6-17 remained the same – did not align with the state's demonstration target. The proportion of discharges with medication continuation remained similar across the years. Although most members interviewed indicated that they were prescribed medication for a MH or substance use condition, some individuals reported challenges with accessing medications (i.e., medication prescribed was not covered by insurance) or being prescribed medication "that worked" for their MH condition. The state noted that since CY2022, the formulary has been updated expanding access to medications covered.

Exhibit IV.16 Trend in Milestone 2 Related Monitoring Metrics Reported by FSSA (Between Baseline and Mid-Point)

Metric #	Metric Name	DY 2020	DY 2022	Absolute Change	Percent Change	State's Demonstration Target	Directionality at Mid-Point	In Desired Direction
4	**30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)**	**25.1%**	**25.9%**	**0.80%**	**3.36%**	**Decrease**	**Increase**	**No**
6*	Medication Continuation Following Inpatient Psychiatric Discharge	2.9%	2.9%	0.05%	1.76%	Increase	Neutral	No
7	7-Day Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	38.7%	37.9%	-0.77%	-2.00%	Increase	Neutral	No
8	**7-Day Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)**	**24.9%**	**29.4%**	**4.52%**	**18.16%**	**Increase**	**Increase**	**Yes**
9	7-Day Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	15.9%	27.6%	11.66%	73.14%	Increase	Increase	Yes
9	30-Day Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	23.4%	39.4%	16.04%	68.60%	Increase	Increase	Yes
10	**7-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)**	**36.2%**	**33.1%**	**-3.12%**	**-8.62%**	**Increase**	**Decrease**	**No**
10	**30-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)**	**50.5%**	**48.5%**	**-1.97%**	**-3.90%**	**Increase**	**Decrease**	**No**

Bolded metrics indicate used to calculate risk assessment.

Note: DY = Demonstration Year. Baseline: DY 2020, Mid-Point: DY 2022.

* Metric is not listed for the corresponding milestone in the CMS Guidance as critical metric. It was included as an additional measure to examine and address the transition from inpatient psychiatric discharge to community-based care. The metric has not been used for milestone risk assessment.

M1: National average for Medicaid health maintenance organization (HMO) population in 2021 was 38.4. (Accessed on 11/20/23, https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/)

M2, M3: National averages for Medicaid HMO population in 2021 was 40.1% and 53.4% respectively (Accessed on 11/20/23, https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/)

MCEs are responsible for ensuring enrollees access follow-up care post-discharge. In fact, MCEs are contractually required to schedule an outpatient follow-up appointment to occur no later than seven calendar days following an inpatient behavioral health hospitalization discharge. If a member misses an outpatient follow-up appointment, the MCEs must ensure that a behavioral health provider or the MCO's case manager contacts the member within three business days of notification of the missed appointment. Additionally, Indiana Medicaid provides coverage for bridge appointments, which are follow-up appointments after inpatient hospitalization for behavioral health issues, when no outpatient appointment is available within seven days of discharge. All five MCEs confirmed that either the behavioral health care provider or the MCE's behavioral health case manager contact members within three business days of a missed appointment. Most of the MCEs reported utilizing a workflow to ensure this outreach happens, followed by specific protocols to re-engage the member. Overall, MCEs believe that reaching out within 3 days is helpful to improving community care.

Both outpatient providers described their care coordination processes for SMI beneficiaries. One provider indicated that transitions from state hospitals to community care improved from 2021-2022. Improvements were attributed to increased communication and coordination with DMHA. The other provider emphasized that their strong relationships with providers contributed to successful care transitions. Both providers indicated that care coordination benefits SMI beneficiaries. Examples of benefits include increased resource alignment, adequate time for treatment planning, and warm hand-offs that promote follow-up. However, both outpatient providers stated that communication with other providers is an ongoing challenge for care coordination and suggested improvement strategies such as intentional messaging and frequent contact with providers.

Based on member interviews, of the members who reported receiving care coordination services (n = 7), feedback was positive. Members indicated that staff were:

- Patient and understanding;
- Helpful in assisting with medication refills, scheduling appointments, and connecting patients to care services; and
- Organized, knowledgeable, and able to identify solutions for patient issues or concerns.

Do beneficiaries discharged from ED receive follow-ups for care coordination? (Quantitative and Qualitative)

More than 40% of the demonstration population and 50% of the state-specific SMI population had at least one ED visit in a single year (**Exhibit IV.10**). Strategies for preventing or decreasing LOS in EDs among SMI beneficiaries are key for improving care. Inherent to these strategies are ensuring that those individuals with SMI have care coordinated post ED visits. Monitoring metric #10 (critical) was used to estimate the percentage of ED visits for beneficiaries aged 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit

for mental illness within 7- and 30-days.[45] To assess the state's risk in achieving this milestone, both measures were used and treated as separate metrics (in combination with the other two metrics [#4 & #8]). Findings indicate that although the number of beneficiaries with follow-up visits increased, the proportion of beneficiaries receiving a follow-up visit decreased between baseline (DY2020) and the waiver mid-point (DY2022) for both 7-day and 30-day follow-up (**Exhibit IV.16**). This decrease did not align with the state's demonstration target.

Monitoring metric #9 (critical) was used to estimate the percentage of ED visits for beneficiaries aged 18 and older with a primary diagnosis of alcohol or other drug abuse dependence irrespective of whether the Medicaid beneficiary had a diagnosis of a MH condition and who had a follow-up visit for SUD within 7 and 30 days. Findings indicate that the proportion of beneficiaries receiving a follow-up visit increased between baseline (DY2020) and the waiver mid-point (DY2022) for both 7-day and 30-day follow-up (**Exhibit IV.16**). This increase aligns with the state's demonstration target and suggests improvement in follow-up care for those beneficiaries with a primary SUD disorder. Indiana's progress in demonstration action items specific to SUD is documented in the report "**Mid-Point Assessment Indiana's Section 1115 Substance Use Disorder Demonstration**".[46]

MCEs are required to identify high utilizers of ED services and ensure members are coordinated and participating in the appropriate disease management or care management services. All MCEs discussed processes for identifying high ED utilizers with SMI. Although MCE processes varied, all MCEs discussed using data to flag beneficiaries with high utilization or emergent conditions as well as outreach strategies to facilitate care coordination. Consistent with findings from the Summative Report, most MCEs stated that the PHE impacted care coordination for high ED utilizers with SMI, noting observations such as provider shortages, facility shutdowns, and patient hesitancy for attending in-person appointments. The quantitative and qualitative findings suggest the need for additional focus on ED follow-up after ED visit for mental illness. However, results should be interpreted with caution as the PHE's impact on the workforce may be a strong contributing factor. Strategies for increasing workforce capacity specific to care transition should be considered.

Does the demonstration help reduce preventable readmissions to acute care hospitals and residential settings? (Quantitative Data Only)

Estimates of readmission rates for individuals admitted to psychiatric hospitals vary and depend on numerous factors including age, condition, time to readmission, and country.[47] Receiving outpatient MH services after hospital discharge has often been a strategy for reducing readmission rates in SMI populations. Although the IN SMI Demonstration Implementation Plan

[45] The denominator for this metric is the number of ED visits for a subset of the state demonstration population restricted to only beneficiaries with a diagnosis of mental illness (a subset of MH diagnosis value set).

[46] This report was submitted to CMS on 12/31/2023 and is not yet available in the public domain.

[47] Owusu E, Oluwasina F, Nkire N, Lawal MA, Agyapong VIO. Readmission of Patients to Acute Psychiatric Hospitals: Influential Factors and Interventions to Reduce Psychiatric Readmission Rates. Healthcare (Basel). 2022 Sep 19;10(9):1808. doi: 10.3390/healthcare10091808. PMID: 36141418; PMCID: PMC9498532.

does not identify a specific action for reducing readmission rates, several action items focus on reducing or preventing unnecessary admissions (discussed in milestones 1 and 3). Additionally for this milestone, the state identified improving care coordination during transition periods to reduce admissions. Consequently, metric #4 (critical) was used to assess the proportion of demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease who had an unplanned readmission within 30-days. Findings indicate that readmission rates were higher at waiver mid-point (DY2022) relative to baseline (DY2020). This finding does not align with the demonstration's target (**Exhibit IV.16**). However, it should be noted that the readmission rate decreased from 2020 to 2021 and then increased from 2021 to 2022. Decreased readmission rates in 2020 may be due to the state's implementation of social distancing parameters during the first year of the PHE, while increasing rates may be a result of "relaxing" social distancing parameters as the PHE continued. Additionally, observations from the MCEs indicate that the PHE (e.g., provider shortages, facility shutdowns, and patient hesitancy for attending in-person appointments) had a negative impact on care coordination and may suggest that SMI beneficiaries experienced challenges with accessing community-based MH services post discharge raising risk for readmission. Additional years of data are required to examine whether preventable readmissions reduced during the demonstration period.

3. Milestone 3: Increasing access to continuum of care including crisis stabilization services

CMS guidance identified one critical SMI monitoring metric (Metric #19: Average Length of Stay [ALOS] in Institutions of Mental Diseases [IMDs]). Although ALOS is not a direct indicator for assessing access to the continuum of care, shorter stays may indicate system wide efficiencies, shifting care from more expensive inpatient facilities to less expensive lower levels of care. Metric #20 (supplemental) counts the number of beneficiaries with SMI treated in an IMD, providing additional information to further understand care access. Given the limited number of monitoring metrics, milestone 3 Mid-Point Assessment questions draw findings from stakeholder interviews and the Provider Availability Assessment.

Do contracted providers use a widely recognized, publicly available assessment tool to determine level of care and length of stay? (Qualitative)

Every individual served by a DMHA contracted provider receives a CANS/ANSA to inform individualized treatment planning and level of care decision making. Individuals are reassessed every six months with adjustments to level of care and/or treatment plan being made accordingly. Further, as stated in Indiana Administrative Code 405 IAC 5-21.5, IHCP reimbursement for MRO services is available for members who meet specific diagnosis and level of need criteria under the approved DMHA assessment tool - ANSA or CANS. The CANS/ANSA also informs individual service needs and informs level of care decision making (e.g., inpatient vs. residential services). Outpatient providers indicated that they utilize the ANSA and the CANS assessment to support decision making, including level of care and service planning. Although two providers highlighted benefits of these tools such as scoring criteria, both providers commented that the length of the

assessment limited rapport building and consequently may inflate/deflate scores requiring the assessment to be repeated.

Do demonstration action items contribute to increased access to the continuum of care? (Quantitative and Qualitative)

FSSA state official interviewees confirmed that behavioral health provider network capacity is monitored annually and used to identify provider deficiencies and build provider recruitment plans. For example, in accordance with the state's approved §1915(b)(4) waivers for MRO services and §1915(i) programs, FSSA utilizes information gathered from analysis of Indiana's Medicaid Management Information System, site reviews, and recipient reports and complaints to evaluate the need to expand provider agencies and/or provide training and/or corrective actions to assist provider agencies in increasing efficiencies for timely access to services. When "timely access" is identified as a provider agency issue, the State uses a request for corrective action and provides technical assistance and training to assist the agency in correcting the issue. If the issue is not remediated satisfactorily, further sanctions are applied, up to and including decertification of the agency as an MRO or §1915(i) provider. Further, OMPP's Provider Relations contractor identifies underserved areas by calculating the ratio of providers to members by county. Recruiting efforts are intensified in counties that are identified as not meeting Health Resources and Services Administration provider-to-member ratio standards. Utilizing the results of this analysis, the Provider Relations team outreaches to behavioral health providers who are not currently Medicaid enrolled. Additionally, FSSA collaborates with DMHA and the IDOH to collect data on various provider settings in order to fully capture provider availability via the Provider Availability Assessment (See **Section IV.E** for additional findings specific to provider capacity).

Additionally, MCEs are contractually required to meet network adequacy standards for behavioral health providers in accordance with 42 CFR §438.68. All MCEs stated that they met network adequacy standard requirements during CY2021 and CY2022.

Statewide strategies for increasing provider capacity to ensure access to the continuum of care. Consistent with findings from the Summative Report, Indiana recognized that the adequacy of provider supply did not meet patient demand and consequently initiated strategies to increase provider supply. Although these strategies were not included in the IN SMI Implementation Plan, they were identified as key efforts for meeting milestones. Examples include:

- **Legislation and Billing System Infrastructure Changes**. To increase the State's capacity of MH Medicaid providers, the House Enrolled Act 1175 passed in the 2019 legislative session expanded access to behavioral health providers for Medicaid enrollees. Under this law, licensed clinical social workers (LCSW), licensed MH counselors (LMHC), licensed clinical addiction counselors, and licensed marriage and family therapists (LMFT) are eligible providers and can certify a MH diagnosis and supervise a patient's treatment plan in outpatient MH or substance abuse treatment settings. Prior to this legislation, mid-level behavioral health practitioners were not eligible to

independently enroll in Indiana Medicaid and were required to bill under the supervision of a health services provider in psychology (HSPP) or a psychiatrist.

With the enactment of the latter legislation, Indiana implemented infrastructure changes within their billing systems to enable mid-level provider enrollment. Enrollment began in Q1 of 2021. The enrollment of mid-level providers allows Indiana to reimburse and monitor the full scope of providers who offer MH services, populations served, location, and service type provided. Although this activity was not codified as an action in the IN SMI Implementation Plan, it positions FSSA to better identify gaps in service and address ongoing training and support needs.

- **Workforce Initiatives Focused on Expansion and Retention.** The state recently offered funding for workforce initiatives through the Workforce Recruitment and Retention Innovation grant via American Rescue Plan Act funding. Through this funding, Indiana has awarded $14.25 million dollars to various programs and initiatives that address recruitment, training, workforce wellness, leadership, scholarships, apprenticeships, incentives for new hires, hiring and training peer workforce, inclusive hiring, supervisor training, money for interns, etc. Additional efforts pursued by the state include:
    - Focusing on early workforce development initiatives (talent pipeline expansion to better engage K-12 and higher education) to increase capacity.
    - Promoting and mapping of behavioral health workforce at the local level to better engage those with lived experience.
    - Implementing "workforce wellness" strategies to improve retention and support for existing workforce.
    - Prioritizing provider-driven skills development to improve retention and quality of care.
    - Improving compensation strategy to offset the high costs of higher education and improve pay equity for the workforce.

Do demonstration action items contribute to increased access to crisis stabilization services? (Quantitative and Qualitative)

Indiana provides comprehensive crisis stabilization services statewide. Services include:

- Outpatient behavioral health services currently delivered by providers across the state.
- MRO delivered by the state's 24 CMHCs. All 92 counties in Indiana have at least one CMHC delivering care in the geographical area and most counties in the state, other than very rural ones, have more than one CMHC offering services within a county. Indiana Administrative Code and DMHA contracts require CMHCs to provide a defined continuum of care directly, or through subcontract.
- Three §1915(i) programs serving individuals with behavioral health needs.

- Expanded SUD services in accordance with the state's approved SUD waiver.
- Partial hospitalization programs which are time-limited medical services intended to provide a transition from inpatient psychiatric hospitalization to community-based care or, in some cases, substitute for an inpatient admission.

Effective July 1, 2019, in accordance with the CMS approval of SPA TN 18-012, Indiana Medicaid expanded crisis intervention services, intensive outpatient program services, and peer recovery services to all Indiana Medicaid programs; these services were previously limited to the MRO option. This change expanded the available provider base from Indiana's CMHCs to all Medicaid enrolled providers meeting the applicable criteria.

Qualitative findings specific to this assessment question aligned to four thematic topics, Crisis Stabilization, CSUs, OpenBeds, and MRSS.

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

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

To assess the use of crisis stabilization services the evaluation team counted providers who submitted an H2011 claim and the number of recipients who received crisis stabilization services by provider type. Given that crisis stabilization (H2011 claims) services are paid for any Medicaid recipient in crisis (i.e., not constrained to those with a primary or secondary SMI condition) and that the data provided was aggregated, the evaluation team was unable to assess the percentage of SMI beneficiaries who received crisis stabilization services during 2021-2022. Rather, providers who provided H2011 services and recipients with H2011 claims during the study time frame were counted to summarize the use of crisis stabilization services among the larger Medicaid population. It is possible that an individual in crisis may be treated by a provider yet not have a H2011 claim submitted. Consequently, the counts listed in **Exhibit IV.17** may underrepresent the number of

providers or recipients served. Findings indicate that thirty-five billing providers submitted H2011 claims for 6,841 Medicaid recipients. Almost two thirds of crisis stabilization services (65%) were provided by a behavioral health provider and accounted for approximately three quarters (72.2%) of recipients. Clinicians, physicians, and hospitals also provided crisis stabilization services, reaching fewer recipients (1.4%, 15.4%, and 11.1% respectively).

Exhibit IV.17. Counts of Providers who Provided H2011 (Crisis Stabilization) Services and Recipients with H2011 Claims in Indiana, 2021-2022.

Provider Type	Billing Provider NPI		Number of Recipients	
	N	%	N	%
Behavioral Health Provider	23	65.7%	4,936	72.2%
Clinic	6	17.1%	97	1.4%
Physician	3	8.6%	1,052	15.4%
Hospital	3	8.6%	756	11.1%
Total	35	100.0%	6,841	100.0%

Note: The number of recipients served per billing provider NPI ranged from 1 to 1,120, with a mean of 195 recipients served.

Of the three advocacy organizations interviewed, only two provided perspectives on crisis stabilization services. Both advocacy organizations highlighted the importance of crisis stabilization services for diverting SMI beneficiaries with non-emergent conditions from the ED to appropriate levels of care. However, both noted challenges specific to coverage, access, and service knowledge. One organization indicated that during CY2021 and CY2022, providers worried about being reimbursed for medical necessity. This organization highlighted recent legislation (House Enrolled Act 100648 – passed in 2023) which has streamlined the process for individuals accessing crisis stabilization and required insurance providers to reimburse for any CSU service under "emergency detention." The advocate stated, "Moving forward, hospitals will not have to worry about whether they are going to get reimbursed because now it is a state law".

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

This expansion of the crisis continuum began in 2014. DMHA partnered with the National Alliance on Mental Illness of Indiana, MH America of Indiana, the Indiana Hospital Association, Key Consumer, and the Indiana Council on CMHCs to conduct a review of Indiana's MH and substance use crisis services. The review was in response to Indiana Senate Enrolled Act No. 248

[48] Specifies the circumstances under which a person may be involuntarily committed to a facility for MH services and specifies that these services are medically necessary when provided in accordance with generally accepted clinical care guidelines; establishes a local MH referral program to provide MH treatment for certain persons who have been arrested; and repeals obsolete provisions and makes technical corrections. (https://iga.in.gov/legislative/2023/bills/house/1006/details)

of 2014, which mandated DMHA to conduct a psychiatric crisis intervention study ("crisis study") and report the results to the legislative council by September 2015. The crisis study included a review of psychiatric and addiction crisis services available in Indiana, a survey of professionals and individuals in Indiana who have experience with the current state of Indiana's crisis response, and a review of crisis services and models implemented by other states that could improve outcomes for individuals who experience psychiatric or addiction crises.

In response to recommendations from the report, DMHA supported two CMHCs, Centerstone Indiana, and Four County, with their CSU pilots. The goals for these units are to provide an alternative to crisis evaluations within EDs and divert admissions to inpatient psychiatric units. Pilots were started July 1, 2020 and completed June 30, 2022. Of the two pilot CSUs, one was interviewed. Findings listed below should be interpreted with caution given they are the perspectives of a single respondent who is employed at the CMHC/CSU. Future studies examining the impact of CSUs may further benefit the state and inform strategies for expansion.

The CSU provider stated that the CSU:

- Provided a 23-hour voluntary crisis observation and receiving center which served 230 individuals during the timeframe.
- Had an ALOS of 8.5 hours; approximately half of individuals served had SMI.
- Connected SMI beneficiaries to the appropriate inpatient or community-based services, as the provider was part of the larger CMHC and consequently had processes in place to connect beneficiaries accordingly via discharge planning and triaging patients.
- Benefited Medicaid beneficiaries with SMI by keeping beneficiaries in the community. The provider noted that a lot of consumers are aware of what they need regarding CSU services and indicated that patient autonomy over their treatment expands their options.

Tracking OpenBeds. In March 2018, FSSA implemented a tool to help Indiana residents seeking treatment for SUD immediately connect with available inpatient or residential treatment services. This tool was made possible by a partnership between the state, OpenBeds (a software platform that manages health services), and Indiana 2-1-1 (a non-profit organization that provides health care and other resource referrals to those in need). Although FSSA hoped to expand the OpenBeds contract in the Fall of 2019, state officials noted that providers experienced challenges using the software and consequently contract renewal was not pursued. Inpatient providers confirmed state official observations. Of the three inpatient providers, two were familiar with OpenBeds and stated that the software was a "failure" or "useless" for identifying and connecting beneficiaries to available beds. Inpatient providers stated that facilities have different requirements for referrals, may not be equipped to treat patients with co-occurring disorders, and fluctuate in the number of beds available. Consequently, inpatient providers asserted that internal processes relying on team members to outreach to providers and determine bed availability based on their patient's needs was a better strategy for facilitating care access among individuals with SMI. MCEs also emphasized

the use of direct contact strategies to providers identifying care opportunities and stated that the loss of OpenBeds did not impact their ability to connect patients to care.

Mobile Response Stabilization Services. Mobile crisis response stabilization services consist of multidisciplinary teams of trained providers who are positioned to respond quickly to behavioral health crises in the community 24 hours a day, 7 days a week. The purpose of a mobile crisis response team is to divert individuals in crisis from hospitals, EDs, and jails to better service individuals in crisis and prevent fatalities from suicide, drug overdose, and other MH and substance use emergencies. Intended to be immediate and short term, MRSS uses evidence-based practices to screen, assess, stabilize, and refer persons in need to CSUs, inpatient hospitals, certified respite facilities, or an individual's established provider. Although FSSA had hoped to conduct a MRSS pilot in partnership with DCS and Juvenile Justice agencies, FSSA state officials indicated that the pilot was delayed indefinitely to allocate resources to other initiatives.

Do SMI beneficiaries have short-term stays and is LOS being tracked? (Quantitative and Qualitative Findings)

Short-stay, hospital-based crisis units have been found to reduce psychiatric holds, increase outpatient follow-up, as well as reduce ED stays and the number of inpatient admissions for those with a MH related condition.[49] IMDs offer the ability for SMI beneficiaries to stabilize in the short-term and then connect beneficiaries to care continuum.

The number of beneficiaries in the state demonstration population who received treatment in an IMD (metric #20) increased from baseline (2020) to the waiver mid-point (2022). This aligns to the state's demonstration target and suggests greater access to IMDs. The ALOS for beneficiaries with SMI at an IMD receiving FFP only (metric #19b) decreased from 7.9 days to 7.4 days while ALOS for stays at an IMD (considering all IMD irrespective of receipt of FFP) decreased from 10.1 to 9 (metric #19a) during the demonstration period (**Exhibit IV.18**). The majority beneficiaries (99%) with an inpatient stay at an IMD had stays of less than 60-days,[50]with an ALOS of 7.3 days in 2022 (**Attachment E**).

[49] Anderson K, Goldsmith LP, Lomani J, Ali Z, Clarke G, Crowe C, Jarman H, Johnson S, McDaid D, Pariza P, Park AL, Smith JA, Stovold E, Turner K, Gillard S. Short-stay crisis units for MH patients on crisis care pathways: systematic review and meta-analysis. BJPsych Open. 2022 Jul 25;8(4):e144. doi: 10.1192/bjo.2022.534. PMID: 35876075; PMCID: PMC9344431.

[50] Monitoring report data specifications for metric #19 defines a short term stay as 60-days

Exhibit IV.18 Trend in Milestone 3 Related Monitoring Metrics Reported by FSSA (Between Baseline and Mid-Point)

Metric #	Metric Name	DY 2020	DY 2022	Absolute Change	Percent Change	State's Demonstration Target	Directionality at Mid-Point	In Desired Direction
19a	All Average Length of Stay in IMDs for all IMDs and populations	10.1	9.0	-1.2	-11.5%	No more than 30 days	Decrease	Yes
19b	**All Average Length of Stay in IMDs receiving FFP only**	**7.9**	**7.4**	**-0.4**	**-5.5%**	**No more than 30 days**	**Decrease**	**Yes**
20*	Beneficiaries With SMI/SED Treated in an IMD for MH	4,463	6,411	1,948	43.6%	Increase	Increase	Yes

Bolded metrics indicate used to calculate risk assessment.
Note: DY = Demonstration Year. Baseline: DY 2020, Mid-Point: DY 2022.
*Metric not identified as critical metric and not used for risk assessment.

FSSA state officials indicated they internally collect LOS data from MCEs and share that information with DMHA. Overall, MCEs indicated that the state was receptive to feedback regarding improvements to reporting templates (e.g., using diagnosis codes [rather than the CMS definition] or tracking LOS separately). Most MCEs indicated that they track LOS and did not report any challenges. MCEs varied in their perceptions of the COVID impact on LOS. Of the three MCEs that reported on COVID impact, one indicated an increase in LOS, one indicated a decrease in LOS, and one stated LOS remained the same. Inpatient providers also tracked LOS (range reported from 3.5 days to 10 days). In general, inpatient providers indicated that LOS remained the same over the course of the two-year time frame.

4. Milestone 4: Earlier identification and engagement in treatment, including through increased integration

CMS guidance identified three critical SMI monitoring metrics (metric #26: Access to Preventative/Ambulatory Health services for Medicaid Beneficiaries with SMI, metric #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics [APM-CH], and metric #30: Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication). Metric #29 is included in the Mid-Point Assessment and provides information on the state's progress in meeting its' demonstration target. However, since the scope of the waiver evaluation focuses on adults, ages 21-64 with a primary diagnosis of SMI, metric #29 was not included in the risk assessment as it exclusively examines a child and adolescent population. Metrics #21 and 22 (supplemental) count the number of beneficiaries with SMI (monthly and annually) providing additional information to further understand treatment engagement. Metric #23 monitors diabetes care for patients with SMI and measures the prevalence of Poor Control (>9.0%) among patients with SMI and hemoglobin A1c (HbA1c) (HPCMI-AD). Metric #23 (critical) is required for state monitoring reports and is listed in the CMS guidance as a metric to provide additional context for milestone 1. However, the metric is grouped under milestone 4 in the technical specifications. The state opted to use metric #23 to demonstrate progress toward milestone 4 for the Mid-Point Assessment. In addition to the monitoring metrics, milestone 4 Mid-Point Assessment questions also draws findings from stakeholder interviews.

Does the demonstration result in earlier identification and engagement of treatment for beneficiaries? (Quantitative and Qualitative Only)

In October 2016, OMPP began coverage for annual depression screening. Providers are expected to use validated standardized tests for screening. These tests include, but are not limited to, the Patient Health Questionnaire (PHQ), Beck Depression Inventory, Geriatric Depression Scale, and Edinburgh Postnatal Depression Scale (EPDS). Coverage applies to all IHCP under Medicaid. The state has also focused on school-based initiatives to increase behavioral health integration. Indiana Medicaid allows enrolled school corporations reimbursement for Medicaid-covered services in an Individualized Education Program (IEP) or Individualized Family Service Plan. Medicaid-covered IEP services include occupational, physical, speech and applied behavior analysis therapy, hearing, nursing and behavioral health evaluation and treatment services as well as IEP-required specialized transportation. In addition, CMHCs across the state work in close collaboration with Indiana schools and school districts have memorandums of understanding with local CMHCs for the provision of behavioral health services. Through these partnerships behavioral health staff are co-located within the schools and provide behavioral health services to youth and their families.

Qualitative findings specific to this assessment question aligned to two thematic topics: Early Identification and Engagement of Treatment and VRS. Quantitative findings are integrated within the topic: Early Identification and Engagement of Treatment.

Early Identification and Engagement of Treatment. Four of the five MCEs interviewed indicated that they had strategies in place (e.g., screening initiatives to identify youth at risk for suicide; data reviews using the IHIE) during CY2021 and CY2022 to identify beneficiaries with a serious MH condition. Of the four MCEs, one also highlighted a program that focuses on connecting individuals with first episode psychosis into care. All MCEs indicated that they have relationships with SBHCs either through a connection via an FQHC or through school-based administrators. Examples of engagement includes:

- Continued development of a team of school outreach specialists.
- A partnership to place emergency medication boxes in schools, including Naloxone.
- Behavioral health telehealth initiatives and various mobile offerings for school-aged, enrolled members.

Overall, advocacy organizations indicated limited awareness of state strategies that supported early identification and engagement for individuals with SMI. All advocacy organizations asserted stigma as a significant barrier for early identification and engagement for SMI beneficiaries, with one organization noting that parents struggle with obtaining assessment and treatment services for children in schools. Advocacy organizations recommended that the state invest in the following strategies to support early identification and engagement in treatment for SMI beneficiaries:

- Build capacity for CCBHCs.

- Increase crisis response teams and build systems of care that focus on the whole person and not just the diagnosis.
- Develop and implement public awareness campaigns to de-stigmatize behavioral health conditions and seeking treatment.

Although the IN SMI Implementation plan did not highlight action items focused on stigma reduction, the state has prioritized stigma reduction initiatives as an overarching strategy to encourage Indiana residents (rather than SMI beneficiaries) to engage in treatment. FSSA state officials highlighted several stigma reduction initiatives that started in the fall of 2022 and ended in the fall of 2023. These initiatives were initially constructed for broader populations between 9/2022 and 2/2023) and narrowed to SMI/SED populations between 3/2023 and 9/2023.

- **Council for Youth Bartholomew County** (9/1/2022 to 2/28/2023): Increased MH awareness for youth and their families by decreasing the MH stigma and promoting family well-being. The Council trained 168 youth and 168 adults (Hispanic/Latino as well as Black, indigenous, and people of color (BIPOC)) in MH first aid. From 3/1/2023 – 9/30/2023, the Council provided MH services and resources to 325 Hispanic/Latino youth with SMI/SED and 44 BIPOC youth with SMI/SED.
- **Intouch Outreach** (9/1/2022 to 2/28/2023): Provided community outreach and educational resources to educate and raise awareness of MH stigma among Black communities. This 6-part speaker series reached a total of 575 individuals and covered a diverse population. From 3/1/2023 to 9/30/2023, InTouch Outreach and SMI Enterprise continued to provide community outreach and education (focused on MH stigma) and engaged a total of 249 persons with an SMI/SED diagnosis.
- **Affiliated Service Providers** (ASPIN) (9/1/2022 to 2/28/2023): Provided a five-part webinar speaker series focused on addressing stigma for members of the Black, Latinx, and lesbian, gay, bisexual, transgender, and queer (LGBTQ+) communities. From 3/1/2023 to 9/30/2023, ASPIN expanded the webinar series to nine parts and focused on addressing SMI/SED stigma for members of the Black/African American, Latinx, and LGBTQ+ communities, as well as immigrant and refugee populations.
- **Marion County Commission on Youth** (MCCOY) (9/1/2022 to 2/28/2023): Created community conversations and projects that addressed MH stigma while simultaneously addressing the disparity that BIPOC individuals face in relation to MH access, services, and stigma. MCCOY leveraged partnerships with Thrival Indy Academy and Allies of Indiana to provide evidence based best practices to youth and families, focused on stigma reduction in BIPOC communities. From 3/1/2023 to 9/30/2023, MCCOY expanded their target population to include youth and families impacted by SMI/SED. Programs and services include resources for parents/caregivers focused on MH, as well as connections to clinicians who specialize in SMI/SED.

Given that general initiatives began at the end of the study period and SMI population focused enhancements began after the study period, more time is needed to assess the impact of initiatives on engagement.

To further examine treatment engagement metrics #21 and #22 were examined to assess how the size of the SMI beneficiary population changed over time. Findings indicated that the number of beneficiaries in the state demonstration population with any MH condition (metric #21 and #22) increased from baseline (2020) to the waiver mid-point (2022). This aligns to the state's demonstration target and suggests that more individuals with SMI are receiving treatment. The annual count of beneficiaries with an SMI condition increased from 266,256 in 2020 to 306,730 in 2021, a 15.2% change (**Exhibit IV.19**).

Exhibit IV.19 Trend in Milestone 4 Related Monitoring Metrics Reported by FSSA (Between Baseline and Mid-Point)

Metric #	Metric Name	Avg. Per Month in DY 2020	Avg. Per Month in DY 2022	Absolute Change	Percent Change	State's Demonstration Target	Directionality at Mid-Point	In Desired Direction
21*	Monthly Count of Beneficiaries With SMI (Monthly average per year)	96,851	113,161	16,310	16.8%	Increase	Increase	Yes
22*	Annual Count of Beneficiaries With SMI	266,256	306,730	40,474	15.2%	Increase	Increase	Yes

Note: DY = Demonstration Year. Baseline: DY 2020, Mid-Point: DY 2022.
* Metric not identified as critical metric and not used for risk assessment.

Qualitative interviews asked members about their treatment experience. Most members (75%, n = 24) were satisfied with their MH or SUD care. (Note. These findings are consistent with the MHSIP findings, indicating that more than 80% of respondents reported satisfaction with care across the years studied.) Approximately half of the respondents reported that they felt supported and/or had a good relationship with the care team (50%). Approximately one third of respondents (29.1%) noted that the wait time for an appointment was appropriate while 8.3% indicated the wait for an appointment was too lengthy. Members suggested that care could be improved by increasing access to medication, matching doctors/therapists to patient needs/preferences, and increasing support for social determinants of health (e.g., transportation, housing, disability, and employment).

Vocational Rehabilitation Services and Supportive Employment. VRS are available statewide, in all regions of the state. Eligibility for VRS is determined in accordance with federal requirements at 34 CFR 361.42(a). Additionally, all applicants determined eligible for Social Security Disability or Supplemental Security Income are presumed eligible for VRS. Individuals receiving VRS have an Individualized Plan for Employment based on the requirements at 34 CFR 361.45, following an assessment for determining vocational rehabilitation needs. SE is available as

a VRS. Through this service, individuals with the most severe disabilities are placed in competitive jobs with qualified job coaches/trainers to provide individualized, ongoing support services. Several of Indiana's CMHCs provide SE services for persons with SMI. These programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-up. Job placements are community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client to staff ratio.

Two CMHCs and two outpatient providers discussed VRS and SE opportunities for beneficiaries with SMI. One CMHC described several programs that focused on skill development, job attainment, and financial autonomy. These programs were designed to increase socialization and enhance quality of life. This CMHC highlighted that funding for these programs are limited and consequently posed financial challenges to the CMHC. The second CMHC stated that beneficiaries are referred to external VR and SE services. This CMHC also emphasized the recent receipt of grant funding which has supported public education efforts specific to individuals with first episode psychosis (e.g., assessment and referral strategies) as well as providing additional opportunities for employment.

Outpatient providers also described VRS opportunities. One provider highlighted the use of an internal accredited clubhouse which focuses on skill building. This outpatient provider noted that the clubhouse has successfully enabled individuals to gain employment opportunities and transition to independent living. The second outpatient provider described an internal program that provides referrals to SE. This outpatient provider also highlighted funding streams as a significant challenge for maintaining VRS/SE noting that rate increases as well as staff salary adjustments were executed during CY2021 and CY2022 to ensure services could continue.

Was there any increase in care integration between primary and behavioral health during the demonstration period? (Quantitative and Qualitative)

FSSA, in partnership with IDOH, launched an initiative in 2012 to develop a statewide strategic plan to integrate primary and behavioral health care services in Indiana. Indiana's PCBHI efforts include the formation of a statewide stakeholder group, formalized definition for integration for Indiana, and the original creation of five subcommittees that spearheaded research and collaboration.

In addition, FSSA and IDOH established a process by which CMHCs, FQHCs, Community Health Centers, and Rural Health Clinics could become a state-certified, integrated care entity (ICE). ICE providers are required to provide care coordination that includes partnering with physicians, nurses, social workers, discharge planners, pharmacists, representatives in the education system, representatives of the legal system, representatives of the criminal justice system and others during any transition of care. The goals of this coordination include reducing unnecessary inpatient and

ED use and increasing consumer and family members' ability to manage their own care and live safely in the community.

Conceived under a separate §1915(i) SPA, the Behavioral and Primary Health care Coordination program offers a service that consists of the coordination of health care services to manage MH, SUD, and physical health care needs of eligible recipients. This includes logistical support, advocacy, and education to assist individuals in navigating the health care system, and activities that help recipients gain the access necessary to manage their physical and behavioral health conditions.

Metric #26 (critical) was used to examine how access to preventative/ambulatory health services changed overtime for Medicaid beneficiaries with SMI. Findings indicate that the percentage of Medicaid beneficiaries, ages 18 and older with SMI who had a preventative/ ambulatory care visit increased from 2020 to 2022. This increase aligns with the state's demonstration target (**Exhibit IV.20**). Indiana's estimated rate is higher than national rates estimated for Medicaid health maintenance organization (HMO) population and comparable to rates estimated for commercial or Medicare (HMO or Preferred Provider Organization [PPO]) population.[51] Of the member respondents (n=23), 92% indicated that they received medical services between 2021 and 2022. Primary care was endorsed the most. Of those that responded 39% indicated that it was easy to make an appointment with little to no wait time. Others indicated that there was symptom improvement (3), that doctors were invested in their care (4), and that they felt supported (3).

Metric #30 was used to assess follow-up care for Medicaid beneficiaries who are newly prescribed antipsychotic medications. Although the percentage of demonstration population beneficiaries aged 18 years and older with new antipsychotic prescriptions who completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication decreased between 2020 and 2022 (not in alignment with state target for the metric), the number of beneficiaries with follow-up visit increased over time which is in alignment with the increase in population with new prescriptions. Differential rates in increase may be due to several overlapping and interrelated factors, such as workforce supply not meeting patient demand, fewer providers offering appointments via telehealth and consequently requiring in-person visits, and challenges with outreach and engagement. (**Exhibit IV.20**).

[51] Adults' Access to Preventive/Ambulatory Health Services - NCQA

Exhibit IV.20 Trend in Milestone 4 Monitoring Metrics Reported by FSSA Related to Integration Between Primary and Behavioral Care (Between Baseline and Mid-Point)

Metric #	Metric Name	DY 2020	DY 2022	Absolute Change	Percent Change	State's Demonstration Target	Directionality at Mid-Point	In Desired Direction
23	**Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)**	**98.3%**	**95.4%**	**-2.9%**	**-2.9%**	**Decrease**	**Decrease**	**Yes**
26	**Access to Prevention/ Ambulatory Health Services for Medicaid Beneficiaries with SMI**	**90.0%**	**95.4%**	**5.4%**	**6%**	**Increase**	**Increase**	**Yes**
29*	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) - Blood Glucose Testing	43.8%	46.4%	2.6%	6.0%	Increase	Increase	Yes
29*	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) - Cholesterol Testing	27.2%	27.7%	0.5%	1.9%	Increase	Neutral	No
29*	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) - Blood Glucose and Cholesterol Testing	25.9%	26.4%	0.5%	1.9%	Increase	Neutral	No
30	**Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication**	**78.4%**	**75.4%**	**-3.0%**	**-3.8%**	**Increase**	**Decrease**	**No**

Bolded metrics were included in risk assessment calculation.

Note: DY = Demonstration Year. Baseline: DY 2020, Mid-Point: DY 2022.

* Metric not identified as critical metric and not used for risk assessment.

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

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

Indiana applied for the PIPBHC grant December 10, 2019, however the award was not granted to the state until March 23, 2021. The implementation of the Health Homes SPA was deprioritized in 2020 due to the PHE. Interviewees in 2020 described that the PHE put significant stress on the primary care and behavioral health systems and emphasized the potential for increased provider burden if new strategies were implemented. Thus, implementation of the Health Homes SPA as well as strategies related to the expansion of the state's model for primary care and behavioral health were delayed. State officials indicated that the Health Homes initiative will be explored as part of the expansion and designation of CCBHC in Indiana.

Do beneficiaries with SMI receive screening or monitoring for co-morbid conditions during the demonstration period? (Quantitative and Qualitative Findings)

Metric #23 was used to examine the percentage of demonstration population beneficiaries aged 18 to 64 with a SMI and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%). Findings indicate that across the study time period, approximately 10% of the demonstration population (more than 12,000 beneficiaries annually) were aged 18 to 75[52] with a SMI and diabetes (type 1 and type 2). Among individuals with SMI and diabetes, more than 95% had hemoglobin A1c (HbA1c) in poor control (> 9.0%). This finding was surprising as it is higher than nationally reported rates (39%) for a Medicaid population.[53] However, this finding is

[52] Technical specifications across monitoring metrics vary. This technical specification extends the age range to 75.

[53] Median rate among states reporting similar measure for Medicaid population is 39% (https://www.medicaid.gov/state-overviews/scorecard/comprehensive-diabetes-care/index.html), varying between 20% and 42% in 2021 based on type of insurance covered population (e.g., Medicare PPO, Medicaid HM)) (Comprehensive Diabetes Care - NCQA). Accessed on 11/20/2023.

likely explained by data capture challenges. The state noted that it did not require systemic use of CPT CAT II codes[54] which capture the necessary detailed information to calculate this metric. Consequently, only a few providers included CPT CAT II codes identifying A1c in poor control yielding the numerator and denominator to be almost duplicative. Going forward (beyond the measurement period for this report), Indiana is implementing processes to capture CPT CAT II codes to enable accurate calculation of this monitoring metric. Consequently, although the percent with A1c in poor control declined from 2020 to 2021 and in alignment with intended goal, findings should be interpreted with caution (**Exhibit IV.20**).

Of the members interviewed (n = 24), 16% of the respondents indicated that they were screened for diabetes at any of the settings (e.g., outpatient, inpatient) where they received MH or SUD care. All inpatient providers noted challenges and barriers in screening or treating SMI beneficiaries for co-occurring conditions. Examples of challenges included receiving patient treatment records from prior services, identifying care opportunities that were accepting new patients, and difficulties in patient follow-up for patients not in the service area. The state may benefit from implementing activities that are designed to increase screening for diabetes and other co-morbid conditions among SMI beneficiaries. Additionally, prioritizing processes to capture CPT CAT II codes will further support the state in making informed decisions for implementation action items.

Metric #29 (critical) was used to examine how metabolic monitoring for children and adolescents changed over time. Metabolic monitoring focused on blood glucose and cholesterol testing either independently or combined. Findings indicate that the percentage of Medicaid beneficiaries, aged 17 and under with SMI who had metabolic monitoring for blood glucose increased – in alignment with the state target for the metric. However, the percentage of Medicaid beneficiaries, aged 17 and under who had metabolic monitoring for cholesterol or both blood glucose and cholesterol remained the same across the study period (not in alignment with the state target for the metric) (**Exhibit IV.20**). The state implementation plan does not include action items specific to children and adolescent metabolic monitoring and consequently, it is not surprising that minimal change was reflected in this metric across the study period.

[54] Supplemental codes used for measuring performance and quality of care (Accessed on 11/20/2023, Category II codes | American Medical Association (ama-assn.org)).

E. State's Capacity to Provide Mental Health Services (Provider Availability)

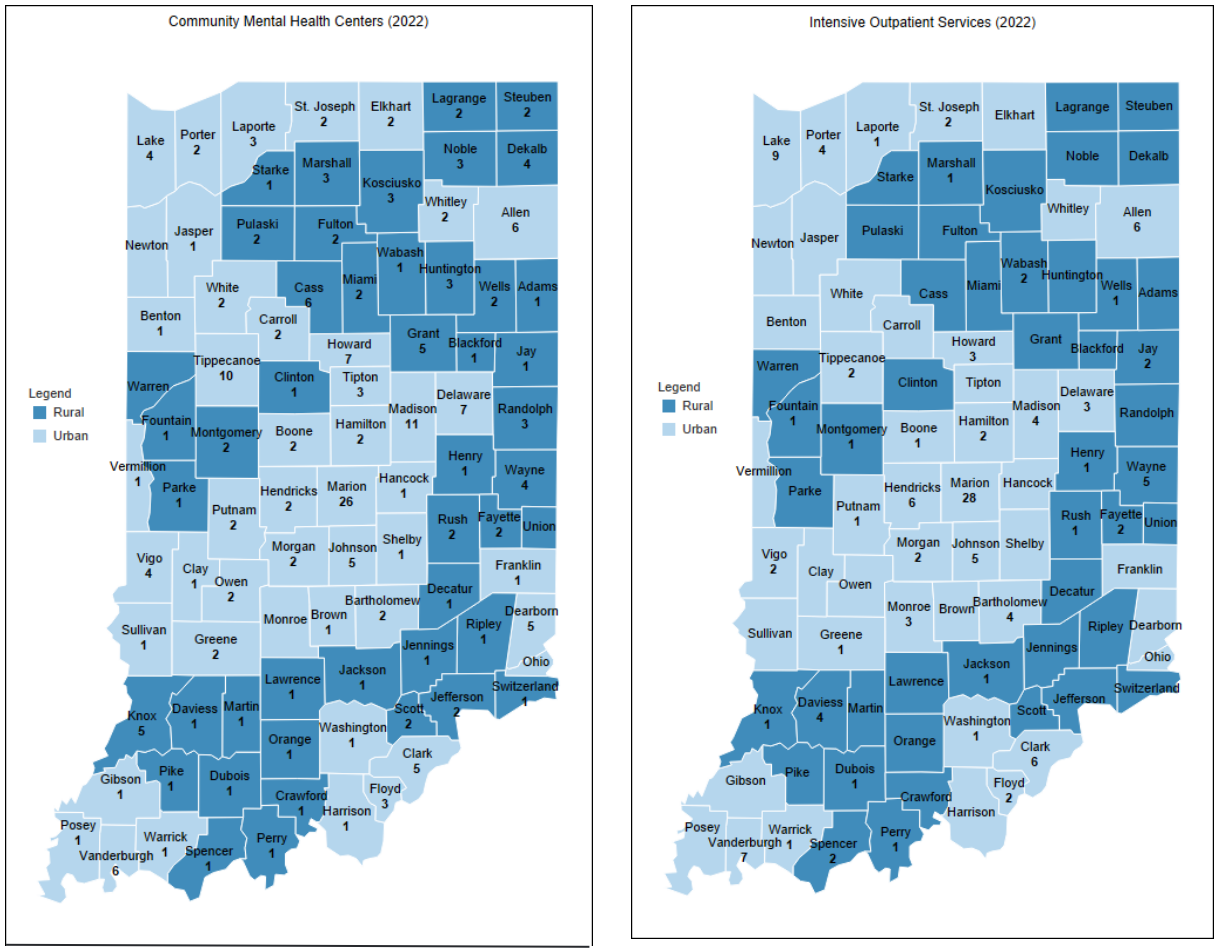
As stated across multiple findings and consistent with the 2020 Summative Report findings, limited provider capacity is an overarching system challenge for the state and has had negative impacts on care planning and coordination. Recognizing provider capacity as a challenge, the state has delineated a strategy to assess provider availability across the state, identify shortage areas, and conduct outreach to increase workforce capacity in geographical areas with shortages. The state uses the annual Provider Availability Assessment to compile provider availability data for different provider types that deliver care to SMI populations. Provider Availability Assessment data was available for 2020, 2021, and 2022 and was used to assess change of provider capacity over time. Provider Availability Assessment data is compiled at the county level and does not account for an individual provider delivering care across multiple counties. Only validated data was included in the Mid-Point Assessment (see **Exhibit III.4** for limitations of provider availability data.) Analyses focused on the count of Medicaid-enrolled providers.

Overall, the number of counties and providers in a county varied across the years. CMHCs and FQHCs reach the most counties and are positioned to provide care across the continuum to SMI beneficiaries. Although crisis services (e.g., MRSS, CSUs) grew over time (2020-2022), gaps are apparent, particularly in rural counties in the southern, eastern, and western part of the state (Note. This gap does not include call centers which reach across the state). Southern counties in general had less provider availability with few Residential Mental Health Treatment (RMHT), psychiatric hospitals that qualify as IMDs, and beds. As expected, Marion County had all provider types and higher rates of providers when compared with other counties. **Exhibits IV.21 - IV.24** presents counts of providers by county for 2022 for several key provider types. Counts of providers by counties for other years are available in **Attachment D**.

CMHCs and Intensive Outpatient Services: There are 24 CMHCs across the state. CMHCs are counted using the number of locations (i.e., CMHCs typically have satellite sites to support service provision). Although the number of counties with CMHC sites decreased from 2020-2022 (all counties had CMHC sites in 2020 compared to 87 counties in 2021 and 2022), the number of CMHC sites increased – from 97 in 2020 to 231 in 2022. At least 25% of the counties had at least one CMHC site (**Attachment E**). The largest number of CMHC sites were in Marion County (4 in 2020, 26 in 2022).

The number of counties delivering intensive outpatient services as well as the total number of providers increased systematically from 2020 to 2022 (2020: 31 counties, total 78 providers, 2022: 41 counties, total 133 providers). The largest increase in the number of providers in a county was for Marion County (19 in 2020 to 28 in 2022). The northern part of the state had the most regional availability gaps for intensive outpatient services. **Exhibit IV.21** visualizes provider counts by counties for CMHC and intensive outpatient services.

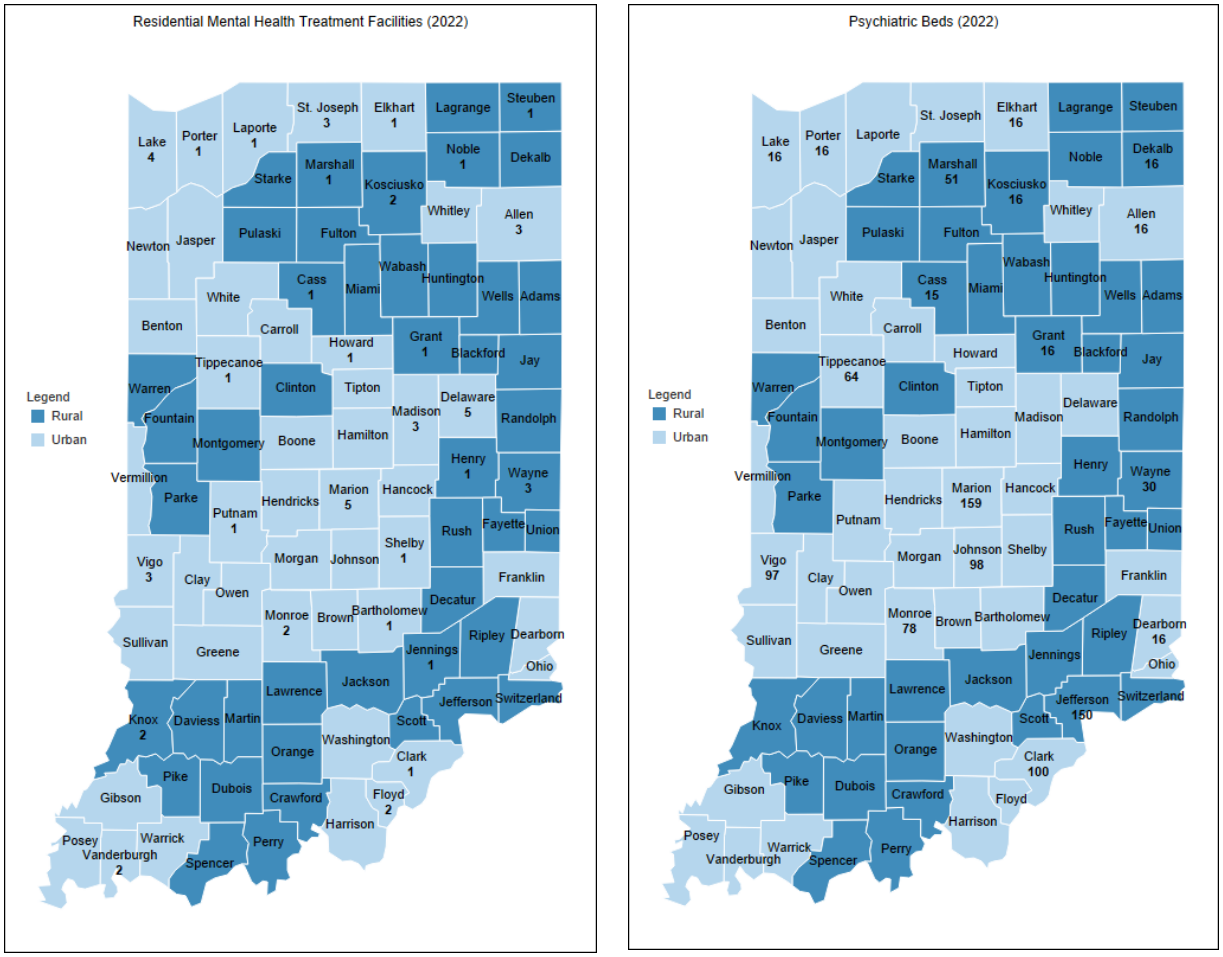
Exhibit IV.21: Number of Providers (CMHC and Intensive Outpatient Services), 2022



RMHTs and Psychiatric Beds: Validated data for RMHTs was available for 2021 and 2022. During both years, 29 counties had RMHT. In 2022, Lake County had a new facility added. The southwestern part of the state had the most regional availability gaps for RMHT.

Validated data for psychiatric beds was available for 2022. In 2022, 18 counties had inpatient facilities that reported counts for psychiatric beds. The total number of beds varied across the counties ranging from 15 in Cass County to 159 in Marion County. Consistent with RMHT data, the southwestern part of the state had the most regional availability gaps for psychiatric beds. **Exhibit IV.22** visualizes provider counts by counties for RMHT and psychiatric beds.

Exhibit IV.22: Number of Providers (RMHT, Psychiatric Beds), 2022

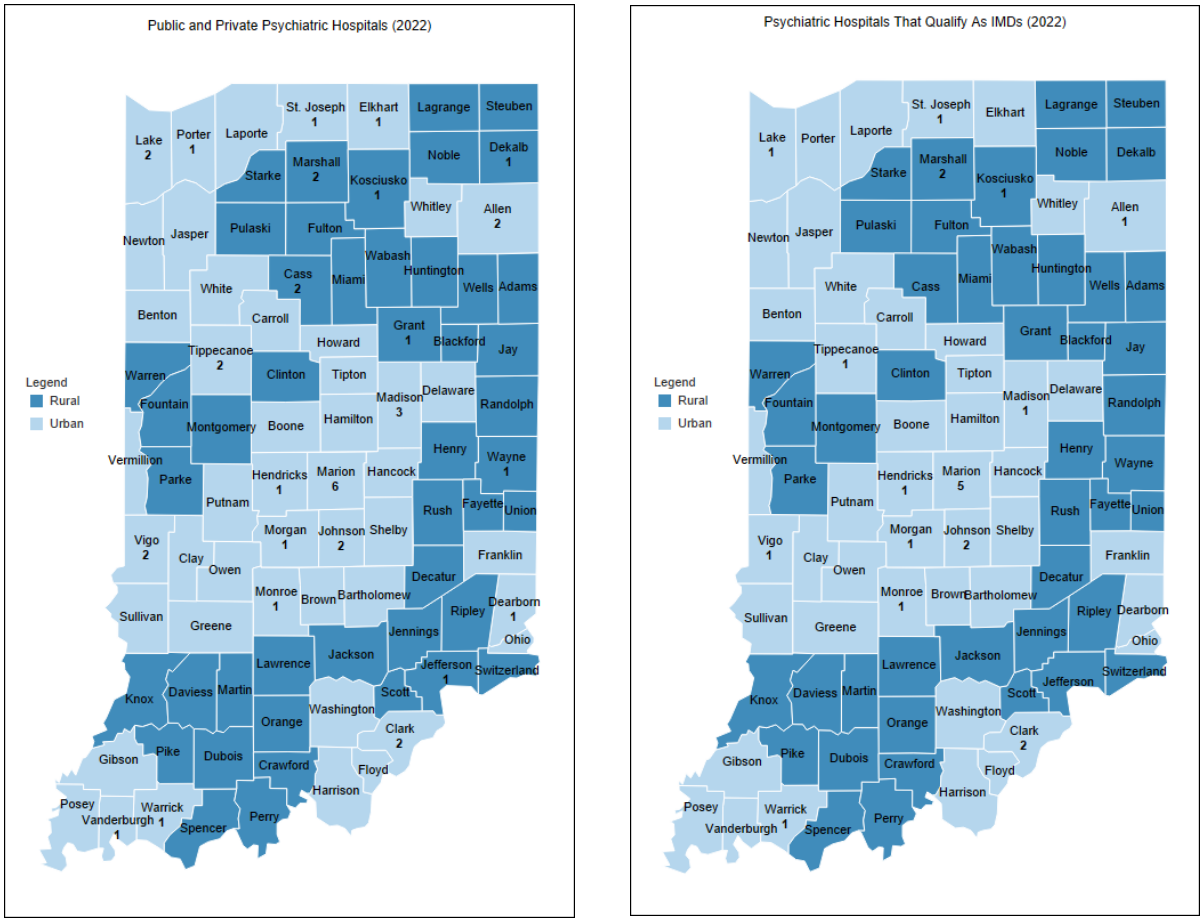


Psychiatric hospitals (Exhibit IV.23): In 2020, 24 counties had at least one psychiatric hospital (public or private), with a total of 34 hospitals statewide. In 2021, the number of hospitals increased to 39 and remained at 39 in 2022. Since 2020, 7 counties gained at least one psychiatric hospital (Allen, Clark, Hendricks, Johnson, Madison, Marion, and Morgan) while 3 counties lost at least 1 psychiatric hospital (Delaware, Dubois, and Vanderburgh). Additionally, there are 6 state operated psychiatric hospitals. These hospitals qualify as an IMD and subsequently are counted in the map on the right.

Public, Private, or State Operated Psychiatric hospitals that qualify as an IMD (Exhibit IV.23). In 2020 and 2021, 14 counties had at least one psychiatric hospital that qualified as an IMD. The number of facilities increased from 19 in 2020 to 22 in 2022. Additional facilities were identified for two counties, Clark and Johnson. Although there were two facilities in Vanderburgh County and one facility in Cass County that were identified as psychiatric hospitals qualifying as an IMD in 2020; during the waiver period (2021-2022), these counties reported not having any psychiatric hospital that qualified as an IMD. In 2022, an additional county (Kosciusko) was identified with a psychiatric hospital that qualified as an IMD.

Consistent with RMHT and psychiatric bed data, the southwestern part of the state had the most regional availability gaps for psychiatric hospitals, followed by the Western part of the state.

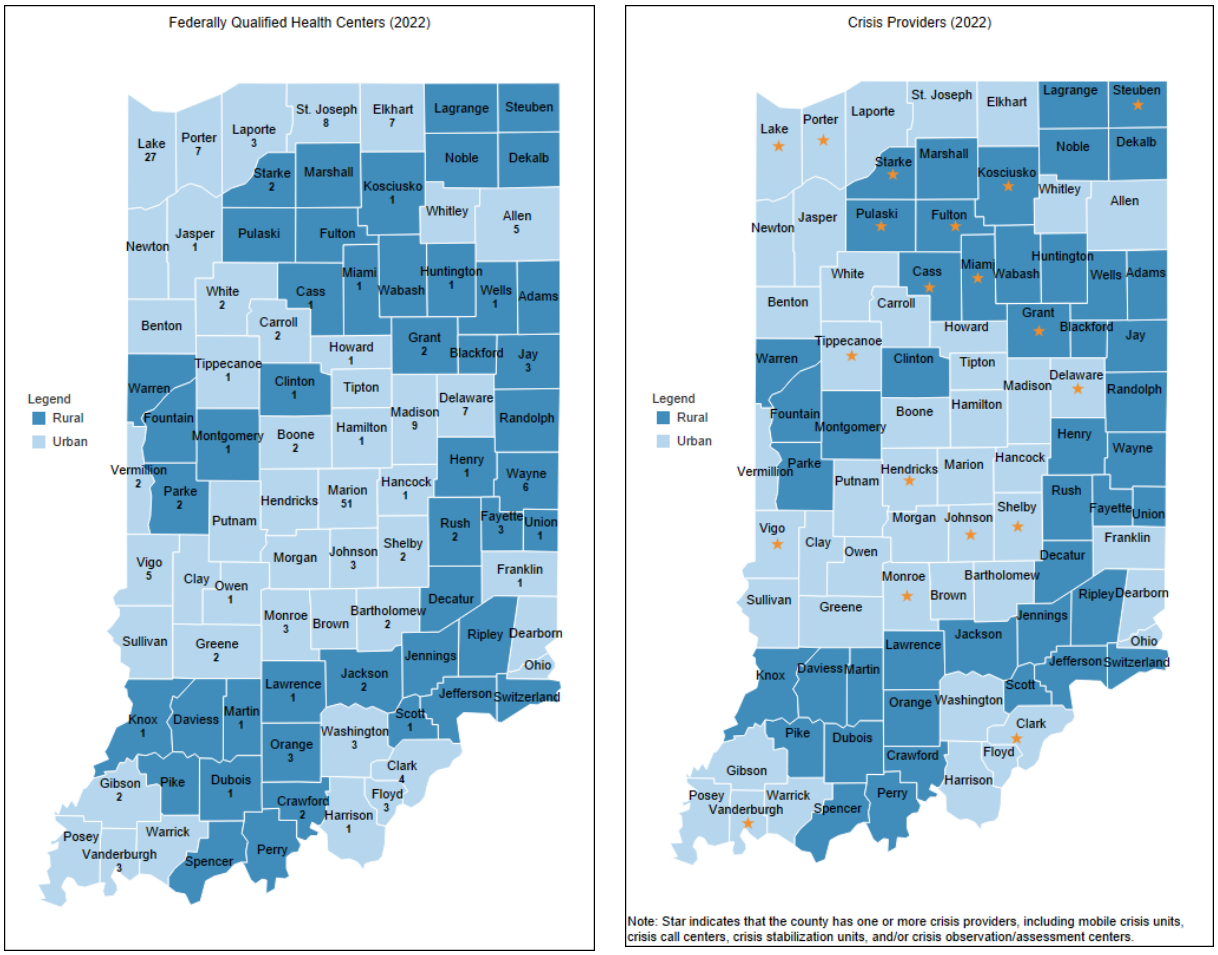
Exhibit IV.23: Number of Psychiatric Hospitals, 2022



Note: The state operates six facilities that qualify as an IMD under CFR, but do not receive FFP under the waiver. The data for public and private psychiatric hospitals did not include these six facilities (map on the left). The data for psychiatric hospitals that qualify as IMDs include these six facilities (map on the right).

FQHC: In 2020 and 2022, 56 counties had at least one FQHC (same counts for all counties, total 213 statewide). For 2021, findings indicate a decrease in the number of FQHCs for 11 counties and increase in counts for 5 counties (counts were same for 2020 and 2022). **Exhibit IV.24** visualizes provider counts by counties for psychiatric hospitals that qualify as IMD and FQHCs.

Exhibit IV.24: Number of FQHCs and Crisis Stabilization Service Locations in 2022



Crisis Stabilization Services: Crisis services included, MRSS, CSUs, crisis observation/assessment centers and call centers. Data for all crisis services was only available for 2022. In 2022, 19 of the 92 counties had one or multiple crisis stabilization services. (**Exhibit IV.24).** Although only 3 call centers were identified in 2022, coverage by these centers was statewide (**Attachment E**). The number of counties having mobile crisis units grew over time from 6 in 2020 to 16 in 2022. Gaps in rural areas were identified, particularly in the southern, eastern, and western parts of the state.

V. Risk Assessment, Recommendations, and Next Steps

Overall, the state is moving in the expected direction relative to its annual goals for all milestones. State progress by milestone was calculated based state's completion of relevant action items (documented in the IN SMI Implementation Plan), the percentage of monitoring metric goals met, themes from stakeholder feedback, and potential risks for impacting success in achieving milestones. A risk level of "low", "medium" or "high" was assigned. **Exhibit V.1** provides overall risk levels by milestone. Milestone findings aligned to relevant assessment questions are summarized followed by risk areas and recommendations (**Exhibits V.2 - V.6**).

Exhibit V.1: Risk Assessment - Actions Completed, Monitoring Metrics Met, Stakeholder Feedback, and Risk Level for Achieving Milestones

Milestone	Action Items in Implementation Plan		Critical Metrics Goals		Stakeholder Feedback Themes	Risk Level
	Total Complete/Total	% Complete	# of metrics in target direction/ total	% of critical metrics goals met		
1	10/10	100%	N/A	N/A	• Policies and procedures focused on quality care. • Access to care perspectives varied. • Telehealth was a good alternative. • Comprehensive screening protocols in place.	**LOW**
2	4/4	100%	1/4	25%	• Case management services were provided during the time frame. • Challenges in treatment and discharge planning collaboration. • Limited provider capacity as an overarching challenge. • Processes for identifying high ED utilizers.	**MEDIUM**
3	2/3	67%	1/1	100%	• Utilization of CANS/ANSA. • Behavioral health provider capacity is monitored annually. • Challenges with the OpenBeds software. • MRSS pilot delayed indefinitely.	**MEDIUM**
4	2/3	67%	2/3	67%	• Strategies to identify beneficiaries with SMI in treatment sooner including relationships with SBHCs and providing VRS and SE services. • Limited awareness of state strategies to engage SMI beneficiaries sooner. • Challenges with treating SMI beneficiaries with co-occurring conditions.	**MEDIUM**

A. Risks and Recommendations by Milestone

1. Milestone 1: Ensuring quality of care in psychiatric hospitals and residential settings.

Milestone 1 focuses on ensuring quality of care in psychiatric hospitals and residential settings. Findings compiled examined the demonstration's impact on maintaining appropriate standards, providing access to appropriate levels and types of care, and requiring inpatient and residential facilities to screen for co-morbid conditions. The state completed all associated action items in support of milestone 1 and is moving in the direction expected according to its annual goals and demonstration target. Few stakeholders identified risks. Risks that were identified are addressable within the time frame. High-level findings are presented by assessment questions followed by risks and recommendations.

Did participating psychiatric hospitals and residential settings maintain appropriate standards to ensure quality of care?

Overall psychiatric hospitals and residential settings maintained appropriate standards to ensure quality of care. Findings indicated that the state upheld licensure requirements for PMHIs and conducted annual unannounced visits throughout the study time frame. Additionally, MCEs implemented policies and procedures that addressed a variety of services across the care continuum (applied to both IMD and non-IMD settings) to ensure quality of care standards. Survey data indicated that more than 80% of respondents were satisfied with the care received, had access to care, and received quality care. However, surveys that assessed member perspectives of the care continuum, did not examine unmet needs for inpatient care or residential settings yielding a gap for monitoring and compiling insights specific to quality care in psychiatric hospitals or residential settings.

Has access to appropriate levels and types of care changed during the demonstration period?

Perspectives on access to care varied, with advocacy organizations indicating access had worsened (attributing declines to the PHE) while members indicated that they received the MH and SUD services they needed. Expanded telehealth services for members increased access to care particularly for SMI beneficiaries who had difficulties accessing transportation or lived in areas with high wait times for MH providers. Consistent with the latter assessment question, information compiled focused on access to the care continuum and did not differentiate findings specific to inpatient care or residential settings.

Did psychiatric hospitals and residential settings incorporate protocols for co-morbid condition screening during the demonstration period?

All inpatient providers reported having a comprehensive screening protocol (inclusive of a COVID screening) in place during CY2021 and CY2022. In general screening protocols across inpatient providers were similar and included a full medical history that covered physical health, MH, comorbid/co-occurring conditions, medication use, and treatments. Inpatient providers indicated

that medical providers are "on staff and ready to treat" for any patient that endorses a physical or co-morbid condition that requires immediate attention.

Exhibit V.2 summarizes potential risks that if not minimized may impact the state's achievement of meeting its' annual goals and demonstration target for milestone 1.

Exhibit V.2: Milestone 1 Potential Risks and Recommendations

Potential Risks	Recommendations
Access to care, particularly in rural areas, continues to be a challenge for the state to ensure quality of care in psychiatric hospitals and residential settings. Although the state continues to build capacity, the workforce supply does not meet demand.	• Build provider capacity (e.g., more beds, more staff, more CSS units) and increase investments in workforce initiatives, level of care assessments, and provider quality training across the state.
Unmet needs for inpatient care or crisis stabilization are not captured by beneficiary interviews and/or other member surveys. Additionally, monitoring metrics do not adequately measure access to or quality of care in psychiatric hospitals or residential settings. Consequently, gaps in data exist yielding the state with limited information to identify insights and implement data driven improvements.	• Conduct studies that focus on access to care and unmet needs on inpatient care or crisis stabilization to better identify gaps and develop strategies for minimizing those gaps. • Identify metrics that assess access and care quality among beneficiaries who have received care in psychiatric hospitals and residential settings. Incorporate these metrics into the state's monitoring plan.
Although telehealth services were identified as a key strategy for increasing access to care across the service continuum, limitations were cited including challenges for some recipients to effectively utilize remote services due to limited mental capacity and technology issues (e.g., bandwidth), difficulties in building rapport with providers via virtual modalities and member costs of technology (e.g., Wi-Fi, computers) associated when coverage was limited.	• Provide technical assistance support for both providers and patients to increase effective use of remote services and identify best practices for patient engagement. • Minimize costs associated with patient use of telehealth services (e.g., increase reimbursement rate, provide increased access to technology).

2. Milestone 2: Improving care coordination and transitions to community-based care

Milestone 2 focuses on pre-discharge planning and care coordination, examining the impact of the demonstration on ED utilization, re-admission, and hospital follow-up. The state completed all associated action items in support of milestone 2. Of the four critical metrics included in the risk assessment, only one (25%) aligned with the expected direction of the demonstration goals. Stakeholders identified some risks that may impact success in meeting milestones. High-level findings are presented by assessment questions followed by risks and recommendations.

Do psychiatric hospitals and residential settings have pre-discharge planning for care coordination to enable transition to community-based care post discharge?

All MCEs stated that case management was provided to members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization. Inpatient providers described a variety of challenges for MCE collaboration

including, the use of non-user-friendly portals, expectations for treating and discharging patients quickly despite need, and inconsistent messaging or communications specific to prior authorization.

Discharge planning between inpatient providers and CMHCs were also explored. CMHCs stated that their case managers provide a myriad of services (i.e., housing services, skills development, appointment coordination, and referrals) and are delivered by certified recovery specialists or individual with at minimum an associate or bachelor level degree. Of the three inpatient providers interviewed, two indicated that CMHCs were not involved in SMI member treatment planning and the discharge process.

Consistent with the findings in the 2020 Summative Report, all interviews described limited provider capacity as an overarching system challenge and specified its' negative impact on care planning and coordination. Most MCEs reported that staffing challenges continued to impact facilities providing care to SMI beneficiaries during CY2021 and CY2022 and emphasized difficulties with care coordination and connecting beneficiaries to community-based care. Member findings also emphasized limited availability for care coordination appointments.

Do psychiatric hospitals and residential settings have established processes for follow-ups post discharge to ensure members have access to and are receiving community-based care?

Findings indicate that between baseline and waiver mid-point (CY 2022), the proportion of beneficiaries 18 and older receiving follow-up care increased - in alignment with the state's demonstration target. The proportion of discharges with medication continuation remained similar across the years.

MCEs are responsible for ensuring enrollees access follow-up care post-discharge. All five MCEs confirmed that either the behavioral health care provider or the MCE's behavioral health case manager contact members within three business days of a missed appointment.

Outpatient providers described their care coordination processes for SMI beneficiaries and indicated that care coordination benefits SMI beneficiaries. Outpatient providers stated that communication with other providers is an ongoing challenge for care coordination. Based on member interviews, of the members who reported receiving care coordination services, feedback was positive.

Do beneficiaries discharged from ED receive follow-ups for care coordination?

Findings indicate that although the number of beneficiaries with follow-up visits increased, the proportion of beneficiaries receiving a follow-up visit decreased between baseline (DY2020) and the waiver mid-point (DY2022) for both 7-day and 30-day follow-up. This decrease did not align with the state's demonstration target.

All MCEs discussed processes for identifying high ED utilizers with SMI. Consistent with findings from the Summative Report, most MCEs stated that the PHE impacted care coordination for high

ED utilizers with SMI, noting observations such as provider shortages, facility shutdowns, and patient hesitancy for attending in-person appointments.

Does the demonstration help reduce preventable readmissions to acute care hospitals and residential settings?

Findings indicate that readmission rates were higher at waiver mid-point (DY2022) relative to baseline (DY2020). This finding does not align with the demonstration's target. However, it should be noted that the readmission rate decreased from 2020 to 2021 and then increased from 2021 to 2022. Decreased readmission rates in 2020 may be due to the state's implementation of social distancing parameters during the first year of the PHE, while increasing rates may be a result of "relaxing" social distancing parameters as the PHE continued. Additional years of data are required to examine whether preventable readmissions reduced during the demonstration period.

Exhibit V.3 summarizes potential risks that if not minimized may impact the state's achievement of meeting its' annual goals and demonstration target for milestone 2.

Exhibit V.3: Milestone 2 Potential Risks and Recommendations

Potential Risks	Recommendations
Limited collaboration and communication during discharge planning and care transitions were identified as negatively impacting patient care. Provider capacity challenges magnified risk, particularly in ED transitions. Stakeholders emphasized that improved collaboration and a more robust workforce across the SOC is needed.	• Increase interactions (e.g., meetings, communications), provide consistent messaging for treatment and discharge expectations, and adopt tools (e.g., user-friendly portals) to support collaboration between MCE and provider groups. • Encourage frequent and intentional provider to provider communication and collaboration during key care transition phases (e.g., treatment planning and discharge). • Identify strategies to increase workforce capacity (e.g., investments in care coordinators) and increase quality interactions (e.g., decrease case manager workloads) for members with SMI.

3. Milestone 3: Increasing access to continuum of care including crisis stabilization services

Milestone 3 focuses on crisis stabilization and examines the impact of the demonstration on increasing access to care across the care continuum. The state completed two of the three associated action items in support of milestone 3. Milestone 3 included one critical metric. Findings for the critical metric was aligned with the expected direction of the demonstration goals. Stakeholders identified some risks. Risks that were identified are addressable within the time frame. High-level findings are presented by assessment questions followed by risks and recommendations.

Do contracted providers use a widely recognized, publicly available assessment tool to determine level of care and LOS?

Findings from stakeholder interviews indicated that providers use a widely recognized, publicly available assessment tool to determine level of care and LOS. Every individual served by a DMHA contracted provider receives a CANS/ANSA to inform individualized treatment planning and level of care decision making. Although providers highlighted the benefits of these tools, feedback emphasized that the length of the assessment impacts rapport building.

Do demonstration action items contribute to increased access to the continuum of care?

FSSA state officials indicated that behavioral health network capacity was monitored annually via several mechanisms including waivers, outreach, and data collection to increase access to the continuum of care, and MCEs confirmed that network adequacy standard requirements were met during the time frame. Consistent with findings from the Summative Report, Indiana recognized that the adequacy of provider supply did not meet patient demand and consequently initiated strategies (legislation and billing system infrastructure changes, workforce initiatives focused on expansion and retention) to increase provider supply. Although these strategies were not included in the IN SMI Implementation Plan, they were identified as key efforts for meeting milestones, including milestone 3.

Do demonstration action items contribute to increased access to crisis stabilization services?

Overall, Indiana provides comprehensive crisis stabilization services statewide include outpatient services, MRO via CMHCs, §1915(i) programs, expanded SUD services, and partial hospitalization programs. Additionally, in 2019, Indiana Medicaid expanded crisis intervention services, intensive outpatient program services, and peer recovery services to all Indiana Medicaid programs, not only the MRO option. Two advocacy organizations highlighted the importance of crisis stabilization services, but noted challenges specific to coverage, access, and service knowledge.

The IN SMI implementation plan highlighted three strategies to contribute to increase access to crisis stabilization services: CSU pilots, OpenBeds, and the MRSS pilot. The state supported two CSU pilots during the time frame, discontinued use of OpenBeds (based on feedback from providers) and delayed the MRSS pilot indefinitely.

Do SMI beneficiaries have short-term stays and is LOS being tracked?

The LOS for beneficiaries with SMI at an IMD receiving FFP only were tracked during the time frame via monitoring metric #19b. The ALOS decreased from 7.9 to 7.4 days during the time frame with an ALOS of 7 days. Additionally, the number of beneficiaries who received treatment in an IMD increased from 2020 to 2022. This aligns with the state's demonstration target and suggests greater access to IMDs.

Exhibit V.4 summarizes potential risks that if not minimized may impact the state's achievement of meeting its' annual goals and demonstration target for milestone 3.

Exhibit V.4: Milestone 3 Potential Risks and Recommendations

Potential Risks	Recommendations
Findings from stakeholder interviews indicated that providers use CANS or ANSA (widely recognized, publicly available assessment tools) to determine level of care and LOS. Providers noted that the length of the assessments impact rapport building between the provider and patient and may result in inflating or deflating scores. Consequently, patients may be matched to an inappropriate level of care and LOS yielding the potential for poor outcomes and increased costs.	• Revisit the use of the CANS/ANSA and determine if a shorter assessment tool could be used to inform individualized treatment planning and level of care decision making.
Although CSU pilots were perceived positively, findings included in this report were limited to feedback from the CSU implementing the pilot. As such, conclusions on increasing access to the continuum of care for SMI beneficiaries cannot be drawn.	• Conduct additional CSU pilots that include evaluation and monitoring protocols to assess the impact of CSUs on increasing access to care across the care continuum and associated health improvements. Insights derived will support potential expansion strategies that can be scaled state-wide.
Suspension of key activities, such as the MRSS pilot and OpenBeds highlights gaps in the state's plan for ensuring treatment access across the care continuum. For example, the MRSS pilot was identified as an action item for diverting individuals in crisis from hospitals, EDs, and jails.	• Update the Implementation Plan to account for actions that the state is no longer executing as well as add additional actions (if any) that the state is pursuing to increase access to care, including crisis stabilization. • Meet with providers, advocates, and state agencies (e.g. DOC, IDOH) to identify strategies for increasing collaboration and minimizing barriers for accessing treatment services.
Consistent methodology to assess provider availability and validated data was not available for all provider types across years (e.g., number of psychiatrists or other practitioners who are authorized to prescribe psychiatric medications, other practitioners certified and licensed to independently treat mental illness, residential MH treatment facilities).	• Develop processes to document methodology to assess provider availability and systematically collect assessment data across time.

4. Milestone 4: Earlier identification and engagement in treatment, including through increased integration

Milestone 4 focuses on identifying and engaging individuals at risk of SMI into treatment and examines the impact of the demonstration on increasing the number of individuals covered by waiver services as well as increased primary and behavioral health integration. The state completed two of the three associated action items in support of milestone 4. The two critical metrics included in the risk assessment for milestone 4 are aligned with the expected direction of the demonstration goals. Stakeholders identified some risks. Risks that were identified are addressable within the time frame. High-level findings are presented by assessment questions followed by risks and recommendations.

Does the demonstration result in earlier identification and engagement of treatment for beneficiaries?

Findings highlighted that the number of beneficiaries in the State demonstration population with any MH condition increased from 2020 to 2022. This aligns with the state's demonstration target and suggests that more individuals with SMI are receiving treatment.

Interviews with MCEs indicated that they did have strategies in place during CY2021 and CY2022 to identify beneficiaries with a serious MH condition. All MCEs indicated that they have relationships with SBHC.

Even though stigma reduction actions were not included in the IN SMI Implementation Plan, FSSA state officials highlighted several initiatives that started in the fall of 2022 and ended in the fall of 2023, with a focus on SMI/SED between 3/2023 and 9/2023. Stigma reduction activities were designed to increase screening and treatment engagement among SMI populations.

Was there any increase in care integration between primary and behavioral health during the demonstration period?

Findings indicate that the percentage of Medicaid beneficiaries, ages 18 and older with SMI who had a preventative/ambulatory care visit increased from 2020 to 2022. This increase aligns with the State's demonstration target. Although the percentage of beneficiaries with a new antipsychotic prescription who completed a follow-up visit within four weeks of prescription decreased between 2020 and 2022, the number of beneficiaries with follow-up visits increased over time, which is in alignment with the increase in population with new prescriptions.

Additionally, Indiana was awarded the PIPBHC grant on March 23, 2021. The overall goal of the grant is to increase integration between primary and behavioral health care. However, the implementation of the Health Homes SPA was deprioritized in 2020 due to the PHE. Interviewees in 2020 described that the PHE put significant stress on the primary care and behavioral health systems and emphasized the potential for increased provider burden if new strategies were implemented. Thus, implementation of the Health Homes SPA as well as strategies related to the expansion of the State's model for primary care and behavioral health were delayed. State officials indicated that the Health Homes initiative will be explored as part of the expansion and designation of CCBHC in Indiana.

Did beneficiaries with SMI receive screening or monitoring for co-morbid conditions during the demonstration period?

Findings indicate that across the study time period, approximately 10% of the demonstration population (more than 12,000 beneficiaries annually) were aged 18 to 75[55] with a SMI and diabetes (type 1 and type 2). Among individuals with SMI and diabetes, more than 95% had

[55] Technical specifications across monitoring metrics vary. This technical specification extends the age range to 75.

hemoglobin A1c (HbA1c) in poor control (> 9.0%). This finding was surprising as it is higher than nationally reported rates (39%) for a Medicaid population.[56] However, this finding is likely explained by data capture challenges. The state noted that it did not require systemic use of CPT CAT II codes[57] which capture the necessary detailed information to calculate this metric. Consequently, only a few providers included CPT CAT II codes identifying A1c in poor control yielding the numerator and denominator to be almost duplicative. Moving forward (beyond measurement period for this report), Indiana is implementing processes to capture CPT CAT II codes to enable accurate calculation of this monitoring metric. Consequently, although the percent with A1c in poor control declined from 2020 to 2021 and in alignment with intended goal, findings should be interpreted with caution.

Of the members interviewed (n = 24), 16% of the respondents indicated that they were screened for diabetes at any of the settings (e.g., outpatient, inpatient) where they received MH or SUD care. All inpatient providers noted challenges and barriers in screening or treating SMI beneficiaries for co-occurring conditions.

Exhibit V.5 summarizes potential risks that if not minimized may impact the state's achievement of meeting its' annual goals and demonstration target for milestone 4.

Exhibit V.5: Milestone 4 Potential Risks and Recommendations

Potential Risks	Recommendations
The state highlighted a number of stigma reduction efforts during the time frame; however, advocacy organizations were unaware of such efforts. Additionally, the implementation of stigma reduction efforts focused on the SMI population began after the time frame.	• Better communication around stigma reduction efforts between state officials and advocacy organizations. • More time is needed to assess the impact of the state's stigma reduction efforts on engagement.
Given that all inpatient providers noted challenges and barriers in screening or treating SMI beneficiaries for co-occurring conditions (e.g., receiving patient treatment records from prior services, identifying care opportunities that were accepting new patients, and difficulties in patient follow-up for patients not in the service area), additional action items may be beneficial to increase opportunities for integrated care.	• Address barriers to behavioral health integration (e.g., enhance infrastructures to support care coordination, identify strategies to improve communications between providers and support information sharing). • Provide trainings and technical support opportunities in evidence-based screening and interventions and building referral networks.

[56] Median rate among States reporting similar measure for Medicaid population is 39% (https://www.medicaid.gov/state-overviews/scorecard/comprehensive-diabetes-care/index.html), varying between 20% and 42% in 2021 based on type of insurance covered population (e.g., Medicare PPO, Medicaid HM)) (Comprehensive Diabetes Care - NCQA). Accessed on 11/20/2023.

[57] Supplemental codes used for measuring performance and quality of care (Accessed on 11/20/2023, Category II codes | American Medical Association (ama-assn.org)).

Potential Risks	Recommendations
Limited monitoring metrics were available that directly measure the integration of primary and behavioral health care (beyond diabetes care) yielding challenges in drawing conclusions for activities associated with behavioral integration. Additionally, the timing of the PIPBHC grant (awarded March 2021) did not align to the study period and subsequent findings were not available. The implementation of the Health Homes SPA as well as strategies related to the expansion of the State's model for primary care and behavioral health were delayed due to the PHE. Health Homes is being explored as part of the CCBHC expansion.	• Update the monitoring protocol to include metrics that align more closely with behavioral integration. • Prioritize processes to capture CPT CAT II codes. CPT CAT II codes will provide additional information specific to provider screening and assessment efforts via claims. • Review the findings of the PIPBHC grant once completed and identify action items that could be added to the implementation plan. • Re-visit the Health Homes SPA.

5. Risks and Recommendations Across Milestones 1-4

In addition to the milestone specific risks, we identified several broad risks that have the potential to impact the state's success in achieving goals. Risk areas focus on data validation challenges, varied population definitions, and missing state actions that support waiver goals.

Exhibit V.6 summarizes potential risks that if not minimized may impact the state's achievement of meeting its' annual goals and demonstration targets.

Exhibit V.6: Overarching Potential Risks and Recommendations

Potential Risks	Recommendations
Inconsistent data and challenges validating data accuracy reduced confidence in drawing conclusions and identifying insights for certain metrics. Consequently, findings for those metrics should be interpreted with caution.	• Continued diligence for data entry, compilation, and reporting. Increase data quality checks when appropriate.
Monitoring metric technical specifications used different populations and limited the connectivity of findings. Additionally, many monitoring metrics did not align (e.g., age, condition type) or there were no monitoring metrics identified with the goal or action being measured limiting interpretations.	• When possible, use the SMI population definition for reporting metrics. • Identify and report additional supplemental metrics that better align with actions and goals.
The implementation plan does not capture several actions (e.g., telehealth, stigma programs) aimed at improving care for SMI populations. Given actions (not identified in the Implementation Plan, but documented in the report) were compiled organically, there may be more actions that the state is executing which are not captured.	• Update the Implementation Plan with current actions aimed at improving care among the SMI population.

B. Next Steps

1. State's Modifications to Implementation Plan

The state reviewed three drafts of the Mid-Point Assessment report. Report reviews provided the state with an opportunity to confirm or deny information as well as answer additional evaluator questions. At no time did the state direct Lewin in the execution of the Mid-Point Assessment

approach or in how findings were reported or interpreted. FSSA met with Lewin to review milestone progress to date, potential risks, and recommendations.

The state prioritized 12 recommendations (**bolded**) out of a total of 25 recommendations and determined whether modifications to the Implementation Plan or other state activities are needed. **Exhibit V.7** lists the recommendations and notates potential adjustments to the Implementation Plan or additional activities being conducted via another Indiana initiative.

Exhibit V.7 Milestone Recommendations and Prioritization

	Recommendations for Potential Modifications to Implementation Plan or Other State Activities	Implementation Plan	Other State Activities
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	1. Conduct studies that focus on access to care and unmet needs on inpatient care or crisis stabilization to better identify gaps and develop strategies for minimizing those gaps.		
	2. Identify metrics that assess access and care quality among beneficiaries who have received care in psychiatric hospitals and residential settings. Incorporate these metrics into the state's monitoring plan.		
	3. Build provider capacity (e.g., more beds, more staff, more CSUs) and increase investments in workforce initiatives, level of care assessments, and provider quality training across the state.		
	4. Provide technical assistance support for both providers and patients to increase effective use of remote services **and identify best practices for patient engagement**.	X	
	5. Minimize costs associated with patient use of telehealth services (e.g., increase reimbursement rate, provide increased access to technology).		
Milestone 2: Improving Care Coordination and Transitions to Community-based Care	**6. Increase interactions (e.g., meetings, communications), provide consistent messaging for treatment and discharge expectations, and adopt tools (e.g., user-friendly portals) to support collaboration between MCE and provider groups.**	X	
	7. Encourage frequent and intentional provider to provider communication and collaboration during key care transition phases (e.g., treatment planning and discharge).	X	
	8. Identify strategies to increase workforce capacity (e.g., investments in care coordinators) and increase quality interactions (e.g., decrease case manager workloads) for members with SMI.	X	
Milestone 3: Increasing Access to Continuum of	**9. Revisit the use of the CANS/ANSA and determine if a shorter assessment tool could be used to inform individualized treatment planning and level of care decision making.**	X	

	Recommendations for Potential Modifications to Implementation Plan or Other State Activities	Implementation Plan	Other State Activities
Care Including Crisis Stabilization Services	10. Conduct additional CSU pilots that include evaluation and monitoring protocols to assess the impact of CSUs on increasing access to care across the care continuum and associated health improvements. Insights derived will support potential expansion strategies that can be scaled state-wide.		
	11. Update the Implementation Plan to account for actions that the state is no longer executing as well as add additional actions (if any) that the state is pursuing to increase access to care, including crisis stabilization.	X	
	12. Meet with providers, advocates, and state agencies (e.g., Department of Health, Department of Corrections) to identify strategies for increasing collaboration and minimizing barriers for accessing treatment services.	X	
	13. Develop processes to document methodology to assess provider availability and systematically collect assessment data across time.		
Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration	14. **Improve communication specific to stigma reducing efforts between state officials and advocacy organizations**.		X
	15. Examine the impact of the state's stigma reducing efforts on engagement.		
	16. Address barriers to behavioral health integration (e.g., enhance infrastructures to support care coordination, identify strategies to improve communications between providers and support information sharing).		X
	17. Provide trainings and technical support opportunities in evidence-based screening and interventions and building referral networks.		X
	18. Update the monitoring protocol to include metrics that align more closely with behavioral integration.		
	19. Prioritize processes to capture CPT CAT II codes. CPT CAT II codes will provide additional information specific to provider screening and assessment efforts via claims.		
	20. Review the findings of the PIPBHC grant and identify action items that could be added to the implementation plan.		
	21. Re-visit the Health Homes SPA.		
Across Mid-Point Assessment	**22. Continued diligence for data entry, compilation, and reporting. Increase data quality when appropriate.**		X
	23. When possible, use the SMI population definition for reporting metrics.		
	24. Identify and report additional supplemental metrics that better align with actions and goals.		
	25. Update the implementation plan with current actions aimed at improving care among the SMI population.	X	

VI. Attachments

Attachment A: Independent Assessor Description and Attestation (e.g., COI)

The Lewin Group (Lewin) serves as the Independent Evaluator of Indiana's SMI waiver (HIP - Project Number 11-W-00296/5). Lewin's scope of work includes:

- Developing the evaluation design;
- Conducting tasks related to the development of and drafting of the Summative Evaluation;
- Conducting tasks related to the development of and drafting of the Mid-Point Assessment; and
- Conducting tasks related to the development of and drafting of the Interim Evaluation.

FSSA Collaboration and Objective Assessment: Lewin met with the FSSA SMI Leadership Team to review the elements required in the Mid-Point Assessment; the approach for conducting the Mid-Point Assessment, and the schedule for completing requirements. Throughout the evaluation time frame, FSSA provided Lewin with data (e.g., quarterly and annual monitoring reports, provider availability assessment), materials (e.g., reports, provider bulletins), and stakeholder (e.g., state officials, providers, advocacy associations) outreach support. Additionally, FSSA was available to answer questions pertaining to data, programmatic activities, and state policies or initiatives. FSSA reviewed three drafts of the report. Report reviews provided FSSA with an opportunity to confirm or deny information as well as answer additional evaluator questions. At no time did FSSA direct Lewin in the execution of the Mid-Point Assessment approach or in how findings were reported or interpreted. Hence, Lewin confirms that the Mid-Point Assessment report is a fair, impartial and objective assessment of Indiana's performance in carrying out the Section 1115 SMI/SED Demonstration Implementation Plan.

Conflict of Interest. As the Professional Services Contractor for the "Health Indiana Plan 1115 Waiver Evaluation" Services contract, Lewin confirms herein that it adheres to stringent organizational conflict of interest ("OCI") policies and procedures that are aligned with the requirements of Federal Acquisition Regulation Part 9.5. As such, Lewin continuously monitors its work for actual or potential OCI. To date, Lewin has not found any facts or circumstances associated with performing its assigned work that create an actual or potential OCI or adversely affect or impact FSSA. If Lewin becomes aware of any circumstances that could present an actual or potential conflict of interest (COI) as it continues its work under this Contract, Lewin will engage with the FSSA Contracting Officer to ensure that appropriate and mutually agreed upon mitigation measures are put in place to address any such OCI prior to Lewin continuing the work.

Sincerely,

Jennifer Weil, PhD
Vice President | The Lewin Group, Part of Optum Serve
Jennifer.weil@lewin.com
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Attachment B: Indiana's Current Behavioral Health System

A. Overview

Indiana's publicly funded behavioral health (both MH and addiction) SOC supports access to prevention, early intervention and recovery-oriented services and supports in all 92 counties, blending federal, state and local funding streams to a provider network of agencies and individual practitioners. Indiana's FSSA and specifically its OMPP and DMHA partner to provide policy oversight and primary funding of services and supports for individuals in need of behavioral health services. OMPP includes a robust continuum of behavioral health services as a benefit to enrollees in its fee-for service and Medicaid managed care programs. DMHA leverages its block grant funding from SAMHSA and state appropriations to compliment the Medicaid service array, with a focus on serving adults with SMI, youth with SED, and individuals with SUD of any age, and that are at or below 350% of the FPL. OMPP and DMHA also partner with the DCS and DOC in supporting access to and oversight of behavioral services for Indiana's most vulnerable Hoosiers.

B. Provider Network

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

C. Community MH Centers

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

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

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

Many of these services are part of the State plan MRO services under which service need is identified through an assessment that confirms need for services with an eligible diagnosis and level of care determination using the CANS/ANSA.

D. Current Service Continuum

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

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

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

E. Adult MH Habilitation Services.

Effective November 1, 2014, Indiana implemented the §1915(i) Adult MH Habilitation (AMHH) services program. The AMHH services program was adopted by Indiana to provide community-

based opportunities for the care of adults with SMI who may most benefit from keeping or learning skills to maintain a healthy safe lifestyle in the community. AMHH services are provided for individuals and their families, or groups of adult persons who are living in the community and who need help on a regular basis with SMI or co-occurring mental illness and addiction disorders. AMHH services are intended for individuals who meet all of the following core target group criteria: enrolled in Medicaid, age 19 or older, reside in a setting which meets federal setting requirements for home and community-based services (HCBS) and has an AMHH-eligible, DMHA-approved diagnosis. An eligible AMHH enrollee will be authorized to receive specific requested AMHH services, according to an individualized care plan, approved by the State Evaluation Team. The following are the AMHH services:

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

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

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

The POC is developed as a result of a diagnostic evaluation that includes an examination of the medical, psychological, social, and behavioral aspects of the member's presenting problem and

previous treatment interventions. The POC is reviewed by the attending or staff physician to ensure that appropriate services are being provided and that they continue to be medically necessary. The attending or staff physician also recommends necessary adjustments in the plan, as indicated by the member's overall adjustment as an inpatient. The POC must be in writing and must be part of the member's record.

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

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

Attachment C: Qualitative Data Collection Tools

Attachment C includes the "master" data collection tools utilized for the Mid-Point Assessment key informant interviews. Interviewees had varied areas of experience and expertise. As such, topics and items asked were tailored to the interviewee and thus a single interviewee was not asked every question.

A. Indiana 1115(a) SMI Demonstration Evaluation: State Officials Key Informant Interview Guide

1. Introduction:

This interview is part of a series of key informant interviews that will provide a better understanding of the activities that were implemented by the state of Indiana due to the IN SMI waiver demonstration, as outlined in Indiana's Section 1115 SMI/SED Demonstration Implementation Plan. Lewin, as the independent evaluator of the IN SMI waiver, will be conducting a series of 30–60-minute interviews (with State officials, MCE representatives, providers, advocacy organizations, and members) to gather information on activities that were implemented in relation to the IN SMI waiver Demonstration, impact of the COVID-19 PHE, factors that supported implementation activities, and any challenges or barriers encountered.

The interview with State Officials will be 60 minutes in length. For this interview, we will focus on:

- FSSA planned activities in the IN SMI/SED Waiver Demonstration Implementation Plan,
- Implementation activities during CY 2021-2022, and
- Impact of the COVID-19 PHE on implementation of planned activities, factors that supported the implementation, any challenges or barriers encountered, and future plans.

This interview guide is organized by topic area including:

- Background
- Milestone 1
- Milestone 2
- Milestone 3
- Milestone 4
- Topic 5: Financing Plan
- Topic 6: Health IT Plan
- Statements of Assurance
- Closed Loop Referrals and e-Referrals,

- Electronic Care Plans and Medical Records
- Consent: E-Consent

Not every activity listed in the State's Implementation Plan is included below. That is because either the implementation activity had already been met by the State prior to the waiver Demonstration beginning or, it was identified as being complete during the last iteration of key information interviews, and there is no further information Lewin needs to gather on these implementation activities.

No one State Official will answer all questions listed in this document. Lewin worked closely with FSSA in identifying individuals who held specific expertise or experience for each question below. During the interview, Lewin will only ask questions relevant to the topic area that have been identified for each State Official interviewee.

For each topic area, we have included background information for context prior to each question.

2. Background Information

Background	Question(s)
Attendee Name and Role at FSSA	• Please describe your current role at FSSA. • How long have you been in this role?
Role in respect to the implementation and monitoring of IN SMI/SED Demonstration Implementation Activities	• Were you involved in developing the Implementation Plan for the IN SMI waiver? • If so, what was your role?

3. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

We will begin with questions related to implementation activities associated with Milestone 1, the impact of the COVID-19 PHE on implementation activities, factors that supported the implementation, any challenges or barriers encountered, and future plans. Milestone 1 focused on ensuring quality of care in psychiatric hospitals and residential settings. Please consider the timeframe of CY 2021-2022 specifically for this discussion. We have also included some follow-up based on information gathered during the 2021 key informant interviews.

#	Background	Question(s)
1	**Section 1c (and 1f):** Section 1c of the Implementation Plan is focused on 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. The Implementation Plan indicates that OMPP would develop a report to monitor ALOS according to CMS guidelines. Information gathered from the Key Informant Interviews compiled from State Officials as it relates to CY 2020 demonstration activities indicated that State Officials had not yet developed a report to monitor the average LOS for all Medicaid programs (an activity outlined in the implementation plan), however, that they do internally review ALOS for all institutes of mental disease that receive federal match, and that the information is reported in quarterly monitoring reports as part of SMI waiver demonstration compliance. State Officials indicated that DMHA leaders would continue to closely monitor the ALOS of SMI beneficiaries.	• During CY2021 and CY2022, how did DMHA leaders monitor the ALOS for all programs serving SMI beneficiaries? • Was DMHA able to develop report to monitor ALOS for all Medicaid programs relevant for SMI beneficiaries? • If DMHA was unable to monitor ALOS for beneficiaries: What limited DMHA from meeting this implementation activity? • What strategies were implemented by DMHA to lower the ALOS during the Demonstration period? • How did the PHE impact the state's ability to monitor and/lower ALOS?
2	**Section 1f (and 1c):** As part of their monitoring process, DMHA planned to meet regularly to discuss methods for lowering the ALOS for IMD.	Is this currently accurate? • IF YES: ▪ How frequently does DMHA meet to discuss this? ▪ What have those conversations looked like? • IF NO: ▪ How has this changed in 2021-2022?
3	**Section 1c:** The implementation plan states that OMPP will review the timeline requirements for submission of the 1216A form. *Note*: Emergency and nonemergency admissions require telephonic precertification review. The precertification review must be followed by a written certification of need through completion of State Form 44697 – Certification of the Need for Inpatient Psychiatric Hospital Services (1216A form) along with a written plan of care.	Was OMPP able to review the timeline requirements for submission for the 1216A form? • IF YES ▪ What did the State learn from this review? • IF NO ▪ What challenges did you face in reviewing the timeline requirements for submission of the 1216A form? What are the steps moving forward in reviewing the timeline requirements?
4	**Section 1e:** Beneficiaries should also be screened for suicide risk.	During the demonstration, has there been a decrease in suicide deaths/rate among those discharged from inpatient or residential settings?

#	Background	Question(s)
5	**Sections 1a, 1b, 1d, 1e, 1f, and 1g:** The Implementation plan indicated the State met the activities related to 1a, 1b, 1d, 1e, 1f, and 1g and will continue established operations, including: • Continued operations to maintain licensure and enrollment. • DMHA conducts annual unannounced site visits of each PMHI, site visits include checklist. • MCOs and PA conduct medical necessity reviews utilizing MCGs (also related to Section 3d). • Compliance with program integrity requirements and state compliance assurance process. • PMHIs have policies and procedures for intake and eligibility assessment process. • Monitor compliance with intake assessment and screening as part of site visits.	• Was the State able to continue implementing planned activities established at, or prior to, 2020 (first year of SMI/SED Demonstration)? • Please elaborate on any benefits or challenges experienced by the state, providers, or beneficiaries in implementing these activities. • What other activities or strategies has the state implemented during CY 2021 and CY 2022 to ensure the quality of care in psychiatric hospitals and residential settings for individuals with SMI? • Please elaborate on any benefits or challenges experienced by the state, providers, or beneficiaries in implementing these activities. • What has the impact of COVID-19 been on these activities?

4. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

Next, we will be discussing Milestone 2, which is focused on improving care coordination and transitioning to community-based care. These questions include the implementation activities associated with Milestone 2, impact of the COVID-19 PHE on the activities, factors that supported the implementation activities, any challenges or barriers encountered, and any future plans. Please consider the timeframe of CY 2021-2022 specifically for this discussion. We have also included some follow-up based on information gathered during 2021 informant interviews. CMS had asked the State to respond to a few prompts around electronic care plans and medical records as creating, utilizing, and sharing this information between providers helps to better address beneficiary needs. Questions related to these are discussed in later section titled “Electronic Care Plan”.

#	Background	Question(s)
6	**Section 2b and 2c:** • Part of improving care coordination is ensuring that psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed. • The State is required to ensure that psychiatric hospitals and residential settings contact beneficiaries and community-based providers through the most effective means possible (e.g., email, text, or phone call) within 72 hours post discharge. • To address these aspects of Milestone 2, the State indicated in the implementation plan that the Indiana Medicaid Provider Manual would be updated to explicitly require psychiatric hospitals to have protocols in place to assess for housing insecurity as part of the social work assessment and discharge planning processes and to refer to appropriate resources AND to have protocols in place to ensure the beneficiary is contacted by the treatment facility within 72 hours of discharge and that follow-up care is available and accessible. • During our last iteration of interviews, the State indicated that the Indiana Medicaid Provider Manual was not updated due to reprioritization of activities and resources related to the PHE. Instead, State Officials stated that these protocols were added to the site visit quality investigation review process to ensure facilities have appropriate processes in place to meet identified standards.	We recognize that in CY2020, OMPP did not update the Medicaid Provider Manual. Was the Medicaid Provider Manual updated in CY 2021 -2022 OR did the State continue to use site visit quality investigation review processes to ensure facilities have appropriate processes in place to assess beneficiary housing situation and coordinate with housing providers? to meet the protocols discussed? • IF YES to Provider Manual: ▪ When was it updated? How was it received by providers? Please elaborate on any feedback from providers. ▪ Were there observed increases in housing insecurity assessments, housing coordination after the update?" ▪ Additionally, the State was to issue provider communication materials detailing the requirements concurrent with the change in the Manual. Was the State able to issue such communication? ○ IF YES: ✓ What types of communications were provided (e.g., email, website update)? How was it received by providers? ○ IF NO: ✓ What prevented the state from conducting the communications. • If YES to Continued Process: ▪ Did the review process increase housing insecurity assessments and result in an increase in housing coordination? Did housing coordination occur within the 72 hours? Or did the review process result in different outcomes than expected? Does the review process result in the same outcomes as you had hoped the provider manual update would have had? • IF NO to either: ▪ What were the challenges faced in assessing if psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge? ▪ Are there plans to update the provider manual in the future?

#	Background	Question(s)
7	**Section 2b and 2c:** In the IN SMI Implementation Plan, the State indicated that in order to meet compliance, psychiatric hospitals would have to have protocols in place to ensure the beneficiary is contacted by the treatment facility within 72 hours of discharge **and** that follow-up care is available and accessible. These protocols will be monitored via annual unannounced site visits of hospitals as part of their recertification.	Has the State been able to assess compliance for these requirements using unannounced site visits as part of their recertification process? • IF YES: ▪ What were the compliance rates during CY 2021 and CY 2022? • IF NO: ▪ Does the State use other strategies to assess psychiatric discharge protocols? Did the COVID-19 PHE impact the unannounced site visits during CY 202 and 2022?
8	**Section 2d:** Part of meeting Milestone 2 is to implement strategies to decrease the average lengths of stay in EDs among beneficiaries with SMI or SED prior to admission. One strategy that was mentioned in the Implementation Plan was that OMPP, in collaboration with its Provider Relations contractor, would monitor provide network capacity on an annual basis and identify underserved areas for targeted provider recruitment.	What strategies did the State implement in order to monitor ED utilization and ALOS? Has OMPP been able to identify, on an annual basis, geographic shortage areas for community-based services? • IF YES: ▪ How were geographic shortage areas identified? Please elaborate on findings for CY 2021 and CY 2022. • IF NO: ▪ Does OMPP have a plan in place to identify geographic shortage areas for upcoming years?
9	**Section 2d:** Additionally, from the implementation plan, DMHA had planned to pilot two CSUs in the northern and southern parts of the state. From the last iteration of interviews, State Officials indicated that the CSU pilots would conclude in June of 2022. Upon conclusion, Indiana House Bill 1222 required that DMHA establish a plan to expand future crisis stabilization services (and certified community behavioral health clinics, use of crisis hotline centers, and mobile crisis teams). The findings from the CSU pilots from 2021-2022 were to inform future crisis stabilization services planning.	• Is this information still correct? • What were some of the findings from the CSU pilots? • Has the State established a plan to expand crisis stabilization services?
10	**Section 2d:** In the last iteration of interviews, we learned that FSSA was planning to evaluate the potential of a MRSS as part of 988 and crisis system planning.	Was an MRSS pilot study conducted? • IF YES: ▪ What was the timeframe of the pilot study? Can you describe the pilot (e.g., goals, design, etc.) What were the findings of the pilot study? What are the next steps? • IF NO: ▪ What has prevented the MRSS pilot from being implemented? Is there a plan to pilot this type of service in the future?

#	Background	Question(s)
11	**Section 2d (and 4c):** It was also noted that DMHA and OMPP will pursue a Medicaid SPA to incorporate the mobile crisis teams as enrolled providers, who would then be eligible to receive reimbursement direct by Indiana Medicaid.	Does this still stand? Did IN pursue a Medicaid SPA to incorporate these services? • IF YES: ▪ How has this SPA impacted care coordination? Has it allowed for greater connection for community-based care for beneficiaries? • IF NO: ▪ What has prevented this pursuit? Are there action steps put in place to pursue this in 2021-2022?
12	**Milestone 2:** Milestone 2 aims at a successful transition to community-based care, and thereby reducing readmission.	Did the State observe a reduction in preventable readmissions to acute care hospitals and residential settings since implementation of the waiver activities? Are there specific activities that can be considered to have more impact?
13	**Sections 2a and 2e:** The Implementation Plan indicated that the State met the activities related to 2a and 2e and will continue established operations. 2a is associated with actions to ensure that psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions. And 2e asked what other State requirements/policies were implemented to improve care coordination and connections to community-based services.	• Was the State able to continue implementing planned activities established at, or prior to, 2020 (first year of SMI/SED Demonstration)? • Please elaborate on any benefits or challenges experienced by the state, providers, or beneficiaries in implementing these activities. • What other activities or strategies has the state implemented during CY 2021 and CY 2022 to improve care coordination and transitioning to community-based care for individuals with SMI? • Please elaborate on any benefits or challenges experienced by the state, providers, or beneficiaries in implementing these activities. • What, if any, has the impact of COVID-19 been on these activities?

5. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Next, we will talk about Milestone 3. Milestone 3 is focused on increasing access to the continuum of care, including crisis stabilization services. These questions will include the implementation activities associated with Milestone 3, impact of the COVID-19 PHE on the activities, factors that supported implementation activities, any challenges or barriers encountered, and future plans. Please consider the timeframe of CY 2021-2022 specifically for this discussion. We have also included some follow-up based on information gathered during 2021 informant interviews. *Please note*: Implementation activities for 3b will be addressed in Topic 5: Financing Plan.

#	Background	Question(s)
14	**Section 3a:** The first section of this Milestone is focused on the State's strategy to conduct annual assessments of the availability of MH providers including psychiatrists, other practitioners, outpatient, CMHCs, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs.	Does OMPP monitor provider network capacity on an annual basis? • IF YES: ▪ Please provide the dates of the annual assessment reports for CY 2021 and CY 2022. Please discuss the findings to date. • IF NOT: ▪ What have been the challenges in monitoring provider network capacity? How does the State plan to implement this type of monitoring?
15	**Section 3c:** Section 3c of the Milestone is focused on strategies to improve state tracking of availability of inpatient and crisis stabilization beds. From the implementation plan, the State indicated that in March of 2018, FSSA had implemented a new tool to help beneficiaries seeking treatment for SUD, immediately connecting them with available inpatient or residential services, and that this was made possible by a partnership between the State, OpenBeds, and Indiana 2-1-1. At the time of the implementation plan, FSSA was in the process of expanding the use of OpenBeds beyond SUD tracking and into psychiatric inpatient and crisis stabilization beds. However, it was noted in the last iteration of interviews with State Officials that there were challenges using the OpenBeds software, and that the State would not be pursuing a contract renewal. It was also noted that the State was considering using new monitoring software.	Has the State identified or implemented monitoring software that will support beneficiaries in connecting with available inpatient or residential services? • IF YES: ▪ Was the software or tool implemented and when (CY 2021 or CY 2022)? What have been the benefits or challenges to date for implementing the software or tool? Are their additional strategies the state is using to connect beneficiaries with available inpatient or residential services? • IF NOT: ▪ What strategies is the state using to connect beneficiaries with available inpatient or residential services?
16	**Section 3d: (and 1c)** The last section of Milestone 3 that we are going to be discussing today focuses on the State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and LOS. In the implementation plan, the State noted that effective July 1, 2019, all Indiana Medicaid MCOs and the UM vendor will be utilizing MCGs to determine appropriate level of care and LOS for behavioral health diagnoses.	Was that deadline of July 1, 2019, met? • IF YES: ▪ How has the utilization of MCGs been received by providers? • If NOT: ▪ What challenges did you face in meeting this deadline? ▪ Are there plans to have all Indiana Medicaid MCOs and the UM vendor utilize MCGs to determine appropriate level of care and LOS for behavioral health diagnoses?
17	**Section 3e:** Section 3e of the implementation plan asks about other state requirements/policies to improve access to a full continuum of care including crisis stabilization.	• What other activities or strategies has the state implemented during CY 2021 and CY 2022 to increase access to the continuum of care, including crisis stabilization services, for individuals with SMI? • Please elaborate on any benefits or challenges experienced by the state, providers, or beneficiaries in implementing these activities. • What, if any, has the impact of COVID-19 been on these activities?

6. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

Milestone 4 is focused on earlier identification of serious MH conditions and focused efforts to engage individuals with these conditions in treatment sooner. These questions will include the implementation activities associated with Milestone 4, impact of the COVID-19 PHE on the activities, factors that supported implementation activities, any challenges or barriers encountered, and future plans. Please consider the timeframe of CY 2021-2022 specifically for this discussion. We have also included some follow-up based on information gathered during 2021 informant interviews. *Please note:* Implementation activities for 4c were addressed previously in the questions related to 2d.

#	Background	Question(s)
18	**Section 4b:** This section of Milestone 4 focuses on a plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment. In the implementation plan, the State indicated that to ensure the financial sustainability of the current ICE model following the end of the current grant funding, that the State intended to implement a Medicaid health homes model, through a state plan authority. OMPP planned to submit a health homes SPA by the end of 2019. From the last iteration of interviews, State Officials indicated that leadership is reassessing priorities and will determine if Health Homes SPA will be included in future implementation.	Did the State include Health Homes SPA as part of demonstration implementation in either CY 2021 or CY 2022?? • IF YES: ▪ How has the Health Homes SPA impacted increased integration? ▪ Are there additional activities or strategies that the State has pursued in CY 2021 or CY 2022 that enhance integration of behavioral health care in non-specialty settings? • IF NO: ▪ Is the State still considering including Health Homes SPA in the future? ▪ Are there other activities or strategies that the State has pursued in CY 2021 or CY 2022 that enhance integration of behavioral health care in non-specialty settings? How has CCBHC increased behavioral health care integration in non-specialty settings to improve early identification and linkages to SMI treatment?
19	**Sections 4a and 4d:** The Implementation plan indicated that the State met the activities related to 4a and 4d and will continue established operations. 4a is focused on strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment. 4d is focused on any other strategies the State utilized to increase earlier identification, engagement, integration, and specialized program for young people.	• What other activities or strategies has the state implemented during CY 2021 and CY 2022 to earlier identify serious MH conditions and focus efforts on engaging individuals with these conditions in treatment sooner? • Please elaborate on any benefits or challenges experienced by the state, providers, or beneficiaries in implementing these activities. • What, if any, has the impact of COVID-19 been on these activities?

7. Topic 5: Financing Plan

Next, we will look at the Financial Planning section of the implementation plan. The State was asked to detail plans to support improved availability of non-hospital, non-residential MH services

including crisis stabilization and non-going community-based care. The financing plan should describe state efforts to increase access to community-based MH providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of the current availability of MH services included in the state's application.

#	Background	Question(s)
20	**Section Fa and Fb:** The Financial Planning section focuses on the increased availability of a number of services, including, both non-hospital and non-residential crisis stabilization services (services made available through crisis call centers, mobile crisis units, observation/assessment centers) as well as on-going community-based services (outpatient, CMHCs, partial hospitalization/day treatment, ACT, services in integrated care settings, etc.). The State indicated that they would annually monitor access to non-residential crisis stabilization services and community-based services through completion of the CMS Template- "Overview of the Assessment of the Availability of MH Services."	It is our understanding that there is a provider assessment that the State uses. Is this the State's primary means of monitoring access to community-based services? Has the State been able to annually monitor access to non-residential crisis stabilization services through completion of the CMS template mentioned? • IF YES: ▪ How has the State used the annual monitoring findings (e.g., non-residential crisis stabilization services) to improve care for beneficiaries with SMI? For example, does the State use the findings to identify areas with geographical service gaps and then increase service providers in those areas? • IF NO: ▪ How will the State monitor non-residential crisis stabilization services in the future?

8. Topic 6: Health IT Plan

The State was asked to submit a Health IT Plan (HIT Plan) that describes the State's ability to leverage health IT, advance HIEs, and ensure health IT interoperability in support of the demonstration goals. The Health IT Plan section of the Implementation Plan includes a number of sections that we will be reviewing during this interview, including statements of assurance, closed loop referrals and e-referrals, electronic care plans and medical records, consent: e-consent, and identity management.

9. Statements of Assurance

The State was asked to complete all Statements of Assurance listed in the Implementation Plan, and the sections of the Health IT Planning Template that were relevant to your state's demonstration proposal.

#	Background	Question(s)
21	**Statement 1:** Statement 1 asked that the State provide an assurance that the State has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. In response to this, the State outlined in the Indiana SMHP that Indiana's HIT environment is active with multi-faceted efforts to support provider HIT capacity and foster sharing. However, a March 2019 assessment of Indiana's health information sharing (HIS) conducted based on capability maturity guidance from CMS and the Office of the National Coordination for HIT (ONC), revealed opportunities for increased electronic documentation and standardization among settings and providers not previously addressed through MU including behavioral health providers.	• What improvements has the State executed in this area? • Please describe and identify when (CY2021 OR CY2022) the State made these improvements. • Please describe how each improvement has impacted settings and providers.
22	**Statement 2:** Statement 2 asked for confirmation that the State's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the State's Behavioral Health IT Plan. If this was not the case, the State was asked to describe how this would be achieved and over what time period. The state responded that the HIT Plan was aligned with the state's broader SMHP. However, that the State was in the process of completing an updated SMHP with targeted completion by the end of calendar year 2019.	Was the State able to complete the updated SMHP with the targeted completion by the end of calendar year 2019? • IF NO: ▪ When did the State complete the updated SMHP? ▪ ***IF*** the State did not complete an updated SMHP, please explain what prevented completion. Does the State have plans to update the SMHP in the future?
23	**Statement 3:** Statement 3 asked for confirmation that the State intends to assess the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. Indiana noted that they will review the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B for potential inclusion into your MCO contracts.	Has the State assessed the applicability of standards references in the ISA? Did the State incorporate an ongoing assessment of standards in their MCO contracts? • IF YES: ▪ When did this occur? • IF NO: ▪ Does the State still plan on reviewing and incorporating into MCO Contracts? What is the anticipated date?

10. Closed Loop Referral and e-Referrals (Section 1)

CMS had asked the State to respond to a few prompts around closed loop referrals and e-referrals as sharing this information between behavioral health providers helps to better closely address beneficiary needs.

#	Background	Question(s)
24	**Sections 1.1, 1.2, and 1.3:** CMS prompted the State to address closed loop referrals and e-referrals between: • Physician/MH provider to physician/MH provider • Institution/hospital/clinic to physician/MH provider • Physician/MH provider to community-based supports • At the time that the implementation plan was completed, the State did not have readily accessible data on the exact number of Medicaid-enrolled behavioral health providers who had adopted certified EHRs and are utilizing them for e-referral and/or closed loop referrals for: • Institution/hospital/clinic to physician/MH provider • Physician/MH provider to community-based supports In a March 2019 HIS Assessment, it was revealed that provider tracking of referrals may be facilitated by tools within the EHR, but most still struggle with closing the referral loop. To better understand referrals and e-referrals, the State said that they will conduct a survey to identify the volume of providers utilizing closed loop referrals and e-referrals in order to identify the baseline of current activity and identify options for increasing provider uptake. The dates for completion would be based on prioritization of this activity as determined during completion of the updated SMHP.	Has FSSA had the opportunity to conduct this survey and garner information on: • Physician/MH provider to physician/MH provider referrals and e-referrals? • Institution/hospital/clinic to physician/MH provider referrals and e-referrals? • Physician/MH provider to community-based supports referrals and e-referrals? • IF YES: • When was the survey(s) completed? • Could you elaborate on the results of this survey(s)? • IF NOT: • Were there any barriers you faced in not being able to conduct this survey(s)? • Are there currently any steps being taken at FSSA to conduct this survey(s)? • What is the current goal date of completion? • Did COVID-19 impact your ability to conduct these surveys?

11. Electronic Care Plans and Medical Records (Section 2)

CMS had asked the State to respond to a few prompts around electronic care plans and medical records as creating, utilizing, and sharing this information between providers helps to better address beneficiary needs.

#	Background	Question(s)
25	**Sections 2.1, 2.2, 2.3, 2.4, and 2.5** The implementation plan indicates that the State and its providers would create and use an electronic care plan. The State noted that they were going to work towards compliance with the forthcoming CMS Interoperability and Patient Access final rule.	Was the final rule released? • IF YES: ▪ When was it released? ▪ What was the State's approach for assessing compliance? ▪ Did the State execute this approach? ○ If not, how will the State assess compliance in the future? ▪ What did the State find? • IF NO: ▪ No further questions
26	**Sections 2.1, 2.2, 2.3, 2.4, and 2.5** The State also indicated that FSSA would survey IMDs to identify the baseline of current activities in order to identify options for increasing IMD activity in this area.	Was the IMD survey completed by FSSA? • IF YES: ▪ When was the survey completed? What were the findings from the survey? • IF NO: ▪ What were the barriers in completing the survey? What are the next steps to be taken in order to complete this survey?

12. Consent: E-Consent (42 CFR Part 2/HIPAA) (Section 3) and Identity Management (Section 7)

CMS had asked the State to respond to prompts around e-consent and identity management to ensure appropriate sharing of sensitive health care information, which would allow providers to better address beneficiary needs.

#	Background	Question(s)
27	**Sections 3.1 and 7.1:** CMS wants to ensure that individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws). Additionally, as appropriate, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records. The State indicated via the implementation plan that consent/privacy was managed in a multitude of mechanisms across the Medicaid Health Information Sharing Enterprise. And that they are now able to link a child's electronic medical records with their respective parent/caretaker medical records. However, the future state of both items were to be determined based on the prioritization of initiatives during the SMHP update process.	Are there any updates to give on the status of either: • The SMHP update process? • Electronic consent? • Linking a child's electronic medical record with their respective parent/caretaker's medical records?

B. Indiana 1115(a) SMI Demonstration Evaluation: MCE Key Informant Interview Guide

1. Introduction:

This interview is part of a series of key informant interviews that will provide a better understanding of the activities that were implemented by the state of Indiana due to the IN SMI waiver demonstration, as outlined in Indiana's Section 1115 SMI/SED Demonstration Implementation Plan. Lewin, as the independent evaluator of IN SMI waiver, will be conducting a series of 30–60-minute interviews (with State officials, MCE representatives, providers, advocacy organizations, and members) to gather information on activities that were implemented in relation to the IN SMI waiver Demonstration, impact of the COVID-19 PHE, factors that supported implementation activities, and any challenges or barriers encountered.

The interview with MCEs will be 60 minutes in length. For this interview, we will focus on understanding the MCE experience of, and perspective on, the activities related to SMI waiver:

- MCE awareness of IN SMI waiver related activities,
- MCE role in the implementation of the activities,
- MCE observations on impact of the IN SMI waiver goals and intended implementation milestones (reduce ED, readmissions, improved access, and care coordination) including:
    - Demonstration's progress,
    - Areas of concern (e.g., policy guidance, barriers encountered, etc.),
    - Risks related to meeting the milestones, and/or
    - Potential modifications to State's demonstration activities and / or implementation of the identified activities State's implementation of demonstration
- MCE observations on the impact of COVID-19 PHE on the waiver activities/experiences, factors that supported the IN SMI waiver, and any challenges or barriers on implementing activities.

This interview guide is organized by topic area in alignment with the State's implementation plan milestones including:

- Background
- Milestone 1
- Milestone 2
- Milestone 3
- Milestone 4
- Health IT Plan

Not every activity listed in the State's implementation plan is included below, as the activities did not identify specific roles for MCEs. However, if there are activities (not included in this guide) that MCEs had a role in implementation or experience with, then we would be interested in collecting feedback related to those topics.

For each topic area, we have included background information for context prior to each question.

2. Background Information

Background	Question(s)
Attendee Name and Role at [MCE]	• Please describe your current role at [MCE]. • How long have you been in this role?
Role in respect to the implementation and monitoring of IN SMI/SED Demonstration Implementation Activities	• Were you aware of the IN SMI waiver and/or the implementation activities? If so, please elaborate. • What has been your role, if any, in relation to activities related to the IN SMI waiver?
We have mapped certain questions to ask [MCE] based on the State's implementation plan. Before we dive into questions that are specific to Milestones in the State Implementation Plan, we wanted to ask about observations related to: • the impact of the waiver activities • MCE experience on factors supporting or barriers related to the activities • impact of COVID-19 and the PHE on services and access to care for population with SMI and waiver activities • clarity from the State around diagnoses for SMI	• Please share any observations you may have regarding: ▪ The impact of the waiver activities on [MCE], beneficiaries, etc. ▪ Any factors that have supported the IN SMI waiver activities. ▪ Any barriers that may have impacted IN SMI waiver activities. ▪ The impact of COVID-19 and the PHE on services/access to care for beneficiaries. ▪ Clarity around diagnoses for SMI from the State.

3. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

We will begin with questions related to the implementation activities associated with Milestone 1. Milestone 1 is focused on ensuring quality of care in psychiatric hospitals and residential settings. We have also included some follow-up based on information gathered during the 2021 key informant interviews. When answering the following questions, please consider the timeframe of CY 2021-2022, the MCE role in the implementation activities, any observations on the impact of the SMI waiver goals, observed risks regarding the State meeting the milestone, and any MCE observations on the impact of the COVID-19 PHE.

Background	Question(s)
Section 1c (and 1f): We will first discuss the utilization review process. The goal for the State is to ensure that SMI beneficiaries have access to the appropriate levels and types of care, as well as oversight on lengths of stay. Based on the implementation plan, the State indicated that they would coordinate with the MCOs in developing reporting specifications to better monitor the ALOS for all Medicaid programs by 1/1/2020. From the last iteration of interviews, [MCE] noted that there were challenges to tracking LOS related to SMI for all beneficiaries, at all inpatient care settings.	Did the State coordinate with [MCE] in developing these reporting specifications? • IF YES: ▪ What was the timeline for development? During CY2021 and CY2022, were there continued challenges in tracking ALOS for all SMI beneficiaries across all inpatient care settings? • IF YES: ▪ What were some of the challenges in tracking LOS related to SMI, particularly for psychiatric hospitals and residential settings? • IF NO: ▪ During this time period, what initiatives were implemented by Anthem to improve the tracking of LOS related to SMI, particularly for psychiatric hospitals and residential settings? How did COVID-19 impact LOS related to SMI?
Section 1c and 3d: In accordance with 405 IAC 5-3-23, all inpatient psychiatric, substance abuse, and rehabilitation admissions require prior authorization to ensure the appropriate level of care. Emergency and nonemergency admissions require telephonic precertification review. The precertification review must be followed by a written certification of need through completion of State Form 44697 – Certification of the Need for Inpatient Psychiatric Hospital Services (1216A form) along with a written plan of care. All requests for PA are reviewed on a case-by-case basis. The MCO or PA entity reviews each State Form 44697 to determine whether the requested acute inpatient services meet medical necessity. Every individual served by a DMHA contracted provider receives a CANS/ ANSA to inform individualized treatment planning and level of care decision making. In addition to the use of the CANS and ANSA, determinations of medical necessity for behavioral health services are based on UM criteria implementation by the State's MCOs and UM vendor. Medical necessity reviews are completed by Indiana's MCOs and the State's FFS prior authorization (PA) entity. Effective on 7/1/19, all entities were to utilize MCGs.	• During CY2021 and CY2022, did [MCE] continue to complete medical necessity reviews based on an individual's enrollment? Could you tell us more about what that process looked like? • From 7/1/19 onward, was [MCE] able to utilize the MCGs? • IF YES: ▪ When did [MCE] start utilizing these guidelines? ▪ How have the MCGsimpacted medical necessity reviews? ▪ How have these guidelines assisted in assuring beneficiaries are accessing the appropriate level of care? ▪ Are there any suggestions for revisions (for the guides, related policies, etc.)? • IF NO: ▪ What have been the barriers in utilizing the MCGs? ▪ Does [MCE] have plans to utilize these guidelines in the future? If so, what is the timeframe?
Section 1c: As part of the COVID-19 PHE, there was a 7-day instant authorization resulting from the PHE.	Was the 7-day instant authorization active during CY2021 and CY2022? • IF YES ▪ What was the impact? • IF NO: ▪ When was this lifted? ▪ What has been the impact of lifting this instant authorization?

Background	Question(s)
Section 1d: The State's implementation plan indicates that MCOs have been reimbursing IMDs as an in lieu of service and are only permitted to contract with Indiana Medicaid screened and enrolled providers, and that the State is currently screening and revalidating this provider type.	• During CY2021 and CY2022, has [MCE] continued to reimburse IMDs as an in lieu of service and only contracted with Indiana Medicaid screened and enrolled providers? • IF NO: ▪ How has this changed?
Section 1g: MCOs annually conduct a CAHPS survey which provides insight into the consumer experience with their health care providers. Areas of interest from the CAHPS include: • Respondent sample: ▪ All SMI beneficiaries, ▪ All Medicaid, ▪ Or Other • Respondent reported: ▪ Health status ▪ Satisfaction with access to needed care and quality of care received, ▪ And satisfaction with providers and health plan.	• Has [MCE] been able to continue to conduct the CAHPS surveys? • IF YES: ▪ During the CY2021 and CY2022 timeframe, what were the findings of this survey as it related to quality of care in inpatient and residential treatment settings for SMI beneficiaries? ▪ Have there been any observed changes in beneficiary perceived access to care, health status, and satisfaction since the implementation of the IN SMI waiver? ▪ Did COVID-19 and the PHE have any impact on the survey (e.g., implementation of survey, response rates, responses, etc.)? • IF NO: ▪ What were the challenges in completing this survey on an annual basis? ▪ What are [MCE]'s plans in reinstating the survey? ▪ Did COVID-19 have an impact on completing the surveys? If so, how?
Section 1g: [MCE] may have other policies or procedures in place to ensure SMI beneficiaries are connected to quality care in inpatient and residential treatment settings.	• During CY2021 and CY2022, what other policies or procedures did [MCE] utilize to ensure that SMI beneficiaries accessed quality care in inpatient and residential treatment settings?

4. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

Next, we will be discussing Milestone 2, which is focused on improving care coordination and transitioning to community-based care. We have also included some follow-up based on information gathered during the 2021 informant interviews. When answering the following questions, please consider the timeframe of CY 2021-2022, the MCE role in the implementation activities, any observations on the impact of the SMI waiver goals, observed risks regarding the State meeting the milestone, and any MCE observations on the impact of the COVID-19 PHE.

Background	Question(s)
Section 2a (and 2b, 2c): MCOs are contractually required to provide case management services to ***any member discharged from an inpatient psychiatric or substance abuse hospitalization*** for no fewer than 90 calendar days.	Does [MCE] provide case management services to all members discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 calendar days? • IF YES: ▪ What do the case management services that [MCE] provides to IN SMI beneficiaries look like? ▪ Please describe any care coordination activities and services provided to SMI beneficiaries transitioning to community-based services. Are these activities and services typically documented in patient discharge documents? ▪ What has the impact of COVID-19 been on post-discharge follow-up, particularly in connecting SMI beneficiaries to community-based services? ▪ How has COVID-19 impacted case management services? • If NO: ▪ What were the challenges that [Anthem] faced in providing case management services to any member discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 calendar days? Did these challenges vary for SMI beneficiaries? ▪ Did COVID-19 have an impact on this? How so?
Section 2a: MCO contracts also require case managers to contact members ***during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization*** and must schedule an outpatient follow-up appointment to occur no later than seven calendar days following the inpatient behavioral health hospitalization discharge.	During CY2021 and CY2022, was [MCE] able to provide case management to members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization? • IF YES (for individuals with SMI): ▪ Was [MCE] able to schedule an outpatient appointment to occur no later than seven calendar days following the inpatient behavioral health hospitalization discharge? ▪ What type of support services does [MCE] provide to beneficiaries during the stay? Were there any changes to these services during CY2021 and 2022? ▪ What, if any, were some challenges/barriers that [MCE] encountered while providing case management services to members in this manner? ▪ What was the observed impact of these support services for [MCE]'s operations, beneficiary access to care, etc.? ▪ How did COVID-19 have an impact on case management? • IF NO: ▪ What were the challenges that [MCE] faced in contacting and providing case management during a member's hospitalization or inpatient behavioral health hospitalization? ▪ Did COVID-19 have an impact on this? How so?

Background	Question(s)
Section 2a: After a case manager schedules a follow-up or continuing treatment for a member, if a member misses either, the MCO is contractually required to ensure that a behavioral health care provider or the MCO's behavioral health case manager contacts that member within three business days of notification of the missed appointment.	For members with SMI, has [MCE] been able to continue to ensure that a behavioral health care provider or [MCE]'s behavioral health case manager contacts a member within three business days of notification of a missed appointment? • IF YES: ▪ How has this type of case management helped in improved care coordination? Particularly to community-based care? ▪ Has COVID-19 had an impact on this type of case management? How so? ▪ Were there any challenges that [MCE] faced in contacting and providing case management during a member's hospitalization or inpatient behavioral health hospitalization? What were those challenges? • IF NO: ▪ What were the challenges that [MCE] faced in contacting and providing case management during a member's hospitalization or inpatient behavioral health hospitalization? ▪ Did COVID-19 have an impact on this? How so?
Section 2b: From the last iteration of interviews, [MCE] indicated that the sickest individuals are often not housed, and that housing situations are very challenging to fit into a patient's well-being.	• What processes and services does [MCE] provide in order to address beneficiaries' (with SMI) housing situations? • Has housing insecurity improved in CY2021 and CY2022? Please describe any observed improvements or challenges for beneficiaries with SMI beneficiaries in obtaining housing. • How has COVID-19 impacted housing availability for beneficiaries with SMI? • Based on MCE experience, are there any suggestions for State to support improvement in access to housing?
Section 2d: One of the State strategies for preventing or decreasing lengths of stay in EDs among beneficiaries with SMI is to require that MCOs identify high utilizers of ED services and ensure members are coordinated and participating in the appropriate disease management services.	• During CY2021 and CY2022, how did [MCE] identify high ED utilizers with SMI? • What steps or processes did [MCE] use to coordinate appropriate disease management services for high ED utilizers with SMI? • How did COVID-19 impact the coordination of appropriate disease management care for high ED utilizers with SMI?
Section 2a, 2b, and 2c: One of the biggest challenges to the SMI waiver, due to the PHE, was that some provider facilities faced staffing issues.	• During CY2021 and CY2022, did staffing issues continue to impact facilities providing care to SMI beneficiaries? • How did staffing issues impact care coordination and connecting beneficiaries to community-based services? • Based on MCE experience, what actions could the State execute to help support connecting beneficiaries to community-based services?

Background	Question(s)
Section 2a, 2b, and 2c: [MCE] noted in the last round of interviews that there was a provider shortage that was mostly likely due to the COVID-19 PHE. Additionally, that due to the COVID-19 PHE, care managers were no longer in the facilities and that this had led to a deterioration in the relationships between care management and discharge.	During DY2021 and CY2022, did [MCE] continue to see a provider shortage, due to the COVID-19 PHE? • IF YES: ▪ Was there a particular type of provider that [MCE] noticed a shortage in? ▪ How did this shortage impact beneficiaries with SMI? Particularly around care coordination and care management? • IF NO: ▪ How did provider availability improve during CY2021 and CY2022? ▪ How did this improvement in provider availability impact beneficiaries with SMI regarding care coordination? During CY2021 and CY2022, did the care managers continue to be absent from the facilities, due to the COVID-19 PHE? • IF YES: ▪ Did this absence continue to deteriorate the relationships between care management and discharge? ▪ How did this impact beneficiaries with SMI regarding their care coordination and their transitions to community-based care? • IF NO: ▪ Have the care managers returned to work in the facilities? ▪ How have the relationships between care management and discharge improved? ▪ What has been the impact on beneficiaries with SMI on their care coordination, particularly to community-based services, due to this absence?

5. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Next, we will talk about Milestone 3. Milestone 3 of the implementation plan is focused on increasing access to the continuum of care, including crisis stabilization services. Increased availability of crisis stabilization programs can help to divert beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities. We have also included some follow-up based on information gathered during 2021 informant interviews. When answering the following questions, please consider the timeframe of CY 2021-2022, the MCE role in the implementation activities, any observations on the impact of the SMI waiver goals, observed risks regarding the State meeting the milestone, and any MCE observations on the impact of the COVID-19 PHE.

Background	Question(s)
Section 3a: MCOs are contractually required to monitor network adequacy standards for behavioral health providers in accordance with 42 CFR §438.68. Corrective action is implemented when standards are not met.	Has [MCE] been monitoring network adequacy standards for behavioral health providers? • IF YES: ▪ What has been the outcome of this monitoring? ▪ How has corrective action been implemented when standards have not been met? ▪ Had anything changed during CY2021 and 2022? • IF NO: ▪ How has [MCE] been meeting this contractual requirement?
Milestone 3 (and Section 5): Telehealth technologies support collaborative care by facilitating broader availability of the continuum of care for beneficiaries with SMI. From the last iteration of interviews, [MCE] indicated the expansion of telehealth services, as part of the COVID-19 PHE.	• During CY2021 and CY2022, did telehealth services continue to be utilized by beneficiaries with SMI? • How did beneficiaries with SMI respond to telehealth services? • How did the services impact beneficiaries with SMI, particularly around increasing access to the continuum of care? • How did the COVID-19 PHE continue to impact these services?
Section 3a (and 2a): CMHCs are required, as codified in Indiana Administrative Code (440 IAC 9-2-4), to be involved in the planning of treatment for and discharge of, consumers during the time a consumer is in inpatient care, to maintain continuity of care. It was noted in the last round of interviews with [MCE] that there was a focus on connecting CMHCs and providers, so that providers could provide necessary follow-up appointments. These appointments were integral to lowering readmission rates and decreasing hospital stays. [MCE] has quarterly meetings with the CMHCs and there is an assigned case manager for each CMHC.	During the timeframe, did [MCE] continue to have quarterly meetings with the CMHC's? • IF YES: ▪ What has been the impact of these meetings on increasing access to continuum of care, including crisis stabilization services, for beneficiaries with SMI? ▪ What has been the impact of these meetings on improving care coordination for beneficiaries with SMI and transitioning them to community-based care? ▪ Has this relationship with the CMHCs continued to lower readmission rates and decrease hospital stays for those beneficiaries with SMI? • IF NO: ▪ How did [MCE] continue to engage with the CMHCs? ▪ How did that engagement increase access to the continuum of care, including stabilization services, for beneficiaries with SMI? In improving care coordination for beneficiaries with SMI and transitioning them to community-based care?
Section 3a, 3c (and 1e): Some of the aspects of the IN SMI implementation plan focus on connecting beneficiaries with SMI, seeking SUD treatment, to available treatment including inpatient and residential services. From the last iteration of interviews, it was noted that [MCE] had been engaged with providers around connecting beneficiaries to SUD treatment.	During CY2021 and CY2022, did [MCE] continue to have those conversations with providers? • IF YES: ▪ How did these conversations help to connect beneficiaries with SMI to SUD treatment? ▪ How did the COVID-19 PHE impact connecting beneficiaries with SMI to SUD services? • IF NO: ▪ What led [MCE] to no longer have these conversations with providers? ▪ What has been the impact of no longer having these conversations with providers on connecting beneficiaries to SUD treatment?

Background	Question(s)
Section 3c: In the last iteration of interviews with [MCE], it was noted that OpenBeds may have a number of features that could assist with making referrals for members who may be in need of social services. However, from the last iteration of interviews with State Officials, there were a number of challenges with using the OpenBeds software, and the State indicated that they would not be pursuing a contract renewal. It was also noted that the State was considering using new monitoring software.	• Was [MCE] made aware that the OpenBeds software would not be pursued for a renewal contract during the CY2021 and CY2022? • IF YES: • What has the impact been on [MCE] in no longer using that software? • Did the State begin utilizing a new monitoring software during CY2021 and CY2022? If so, what is the new monitoring software? • What has the impact of this new monitoring software been on connecting beneficiaries with SMI to the continuum of care?

6. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

Milestone 4 is focused on earlier identification of serious MH conditions and focused efforts to engage individuals with these conditions in treatment sooner. We have also included some follow-up based on information gathered during 2021 informant interviews. When answering the following questions, please consider the timeframe of CY 2021-2022, the MCE role in the implementation activities, any observations on the impact of the SMI waiver goals, observed risks regarding the State meeting the milestone, and any MCE observations on the impact of the COVID-19 PHE.

Background	Question(s)
Milestone 4: Milestone 4 is focused on earlier identification and engagement of SMI beneficiaries in treatment. Critical strategies for improving care for individuals with SMI include earlier identification of serious MH conditions and focused efforts to engage individuals with these conditions sooner.	• What strategies during the CY2021 and CY2022 timeframe did [MCE] utilize to identify ESMI (Early Serious Mental Illness) (i.e., prodromal symptoms, first episode psychosis) beneficiaries with a serious MH condition? Please elaborate. • Did [MCE] experience any barriers or challenges in earlier identification and engagement in treatment of SMI beneficiaries? Please elaborate. • How did COVID-19 impact these strategies?
Section 4b: School-based health centers (SBHC) provide on-site comprehensive preventative and primary health services including behavioral health, oral health, ancillary and enabling services. MCOs are encouraged to plan for, develop, and or/enhance relationships with SBHCs with the goal of providing accessible services to school-aged, enrolled members.	• During CY2021 and CY2022, how did [MCE] engage with the SBHCs? • How have these enhanced relationships with the SBHCs helped in providing accessible services to school-aged, enrolled members?
Section 4b: [MCE] noted in the last iteration of interviews that it has been challenging for providers to engage with [MCE], as providers may not understand the value of this relationship.	• How have communications between [MCE] and providers changed during CY2021-CY2022? • If communication has improved, how has it impacted earlier identification of serious MH conditions and the ability to engage individuals with these conditions in treatment sooner?

7. Topic 6: Health IT Plan

The Health IT Plan (HIT Plan) portion of the implementation plan describes the State's ability to leverage health IT, advance HIEs, and ensure health IT interoperability in support of the demonstration goals. This part of the implementation plan includes two sub-sections that we will be reviewing during this interview, including statements of assurance and electronic care plans and medical records, as those topics relate to the MCEs.

8. Statements of Assurance

The implementation plan includes a section on Statements of Assurance related to the Health IT Plan. As MCEs play an important role in care coordination and case management, we would like to better understand your role in the sharing care plans, having agreements with HIEs, and reporting HEDIS measures. When answering the following questions, please consider the timeframe of CY 2021-2022, the MCE role in the implementation activities, any observations on the impact of the SMI waiver goals, observed risks regarding the State meeting the milestone, and any MCE observations on the impact of the COVID-19 PHE.

Background	Question(s)
Statement 3: Part of Statement 3 of the Statements of Assurance indicated that the MCOs are contractually obligated to share care plans with primary medical providers (PMPs) and behavioral health providers with appropriate consent.	• During the timeframe, was [MCE] able to share care plans with primary medical providers and behavioral health providers with appropriate consent? • Were there challenges with sharing care plans with PMPs. If yes, please describe. If yes, how have MCEs overcome these challenges?
Statement 3: It was also noted in Statement 3 that the MCOs have agreements with HIEs, such as the IHIE and the MHIN.	• During the timeframe, did [MCE] have agreements with HIEs, such as the IHIE and the MHIN? • How have these agreements allowed [MCE] to better provide case management and care coordination to SMI beneficiaries?

Background	Question(s)
Statement 3: As part of clinical quality measurement and reporting the MCEs report on the following HEDIS quality measures related to behavioral health: • Follow-up care for children prescribed ADHD medication, initiation phase. • Follow-up care for children prescribed ADHD medication, maintenance phase. • 30-day follow-up after hospitalization for mental illness. • 7-day follow-up after hospitalization for mental illness. • Use of multiple concurrent antipsychotics in children and adolescents up to age 17. • Use of first-line psychosocial care for children/adolescents on antipsychotics up to age 17. • Antidepressant medication management, acute phase. • Antidepressant medication management, continuation phase. • 30-day follow-up after emergency department (ED) visit for mental illness. • 7-day follow-up after ED visit for mental illness.	• During the timeframe, was [MCE] able to continue to report on HEDIS quality measures mentioned related to behavioral health? • Does [MCE] regularly collect other clinical quality measures? If yes, what measures were collected? • How did COVID-19 impact the HEDIS measures that [MCE] reported on related to behavioral health?
Statement 3: Statement 3 of the Statements of Assurance asked for confirmation that the State intends to assess the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. Indiana noted that they will review the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B for potential inclusion into their MCO contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Did the State engage with [MCE] to incorporate an ongoing assessment of standards in their MCO contract? • IF YES: ▪ When did this occur? • IF NO: ▪ Has the State indicated that they plan on reviewing and incorporating the standards referenced in the ISA and 45 CFR 170 Subpart B into [MCE]'s contract? What is the anticipated date?

9. Electronic Care Plans and Medical Records (Section 2)

The IN SMI implementation plan also included a prompt around electronic care plans and medical records. Creating, utilizing, and sharing this information between providers and MCEs helps to better address beneficiary needs.

Background	Question(s)
Section 2.2: Indiana contracts with the IHIE to aggregate Medicaid claims with medical and pharmacy data in its repository to create a continuity of care (CCD) record that can be shared between Medicaid providers. The March 2019 Indiana health information sharing (HIS) Assessment indicated that some MCOs and providers are receiving admit-discharge-transfer (ADT), CCDs, or other clinical data points and are incorporating those points directly into their workflow for care coordination and quality management.	During CY2021 and 2022, did [MCE] receive any admit-discharge-transfer (ADT), CCDs, or other clinical data points, and incorporate those points directly into their workflow for care coordination and quality management? • IF YES: ▪ How did those data points impact care coordination of SMI beneficiaries? ▪ Were there any challenges or barriers in receiving these data points? ▪ How did the COVID-19 PHE impact receiving these data points? • IF NO: ▪ What were the challenges or barriers [MCE] faced in receiving these data points? ▪ Are there plans to receive this type of data in the future, in order to improve care coordination for SMI beneficiaries?

C. Indiana 1115(a) SMI Demonstration Evaluation: Provider Key Informant Interview Guide

1. Introduction:

This interview is part of a series of key informant interviews that will provide a better understanding of the activities that were implemented by the state of Indiana due to the IN SMI waiver demonstration, as outlined in Indiana's Section 1115 SMI/SED Demonstration Implementation Plan. Lewin, as the independent evaluator of IN SMI waiver, will be conducting a series of 30–60-minute interviews (with State Officials, MCE representatives, providers, advocacy organizations, and members) to gather information on activities that were implemented in relation to the IN SMI waiver Demonstration, impact of the COVID-19 PHE, factors that supported implementation activities, and any challenges or barriers encountered. We are particularly interested in understanding the provider experience of, and perspective on:

- The expanded services made available to Medicaid beneficiaries with SMI, including mobile crisis units, community-based care, crisis stabilization services, etc.
    - What has worked well?
    - What could be improved upon?
- Provider role, if any, in the implementation of the activities,
- The impact of COVID-19 PHE on Medicaid beneficiaries with SMI during CY2021 and CY2022, and
- Any challenges or barriers Medicaid beneficiaries with SMI faced during CY2021 and CY2022.

This interview guide is organized by topic area in alignment with the State's implementation plan milestones including:

- Background Information
- Milestone 1
- Milestone 2
- Milestone 3
- Milestone 4

For each topic area, we have included background information for context prior to each question.

2. Background Information

Background	Question(s)
Attendee Name and Role at [provider name]	• Please describe your current role at [provider name]. • How long have you been in this role?
Awareness of the implementation and monitoring of IN SMI/SED Demonstration Waiver and Implementation Activities	• Were you aware of the IN SMI waiver and/or the implementation activities? If so, please elaborate.

3. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

We will begin with questions related to the implementation activities associated with Milestone 1. Milestone 1 is focused on ensuring quality of care in psychiatric hospitals and residential settings. When answering the following questions, please consider the timeframe of CY2021 and CY2022, provider experience of ensuring quality of care, any improvements to be made to these services, and any observations of the impact of the COVID-19 PHE.

#	Background	Question(s)
1	**Section 1c:** One focus of the waiver is to ensure that beneficiaries have access to the appropriate levels and types of care, as well as the appropriate LOS.	• During CY2021 and 2022, what were some of the trends in LOS for beneficiaries with SMI? (Less than 30 days, over 30 days, etc.) • How did these trends differ from years prior? • What impacted (positively/negatively) the lengths of stay for beneficiaries with SMI during the timeframe? (pre-authorization, caps on LOS, changes in demand for inpatient treatment, etc.)
2	**Section 1c:** As part of the COVID-19 PHE, there was a 7-day instant authorization resulting from the PHE.	• How did the 7-day instant authorization impact the impatient IMD and beneficiaries with SMI during CY2021 and CY2022?

#	Background	Question(s)
3	**Section 1e:** Individuals with SMI often have co-morbid physical health conditions and SUDs and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and SUD, and can also interfere with effective treatment for their MH condition. Additionally, individuals with SMI should also be screened for suicidal risk.	• Please describe [provider name] screening protocol during CY2021 and CY2022 (Prompt: physical conditions, other MH conditions, suicide risk). • Please describe how the findings from an individual's screen were used? For example, if an individual endorsed suicide ideation, what happened next (Prompt: greater assessment, services identified and integrated into treatment plan). • Please describe the treatment opportunities for individuals with co-occurring conditions. How has treating co-occurring conditions impacted patients during their impatient stay? • How do patients with co-occurring conditions impact their discharge plan and care coordination? • Please describe any challenges/barriers in screening or treating SMI beneficiaries for co-occurring conditions.

4. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

Next, we will discuss questions related to the implementation activities associated with Milestone 2. Milestone 2 is focused on improving care coordination and transitioning to community-based care. When answering the following questions, please consider the timeframe of CY2021 and CY2022, provider experience of care coordination and transitioning to community-based care, any improvements to be made to these services, and any observations of the impact of the COVID-19 PHE.

#	Background	Question(s)
4	**Section 2a:** CMHCs are required to be involved in the planning of treatment for, and the discharge of, consumers during the time a consumer is in inpatient care in order to maintain continuity of care.	• During CY2021 and CY2022, please describe how CMHCs were involved in treatment planning as well as the discharge process for SMI beneficiaries? • How did CMHC involvement benefit SMI beneficiaries? • Were there any challenges in working with CMHCs? If so, please elaborate. • What improvements could be made to this process? • What, if any, was the impact of COVID-19 on this process?

#	Background	Question(s)
5	**Section 2b** CMHCs are required as a component of case management, to provide advocacy and referral including helping individuals access entitlement and other services, such as Medicaid, housing, food stamps, education services, recovery groups, and vocational services.	• Please describe the case management services that CMHCs provide for beneficiaries with SMI? • Who (e.g., type of provider) provides case management services? • Considering the timeframe of CY2021 and CY 2022, please describe any challenges or barriers to providing case management services? • How has case management impacted beneficiaries with SMI? • What improvements could be made to case management services? (Prompts: care coordination; care transitions). • During CY2021 and CY2022, what was the impact of COVID-19 on care management services?
6	**Section 2a, 2b, and 2c:** One of the greatest challenges to the SMI waiver, due to the PHE, was that some provider facilities faced staffing issues.	• During CY2021 and CY2022, did [provider name] experience staffing issues? If yes, please describe. • How did staffing issues impact SMI beneficiaries? • What steps did [provider name] implement to address any staffing issues?
7	**Section 2d (3a, 4c, and Fa):** One aspect of Milestone 2 is focused on strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI prior to admission. One of the strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission was for the State to pilot two CSU in the northern and southern parts of the state in SFY2020. The goals of these units are to provide an alternative to crisis evaluations within EDsand divert admissions to inpatient psychiatric units. It is our understanding that [provider name] was one of the two CSU pilots.	• Please confirm our understanding that Four County was a CSU pilot. • During CY2021 and CY2022, please tell us more about the services [provider name] provided to Medicaid beneficiaries. • During CY2021 and CY2022, what percentage (Prompt: majority, some, few, none) of Medicaid beneficiaries who interacted with the CSU had an SMI? • Please describe how CSUs during CY2021 and CY2022: • Connected members to the appropriate inpatient or community-based services. • Supported members with care coordination. • How did the CSU benefit Medicaid beneficiaries with SMI? • During the timeframe, what challenges or barriers did you encounter with operating a CSU? Particularly as it relates to connecting members to the appropriate inpatient or community-based care services? • What, if any, changes/improvements could be made to the CSUs in order to better improve care coordination and transitioning to community-based care for SMI beneficiaries? • What was the impact of COVID-19 on CSU services you provide? Particularly on beneficiaries with SMI. • As this was a pilot, please share with us any lessons learned. From your experience, is this a provider type that could benefit SMI beneficiaries across the state?

#	Background	Question(s)
8	**Milestone 2:** MCEs are required to track and coordinate the care of members receiving care in an IMD.	• Please describe [provider name] relationship with the MCEs. • Please describe any challenges/barriers in your relationships with the MCEs. • How have these relationships impacted care for beneficiaries with SMI during the timeframe? • If necessary, how can these relationships be improved upon in order to better support beneficiaries with SMI? • What was the impact of COVID on these relationships?
9	**Milestone 2:** As mentioned, Milestone 2 is focused on improving care coordination, particularly in transitioning SMI beneficiaries to community-based care. This requires partnerships between hospitals, residential providers, community-based care providers, etc.	• During the timeframe, how have hospitals, residential providers, and other inpatient providers partnered with [provider name] in ensuring that SMI beneficiaries are connected to care? What does care coordination look like? How has care coordination benefited SMI beneficiaries? • Were there any challenges/barriers in partnering with other provider types in ensuring appropriate care coordination for SMI beneficiaries? If so, please elaborate. How has [provider name] addressed some of these challenges? • What improvements can the State make regarding care coordination between provider types, particularly for SMI beneficiaries? • During the timeframe, how did COVID-19 impact care coordination?

5. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Next, we will talk about Milestone 3. Milestone 3 is focused on increasing access to the continuum of care, including crisis stabilization services. Increased availability of crisis stabilization programs can help to divert beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities. When answering the following questions, please consider the timeframe of CY 2021 and CY2022, provider experience of crisis stabilization services, any improvements to be made to these services, and any observations of the impact of the COVID-19 PHE.

#	Background	Question(s)
10	**Section 3a:** Indiana Administrative Code and DMHA contracts encourage CMHCs to provide a defined set of services that align to the continuum of care directly, or through a subcontractor, which includes: • Individualized treatment planning to increase patient coping skills and symptom management. • 24/7 crisis intervention • Case management to fulfill individual patient needs, including assertive case management. • Outpatient services, including intensive outpatient services, substance abuse services, counseling, and treatment. • Acute stabilization, including detoxification services. • Residential services • Day treatment • Family support services • Medication evaluation and monitoring • Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.	• Please describe the services available to SMI beneficiaries across the Continuum of Care (i.e., prevention to treatment to recovery) at [provider name] during CY2021 and CY2022. • Please describe any service gaps for SMI beneficiaries across the continuum of care (Prompt: inpatient services; residential services, crisis stabilization services). If gaps are described: Please discuss how gaps are impacting care for the SMI population. Are there steps the State could take to support minimizing gaps? • Of the available services across the care continuum, what services have had the greatest impact on the SMI population? Please describe the service and the impact. • Beyond gaps, what other challenges do SMI beneficiaries experience across the continuum of care? (Prompt: specify which phase of the continuum for the challenge of if its more general across the phases). How can services across the continuum of care or for a particular phase of the continuum be improved for SMI beneficiaries? • Please think specifically about crisis stabilization services during CY2021 and CY2022. Please describe the benefits and challenges for SMI beneficiaries specific to this service. Please identify any actions that the state could take to improve the service. What was the impact of COVID-19 on services rendered across the continuum of care? Did COVID impact some phases of the continuum more than others? If yes, please describe.

#	Background	Question(s)
11	**Section 3c:** Section 3c of the Milestone is focused on strategies to improve state tracking of the availability of inpatient and crisis stabilization beds. From the implementation plan, the State indicated that in March of 2018, they had implemented a new tool to help beneficiaries seeking treatment for SUD, immediately connecting them with available inpatient or residential services, and that this was made possible by a partnership between the State, OpenBeds, and Indiana 2-1-1. At the time of the implementation plan, the State was in the process of expanding the use of OpenBeds beyond SUD tracking and into psychiatric inpatient and crisis stabilization beds. However, it was noted in the last iteration of interviews with State Officials that there were challenges using the OpenBeds software, and that the State would not be pursuing a contract renewal. It was also noted that the State was considering using new monitoring software.	• During CY2021 and CY2022, how did [provider name] identify available residential beds to refer individuals for care? • How did [provider name] alert other providers, that beds were or were not available? • Please describe benefits, challenges, and impacts for identifying and tracking open beds in the state. • Please describe any strategies or tools (e.g., software) that could support monitoring open beds for inpatient, residential, and CSUs? • What actions can the state take to support access to care for individuals with SMI who require inpatient or residential or crisis stabilization services? • How did COVID-19 impact access to inpatient, residential and CSUs?
12	**Section 3d:** The State requires that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and LOS. It was noted in the implementation plan that every individual served in a DMHA contracted provider receives a CANSANSA to inform individualized treatment planning and level of care decision making. Individuals are reassessed every six months with adjustments to level of care and/or treatment plan being made accordingly. Additionally, that any member who meets specific diagnosis and level of need criteria under the assessment is provided MRO services.	• Please describe the process and tools [provider name] used to assess beneficiaries with SMI during CY2021 and CY2022 (Prompt: ANSA and frequency of assessment). • How did the assessment tools assist in treatment planning and level of care decision making for SMI beneficiaries? • How frequently did SMI beneficiaries meet the criteria for MRO services? How did [provider name] connect beneficiaries with MRO services? How do these services support SMI beneficiaries? • IF ANSA was used: please describe the benefits and challenges of this tool (prompt: focus on treatment planning and level of care decision making). Should the state consider other tools? If yes, do you have suggestions? If challenges were identified: How has [provider name] overcome these challenges?
13	**Milestone 3:** As noted, Milestone 3 is focused on increasing access to the continuum of care, including crisis stabilization services, to SMI beneficiaries. Increased availability of crisis stabilization programs can help to divert beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities. The goals for the CSUs are to provide an alternative to crisis evaluations within EDs and divert admissions to inpatient psychiatric units.	• During the timeframe, did [provider name]'s CSU conduct crisis evaluations? If yes, please describe the impact of these evaluations on the larger health system (e.g., impact on inpatient psychiatric units). • From your perspective, how have the CSUs diverted beneficiaries from unnecessary visits to the EDs and admissions to inpatient facilities? • Please describe the benefits and challenges specific to the CSU in diverting beneficiaries from unnecessary visits to the EDs and admissions to inpatient facilities? What improvements can be made? • What was the impact of COVID-19?

#	Background	Question(s)
14	**Milestone 3 (and Section 5):** Telehealth technologies support collaborative care by facilitating broader availability of services across the continuum of care for beneficiaries with SMI.	• During CY2021 and CY2022, how had [provider name] utilized telehealth services for beneficiaries with SMI? • What challenges, if any, did [provider name] encounter with telehealth services?

6. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

Milestone 4 is focused on earlier identification of serious MH conditions and focused efforts to engage individuals with these conditions in treatment sooner. When answering the following questions, please consider the timeframe of CY2021 and CY2022, provider experience of earlier identification and engagement in treatment, any improvements to be made to these services, and any observations of the impact of the COVID-19 PHE.

#	Background	Question(s)
15	**Section 4a:** Part of Section 4 of the implementation plan is focused on strategies in identifying and engaging beneficiaries with, or at risk of, SMI in treatment sooner, e.g., with supported education and employment. It was noted that several of the CMHCs provide SE services.	• Please describe any SE services provided to SMI beneficiaries during CY2021 and CY2022. • How have SE services benefited beneficiaries with SMI? • Please describe any challenges in providing SE services to SMI beneficiaries. • What improvements could be made to SE services? What action can the State take to improve SE services for beneficiaries with SMI?? • What, if any, has the impact of COVID-19 been on SE services? • During the timeframe, please describe additional strategies that [provider name] has implemented in order to identify and engage beneficiaries with, or at risk of, SMI in treatment sooner. How did these strategies impact the SMI population? Please describe both negative and positive impacts.
16	**Milestone 4:** Critical strategies for improving care for individuals with SMI include earlier identification of serious MH conditions and focused efforts to engage individuals with these conditions in treatment sooner.	• During CY2021 and CY2022, please describe any strategies [provider name] had implemented in order to identify and engage beneficiaries with, or at risk of, SMI in treatment sooner. • How did these strategies impact the SMI population? Please describe both negative and positive impacts. • How can earlier engagement in treatment be improved upon for SMI beneficiaries in need of inpatient treatment? • What, if any, was the impact of COVID-19?

#	Background	Question(s)
17	**Milestone 4:** One strategy to identify and engage beneficiaries with or at risk of SMI in treatment sooner is through supported education and employment, via the VRS.	• Please describe any SE services provided to SMI beneficiaries during CY2021 and CY2022. • How have SE services benefited beneficiaries with SMI? • Please describe any challenges in providing SE services to SMI beneficiaries. • What improvements could be made to SE services? What action can the state take to improve SE services for beneficiaries with SMI?? • What, if any, has the impact of COVID-19 been on SE services? • During the timeframe, please describe additional strategies that [provider name] has implemented in order to identify and engage beneficiaries with, or at risk of, SMI in treatment sooner. How did these strategies impact the SMI population? Please describe both negative and positive impacts. Were there any barriers in engaging SMI beneficiaries sooner? • How did COVID-19 impact earlier identification and engagement?

D. Indiana 1115(a) SMI Demonstration Evaluation: Member Key Informant Interview Guide

1. Background:

The goal of the 2023 Mid-Point Assessment Key Informant Interviews with members is to better understand their experiences of SMI services during the CY2021 and CY2022 timeframe.

The member interviews are scheduled to last up to 15 minutes.

2. Voicemail Script:

Hello, my name is [insert name], calling on behalf of Indiana Family Social Services Administration (FSSA). I would like to speak to [insert respondent name]. We are talking with Medicaid beneficiaries to get their opinions about MH and/or SUD services received during 2022. Please call me back at 123-456-7890 to discuss further. Thank you.

3. Script:

Need a title for this column?	Mapping	#	Question/Response
	N/A	Introduction	Hello, my name is _____, calling on behalf of Indiana Family Social Services Administration (FSSA). May I please speak with (**insert respondent name**)? (OBTAIN CORRECT RESPONDENT; REINTRODUCE IF NECESSARY) Today we are talking with Medicaid beneficiaries to get their opinions about MH or SUD services received during 2022. Your answers to all questions will remain anonymous and your participation will not affect your benefits. May we begin? • Yes [**Go to I1**] • No [**Go to Closing**] IF NEEDED: Your name was picked randomly from a list of all people who received MH services in 2022 and had Medicaid coverage through December 2022. IF NEEDED: This survey will take approximately 5 – 15 minutes. IF NEEDED: Our company was hired by Indiana FSSA to make these calls. IF NEEDED: The answers you give will be combined with answers from other interviewees and will be anonymous. Your participation does not affect your Medicaid benefits.
Introduction (I)	N/A	I1	Are you enrolled in Medicaid at this time? (2022) • Yes [**Go to A1**] • No [**Go to I2**] • Don't know [**Go to I2**] • Refused [**Go to I2**]

Need a title for this column?	Mapping	#	Question/Response
		I2	Sorry, but just to confirm, the State of Indiana provides Medicaid coverage for Indiana residents between the ages of 19 to 64. Based on the information we have from the State, it looks like you had Medicaid coverage as of December 2022. You may know this program by the name of your health plan such as Anthem, CareSource, MDwise (M-D- WISE SOMETIMES PRONOUNCED MED-WISE), or Managed Health Services (MHS). Is this correct? • Yes [**Go to A1**] • No [**Go to Closing**] • Don't know [**Go to Closing**] • Refused [**Go to Closing**]
Access (A)	Milestone 3	A1	During 2021 and 2022, did you receive MH or SUD care services? Examples of MH or SUD care services include individual screening or assessment, psychotherapy, group therapy, medication, resources, or any specific treatment for a MH or SUD condition. • Yes [**Go to A2**] • No [**Go to P2**] • Don't Know [**Go to A2**] • Refused [**Go to A4**]
		A2	During 2021 and 2022, did you receive care in any of the following settings? [***Note***: Read each item and select ***all that apply***.] • Emergency Room- Hospital **[Go to A4]** • Inpatient **[Go to A3]** ▪ Inpatient Unit- Hospital ▪ *Note: Also known as an inpatient psychiatric unit. For people who can no longer be supported at home and need to be admitted to the hospital due to severe MH problems.* • Residential **[Go to A4]** ▪ *Note: Residential treatment is a structured, live-in program at a licensed treatment facility for clients. Services include assessment, individual and group counseling, family counseling. The length of the residential services depends on an assessment of an individual's needs.*

Need a title for this column?	Mapping	#	Question/Response
Access (A) (continued)	Milestone 3 (continued)	A2 (continued)	• Outpatient **[Go to A4]** ▪ Intensive Outpatient ▪ *Note: An Intensive Outpatient Program (IOP) is a **structured** non-residential psychological treatment program which addresses MH disorders and SUD that do not require detox. Services offered are group therapy, individual therapy, family counseling, educational programs, etc. Does **NOT** offer the more intensive residential or partial day services typically offered by a larger, more comprehensive treatment facility. This is very similar to day treatment. The only difference is the number of hours spent in therapy each week. Goal is to provide stabilization and prevent admission to inpatient services.* ▪ Outpatient- Hospital or Office Practice and counseling ▪ *Note: Might be referred to as an outpatient clinic, this type of treatment includes psychopharmacology management, individual therapy, group therapy, couples therapy, and family treatment. This way, individuals can receive care within their communities, without having to stay overnight. (Probably the least intensive)* • Day Treatment **[Go to A4]** ▪ *Note: Day treatment services provide intensive, non-residential services. Sometimes called partial hospitalization, this is often a structured, supportive environment for those who can live in the community and can be treated outside of the inpatient setting. This is very similar to intensive outpatient. The only difference is the number of hours spent in therapy each week (patients can receive treatment while carrying on with everyday responsibilities).* • Crisis Stabilization **[Go to A4]** ▪ Crisis Stabilization Unit ▪ *Note: (This is from one of the provider interviews. This provider is part of a much larger system, so I think the idea is to connect beneficiaries with services quickly as opposed to going to the ER, however, this is an assumption.) The CSU is a 23-hour voluntary crisis observation and receiving center. The ALOS was 8.5 hours for a member during 2021-2022.* • Unsure, but did receive care in a setting. **[Go to A4]** **Follow-up Item**: Of the settings identified, which setting best describes where the majority of your care was provided? [Read each item and **select one**].
	Milestone 3; Metric #19	A3	How long was your stay in the inpatient facility? [**Prompt**: Approximate number of days?]
		A4	Were you prescribed medication for a MH or substance use condition? • Yes: If yes- did you fill your prescription? **[Go to A5]** • No **[Go to A5]** • Don't Know **[Go to A5]** • Refused **[Go to A5]**

Need a title for this column?	Mapping	#	Question/Response
Access (A) (continued)	Milestone 3	A5	Are you familiar with the term IMD (Institution for Mental Diseases)? IMDs are facilities with more than 16 beds primarily engaged in providing MH diagnosis or treatment services to individuals with MH conditions. • Yes [**Go to A6**] • No [**Go to A7**] • Don't Know [**Go to A7**] • Refused [**Go to A7**]
	Milestone 3; Monitoring #20	A6	Did you receive services at an IMD? • Yes [**Go to A7**] • No [**Go to A7**] • Don't Know [**Go to A7**] • Refused [**Go to A7**]
	Milestone 4; Monitoring #24	A7	Were you screened for depression at any of the settings where you received care? • Yes [**Go to A8**] • No [**Go to A8**] • Don't Know [**Go to A8**] • Refused [**Go to A8**]
	Milestone 4; Monitoring #23	A8	Were you screened for diabetes at any of the settings where you received care? [**Prompt**: Did you have a blood sugar test? Did your provider tell you HbA1c level?] • Yes [**Go to A9**] • No [**Go to A9**] • Don't Know [**Go to A9**] • Refused [**Go to A9**]
	Milestone 4; Monitoring #27 and #28	A9	Were you screened for tobacco or alcohol use at any of the settings where you received care? • Yes [**Go to A10**] • No [**Go to A10**] • Don't Know [**Go to A10**] • Refused [**Go to A10**]
Access (A) (continued)	Utilization	A10	During 2021 and 2022, did you receive MH or SUD care via the computer or phone? • Yes [**Go to S1**] • No [**Go to S3**] • Don't Know [**Go to S3**] • Refused [**Go to S3**]

Need a title for this column?	Mapping	#	Question/Response
Satisfaction (S)	Others: H7	S1	How satisfied were you with your MH or SUD care? • Very satisfied **[Go to S2]** • Somewhat satisfied **[Go to S2]** • Neither satisfied nor dissatisfied **[Go to S2]** • Somewhat dissatisfied **[Go to S2]** • Very dissatisfied **[Go to S2]** • Don't know **[Go to S2]** • Refused **[Go to S2]**
	Utilization	S2	Describe what you liked and didn't like about receiving MH or SUD via the computer or phone. **[Go to S3]**
	Others: H7	S3	Thinking about your MH and SUD care in 2021 and 2022, please describe the most helpful things about the services you received [**Prompt**: Staff Support; Treatment Plan During Discharge; Availability of Doctors; Wait Time; Access to Treatment, Care Coordination; Assistance with Medication Management; Symptom Improvement]. **[Go to S4]** Anti-depressant (helped her feel better)
	Milestone 4 (Access to Treatment); Others: H7	S4	Thinking about your MH and SUD care in 2021 and 2022, what improvements could be made to the services you received [**Prompt**: Staff Support; Treatment Plan During Discharge; Availability of Doctors; Wait Time; Access to Treatment, Care Coordination; Assistance with Medication Management; Symptom Improvement]. **[Go to S5]**
	Milestone 3; Others: H7	S5	Thinking about your MH and SUD care in 2021 and 2022, are there services [**Prompt**: other programs, treatments, or resources] that you wished were available? **[Go to C1]**

Need a title for this column?	Mapping	#	Question/Response
Care Coordination	Milestone 2	C1	Thinking about your MH and SUD care in 2021 and 2022, did a professional, such as a nurse or case manager help you coordinate care [**Prompt**: For example, if you were at an outpatient facility, did someone help you connect to transportation or needed medical appointments.]. • Yes [Go to C2] • No [Go to P1] • Don't Know [Go to P1] • Refused [Go to C2]
		C2	Describe what you liked and didn't like about the care coordination you received. **[Go to C3]**
		C3	How could care coordination for individuals with MH and SUD be improved? [**Prompt**: Timeliness of coordination, medical records, etc.; Smooth transitions of medical care (including medication management); Staff Support] **[Go to P1]**
Physical Conditions	Milestone 4	P1	During 2021 and 2022, did you receive any medical services? • Yes [**Go to P2**] • No [**Go to Closing**] • Don't Know [**Go to P3**] • Refused [**Go to P3**]
	Milestone 4; Metric #23	P2	What types of medical services did you receive? • Preventative [**Prompt**: annual health exams, lab work, vaccines] **[Go to P3]** • Primary Care [**Prompt**: diagnosis or treatment of medical conditions like asthma, diabetes, high blood pressure] **[Go to P3]** • Specialty Care [**Prompt**: OBGYN, Cardiologist, Physical Therapist, Radiologist] **[Go to P3]** • Urgent Care [**Prompt**: Walk-In Clinics, Express Care Centers] **[Go to P3]** • Emergency Room [**Prompt**: confirm services for physical condition only] **[Go to P3]**
	Milestone 4	P3	Thinking about your physical health care in 2021 and 2022, please describe the most helpful things about the services you received [**Prompt**: Staff Support; Access to Treatment, Care Coordination; Symptom Improvement]. **[Go to P4]**
		P4	Thinking about your physical health care in 2021 and 2022, what improvements could be made to the services you received [**Prompt**: Staff Support; Access to Treatment, Care Coordination; Symptom Improvement]. **[Go to P5]**
		P5	Thinking about your physical health care in 2021 and 2022, are there services [**Prompt**: other programs, treatments, or resources] that you wished were available? **[Go to Closing]**
Closing	N/A		On behalf of the Family Social Services Administration (FSSA), we thank you for participating in this survey. Your answers will help improve the program.

Attachment D: Quantitative Data Process

A. Data Source – Detailed Description

Monitoring Reports. In alliance with the CMS-approved monitoring protocol, the state generated monitoring reports each quarter using a variety of data sources including claims data, member enrollment data, medical and administrative records, and other state-specific databases. The monitoring metrics were calculated as specified in the specification file, Medicaid Section 1115 SMI and SED Demonstrations: Technical Specifications for Monitoring Metrics Version 4.0 (Technical Specification). Metrics are calculated for either monthly, quarterly, or annual time frames.

MHSIP Survey Report. The FSSA's DMHA is required by SAMSHA's Center for MH Services to conduct the annual survey. The MHSIP survey methodology uses a convenience sample selecting designated liaisons at 24 CMHCs and 7 contracted providers in Indiana to distribute the survey to all adults receiving outpatient, community based or residential services.

The MHSIP adult survey instrument has 36 questions grouped into 7 quality of care performance domains (**Exhibit D.1).** Each question uses Likert scale response options (Strongly Agree = 1, Agree = 2, Neither Agree or Disagree = 3, Disagree = 4, Strongly Disagree = 5). For each respondent with a "complete" response for a domain (identified as no less than two-thirds of the questions in the domain completed), a composite score was calculated as the average response value. The respondent was flagged to have a positive response (or satisfied) for a particular domain if the composite score was less than 2.5. For each domain, the percentage of respondents with a positive response (or satisfied) was calculated as the proportion of respondents with a composite score less than 2.5 among those with a complete response. In addition to the 7 domains, the instrument includes two questions related to access to care: "8. I was able to get all the services I thought I needed" and "9. I was able to see a psychiatrist when I wanted to.". For the Mid-Point Assessment, the summary findings for each domain were extracted from the prepared report.

Exhibit D.1 MHSIP Survey Instrument Questions by Performance Domain

Quality of Care Performance Domain	MHSIP Question
General Satisfaction	1. I like the services that I received here. 2. If I had other choices, I would still get services from this agency. 3. I would recommend this agency to a friend or family member.
Access to Services	4. The location of the services was convenient. 5. Staff is willing to see me as often as I felt it was necessary. 6. Staff returned my call in 24 hours. 7. Services were available at times that were good for me.

Quality of Care Performance Domain	MHSIP Question
Quality and Appropriateness	10. Staff here believe I can grow, change and recover. 12. I feel free to complain. 13. I was given information about my rights. 14. Staff encouraged me to take responsibility for how I live my life. 15.Staff told me what side effects to watch out for. 16. Staff respected my wishes about who is and who is not to be given information about my treatment. 18. Staff were sensitive to my cultural background. 19. Staff helped me obtain the information I needed so that I could take charge of managing my illness. 20. I was encouraged to use consumer-run programs.
Participation in Treatment Planning	11. I felt comfortable asking questions about my treatment and medication. 17. I. not staff, decided my treatment goals.
Outcomes from Services	21. I deal more effectively with daily problems. 22. I am better able to control my life. 23. I am better able to deal with crisis. 24. I am getting along better with my family. 25. I do better in social situations. 26. I do better in school and/or work. 27. My housing situation has improved. 28. My symptoms are not bothering me as much.
Functioning	29. I do things that are more meaningful to me. 30. I am better able to take care of my needs. 31. I am better able to handle things when they go wrong. 32. I am better able to do things that I want to do.
Social Connectedness	33. I am happy with the friendships I have. 34. I have people with whom I can do enjoyable things. 35. I feel I belong in my community. 36. In a crisis, I would have the support I need from family or friends.

Provider Availability Assessment Data. FSSA conducts an annual Provider Availability Assessment (typically every year in February for the prior year) to determine provider availability and shortages. The assessment captures various measures (including number of beneficiaries, total number of providers, total number of Medicaid-enrolled providers) for each county for multiple provider types (include psychiatric practitioners, CMHCs, crisis stabilization services, and FQHCs). The Provider Availability Assessment Data is compiled at the county level and does not account for an individual provider delivering care across multiple counties. The objective of this assessment is that when provider shortages are identified, Indiana intensifies recruiting efforts to increase workforce capacity within counties and across the state. For this report, Lewin used the counts for identified Medicaid-enrolled providers who provided MH services in 2020, 2021, and 2022. Only data that was validated by the state was included in the analysis.

B. Demonstration and State-Specific Population Identification Using Claims and Enrollment Data

1. Medicaid-Eligible Population

Medicaid eligible enrollment was defined as at least one month Medicaid enrollment within a measurement period, including Medicaid managed care, FFS, and dual enrollment. Individuals with the following status or services were excluded:

a. Medicare dually eligible including QMB only, SLMB only, QDWI, and QI.

b. Only eligible for family planning services, including Presumptive Eligibility (PE) Family Planning Services, Hospital PE Family Planning, and pregnant women.

c. Having ED services only.

Exhibit D.2 lists the detailed data specification for each exclusion criterion. Based on enrollment data, approximately 93% of Medicaid recipients were identified as eligible among the overall population.

Exhibit D.2 Enrollment Data Specification for Medicaid Eligibility Exclusion

Exclusion Criteria	Categories	Enrollment Data Specification
Medicare dually eligible	QMB only	Recipient_aid_catgy='L' and I_dual_aid ='Y'
	SLMB only	Recipient_aid_catgy='J' and I_dual_aid ='Y'
	QDWI	Recipient_aid_catgy='G' and I_dual_aid ='Y'
	QI	Recipient_aid_catgy='I' and I_dual_aid ='Y'
Eligible for family planning services	PE Family Planning Services	Recipient_aid_catgy='E'
	Hospital PE Family Planning	Recipient_aid_catgy='HF'
	PE Pregnant Women	Recipient_aid_catgy='PN'
Having ER services only		I_Emergency_Services_Only='Y'

2. Demonstration Population

The demonstration population was identified using claims data and enrollment data based on the definition outlined in **Exhibit III.2**. The following steps outline the process used for identifying the population:

1. Identified all claims with any MH diagnosis in the primary diagnosis position.
2. Excluded claims not paid by third-party (with Amt_TPL_Total>0).
3. Identified a distinct list of individuals having a claim with MH diagnosis for each month using claims from Step 2.
4. Identified the population for different measurement periods (annual and quarterly) based on whether a Medicaid eligible beneficiary (any month during the measurement period) had at least one claim with MH diagnosis in the measurement period.

3. State-Specific SMI Population

The SMI population was identified using claims data and enrollment data based on the definition outlined in **Exhibit III.2**. The following steps outline the process used for identifying the population:

1. Identified all claims with SMI diagnosis in the first two positions.
    a. SMI diagnosis codes are any codes that begin with "F20","F25","F31", or "F33".
2. Excluded claims not paid by third-party (with Amt_TPL_Total>0).
3. Identified a distinct list of SMI individuals for each month using claims from Step 2.
4. Identified the population for different measurement periods (annual and quarterly) based on whether a Medicaid eligible beneficiary (any month during the measurement period) had at least one claim with SMI diagnosis in the measurement period.

C. Member KII – Sampling

Stratified sampling was used to select member samples for the member key informant interview from the state-specific SMI beneficiary population. The sampling population was compiled in December 2022. The following steps were used to construct the sample:

1. Retained beneficiaries aged between 21 and 64 (65%) from the Medicaid eligible population in December 2022.
2. Excluded individuals with invalid sociodemographic characteristics. Given that over 25% of the eligible population had no race or ethnicity data, exclusions were only applied for gender (7 removed because of missing or invalid gender).
3. Excluded beneficiaries with invalid phone numbers (about 10%).

The sample was stratified by gender (Female and Male), age (age groups stratified: 21-30, 31-50, and 51-64), and race (racial groups stratified: African American/Black, Caucasian, and other). Given the potential for non-response, a sample of 500 beneficiaries was derived to maximize data collection efforts for completing 25 interviews (target number of responses from the evaluation design). The number of sample cohorts selected per strata (of the total 500) was proportional to the relative volume (number of beneficiaries) of each stratum. The PROC SURVEYSELECT procedure in SAS was used to construct the sample.

Since interviews were expected to take weeks to complete and response rates typically vary by member characteristics, the sampled beneficiaries were split into five outreach waves and sorted by beneficiary characteristics to maximize the number of completed interviews from the varied member pool. **Exhibit D.3** presents the counts for the sampling population, outreach sample and respondent by gender, age, and race categories.

Exhibit D.3 Counts of SMI Population, Outreach Sample, and Respondents by Gender, Age and Race

Population to Sample	Sampling	N	Strata	Gender		Age Group			Race		
			Category	Female	Male	21-30	31-50	51-64	Caucasian	African American / Black	Other
SMI Population in December 2022	With Available Strata Information	72,975	N	46,652	26,323	17,343	35,036	20,603	47,068	6,949	18,958
			%	63.9%	36.1%	23.8%	48.0%	28.2%	64.5%	26.8%	73.2%
	With Valid Phone Number	67,268	N	42,879	24,389	15,474	32,236	19,558	42,450	6,345	18,473
			%	63.7%	36.3%	23.0%	47.9%	29.1%	63.1%	25.6%	74.4%
SMI Sample	Overall	500	N	318	182	116	239	145	316	47	137
			%	63.6%	36.4%	23.2%	47.8%	29.0%	63.2%	25.5%	74.5%
SMI Respondents Interviewed	Overall	25	N	22	3	7	8	10	20	2	3
			%	88.0%	12.0%	28.0%	32.0%	40.0%	80.0%	8.0%	12.0%

D. Monitoring Report Metric Specifications for Critical Metrics Included in the Risk Assessment

Exhibit D.4 list the specifications for the critical monitoring report metrics included in the risk assessment (**Section V**). The specifications were compiled from the state's Technical Specifications.

Exhibit D.4 Monitoring Report Relevant Metric Specification

Milestone #	Metric #	Metric Name	Demonstration Reporting	
			Denominator	Numerator
Milestone 2. Improving care coordination and transitions to community-based care	4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	Count of index hospital admissions to IPFs.	Count of 30-day readmissions to IPFs or short-stay acute care hospital that occurs within 30 days after discharge date from IPFs.
	8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD), Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Discharges from IPF for principal dx of mental illness, intentional self-harm.	A follow-up visit with a mental health provider within 7 days after discharge.
	10	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD), Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit	ED visits for principal diagnosis of mental illness or intentional self-harm.	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 30 days after the ED visit.
	10	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD), Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	ED visits for principal diagnosis of mental illness or intentional self-harm.	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 7 days after the ED visit.
Milestone 3. Increasing access to continuum of care including crisis stabilization services	19	Average Length of Stay in IMDs ALOS for all IMDs and populations	Total number of days of inpatient and residential discharges from an IMD for beneficiaries with SMI.	Total number of IMD stays.

Milestone #	Metric #	Metric Name	Demonstration Reporting	
			Denominator	Numerator
Milestone 4. Earlier identification and engagement in treatment including through increased integration	23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2).	Patients who had Hemoglobin A1c (HbA1c) testing (HbA1c>9% or missing).
	26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	Medicaid beneficiaries aged 18 years or older with a diagnosis code of mental health.	Adults' Access to Preventive/Ambulatory Health Services.
	30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Medicaid beneficiaries aged 18 years and older with at least one new antipsychotic medication fill during the year January 1 through November 30.	The number of new antipsychotic medication prescriptions with a qualifying outpatient visit within 28 days (4 weeks) of the prescription fill date.

E. Metric Calculation

1. Emergency Department Visits

All-cause Emergency Department (ED) visits were extracted from claims data for each population by measurement year from the baseline (CY 2020) to the mid-point (CY2022). Data processing steps to calculate utilization rates are detailed below.

1. Identify ED claims: Among claims with latest transaction that were not paid through third party payers, identify all claims with proc_code_l in (‘99281’,’99282’,’99283’,’99284’,’99285’) or Revenue_Code in ('450', '451', '452', '456', '459', '981').
2. Retain ED claims for those months where the beneficiary was Medicaid eligible: Keep ED claims identified in Step 1 for only eligible Medicaid enrollees per ED occurance month. The Medicaid eligibility criteria are specified in Exhibit VI.IV.2.
3. For each year, subset ED claims identified by Step 2 for each population: demonstration population or State-specific SMI population.
4. Count distinct ED service dates per recipient as number of ED visits per recipient within a year for each population.
    a. The number of ED visits per year was the total number of ED visits within a calendar year for each population.
    b. The member months per year was calculated as the number of eligible enrollment months in a calendar year for each population, identified in the member enrollment data.
    c. The annual utilization rates, ED visits per 1,000 member month per year, was calculated as the total number of ED visits in a year divided by the total number of population member enrollment months times 12,000. The formula to calculate the annual utilization rates is specified below:

$$\frac{\#\ ED\ visits}{Total\ member\ months}\ x\ 1{,}000\ x\ 12\ months$$

2. Average Length of Stay for Inpatient Admissions

Inpatient admissions were extracted from claims data for state-specific SMI population per measurement year from the baseline (CY2020) to the mid-point (CY2022). Length of stay for all inpatient admissions was calculated as one plus the number of days from the admission begin date to the admission end date. Average length of stay was calculated as total number of days related to all inpatient admissions divided by number of inpatient admissions in a year. The specific data processing steps and calculation details are listed below:

1. Identify all inpatient claims[58] with Claim_Type "I" ("I" means inpatient) among claims with latest transaction that were not paid through third party payers
2. Flag any inpatient claim with a primary ICD10 MH diagnosis code (Primary_Diag_Code).
3. Construct inpatient admissions from inpatient claims. Inpatient stays were constructed based on unique Recipient_IDs and their service dates. The considerations and the steps to construct inpatient admissions from inpatient claims were:
    a. Sort inpatient claims identified in Step 1 by recipient_id and dates of services (Date_Begin_Service_Header and Date_End_Service_Header)
    b. For each recipient, identify inpatient claims with overlap or adjacent service dates based on the number of days between Date_End_Service_Header of one claims to Date_Begin_Service_Header of subsequent claim.
    c. For cases where the difference in days (in step 3.c.) was less than or equal to 1, concatenate the claims to create a continous inpatient stay.
4. Date_Begin_Service_Header of one inpatient stay was considered as its admission date, and Date_End_Service_Header was considered as the end date of the stay. For instances where multiple claims were concatenated, the Date_End_Service_Header for the last claim was used as the end date for the stay.
5. Identify inpatient stays related to MH diagnosis based on the existence of a primary MH diagosis code (flag created in Step 2).
6. Subset inpatient stays for a defined population for each year (demonstration population and State-specific SMI population).
7. Calculate the LOS for each inpatient admission as one plus the number of days from admission begin dates to end dates of inpatient stays per year.
8. Calculate ALOS per year per population:
    a. Calculate the total length of stay in a year as the summation of LOS related to the type of inpatient stay (overall or related to MH)
    b. Count the number of inpatient stays
    c. Divide the total length of stay by the number of inpatient stays

[58] This analysis only includes inpatient claims. It does not include inpatient stays that had a crossover claim.

Attachment E: Findings – Additional Exhibits

A. MHSIP Survey

Report findings from the MHSIP survey were used in this report to examine patient satisfaction with care at CMHCs (milestone 1). **Exhibit E.1** presents the count of respondents in each survey year.

Exhibit E.1 Number of MHSIP Survey Respondents

Year	2020	2021	2022
Number of Respondents	4,193	5,951	5,333

The MHSIP survey contained two questions related to access to care:

1) Was the beneficiary able to receive all the care that they perceived they needed?
2) Was the beneficiary able to see a psychiatrist when they needed it.

Findings from the 2022 MHSIP survey denote the proportion of respondents who indicated having a positive response for each of the questions. Overall, 85% of respondents (5,299) indicated they were able to get all the services they needed while 72% of respondents indicated having been able to see a psychiatrist when they wanted **(Exhibit E.2)**. **Exhibit E.2** also presents findings by each provider (name/number not shown).

Exhibit E.2 Percentage Respondent with Positive Response to Access to Care (Not included in Domain), 2022

Provider	8. I was able to get all the services I thought I needed.			9. I was able to see a psychiatrist when I wanted to.		
	Percent Positive Response (R)	Score	# of Respondents (n)	(R)	Score	(n)
Overall	85	1.7	5,299	72	2	5,271
P1	91	1.6	296	76	1.9	296
P2	84	1.6	253	70	1.9	250
P3	89	1.6	142	82	1.7	141
P4	89	1.6	208	71	1.9	208
P5	87	1.7	195	65	2.1	192
P6	91	1.6	117	77	1.9	117
P7	79	1.8	414	66	2.1	411
P8	79	1.9	357	68	2.1	255
P9	74	2.1	156	64	2.2	156
P10	91	1.7	94	76	1.9	92
P11	79	1.8	314	66	2.1	314
P12	92	1.5	261	81	1.6	257
P13	87	1.6	315	76	1.9	318
P14	85	1.7	275	71	2	271
P15	83	1.9	151	75	2.1	151

Provider	8. I was able to get all the services I thought I needed.			9. I was able to see a psychiatrist when I wanted to.		
	Percent Positive Response (R)	Score	# of Respondents (n)	(R)	Score	(n)
P16	92	1.6	105	74	2	104
P17	90	1.5	175	78	1.7	176
P18	92	1.6	92	70	2	91
P19	86	1.7	220	75	2	225
P20	92	1.5	50	73	1.9	51
P21	87	1.6	187	79	1.8	187
P22	88	1.6	130	70	2	131
P23	82	1.8	440	70	2	438
P24	84	1.7	184	72	1.9	181

B. Metrics by Milestone and Action Item

Exhibit E.3 provides the counts for the denominator, numerator by demonstration year (DY) for each monitoring metric included in the Mid-Point Assessment. The metric value for all monitoring metrics is also included. Data was compiled using the state's monitoring reports.

Exhibit E.3 Monitoring Metric by Year from Baseline to Mid-Point (2020 – 2022)

Milestone	Metric #	Metric Name	DY*	Demonstration Reporting		
				Denominator	Numerator	Rate/Percentage
1. Ensuring quality of care in psychiatric hospitals and residential settings	2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	2020	4,536	2,496	55.03
			2021	4,941	2,986	60.43
			2022	5,201	3,026	58.18
2. Improving care coordination and transitions to community-based care	4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	2020	32,895	8,245	25.06
			2021	36,023	8,994	24.97
			2022	36,509	9,458	25.91
	6	Medication Continuation Following Inpatient Psychiatric Discharge	2020	5,184	15	2.89
			2021	5,847	21	3.59
			2022	6,113	18	2.94
	7	Follow-up After Hospitalization for Mental Illness: Age 6-17 (FUH-AD) Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge	2020	584	353	60.45
			2021	526	345	65.59
			2022	588	386	65.65
		Follow-up After Hospitalization for Mental Illness: Age 6-17 (FUH-AD) Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	2020	584	226	38.70
			2021	526	229	43.54
			2022	588	223	37.93
	8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge	2020	1,908	774	40.57
			2021	1,712	842	49.18
			2022	1,727	767	44.41
		Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	2020	1,908	475	24.90
			2021	1,712	580	33.88
			2022	1,727	508	29.42

Milestone	Metric #	Metric Name	DY*	Demonstration Reporting		
				Denominator	Numerator	Rate/Percentage
	9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD) Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit	2020	10,924	2554	23.38
			2021	12,893	3050	23.66
			2022	16,262	6410	39.42
		Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD) Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	2020	10,924	1742	15.95
			2021	12,893	2122	16.46
			2022	16,262	4490	27.61
Milestone 2 (continued)	10	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit	2020	7,674	3,876	50.51
			2021	8,594	4,349	50.61
			2022	9,265	4,497	48.54
		Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	2020	7,674	2,778	36.20
			2021	8,594	3,104	36.12
			2022	9,265	3,065	33.08
3. Increasing access to continuum of care including crisis stabilization services	19a	Average Length of Stay in IMDs ALOS for all IMDs and populations	2020	8,428	85,395	10.1
			2021	9,310	91,561	9.8
			2022	9,899	88,812	9
		Average Length of Stay in IMDs ALOS among short-term stays (less than or equal to 60 days)	2020	8,322	64,317	7.7
			2021	9,203	72,239	7.8
			2022	9,789	71,134	7.3
		Average Length of Stay in IMDs ALOS among long-term stays (greater than 60 days)	2020	106	21,078	198.8
			2021	107	19,322	180.6
			2022	110	17,678	160.7
	19b	Average Length of Stay in IMDs (IMDs receiving FFP only) ALOS for all IMDs and populations	2020	8,327	65,404	7.9
			2021	9,175	72,196	7.9
			2022	9,780	72,587	7.4
		Average Length of Stay in IMDs (IMDs receiving FFP only) ALOS among short-term stays (less than or equal to 60 days)	2020	8,311	64,009	7.7
			2021	9,160	70,696	7.7
			2022	9,754	69,861	7.2
		Average Length of Stay in IMDs (IMDs receiving FFP only) ALOS among long-term stays (greater than 60 days)	2020	16	1,395	87.2
			2021	15	1,500	100
			2022	26	2,726	104.8

Milestone	Metric #	Metric Name	DY*	Demonstration Reporting		
				Denominator	Numerator	Rate/Percentage
	20	Beneficiaries With SMI/SED Treated in an IMD for MH	2020		4,463	
			2021		5,698	
			2022		6,411	

Milestone	Metric #	Metric Name	DY*	Demonstration Reporting		
				Denominator	Numerator	Rate/Percentage
4. Earlier identification and engagement in treatment including through increased integration	21	Count of Beneficiaries With SMI/SED (monthly average per year)	2020		96,851	
			2021		109,638	
			2022		113,161	
	22	Count of Beneficiaries With SMI/SED (annually)	2020		266,256	
			2021		300,734	
			2022		306,730	
	23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	2020	13,327	13102	98.31
			2021	14,648	14291	97.56
			2022	12,486	11916	95.43
	26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	2020	356,821	321,093	89.99
			2021	411,219	390,756	95.02
			2022	431,765	411,959	95.41
	29	Metabolic Monitoring for Children and Adolescents on Antipsychotics Percentage of children and adolescents on antipsychotics who received blood glucose testing	2020	12,806	5,606	43.78
			2021	13,027	5,867	45.04
			2022	13,322	6,183	46.41
		Metabolic Monitoring for Children and Adolescents on Antipsychotics Percentage of children and adolescents on antipsychotics who received cholesterol testing	2020	12,806	3,483	27.20
			2021	13,027	3,624	27.82
			2022	13,322	3,692	27.71
		Metabolic Monitoring for Children and Adolescents on Antipsychotics Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	2020	12,806	3,323	25.95
			2021	13,027	3,458	26.54
			2022	13,322	3,521	26.43
	30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	2020	37,994	29,792	78.41238
			2021	48,064	37,395	77.80251
			2022	51,703	39,004	75.43856

Notes: DY = Demonstration Year. Dates Covered (based on service start and service end and enrollment) for each DY are: DY 2020 = 01/01/2020-12/31/2020, DY 2021 = 01/01/2021-12/31/2021, DY 2022 = 01/01/2022-12/31/2022.

C. Provider Availability Assessment

Exhibits E.4 – E.5 summarize state data from the Provider Availability Assessment. **Exhibit E.4** presents the distribution of providers by county for each of the demonstration years (2020-2022). Both the minimum and maximum number of providers are listed as well as the average number of providers per county. Blank cells indicate that validated data was not available for a provider type in a given year. **Exhibit E.5** focuses on crisis stabilization services and identifies the number of services by type of crisis stabilization service (e.g., mobile crisis team, crisis observation center, CSU, call center) for each county. The exhibit also includes information detailing the reach of counties served by all the crisis stabilization services for a given county. **Exhibits E.6 – E.10** provide maps for each provider type for 2020 and 2021. Maps for 2022 are included in the body of the report (**Section IV.E**).

Exhibit E.4 Distribution of Providers Per County by Type of Providers and Year

Provider	Year*	# of Counties with no Provider	# of Counties with available Provider	Min. # of Provider in a County	Distribution of # of providers in a county among counties with available assessment data			Max. # of Provider in a County	Avg. # of Provider per County	Total # of Provider Across Counties
					25% of counties	50% of counties	75% of counties			
Community MH Centers	2020	0	92	1	1	1	1	4	1.05	97
	2021	5	87	1	1	2	3	24	2.53	220
	2022	5	87	1	1	2	3	26	2.66	231
Intensive Outpatient Services	2020	61	31	1	1	1	2	19	2.52	78
	2021	53	39	1	1	2	3	27	3.10	121
	2022	51	41	1	1	2	4	28	3.24	133
Psychiatric Beds	2020	92	-*							
	2021	92	-*							
	2022	74	18	15	16	23	97	159	53.89	970
Residential MH treatment facilities	2020	92	-*							
	2021	63	29	1	1	1	3	5	1.86	54
	2022	63	29	1	1	1	3	5	1.90	55
Psychiatric Hospitals That Qualify as IMDs	2020	78	14	1	1	1	1	4	1.36	19
	2021	78	14	1	1	1	2	4	1.43	20
	2022	77	15	1	1	1	2	5	1.47	22
Public and Private Psychiatric Hospitals	2020	68	24	1	1	1	2	4	1.42	34
	2021	68	24	1	1	1	2	6	1.63	39

* The data for 'number of countries with available provider' was not available to the state at the time of the Mid-Point Assessment.

Provider	Year*	# of Counties with no Provider	# of Counties with available Provider	Min. # of Provider in a County	Distribution of # of providers in a county among counties with available assessment data			Max. # of Provider in a County	Avg. # of Provider per County	Total # of Provider Across Counties
					25% of counties	50% of counties	75% of counties			
	2022	68	24	1	1	1	2	6	1.63	39
Crisis Call Centers	2020	92	-*							
	2021	92	-*							
	2022	89	3	1	1	1	1	1	1.00	3
Mobile Crisis Units	2020	86	6	1	1	1	1	1	1.00	6
	2021	82	10	1	1	1	1	2	1.20	12
	2022	76	16	1	1	1	1	1	1.00	16
Crisis Observation/ Assessment Centers	2020	90	2	1	1	1	1	1	1.00	2
	2021	92	-*							
	2022	89	3	1	1	1	1	1	1.00	3
Crisis Stabilization Units	2020	89	3	1	1	2	3	3	2.00	6
	2021	88	4	1	1	1	1	1	1.00	4
	2022	88	4	1	1	1	1	1	1.00	4
Number of FQHC	2020	36	56	1	1	2	3	51	3.80	213
	2021	38	54	1	1	2	3	48	3.74	202
	2022	36	56	1	1	2	3	51	3.80	213
With any of crisis services, one of Crisis Call Centers, Mobile Crisis Units, Crisis Observation/Assessment Centers, and Crisis Stabilization Units	2020	92	-*							
	2021	92	-*							
	2022	73	19	1	1	1	1	1	1.00	19

* The data for 'number of countries with available provider' was not available to the state at the time of the Mid-Point Assessment.

Exhibit E.5 Crisis Service Location and Served Counties, 2022

County - Service Location	Mobile Crisis Team	Crisis Observation Center	Crisis Stabilization Unit	Call Center	Counties Served by Service
Cass	1		1		
Clark	1				Clark, Floyd, Harrison
Delaware				1	Adams, Allen, Bartholomew, Blackford, Brown, Clark, Crawford, Daviess, De Kalb, Dearborn, Decatur, Dekalb, Delaware, Dubois, Elkhart, Fayette, Floyd, Franklin, Grant, Hamilton, Hancock, Harrison, Henry, Huntington, Jackson, Jay, Jefferson, Jennings, Johnson, Kosciusko, Lagrange, Lawrence, Madison, Marshall, Martin, Monroe, Morgan, Noble, Ohio, Orange, Pike, Randolph, Ripley, Rush, Scott, Shelby, Spencer, St Joseph, Steuben, Switzerland, Union, Wabash, Warrick, Washington, Wayne
Fulton	1				
Grant	1	1			
Hendricks	1				
Johnson	1				
Kosciusko	1		1		Huntington, Kosciusko, Marshall, Wabash, and Whitley
Lake				1	Jasper, La Porte, Lake, Porter
Miami	1				
Monroe	1	1			
Porter	1				
Pulaski	1				
Shelby	1				
Starke	1				
Steuben	1				Steuben, DeKalb, LaGrange
Tippecanoe				1	Benton, Boone, Carroll, Cass, Clay, Clinton, Fountain, Fulton, Gibson, Greene, Hendricks, Howard, Knox, Marion, Miami, Montgomery, Newton, Owen, Parke, Perry, Posey, Pulaski, Putnam, Starke, Sullivan, Tippecanoe, Tipton, Vanderburgh, Vermillion, Vigo, Warren, White

County - Service Location	Mobile Crisis Team	Crisis Observation Center	Crisis Stabilization Unit	Call Center	Counties Served by Service
Vanderburgh	1		1		
Vigo	1	1	1		Vigo, Parke, Putnam, Clay, Vermillion, Sullivan, Owen, Green, Hendricks, Marion, Knox

Exhibit E.6: Number of Providers by County - CMHC, 2020 - 2021

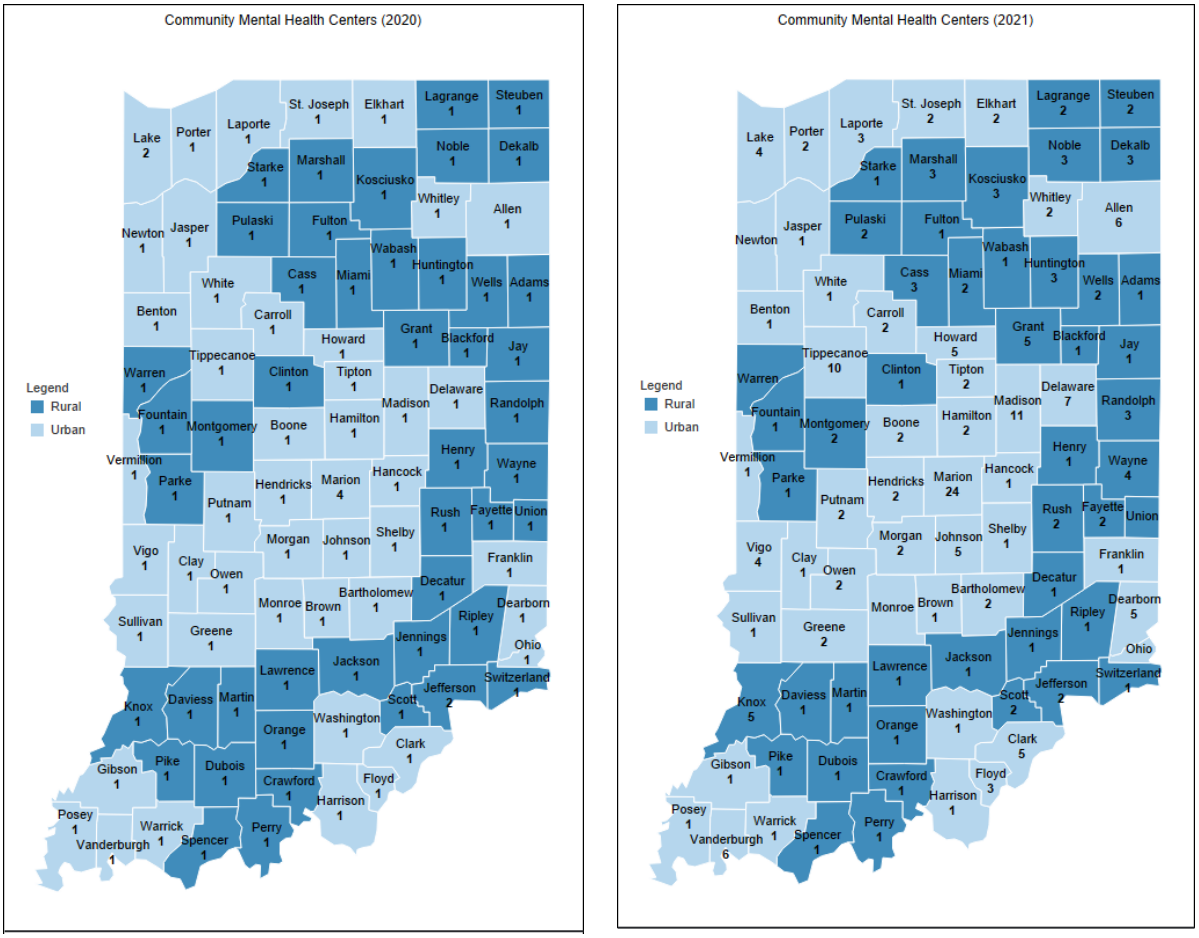


Exhibit E.7: Number of Providers by County - Intensive Outpatient Services, 2020 - 2021

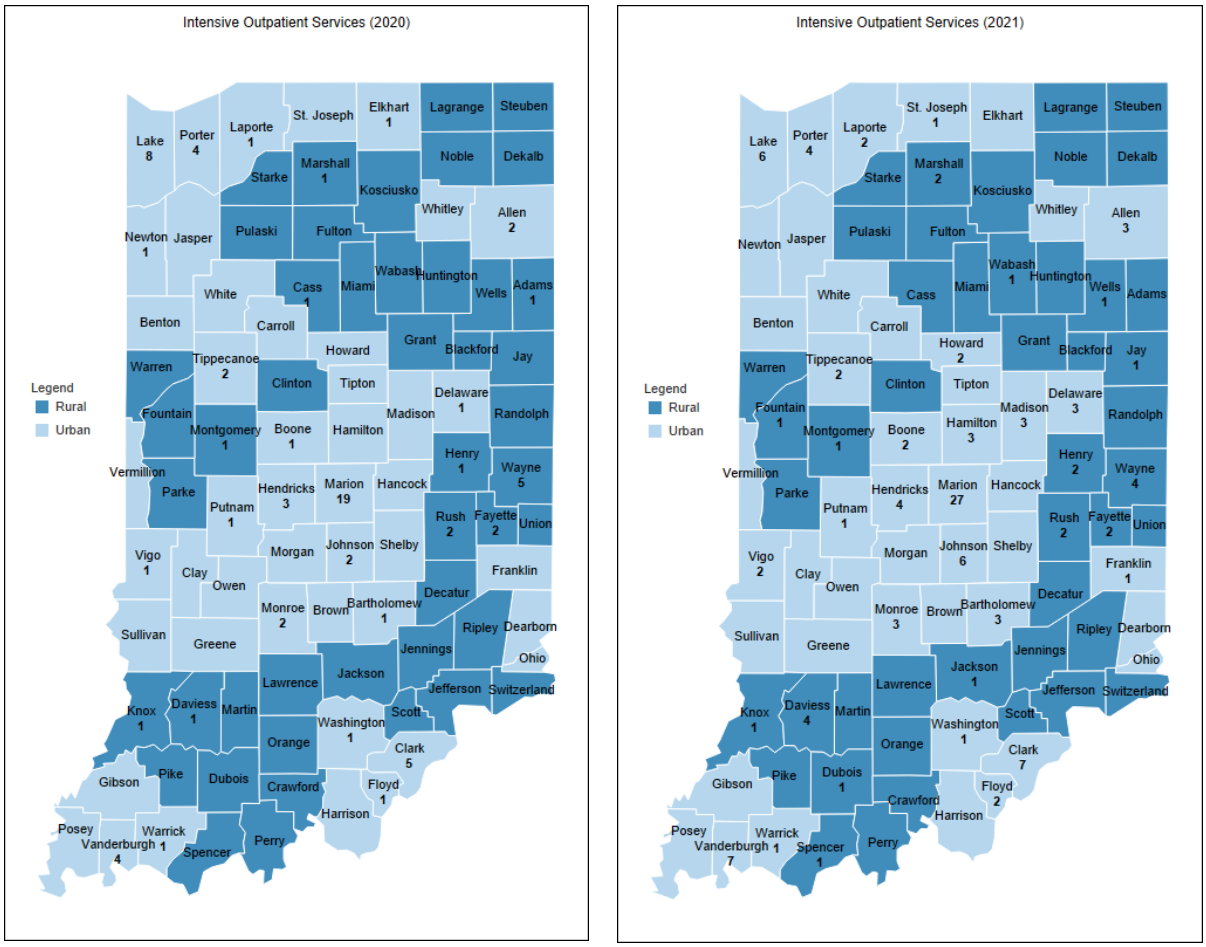


Exhibit E.8: Number of Providers by County - Residential MH treatment facilities, 2021

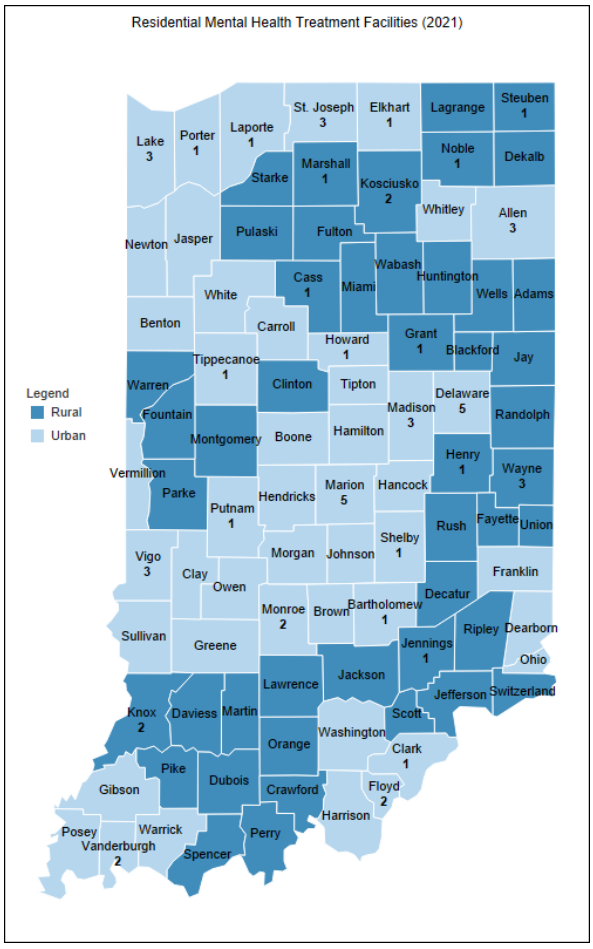
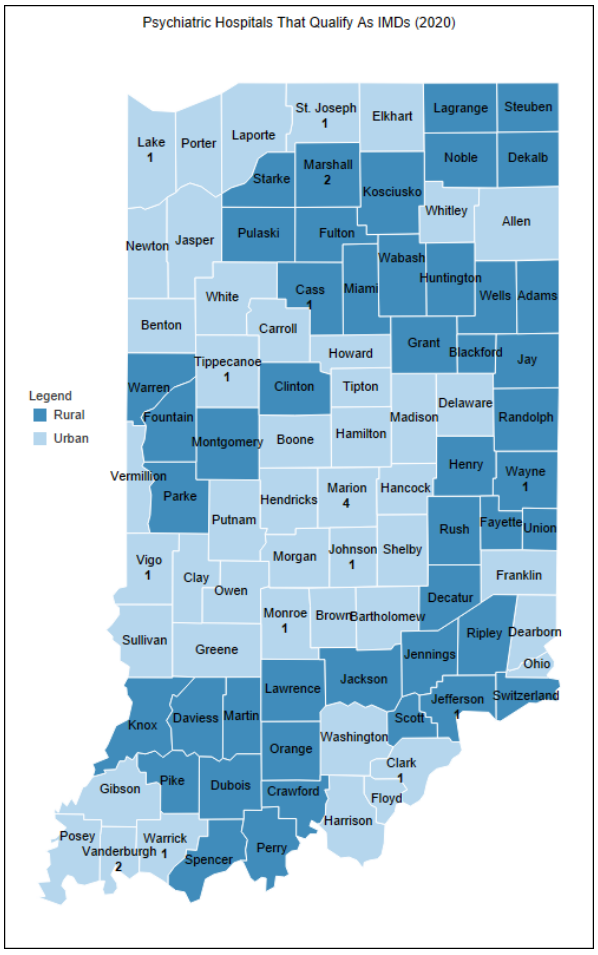


Exhibit E.9: Number of Providers by County - Psychiatric Hospitals That Qualify As IMDs, 2020 - 2021



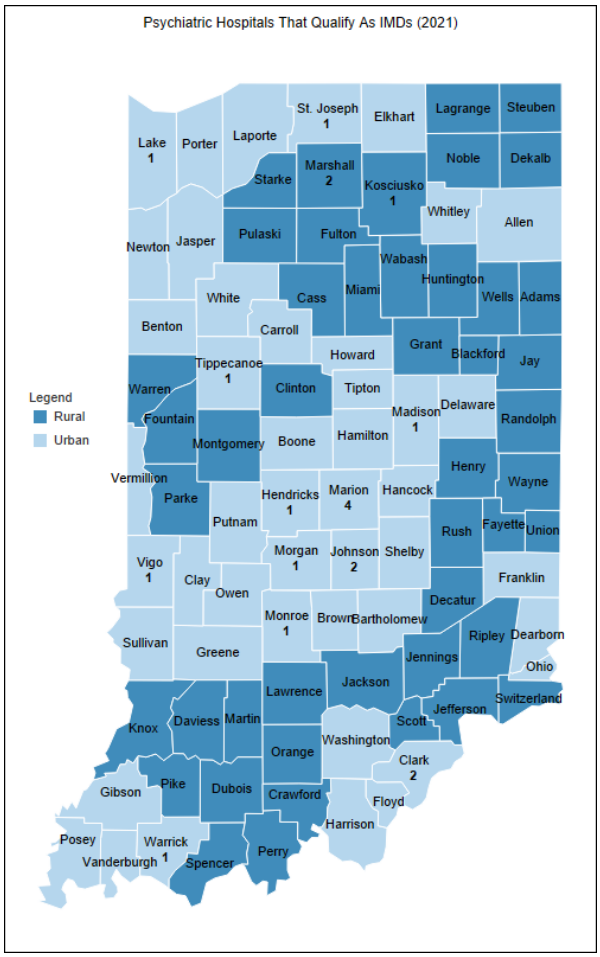


Exhibit E.10: Number of Providers by County - FQHC, 2020 - 2021

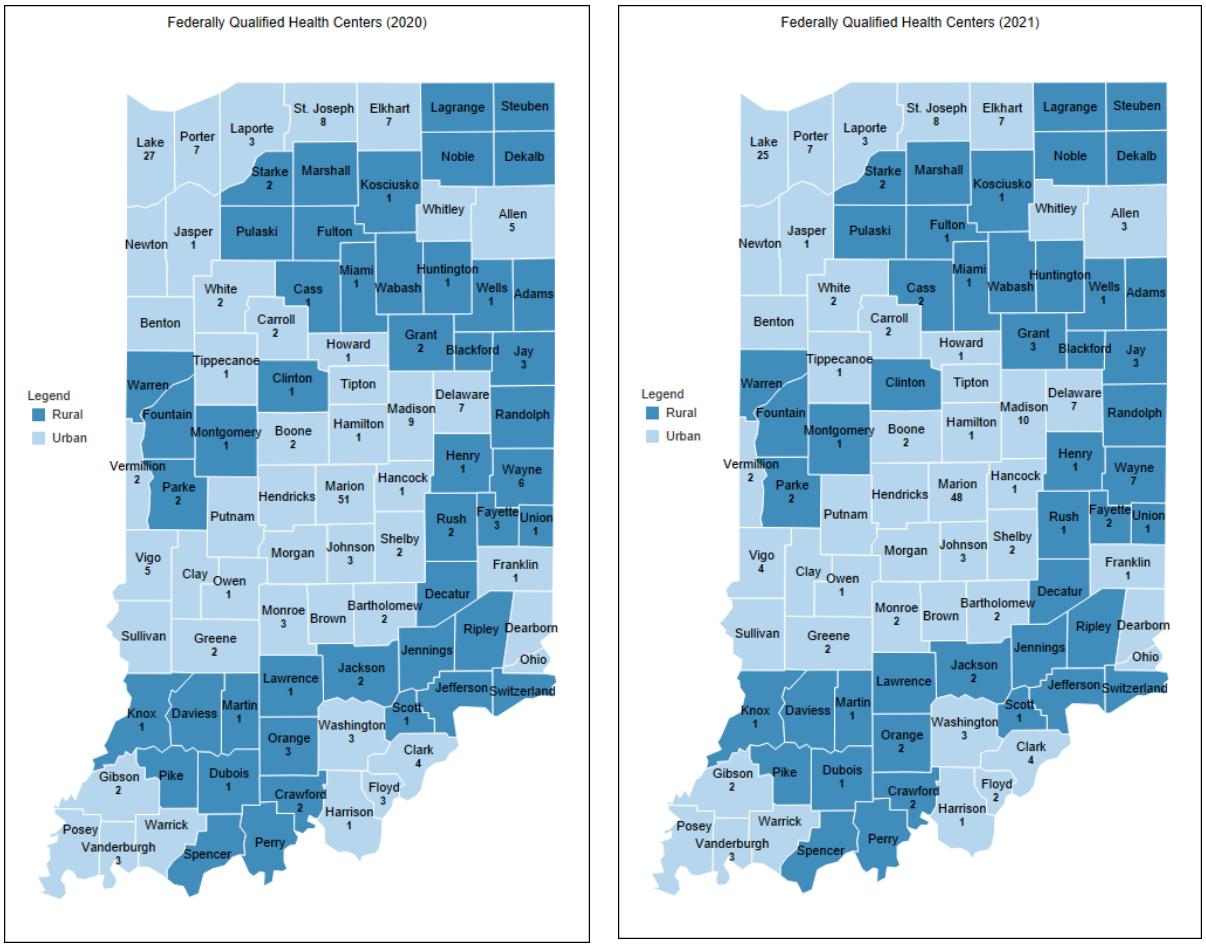
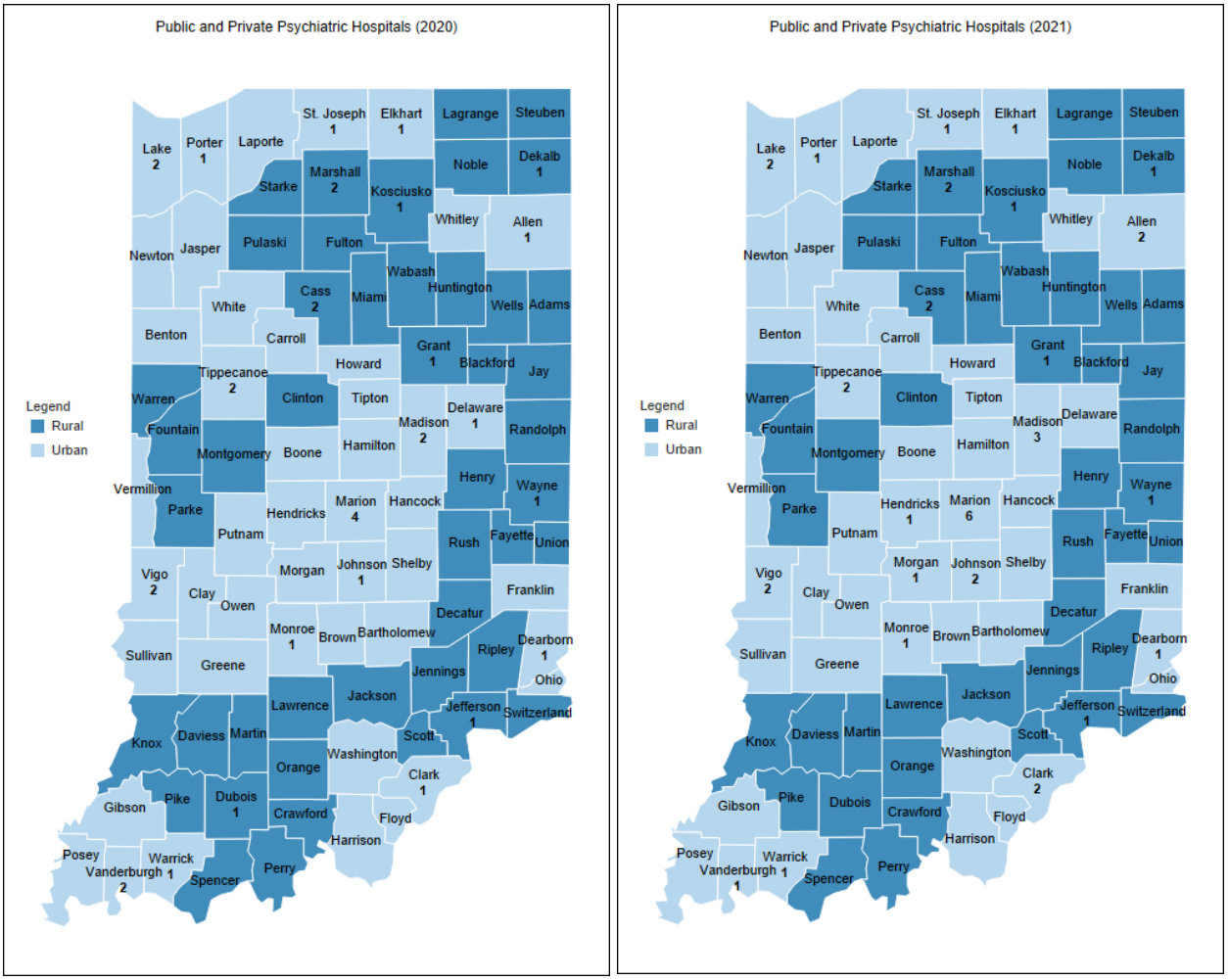


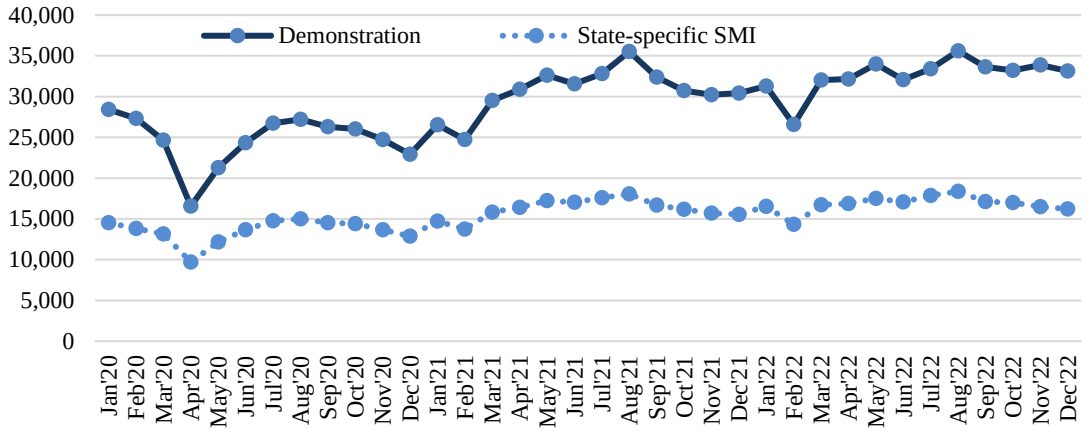
Exhibit E.11 Number of Public and Private Psychiatric Hospitals by County, 2020 - 2021



D. Claims Based ED and Inpatient Utilization

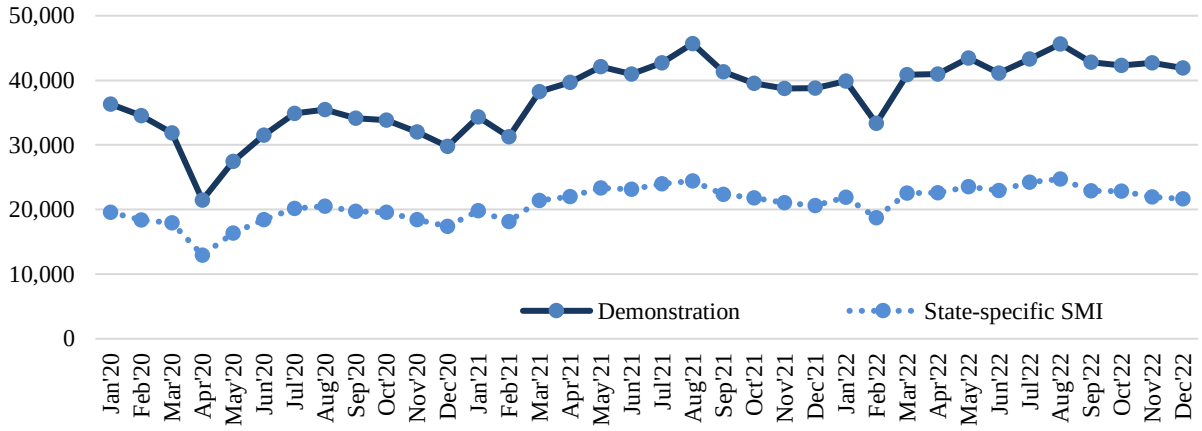
Claims and enrollment data were used to calculate ED utilization and inpatient stays - irrespective of whether the utilization was related to MH. Exhibits **E.11** - **E.14** show the ED utilization by month and the inpatient stays by length of stay.

Exhibit E.11 Number of Beneficiaries having ED Visits by Month (2020-2022)



Source: Claims and Enrollment data, 2020-2022.

Exhibit E.12 Number of ED Visits by Month (2020-2022)



Source: Claims and Enrollment data, 2020-2022.

Exhibit E.13 Inpatient Stays by Length of Stay (2020-2022)

Population	Length of Stay (LOS) Category	2020		2021		2022	
		Number of inpatient stays	ALOS	Number of inpatient stays	ALOS	Number of inpatient stays	ALOS
Demonstration	Short-term (1-15 days)	43,788	5.6	49,400	5.6	41,968	5.7
	Medium-term (16-60 days)	2,517	25.4	3,078	25.2	2,573	25.4
	Long-term (61+ days)	293	132.1	282	140.8	302	134.5

	Overall	**46,598**	**7.4**	**52,760**	**7.5**	**44,843**	**7.7**
State-specific SMI	Short-term (1-15 days)	31,365	5.8	35,133	5.9	30,080	5.9
	Medium-term (16-60 days)	1,704	24.8	2,073	24.8	1,751	24.7
	Long-term (61+ days)	184	143.8	170	158.0	170	151.3
	Overall	**33,253**	**7.6**	**37,376**	**7.6**	**32,001**	**7.7**

Source: Claims and Enrollment data, 2020-2022. Note: Beneficiaries can have multiple stays and combination of short and long term stays within same year.

Exhibit E.14 Inpatient Stays Related to Mental Health by Length of Stay (2020-2022)

Population	Length of Stay (LOS) Category	2020		2021		2022	
		Number of inpatient stays	ALOS	Number of inpatient stays	ALOS	Number of inpatient stays	ALOS
Demonstration	Short-term (1-15 days)	18,009	6.4	19,730	6.5	17,661	6.4
	Medium-term (16-60 days)	926	24.5	1,051	24.7	872	24.7
	Long-term (61+ days)	187	157.1	168	170.4	168	163.2
	Overall	**19,122**	**8.7**	**20,949**	**8.7**	**18,701**	**8.7**
State-specific SMI	Short-term (1-15 days)	15,692	6.5	17,461	6.5	15,821	6.4
	Medium-term (16-60 days)	851	24.2	963	24.3	788	24.2
	Long-term (61+ days)	145	157.0	127	179.1	126	170.0
	Overall	**16,688**	**8.7**	**18,551**	**8.6**	**16,735**	**8.5**

Source: Claims and Enrollment data, 2020-2022. Note: Beneficiaries can have multiple stays and combination of short and long term stays within same year.