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Mid-Point Assessment

Indiana's Section 1115 Substance Use Disorder Demonstration

Prepared for
Indiana Family and Social Services Administration

December 31, 2023

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SECTION A: General Background Information

Demonstration Name, Approval Date, and Time Period of Data Analyzed in the Assessment

Name: Healthy Indiana Plan

Project Number: 11-W-000296/5

Approval Date: October 26, 2020

Time Period Covered by Evaluation: The demonstration covers the period from January 1, 2021 through December 31, 2025. This assessment covers the period with dates of service from January 1, 2021 through June 30, 2023.

Description of the Demonstration's Policy Goals

Indiana proposes to test whether it can enhance the effectiveness of the SUD treatment system in Medicaid by maintenance and expansion of SUD residential services, as part of a coordinated and full continuum of care resulting in increased access and improved health outcomes for individuals with SUD.

Under the broader waiver demonstration goal stated above, as set forth in the SUD Implementation Plan, Indiana is aligning the six goals for the SUD waiver component with the milestones outlined by the Centers for Medicare and Medicaid Services (CMS) as follows:[1]

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

In accordance with CMS guidance contained in SMD #17-003, Indiana submitted an Implementation Plan in draft form to CMS on October 30, 2019. The Plan describes the planned activities in the waiver period organized by CMS milestone. In cooperation with CMS, Indiana identified its own milestones in its approved Implementation Plan which include:

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication-assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

[1] State Medicaid Director Letter #17-003 Re: Strategies to Address the Opioid Epidemic, November 1, 2017, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

Background on the Indiana Medicaid Program

Indiana's Section 1115 Waiver Authority

Indiana Medicaid provides coverage of SUD treatment services to its members based on standards outlined through the American Society of Addiction Medicine (ASAM). The matrix below provides an overview of each ASAM level of care with Indiana Medicaid's coverage prior to and then starting with the demonstration period. Many services that align with an ASAM level of care were covered prior to the implementation of the 1115 demonstration waiver. The most notable change with the demonstration was the implementation of residential treatment at ASAM levels 3.1 and 3.5. Also, Indiana modified coverage to move what had been Medicaid Rehabilitation Option (MRO) services to state plan services. These services became available to all Medicaid members.

Indiana Medicaid SUD Service Coverage Pre- and Post-Waiver by ASAM Level of Care				
ASAM	**Service**	**Description**	**Pre-Waiver Coverage**	**Post-Waiver Coverage**
OTP	Opioid Treatment Program	Pharmacological and non-pharmacological treatment in an office-based setting (methadone)	Yes (as of Sept. 2017)	Yes
0.5	Early Intervention	Services for individuals who are at risk of developing substance-related disorders	Yes, all populations	Yes, all populations
1.0	Outpatient Services	Outpatient treatment (usually less than 9 hours a week), including counseling, evaluations and interventions	Yes, all populations	Yes, all populations
2.1	Intensive Outpatient Services	9-19 hours of structured programming per week	Yes, but for the MRO-eligible population only	**Yes, all populations**
2.5	Partial Hospitalization	20 or more hours of clinically intensive programming per week	Yes, all populations	Yes, all populations
3.1	Clinically Managed Low- Intensity Residential	24-hour supportive living environment; at least 5 hours of low-intensity treatment per week	No coverage	**Yes, all populations**
3.5	Clinically Managed High- Intensity Residential	24-hour living environment, more high-intensity treatment	No coverage	**Yes, all populations**
3.7	Medically Monitored Intensive Inpatient Services	24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting	Yes, for all (based on medical necessity)	Yes, based on medical necessity
4.0	Medically Managed Intensive Inpatient	24-hour inpatient treatment requiring the full resources of an acute care or psychiatric hospital	Yes, for all (based on med. necessity)	Yes, based on medical necessity
Sub-supported	Addiction Recovery Management Services	Services to help people overcome personal and environmental obstacles to recovery	No coverage	**Yes, all populations**
	Supportive Housing Services	Services for individuals who are transitioning or sustaining housing	No coverage	Explore options to cover

Administration of Indiana's Medicaid Program

The Family and Social Service Administration's (FSSA's) Office of Medicaid Policy and Planning (OMPP)[2] has responsibility for the administration and oversight of Indiana's Medicaid program under waiver and state plan authorities. As of June 2023, 83 percent of beneficiaries were enrolled in one of the State's three risk-based managed care programs that each serves a targeted population—Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect.[3] The remaining 17 percent were enrolled in fee-for-service (FFS).

The approved waiver provides access to the enhanced SUD benefit package for all Indiana Medicaid beneficiaries, regardless of enrollment in FFS or with one of the managed care entities (MCEs).

The **Hoosier Healthwise (HHW)** program (40% of total Medicaid enrollment) began in 1994. By 2005, enrollment with an MCE was mandatory for low income families, pregnant members, and children. This program is authorized by a 1932(a) state plan amendment. Today, HHW primarily has an enrollment base of child Medicaid members and pregnant members including those enrolled in the Children's Health Insurance Program.

The **Healthy Indiana Plan (HIP)** program (39% of total Medicaid enrollment) was first created in January 2008 under a separate Section 1115 waiver authority. This program covered adults with family income up to 200 percent of the federal poverty level (FPL) who were not otherwise eligible for Medicaid or Medicare. In more recent years, adult caretakers and most all of the pregnant members who had been enrolled in HHW are now enrolled in HIP.

The **Hoosier Care Connect (HCC)** program (5% of total Medicaid enrollment) was implemented in April 2015 under a 1915(b) waiver authority. The HCC is a program that administers and deliver services to aged, blind and disabled members. Children in foster care are also enrolled in HCC.

Traditional Medicaid (FFS) is comprised of the remaining Medicaid enrollees and includes the following populations:

- Individuals dually enrolled receiving Medicare and Medicaid benefits;
- Individuals receiving home- and community-based waiver benefits;
- Individuals receiving care in a nursing facility or other State-operated facility;
- Individuals in specific aid categories (e.g., refugees); and
- Individuals awaiting an assignment to an MCE.

During the demonstration period, five MCEs were under contract with the OMPP to administer services to its managed care programs:

- Anthem has been under contract since 2007 and serves members in HHW, HIP, and HCC.
- Managed Health Services, a subsidiary of the Centene Corporation, has been under contract since 1994 and serves members in HHW, HIP, and HCC.
- MDwise, a subsidiary of McLaren, has been under contract since 1994 and serves members in HHW and HIP.
- CareSource has been under contract since 2017 and serves members in HHW and HIP.
- United Healthcare has been under contract since 2021 and serves members in HCC.

The OMPP has worked in close collaboration with the Division of Mental Health and Addiction (DMHA), another agency under the FSSA, since the implementation of the SUD waiver demonstration. The DMHA holds responsibility for licensing residential treatment facilities. The

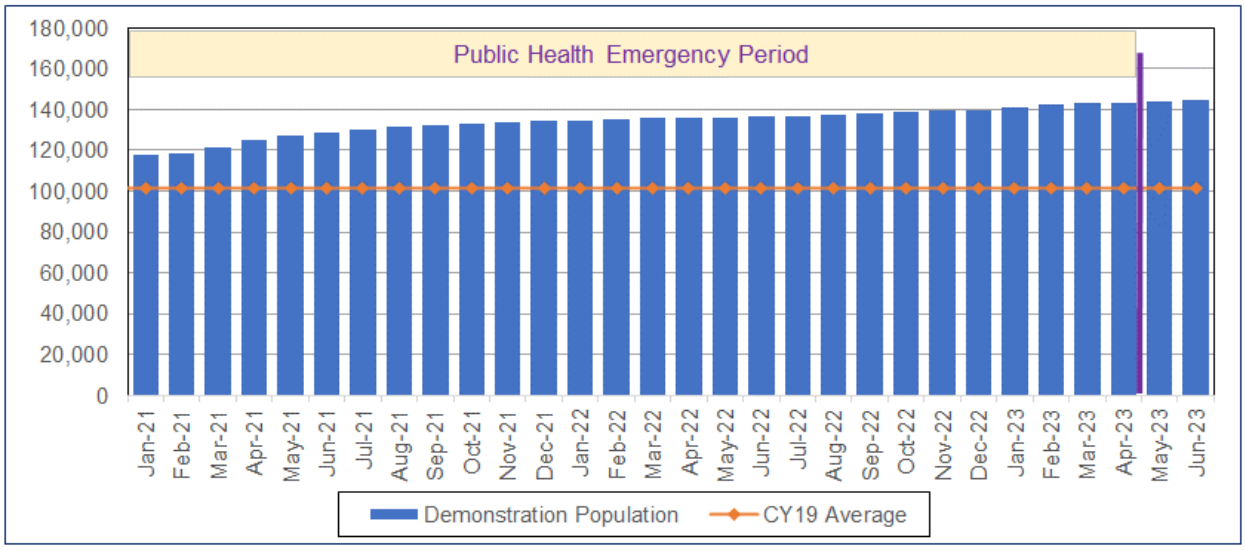
[2] FSSA and OMPP are collectively referred to as Indiana Medicaid throughout this report.
[3] https://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-monthly-enrollment-reports/

DMHA has also undertaken a comprehensive review of its regulations related to service providers and service delivery with an eye toward alignment with ASAM. On a regular basis, a team comprised of OMPP and DMHA staff meet to assess and review policies and procedures related to SUD services. Both divisions met with MCEs and SUD providers frequently at the start of the demonstration and continue to do so today.

Indiana Medicaid Enrollees with SUD

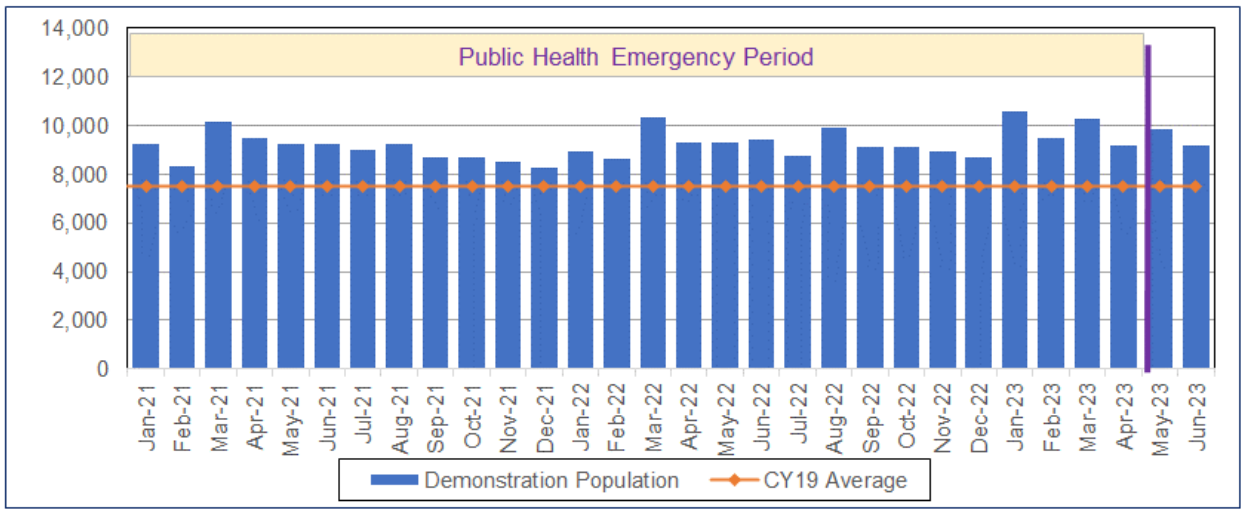
Since the beginning of the current SUD demonstration period that began January 1, 2021, between 117,532 and 144,404 Medicaid enrollees have been identified with an SUD each month. Refer to Exhibit A.1 which details the count of members by month using CMS's SUD Metric #3 specification. The average number of enrollees identified with an SUD in Calendar Year (CY) 2022 was 136,904. With an average total enrollment in excess of two million since the waiver period began, this means that between 6.4 and 6.7 percent of the total Medicaid enrollees have been identified with an SUD each month.

Exhibit A.1
CMS Metric #3: Count of Medicaid Beneficiaries with SUD Diagnosis, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



Since the SUD demonstration period began in January 2021, between 8,237and 10,559 Medicaid enrollees have been identified with a newly-initiated treatment or diagnosis for an SUD in each month. Exhibit A.2 below details the count of members by month using CMS's SUD Metric #2 specification. The average number of enrollees identified with an SUD in Calendar Year (CY) 2022 was 9,208.

Exhibit A.2
CMS Metric #2: Count of Medicaid Beneficiaries with Newly Initiated SUD Treatment or Diagnosis, by Month For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



SECTION B: Methodology Used in Assessment

This section describes the multiple modalities used by the independent assessment team, Burns & Associates, a Division of Health Management Associates (HMA-Burns) to conduct this Mid-Point Assessment of Indiana's SUD waiver demonstration. Data collection and analysis includes secondary sources such as fee-for-service claims, managed care encounters, Medicaid member and Medicaid provider enrollment files from the FSSA's data warehouse. Qualitative information collection includes interviews with FSSA staff regarding SUD Implementation Plan activities and interviews with MCE and provider representatives. An online survey was made available to Medicaid providers and a short survey was released for Medicaid members with SUD to complete on a voluntary basis.

Data Sources

The data sources used to report results in the Findings section are defined in the section below.

Critical Metrics

The information source to compute the metrics defined by and reported to CMS is the same as that used by FSSA to submit its SUD metrics to CMS in its quarterly SUD waiver monitoring report. The HMA-Burns team receives, and intakes claim/encounter and enrollment data delivered from the State's Enterprise Data Warehouse (EDW) on a monthly basis. The data is validated by the HMA-Burns team upon intake and trended against information received in prior months across multiple dimensions. The HMA-Burns team has built a comprehensive database that incorporates utilization and enrollment data going back to CY 2016 up to the present and includes claim and encounter paid dates through August 2023.

Provider Availability Assessment Data

Although the FSSA Provider enrollment file was used as a starting point to assess provider availability, the HMA-Burns team ultimately used actual paid claims and encounters to assess which providers are actually delivering services. HMA-Burns identified the provider billing IDs attached to claims/encounters for the SUD services identified in CMS's metrics 7 through 12. Individual provider IDs were mapped to a Federal ID (FEIN) number on FSSA's provider file to count the number of unique providers.

Implementation Plan Action Items

HMA-Burns identified all of the items identified in FSSA's SUD Implementation Plan to determine where action had or had not yet been taken on each item. The assessment team conducted a desk review of materials released by FSSA prior to and after the waiver implementation date. After review of these materials, interviews were conducted with key staff at FSSA to confirm our assessment of each of the planned implementation activities.

Qualitative Interviews with Key Stakeholders

While there were not fundamental changes to the delivery of SUD services with the extension of the waiver, the HMA-Burns team collected feedback from a variety of stakeholders to gain perceptions about the implementation of the SUD waiver, as well as their perspectives related to SUD service delivery for Medicaid beneficiaries. For the Mid-Point Assessment, HMA-Burns built upon the methodology used in the Summative Evaluation of the February 2018 through December 2020 Demonstration by using providers identified as delivering services in CY 2022 using the specifications for CMS's Metrics #7 through #12 to identify actively billing SUD providers. For each

of the metrics, the top 20 providers by metric were identified and consolidated into one unduplicated provider list across the metrics. Providers outside of the top 20 were added to the contact list if they met any of the following: previously appeared in the top twenty providers in the Summative Evaluation; had a specialty of 835 and 836; or appeared on a SUD and SMI stakeholder list as provided by FSSA. In total, HMA-Burns outreached 318 providers representing 80.5% of total dollars paid for SUD services to offer the opportunity to provide feedback. Of the 318, 61 providers (78.6% of payments) were offered a choice of in-person or online survey options to provide feedback. The remaining 257 providers received a link to the online provider survey.

Three options were offered to providers to give feedback:

1. A link to a 12-question online survey. For most questions on the survey, providers selected from a pre-determined list of responses. There was an opportunity to provide written feedback as well. Providers were given the option of remaining anonymous. A total of 51 providers completed the online survey, with 21 providing the name of the organization.
2. Participate in an interview over Zoom with the evaluation team. Each provider was asked to provide feedback on the same set of questions. Only one provider and the Indiana Council offered to participate in the interview.
3. Both options. One provider completed the online survey and participated in the interview.

The in-person appointments were set in advance so that the appropriate provider representatives could be present. Each provider was sent the same set of questions in advance. Although the evaluators covered the topics in each question, providers were encouraged to provide feedback on any other topic related to the SUD waiver as well.

The providers were given discretion as to who from their organization attended the interview. The HMA-Burns team consisted of three members, two of whom have performed SUD evaluation activities since 2019. Interviews were set for 60 minutes in duration.

The list of questions sent to providers in advance of each interview appear in **Attachment 1**.

The online survey tool released to providers appears in **Attachment 2**.

The Public Health Emergency (PHE) posed unique challenges with conducting in-person interviews with Medicaid clients in preparing the Summative Evaluation and continued with the current Mid-Point Assessment. In response to these challenges, the HMA-Burns team created a 5-question online survey to augment the feedback received during the prior Mid-Point Assessment and Summative Evaluation. Providers were asked to assist HMA-Burns with outreaching to members by making the survey available to their Medicaid clients. Survey respondents were totally anonymous. A total of two Medicaid beneficiaries completed the survey, with only one answering all five questions. To the extent that beneficiary themes continued from the most immediate demonstration period, their responses were considered when developing themes for the current demonstration Mid-Point Assessment.

The online survey tool released to Medicaid clients for this Mid-Point Assessment appears in **Attachment 3.**

As done in the prior Mid-Point Assessment and Summative Evaluations, HMA-Burns conducted one interview session with all MCEs contracted with the FSSA. The MCEs were asked to ensure that representatives that regularly communicate with SUD providers participate in this meeting. Each MCE complied with this request.

Similar to the provider interviews, the MCEs were given questions in advance of the meetings so that they could be prepared for a meaningful discussion. The session was 90 minutes in length. All three of the HMA-Burns team members who conducted the provider and client interviews attended

the MCE meeting. There was equal participation and feedback from the representatives from all MCEs.

The list of questions sent to the MCEs in advance of their Mid-Point interview appears in **Attachment 4**.

The HMA-Burns team mapped the themes identified by each stakeholder group (service providers, beneficiaries, and MCEs) to the six milestones set out by the FSSA in its SUD waiver. Summaries of responses related to each CMS Milestone appear in **Section C**.

Analytic Methods

The HMA-Burns team used criteria defined by CMS for computing the critical metrics. More information on each method, as well as our approach to tabulating stakeholder feedback, is described below.

Critical Metrics

While FSSA computes the metrics reported in the quarterly monitoring reports, the HMA-Burns team computed all metrics reported in this Mid-Point Assessment. It should be noted that, based on the timing of when CMS specifications were released, the results reported may use either Version 4 or Version 5 of CMS's specifications. For the data reported on all CMS-defined metrics, the Version 5 specifications were used to report the baseline and Mid-Point period results. For all data reported on the established quality measures, the Version 4 specifications were used to report values in the baseline period whereas Version 5 specifications were used to report values in the defined Mid-Point period.

Provider Availability Assessment Data

HMA-Burns mapped the physical location where providers render services and the home address of individual Medicaid beneficiaries to show on a map the Medicaid members who received services within ten miles of their home location. This process was completed for residential SUD treatment for Medicaid clients receiving these services during CY 2020 and CY 2022.

Provider availability heat maps were developed for inpatient, residential, MAT and outpatient services using the physical location where providers render services for CY 2020 and CY 2022. Counties are color-coded based on the number of Medicaid beneficiaries residing in the county who have an SUD diagnosis as defined using CMS Metric #3 specifications.

Stakeholder Feedback Data

After each interview was conducted with the MCEs and providers, HMA-Burns recorded the qualitative feedback from each meeting. Results from the online provider surveys were tabulated after the November 10, 2023 submission deadline. Once all interviews and online surveys were completed, the feedback was categorized into themes. In total, 15 themes resonated with MCE and provider stakeholders.

The feedback from the beneficiary survey was also captured and, in conjunction with feedback from the prior demonstration, were identified for themes. Some, but not all, of the themes that resonated with MCEs and providers also resonated with beneficiaries. The themes that resonated with beneficiaries among the 15 themes identified were also tracked.

The HMA-Burns team mapped the 15 themes identified to the six milestones set out by the FSSA in its SUD waiver. The number and type of respondents that mentioned each theme in their feedback to the assessment team was summarized in a table.

Assessment of Overall Risk of Not Meeting Milestones

The HMA-Burns team utilized the methodology outlined by CMS in its Mid-Point Assessment Technical Assistance guidance from October 2021 for considering whether Indiana is at risk of not meeting any of its milestones in its SUD demonstration waiver. This criteria is shown in Exhibit B.1. Although each element shown in the exhibit was assessed individually, the HMA-Burns team considered the assessment of all factors in totality when making its final assessment related to each milestone that is shown in Section D of this report.

Exhibit B.1
Considerations for Assessing Risk of Not Achieving Each Demonstration Milestone

	Overall Risk of Not Meeting Milestone		
Data Source	**Low**	**Medium**	**High**
Critical Metrics	All or nearly all (>75%) of the critical metrics are trending in the expected direction	Some (25% - 75%) of the critical metrics are trending in the expected direction	**Few (<25%) of the critical metrics are trending in the expected direction**
Implementation Plan Action Items	All or nearly all (>75%) of the action items completed	Some (25% - 75%) of the action items completed	**Few (<25%) of the action items completed**
Stakeholder Feedback	Few stakeholders identified risks; any risks can be easily addressed	Multiple stakeholders identified risks that may cause challenges meeting the milestone	**Stakeholders identified significant risks that may cause challenges meeting milestone**
Provider Availability	SUD provider availability is adequate	SUD provider availability is not yet adequate but is moving in expected direction	**SUD provider availability is not yet adequate and not moving in expected direction**

Limitations

The HMA-Burns assessment team identified two limitations with data sources while conducting this Mid-Point Assessment. Although the limitations of this data does not impact the overall findings of this assessment, evaluation activities will be enhanced in future reporting on Indiana's SUD waiver demonstration once this data becomes available.

- ***Additional in person provider feedback.*** The PHE prohibited the preferred method of receiving Medicaid provider feedback which is through one-on-one or small group interviews face-to-face. For this Mid-Point Assessment, interviews through Zoom and fill-in surveys were conducted in lieu of in person interviews. The evaluators will offer face-to-face in person interviews with providers as a method to augment provider feedback in the Interim and Summative Waiver Evaluations.
- ***Additional beneficiary feedback***. The PHE prohibited the preferred method of receiving Medicaid beneficiary feedback which is through one-on-one or small group interviews face-to-face. For this Mid-Point Assessment, fill-in surveys were conducted in lieu of interviews online. The evaluators will offer face-to-face interviews with beneficiaries as a method to collect and report beneficiary feedback in the Interim and Summative Waiver Evaluations.

SECTION C: Findings

The findings from HMA-Burns' assessment of Indiana's SUD demonstration waiver to date is summarized in four components:

1. Review of the critical monitoring metrics as defined by CMS in its SUD monitoring protocol;
2. Status of the State's efforts to date in completion of the items identified in its SUD Implementation Plan;
3. Review of the availability of SUD providers; and
4. Feedback from stakeholders.

Critical Monitoring Metrics

Exhibit C.1 on page 13 summarizes the results of the critical monitoring metrics reported to CMS on an annual or quarterly basis. The data presented shows the value for each metric at the baseline period and at the Mid-Point period. For metrics that are reported with monthly values to CMS, the baseline period is defined as the three-month average of values for the service period of Quarter 2 (April, May, June) of CY 2019. The Mid-Point period is defined as the three-month average of values for the service period of Quarter 2 of CY 2023. For metrics that are reported annually to CMS, the baseline period is defined as the CY 2019 value; the Mid-Point period is defined as the CY 2022 value. Baseline periods were defined using CY 2019 instead of CY 2020 due to the start of the Public Health Emergency Period and decreased utilization trends especially found in Quarter 2 (April, May, June) of that year.

In its SUD Monitoring Plan, the FSSA indicated the target for each metric, with the majority indicating "increase" as the desired direction for the values of metrics shown in the exhibit. Per CMS guidance, if a state shows consistent values between the baseline and Mid-Point period, then progress has been shown.

For the 22 metrics shown, Indiana saw an increase or improvement on 20 metrics between the baseline and the Mid-Point period, and a decrease or worsened result on 2 metrics. It should be noted that, for some metrics, the term "improved" is used instead of "increased" because a lower rate at the Mid-Point indicates improvement. Likewise, "worsened" is used instead of "decreased" because a higher rate at the Mid-Point indicates worsened status.

Based on these results, the HMA-Burns team has assigned 20 metrics as showing progress and 2 metrics as not showing progress.

Some explanation is needed on the first metric presented, CMS Metric #7 Early Intervention. The values at the Mid-Point are zero due to the hierarchical nature of CMS's specification for computing the results for this measure. If the hierarchy is not applied, HMA-Burns computed the value at the baseline as 36 and at the Mid-Point as 132. The state has made some progress on this measure, albeit the counts are very low and could improve.

Exhibit C.1

Findings from the Mid-Point Assessment of Critical Monitoring Metrics by Milestone

Values shown below are for the entire Demonstration population

CMS Milestone	CMS Metric #	Metric Name	Value At Baseline	Value At Mid-Point	Absolute Change	Percent Change	State's Demonstration Target	Directionality at Mid-Point	Progress	Milestone Risk Assessment
1	7	Early Intervention	0	0	0	0.0%	Increase	Increase	Yes	Low
	8	Outpatient Services	19,102	36,357	17,255	47.5%	Increase	Increase	Yes	
	9	Intensive Outpatient and Partial Hosp.	363	1,433	1,070	74.7%	Increase	Increase	Yes	
	10	Residential and Inpatient Services	1,208	3,782	2,574	68.1%	Increase or Decrease	Increase	Yes	
	11	Withdrawal Management	787	3,172	2,385	75.2%	Increase	Increase	Yes	
	12	Medication-Assisted Treatment	16,686	34,351	17,666	51.4%	Increase	Increase	Yes	
	22	Continuity of Pharmacotherapy for OUD	26.2%	24.7%	-1.5%	-6.0%	Increase	Decrease	No	
2	5	Medicaid Beneficiaries Treated in an IMD for SUD	3,271	15,799	12,528	79.3%	Increase	Improved	Yes	Low
	36	Average Length of Stay in IMDs	4.6	2.5	-2.1	-85.8%	Consistent or Decrease	Improved	Yes	
4	13	Provider Availability	4234	5060	826	16.3%	Increase	Increase	Yes	Low
	14	Provider Availability - MAT	134	233	99	42.5%	Increase	Increase	Yes	
5	18	Use of Opioids at High Dosage Persons w/o Cancer	4.9%	2.9%	-2.0%	-68.4%	Decrease	Improved	Yes	Low
	21	Concurrent Use of Opioids and Benzodiazepines	13.5%	10.9%	-2.6%	-23.5%	Decrease	Improved	Yes	
	23	ED Utilization for SUD per 1,000 Medicaid Beneficiaries	6.4	6.2	-0.2	-3.5%	Decrease	Improved	Yes	
	27	Overdose Death Rate	0.8	0.6	-0.2	-39.5%	Decrease	Improved	Yes	
6	15	Initiation of AOD Treatment	53.3%	56.0%	2.7%	4.8%	Increase	Increase	Yes	Low
	15	Engagement of AOD Treatment	33.2%	38.1%	4.9%	12.9%	Increase	Increase	Yes	
	17(1)(a)	Follow-up After ED Visit for AOD, 7 day	10.4%	13.7%	3.3%	24.0%	Increase	Increase	Yes	
	17(1)(b)	Follow-up After ED Visit for AOD, 30 day	15.8%	20.0%	4.2%	21.0%	Increase	Increase	Yes	
	17(2)(a)	Follow-up After ED Visit for Mental Illness, 7 day	31.8%	36.3%	4.5%	12.3%	Increase	Increase	Yes	
	17(2)(b)	Follow-up After ED Visit for Mental Illness, 30 day	44.9%	48.8%	3.9%	8.0%	Increase	Increase	Yes	
	25	Readmissions Among Beneficiaries with SUD	17.6%	21.1%	3.5%	16.7%	Decrease	Worsened	No	

Time Period for Baseline:

For measures #7, #8, #9, #10, #11, #12, and #23 - average of the three months for service period Q2-2019

For measures #22, #5, #36, #13, #14, #18, #21, #15, #17(1), #17(2), and #25 - annual value for service period CY2019

Time Period for Mid-Point:

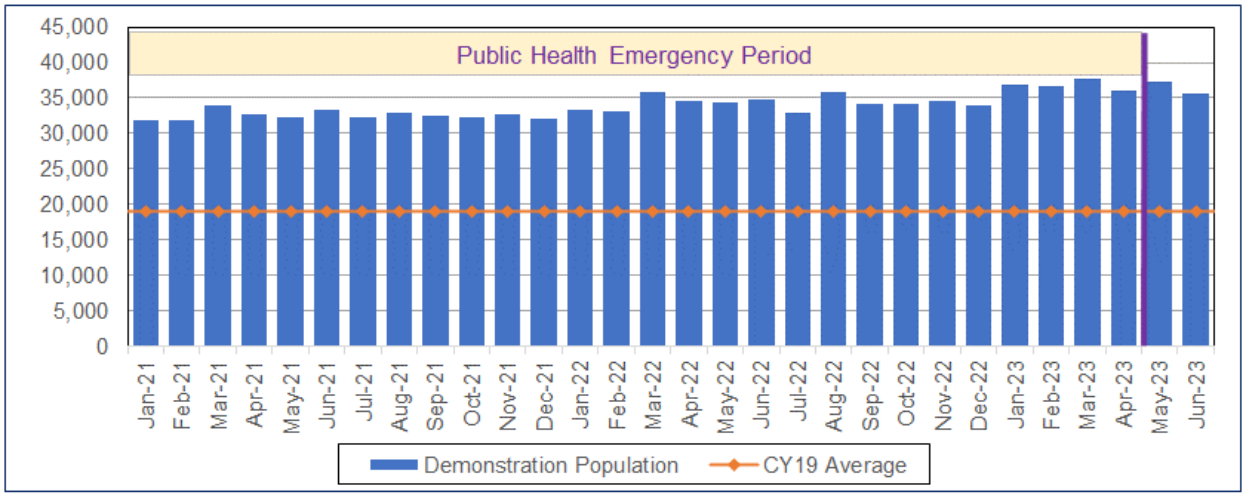
For measures #7, #8, #9, #10, #11, #12, and #23 - average of the three months for service period Q2-2023

For measures #22, #5, #36, #13, #14, #18, #21, #15, #17(1), #17(2), and #25 - annual value for service period CY2022

As was seen in Exhibit C.1, many of the metrics related to CMS Milestone #1, Access to Critical Levels of Care for SUD Treatment, have increased from the baseline to the Mid-Point time periods, with the exception of CMS Metric #22 Continuity of Pharmacotherapy for OUD. In an effort to provide more context on current trends, Exhibits C.2 through C.6 shows the month-by-month trends for the count of Medicaid beneficiaries using each service. Data is shown from the start of the demonstration (January 2021) through the most recent period available (June 2023), with the majority of services rendered during the PHE. Note that the count of Medicaid beneficiaries for metrics 7 through 12 drops slightly in June 2023 due to claims lag. For context, data is shown with the average count of users in the CY 2019 baseline period to provide a pre-PHE perspective on service utilization.

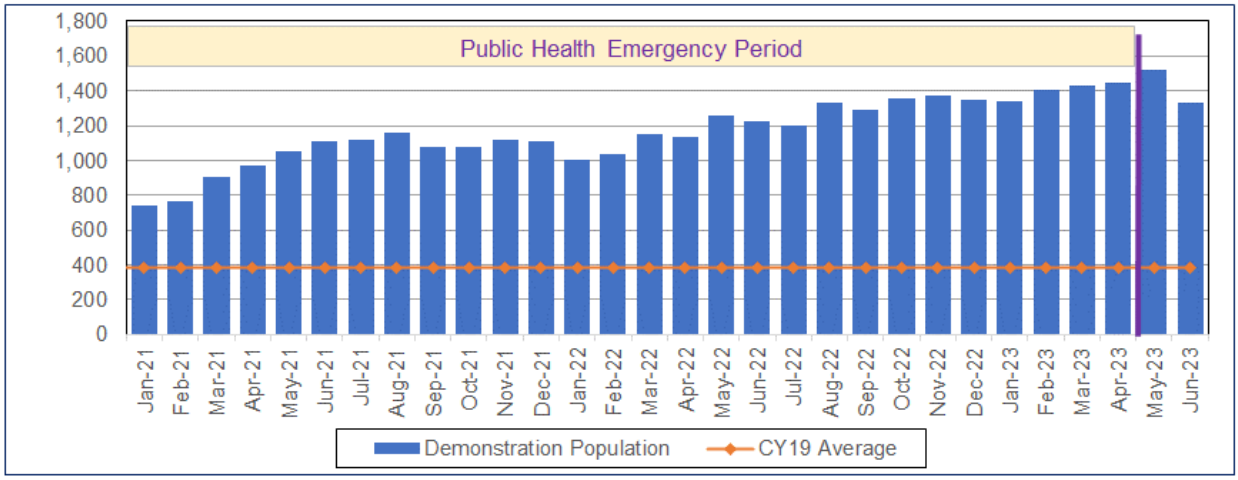
For CMS Metric #8, Outpatient Services, the count of users by month was increasing or steady throughout the initial demonstration period and is well above the CY 2019 average. Exhibit C.2 shows that the count of users by month increased 47.5% from the benchmark period and continued to increase by 10.4% from start of the demonstration (January 2021) through the most recent period available (June 2023).

Exhibit C.2
CMS Metric #8: Count of Medicaid Beneficiaries with Outpatient Services, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



As shown in Exhibit C.3 on the following page, the count of users for CMS Metric #9, Intensive Outpatient or Partial Hospitalization was increasing during the initial demonstration months and at all times was above the CY 2019 average. In total, the count of users increased by 74.7% from the CY 2019 baseline period and 44% since January 2021.

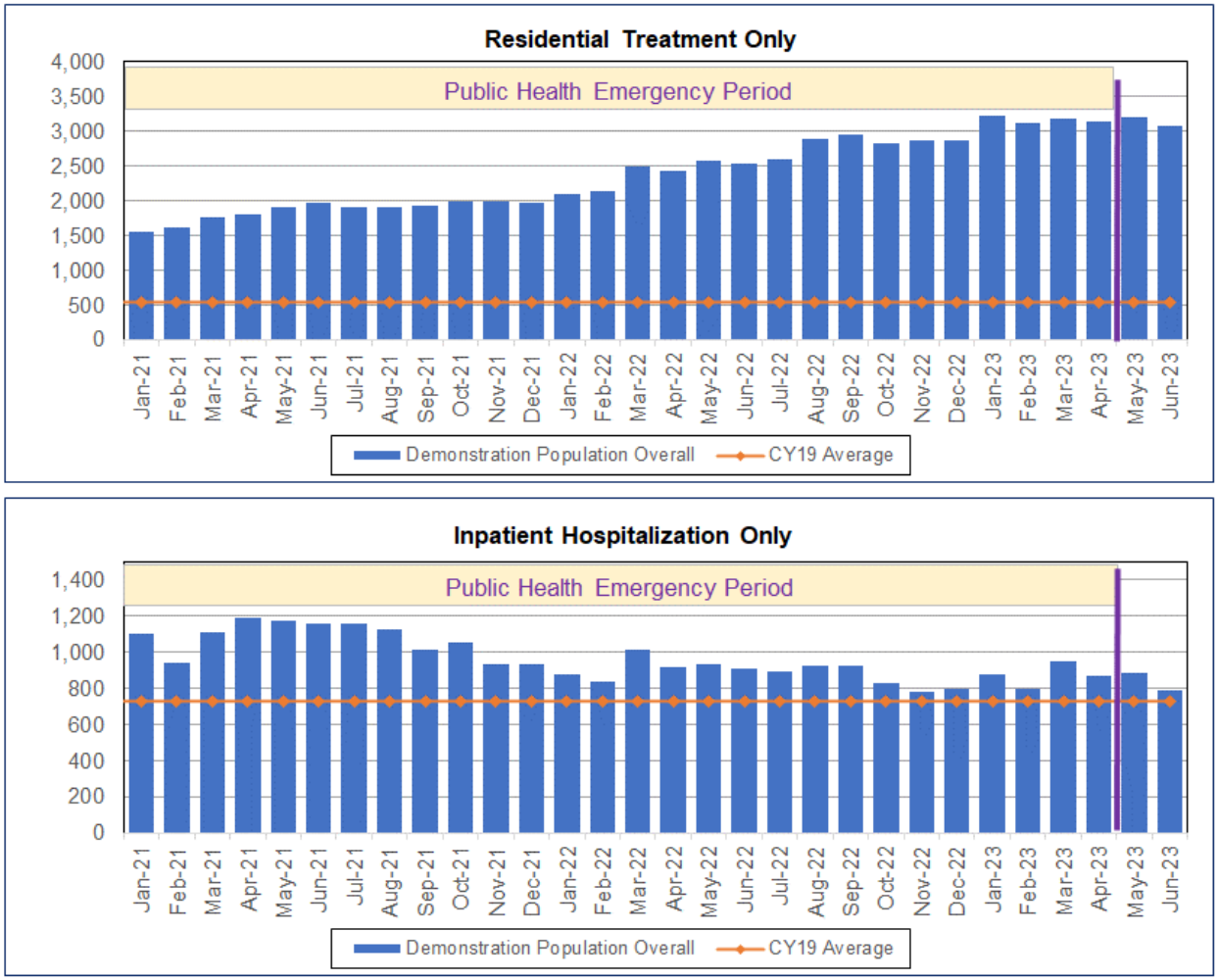
Exhibit C.3
CMS Metric #9: Count of Medicaid Beneficiaries with Intensive Outpatient or Partial Hospitalization, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



For CMS Metric #10, Inpatient Hospitalization and Residential Treatment, the HMA-Burns team split the reporting of count of Medicaid users between the two services as FSSA has a different demonstration targets for residential treatment (increase) and inpatient services (decrease). Exhibit C.4 on the following page shows the trends for both services. For residential treatment, the count of users increased from the beginning of the demonstration through the Mid-Point by more than 47%. While much of the initial demonstration period occurred during the PHE, at all times the count of users of residential treatment was almost three times higher than the CY 2019 average.

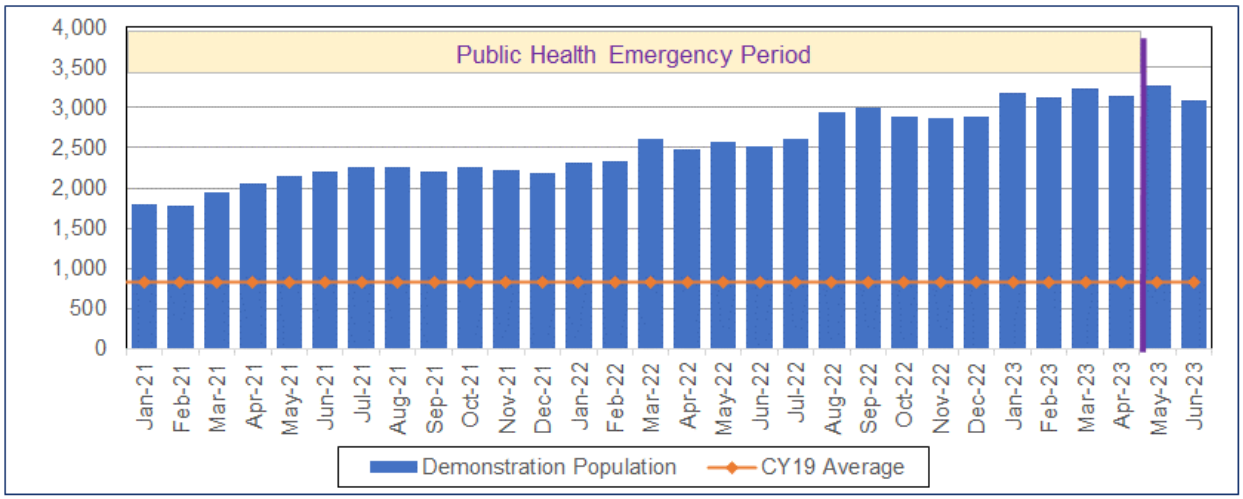
The trend for the count of Medicaid users of inpatient services has steadily declined from the start of the demonstration through the midpoint by 28.2% and is approaching the pre-PHE CY 2019 average.

Exhibit C.4
CMS Metric #10: Count of Medicaid Beneficiaries with Residential Treatment or Inpatient Stays, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



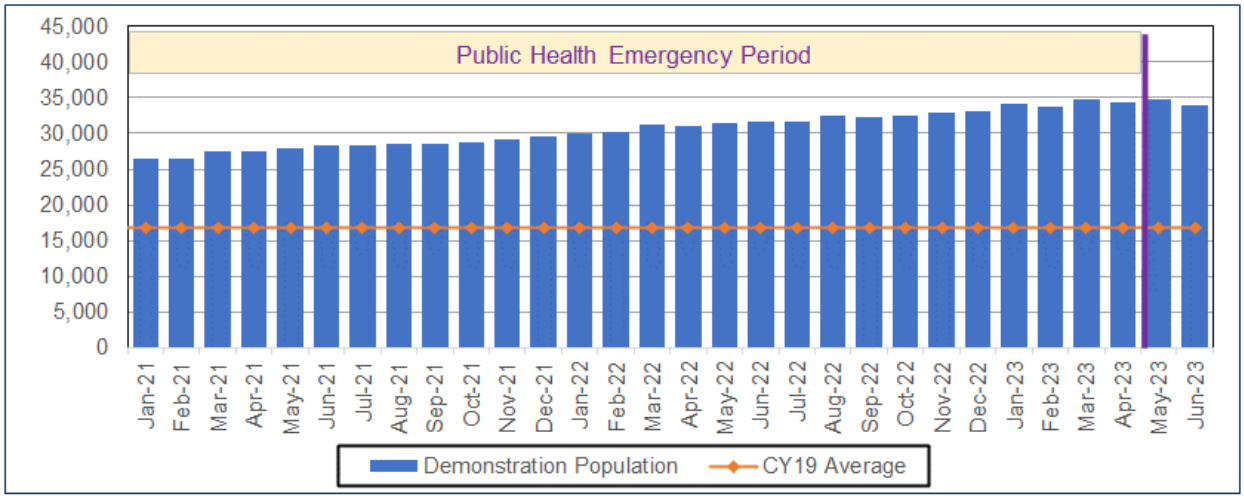
The count of Medicaid clients using Withdrawal Management, CMS Metric #11, increased by more than 75% from the CY 2019 baseline period through the midpoint. Exhibit C.5 on the following page shows the trend during the demonstration period, which saw a 42% increase in the number of Medicaid clients using Withdrawal Management services.

Exhibit C.5
CMS Metric #11: Count of Medicaid Beneficiaries with Withdrawal Management Services, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



For CMS Metric #12, Medication Assisted Treatment (MAT), the count of Medicaid clients using MAT increased by 51.4% from the CY 2019 baseline period, and a 22% increase during the demonstration period. Exhibit C.6 demonstrates the upward trend in the count of clients using MAT from January 2021 through the midpoint.

Exhibit C.6
CMS Metric #12: Count of Medicaid Beneficiaries with Medication Assisted Treatment, by Month
For Demonstration Population As Reported in Quarterly Monitoring Reports to CMS



From the initial demonstration period through CY 2020, the desired outcome was met for CMS Metric #22, Continuity of Pharmacotherapy for Opioid Use Disorder. During the current demonstration, the percentage of adults with pharmacotherapy for OUD who have at least 180 days of continuous treatment experienced a 6% decline in comparison to the CY 2019 benchmark. Overall, there has been a 64.4% increase in the number of adults with pharmacotherapy for OUD, of which 51.1% with at least 180 days of continuous treatment during the current demonstration, which is a positive trend given the initial period occurred almost completely during the PHE. Refer to Exhibit C.7 for additional details.

While the trend for CMS Metric #25, Readmissions Among Beneficiaries with SUD, increased 16.7% from the CY 2019 benchmark period to the midpoint, it has actually declined 1.8% when comparing CY 2021 to CY 2022 as shown in Exhibit C.8.

Exhibit C.7
CMS Metric #22: Continuity of Pharmacotherapy for Opioid Use Disorder
For Demonstration Population As Reported in SUD Monitoring Reports to CMS

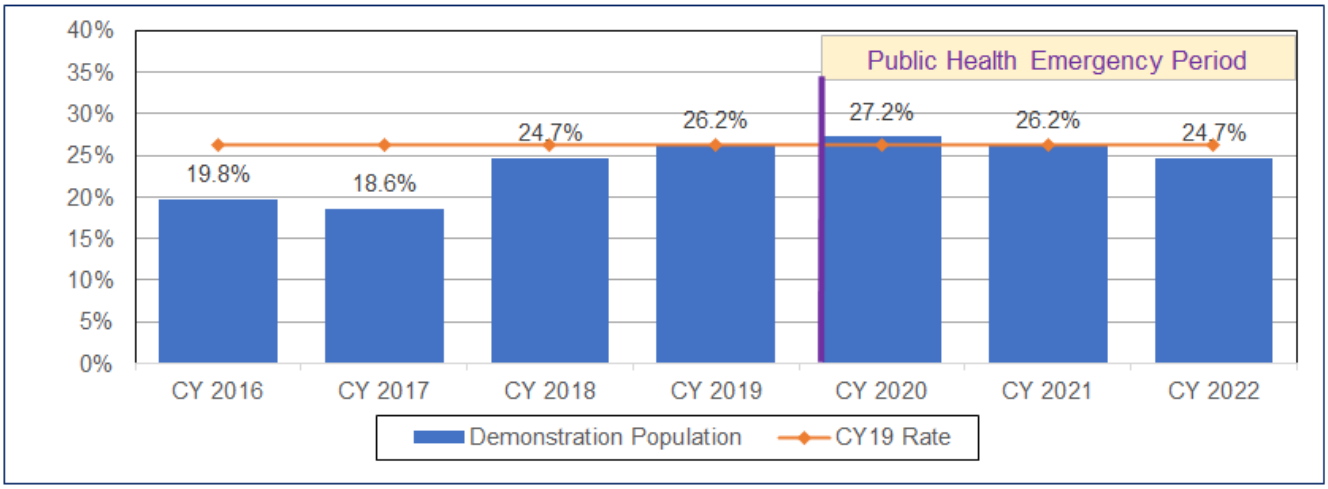
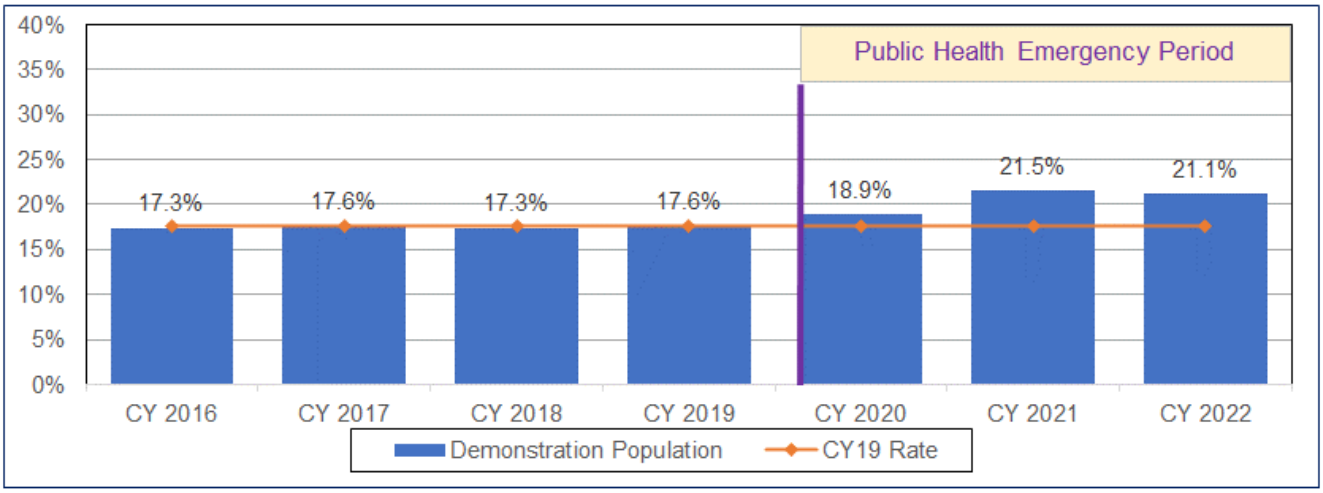


Exhibit C.8
CMS Metric # 25: Readmissions Among Beneficiaries with SUD
For Demonstration Population As Reported in SUD Monitoring Reports to CMS



SUD Implementation Plan Action Items

Of the thirty-one action items in the Implementation Plan, FSSA has completed twenty-four items and abandoned one item at the request of the provider community. The remaining six are in an ongoing status. The Implementation Plan, action items along with the current status is presented in this section by CMS milestone.

Milestone #1: Access to Critical Levels of Care for SUD Treatment

FSSA identified seventeen specific items in its Implementation protocol related to access to critical levels of care. Among these, twelve have been completed. Refer to Exhibit C.9 on the following page for additional details.

Exhibit C.9

Tracking Completion of Action Items in the FSSA Approved SUD Implementation Plan for CMS Milestone 1

	Action Item Description	Intended Completion Date	Current Status
1	Pursue Indiana Administrative Code (IAC) change for coverage and reimbursement of	12/31/2018	**Completed**
2	Pursue IAC amendments to Mental Health Services Rule	12/31/2018	**Open.** Added LCAC 09/01/2021; IAC changes pending.
3	Pursue IAC change to remove Intensive Outpatient Treatment (IOT) from MRO	12/31/2018	**Open**. SPA approved 03/19/19; IAC changes on hold.
4	Pursue State Plan Amendment (SPA) to move IOT coverage from MRO	06/30/2018	**Completed**
5	Pursue amendment to 1915(b)(4) waiver	06/30/2018	**Completed**
6	Make necessary system changes to CoreMMIS to remove IOT from MRO	06/30/2018	**Completed**
7	Develop provider communication over new benefits- billing for IOT/IOP	Contingent upon approval of SPA	**Completed**
8	Make necessary system change to CoreMMIS to enroll residential addiction facilities and to reimburse for residential treatment	03/01/2018	**Completed**
9	Develop provider communication over new benefits- residential treatment	Ongoing and as part of roll-out	**Completed.** Communcation was ongoing throughout 2018.
10	Determine final action and necessary system changes to CoreMMIS to allow reimbursement for inpatient SUD stays on a per diem basis	Fall 2018	**Abandoned.** Not pursuing proposed change based on provider input.
11	Develop provider communication over new benefits- inpatient SUD stays	Ongoing and as part of roll-out	**Completed.** Communcation was ongoing throughout 2018.
12	Make necessary system changes to allow reimbursment for Addiction Recovery Management Services	Spring 2018	**Completed**
13	Pursue SPA to add coverage and reimbursement of Addiction Recovery Management Services	Spring 2018	**Completed**
14	Pursue IAC changes to add coverage of Addiction Recovery Management Services	12/31/2018	**Open**. SPA approved 03/19/19; IAC changes pending.
15	Develop provider communication over new benefits Addiction Recovery Management	Ongoing and as part of roll-out	**Completed.** Communcation ongoing including updated Behavioral Health
16	Invite representatives from each of the MCEs, the Indiana Housing and Community Development Authority (IHCDA) and other interested stakeholders towards developing a supportive housing solution	No specific date-implied some time in 2018	**Open.** Ongoing discussions; DMHA issued two housing related request for funding grants in 2022.
17	Establish allowed criteria to use for authorizing inpatient detoxification	02/01/2018	**Completed**

Milestone #2: Use of Evidence-Based, SUD-specific Patient Placement Criteria

All four specific items identified by FSSA related to evidence-based patient placement criteria have been completed, as found in Exhibit C.10.

Exhibit C.10
Tracking Completion of Action Items in the FSSA Approved SUD Implementation Plan for CMS Milestone 2

	Action Item Description	Intended Completion Date	Current Status
18	Provider education on ASAM criteria	Ongoing throughout 2018	**Completed.** ASAM trainings sponsored by FSSA ongoing since 2019.
19	Development of standard prior authorization SUD treatment form	07/01/2018	**Completed**
20	Review MCE and FFS vendor contracts and pursue amendments, where necessary	07/01/2018	**Completed**
21	Review CANS/ANSA for alignment with ASAM criteria	12/31/2018	**Completed.** Determined consolidated tool not feasible and providers will continue to use CANS or ANSA tool along with ASAM tool.

Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment

There are two items identified by FSSA related to SUD-specific program standards for residential treatment. The item related to provisional ASAM designation was completed with the FSSA developing a formal licensure process for ASAM residential levels 3.1 and 3.5 which has been in place since July 2018. The task related to IAC language changes are pending.

Exhibit C.11
Tracking Completion of Action Items in the FSSA Approved SUD Implementation Plan for CMS Milestone 3

	Action Item Description	Intended Completion Date	Current Status
22	Finalize process for provisional ASAM designation	12/31/2017	**Completed**
23	Insert permanent certification language in IAC	12/31/2018	**Open.** IAC changes pending.

Milestone #4: Sufficient Provider Capacity at Critical Levels of Care

Four items were built into FSSA's protocol related to provider capacity. All have been completed in the timeframe outlined by FSSA. The items included in the protocol are specific to systems tracking and reporting by ASAM levels as opposed to items related to expanding capacity per se.

Exhibit C.12
Tracking Completion of Action Items in the FSSA Approved SUD Implementation Plan for CMS Milestone 4

	Action Item Description	Intended Completion Date	Current Status
24	Create new provider specialty for residential addictions facilities	03/01/2018	**Completed**
25	Data reporting by provider specialty and ASAM level of care	03/31/2018	**Completed**
26	New training materials on 1115-approved services as well as provider enrollment for residential facilities	Early 2018	**Completed.** Initial materials released 01/04/2018. Additional materials released throughout 2018.
27	Assessment of ASAM providers and services (by level of care, includes MAT)	12/31/2018	**Completed**

Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse

Two of the three items in the Implementation Protocol related to treatment and prevention strategies for opioid abuse have been completed. These relate to emergency responder reimbursement of naloxone and expanded coverage of peer recovery coaches, crisis intervention, and intensive outpatient treatment. The expanded use of INSPECT (Indiana's prescription drug monitoring program) across all hospitals in the State is still in process.

Exhibit C.13
Tracking Completion of Action Items in the FSSA Approved SUD Implementation Plan for CMS Milestone 5

	Action Item Description	Intended Completion Date	Current Status
28	Consider options for emergency responder reimbursement of naloxone	Early 2018	**Completed**
29	Integrate all Indiana hospitals with INSPECT (the State's prescription drug monitoring program)	Within 3 years	**Open.** In process; 150 of 171 (87.7%) hospitals integrated as of 03/31/2023
30	Expand coverage of peer recovery coaches	No specific date	**Completed**

Milestone #6: Improved Care Coordination and Transitions Between Levels of Care

One activity was included in the protocol related to expanding MCE case management services for individuals transitioning from residential treatment facilities and it has been completed.

Exhibit C.14
Tracking Completion of Action Items in the FSSA Approved SUD Implementation Plan for CMS Milestone 6

	Action Item Description	Intended Completion Date	Current Status
31	Extend MCE case management to individuals transitioning from residential treatment facilities	No specific date	**Completed**

Provider Availability

In order to assess provider capacity at different levels of care, the HMA-Burns team plotted the physical location of where SUD treatment is currently being delivered to Medicaid beneficiaries. The home locations of Medicaid beneficiaries who received each service reviewed were also plotted.

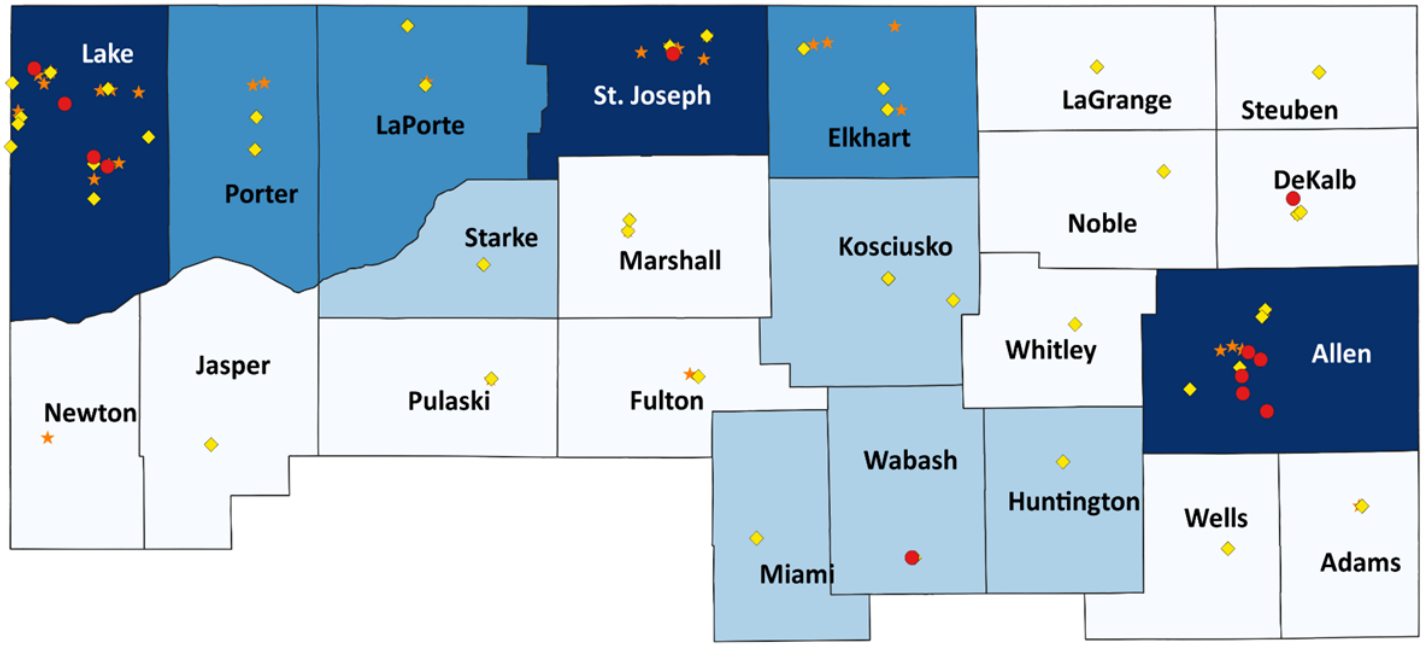
Exhibits C.15 through C.20 appear on subsequent pages. Each exhibit shows a region of the state (northern, central, and southern). In the first of two maps for each region, SUD providers identified as inpatient hospitals, residential treatment centers, or medication assistance treatment providers are plotted to show their service location in the region. In the second map, SUD outpatient providers are plotted. A comparison is shown of the providers available to Medicaid beneficiaries in December 2020 compared to December 2022 to show any growth in provider capacity. The counties in each region are color-coded to show the density of Medicaid beneficiaries with SUD in each county. Key findings from these maps are as follows:

- In the Northern Region, MAT and outpatient provider supply increased, while residential and inpatient remained relatively unchanged between December 2020 and December 2022. There appears to be lower residential provider capacity than there is need.
- In the Central Region, provider supply increased for each of the provider categories between December 2020 and December 2022. There was an increase in some but not all of the rural counties located in the region. Marion County saw the largest increase in the supply of MAT providers.
- In the Southern Region, MAT and outpatient provider supply increased, while the remaining provider types remained relatively unchanged between December 2020 and December 2022.

Exhibit C.21 shows the location of SUD residential treatment facilities and the 20-mile radius around each facility to show coverage. From December 2020 to December 2022, coverage has improved in Vigo and Wells counties.

Exhibit C.15
Location of SUD Providers in the Northern Regions of the State
December 2020 versus December 2022

December 2020



December 2022

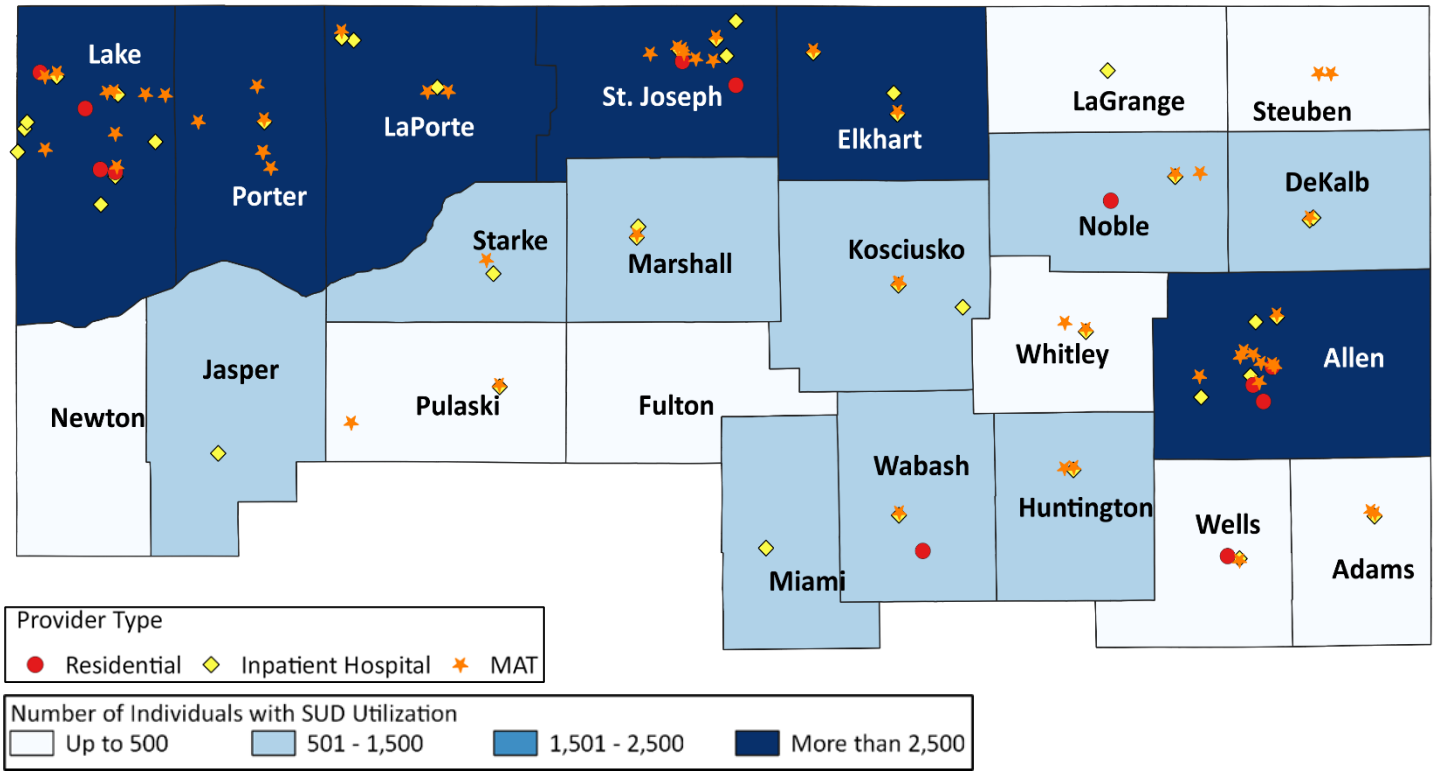
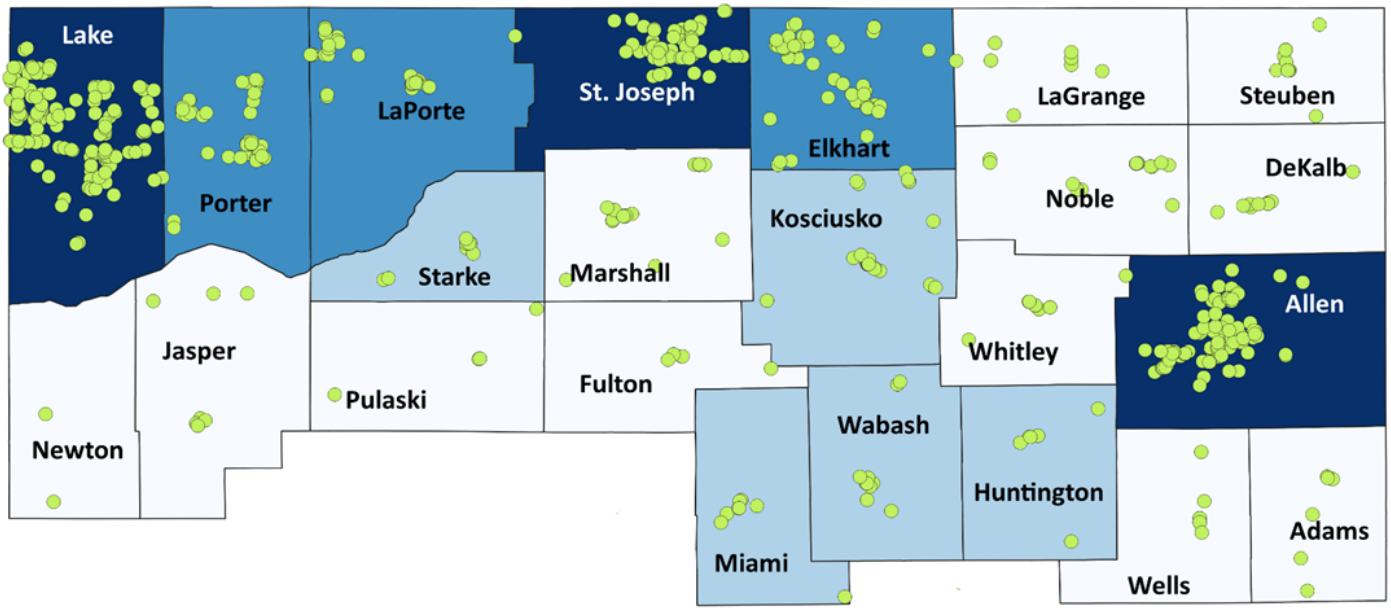


Exhibit C.16
Location of Outpatient SUD Providers in the Northern Regions of the State
December 2020 versus December 2022

December 2020



December 2022

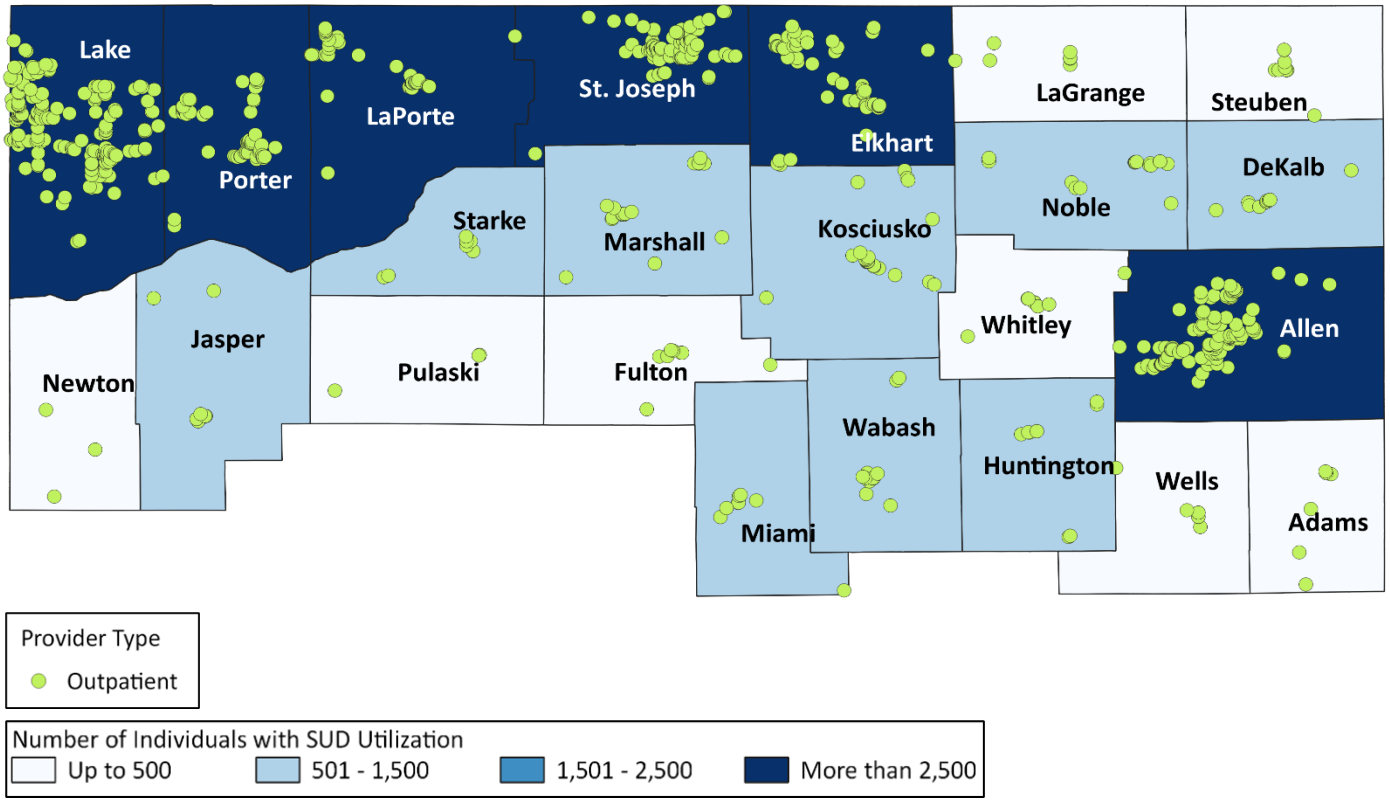
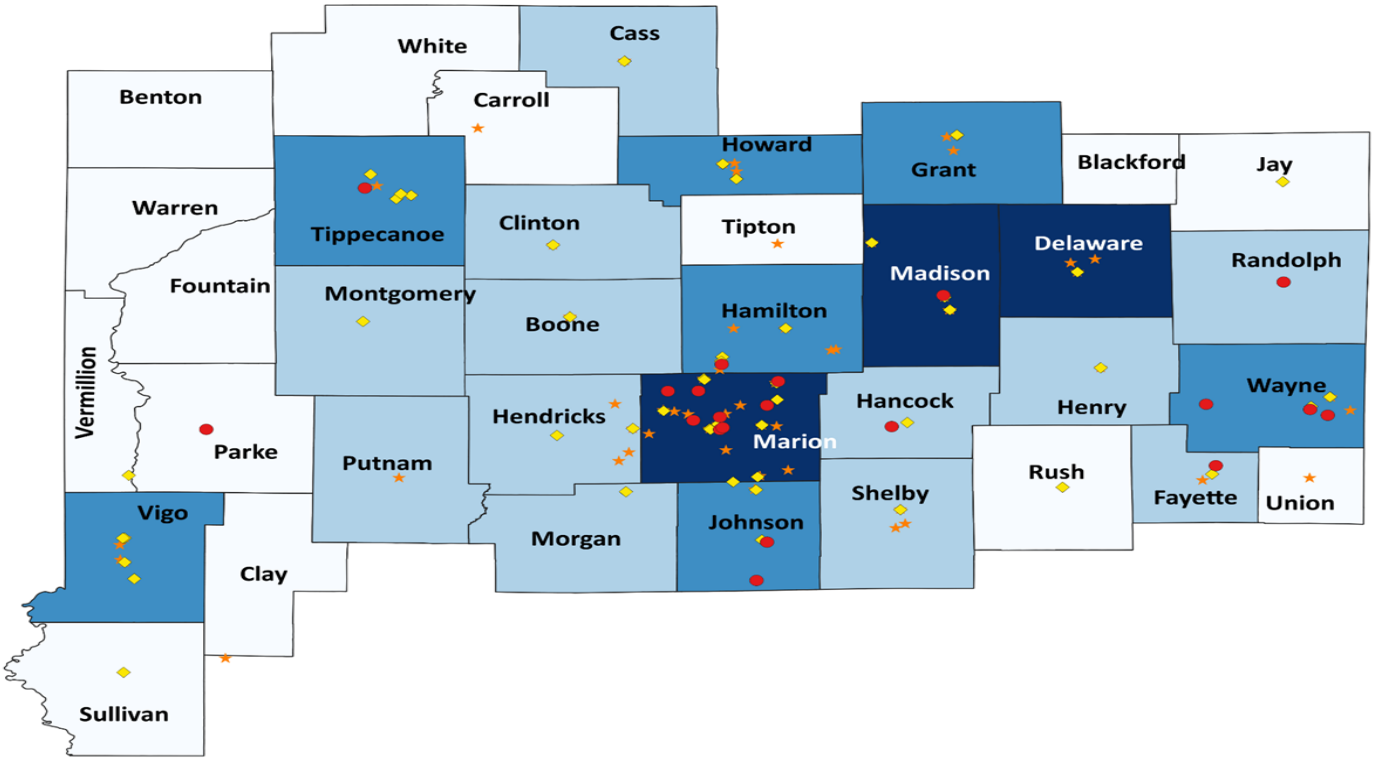


Exhibit C.17
Location of SUD Providers in the Central Regions of the State
December 2020 versus December 2022

December 2020



December 2022

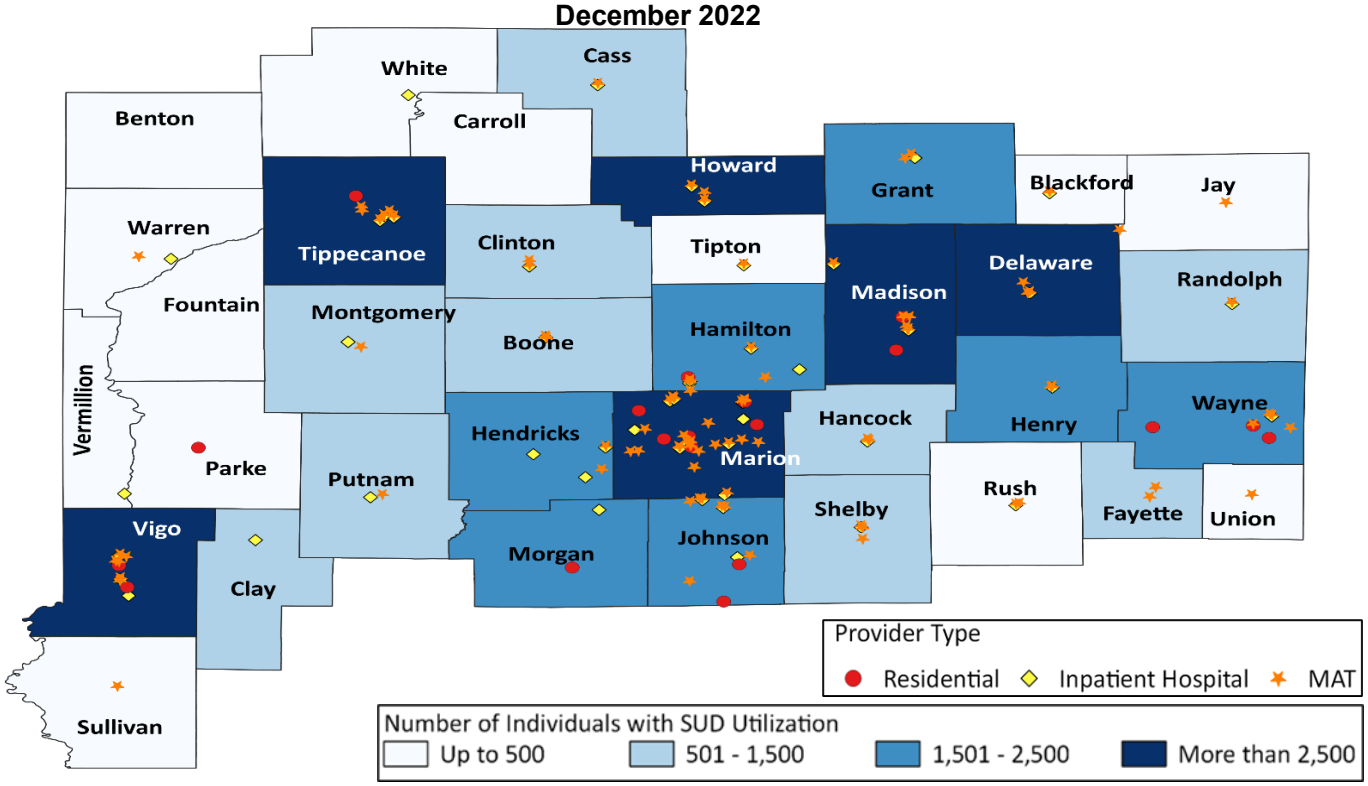
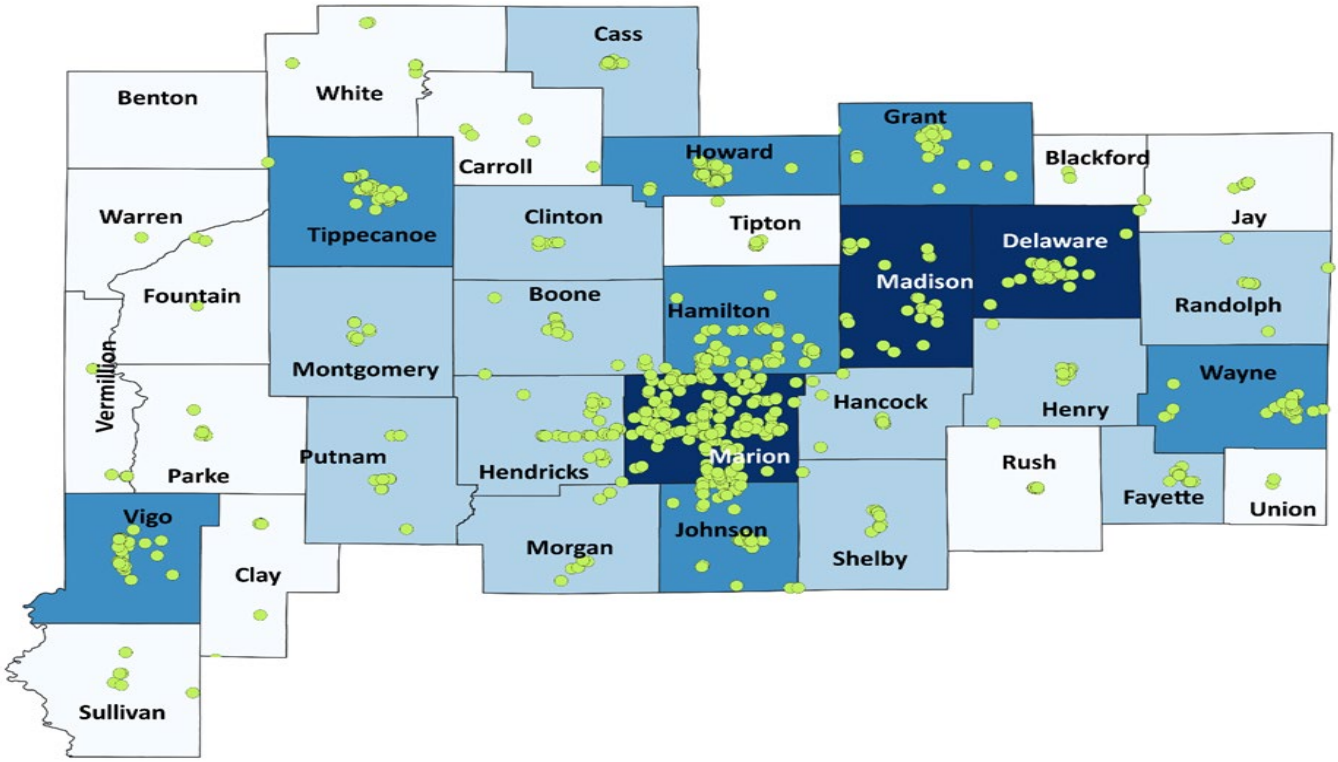


Exhibit C.18
Location of Outpatient SUD Providers in the Central Regions of the State
December 2020 versus December 2022

December 2020



December 2022

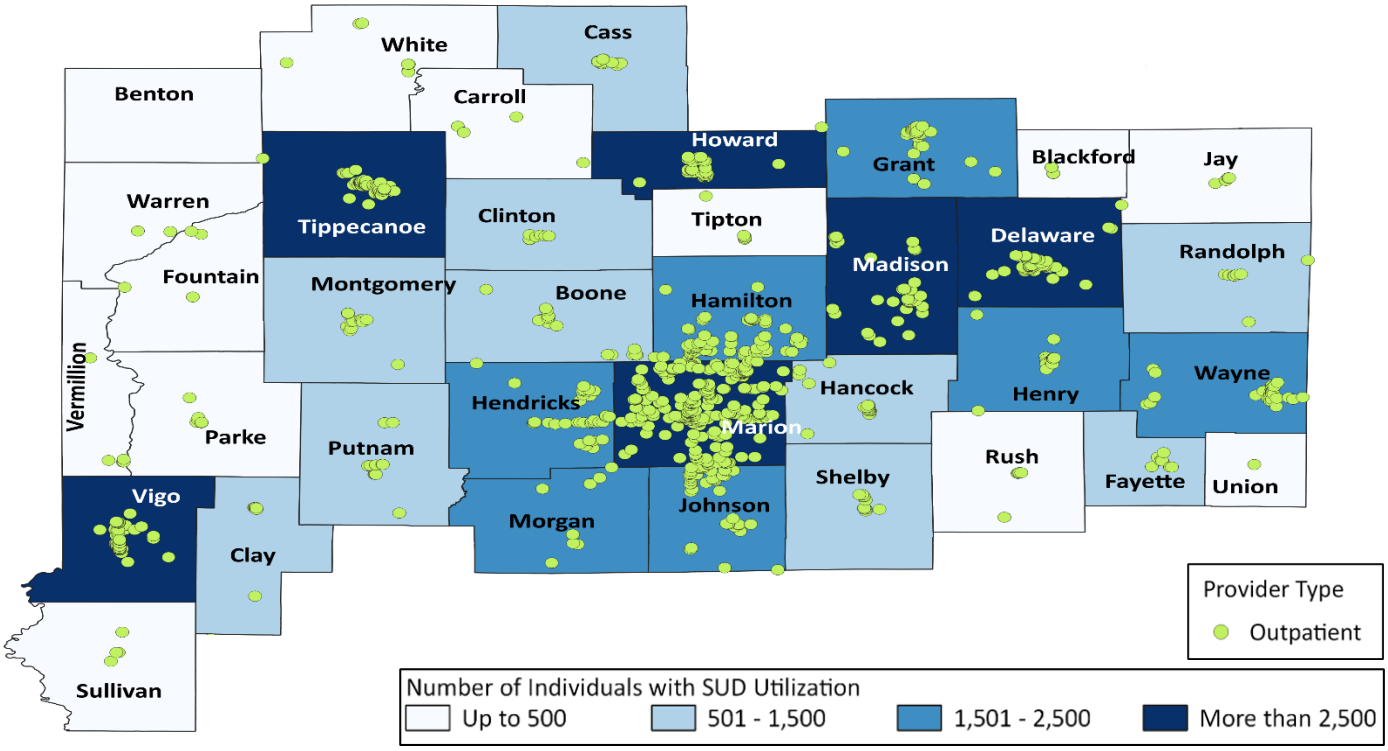
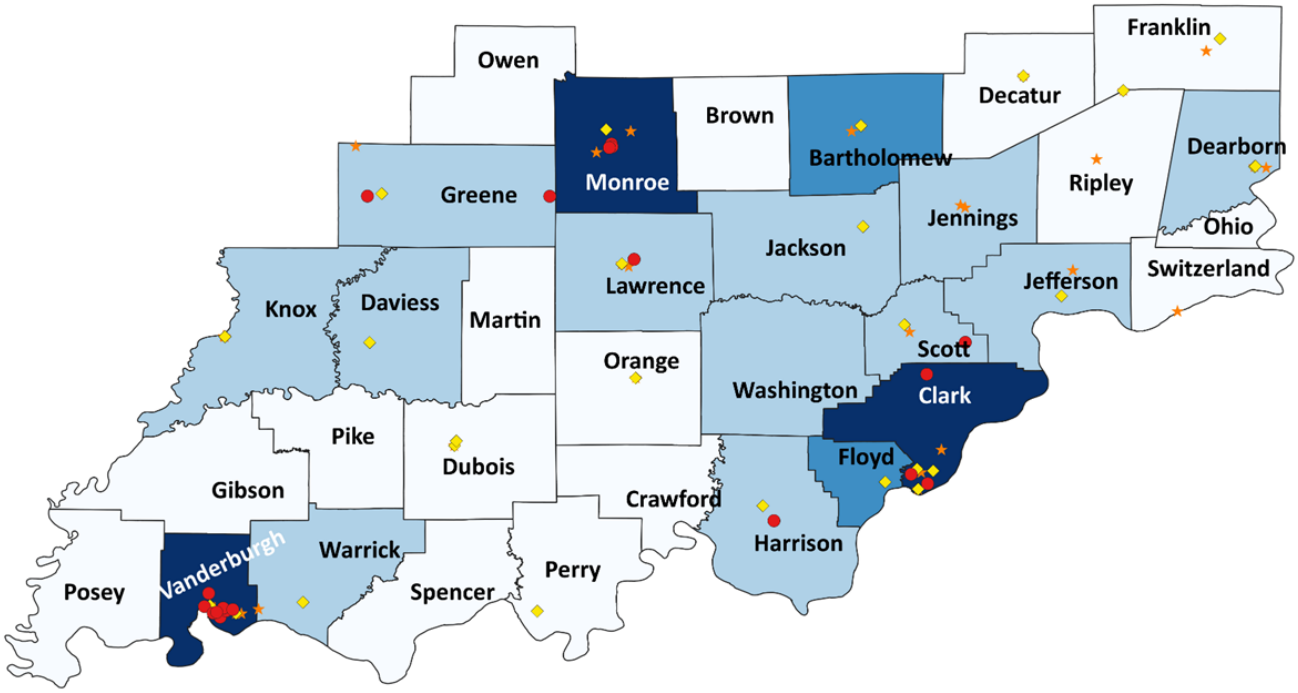


Exhibit C.19
Location of SUD Providers in the Southern Regions of the State
December 2020 versus December 2022

December 2020



December 2022

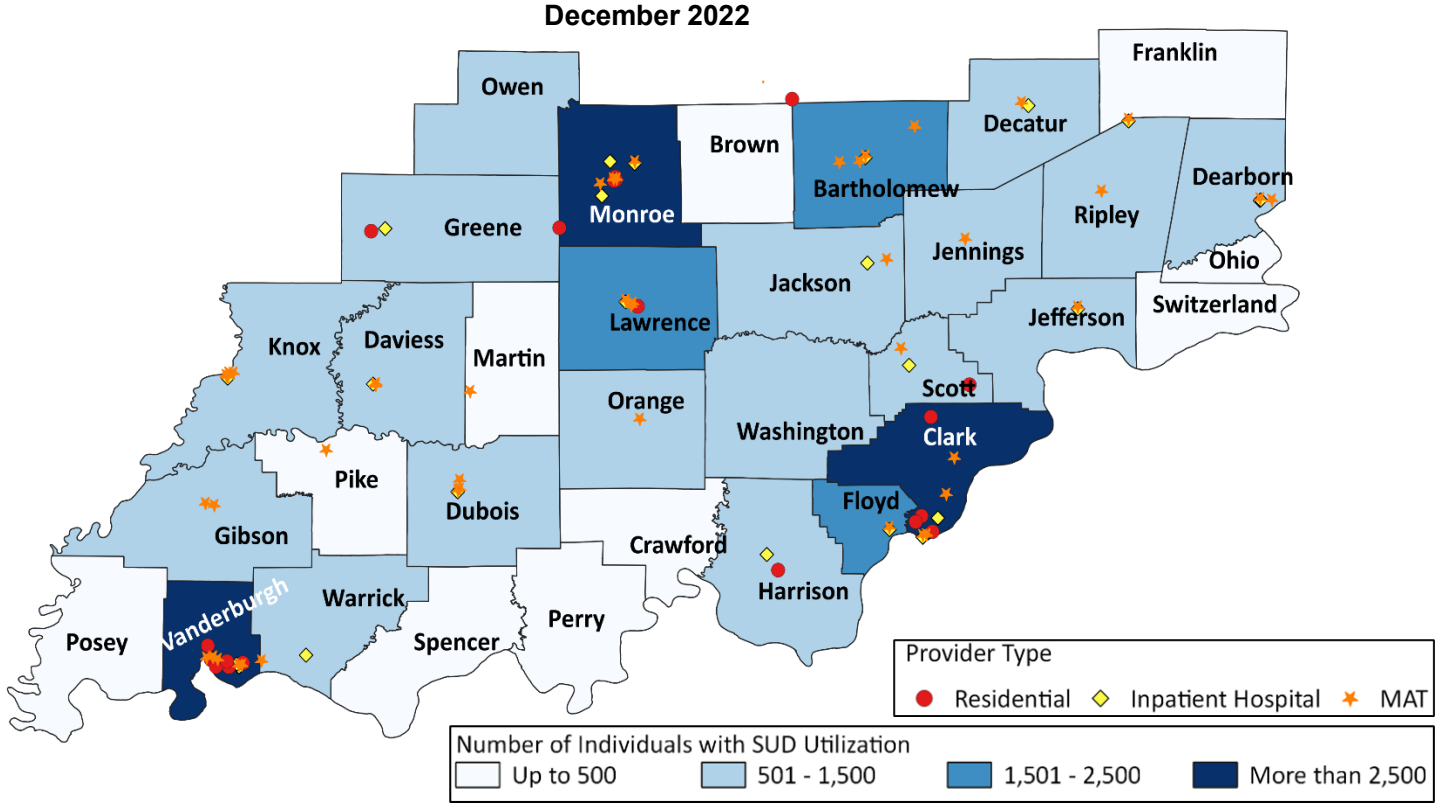


Exhibit C.20
Location of Outpatient SUD Providers in the Southern Regions of the State
December 2020 versus December 2022

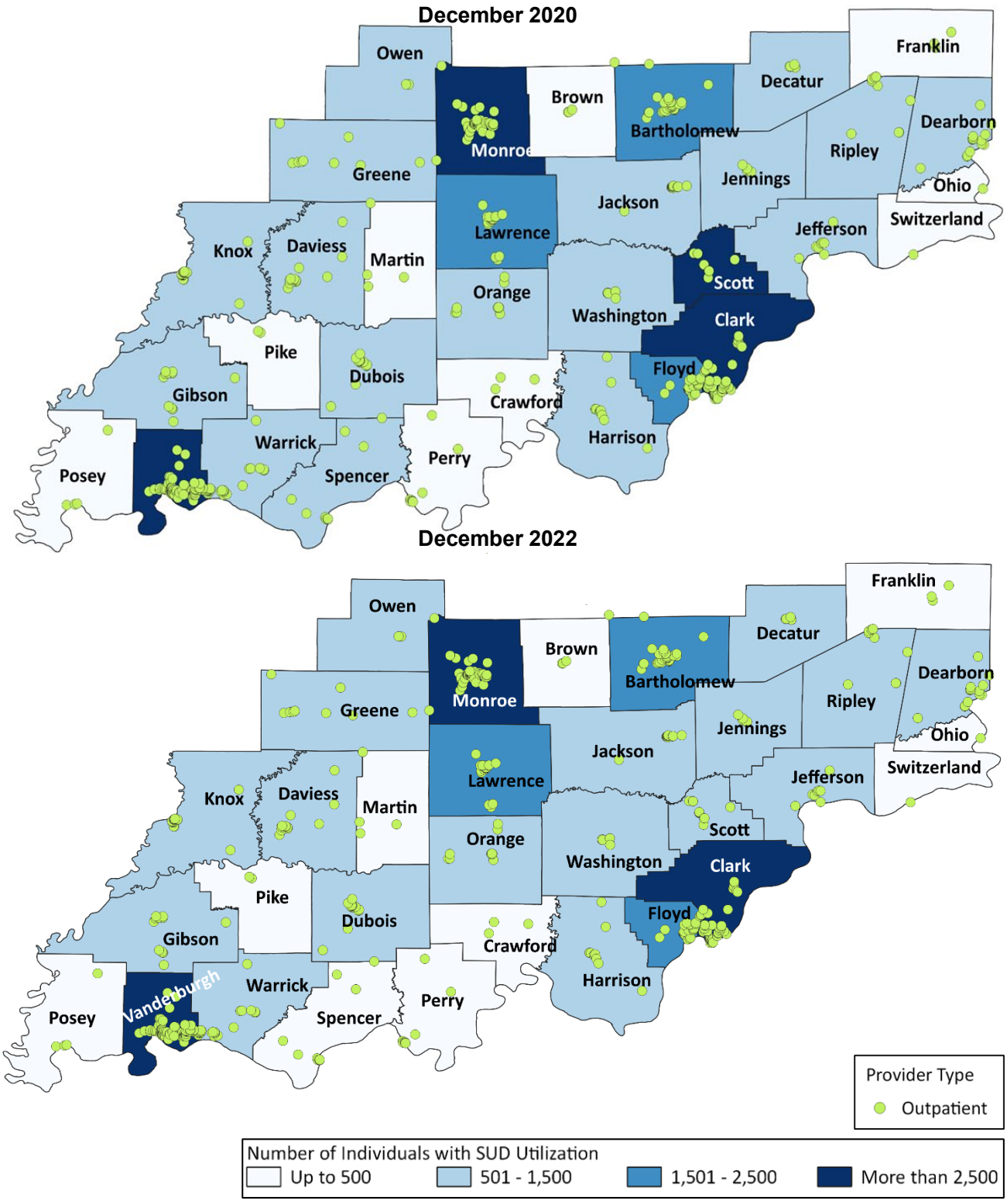
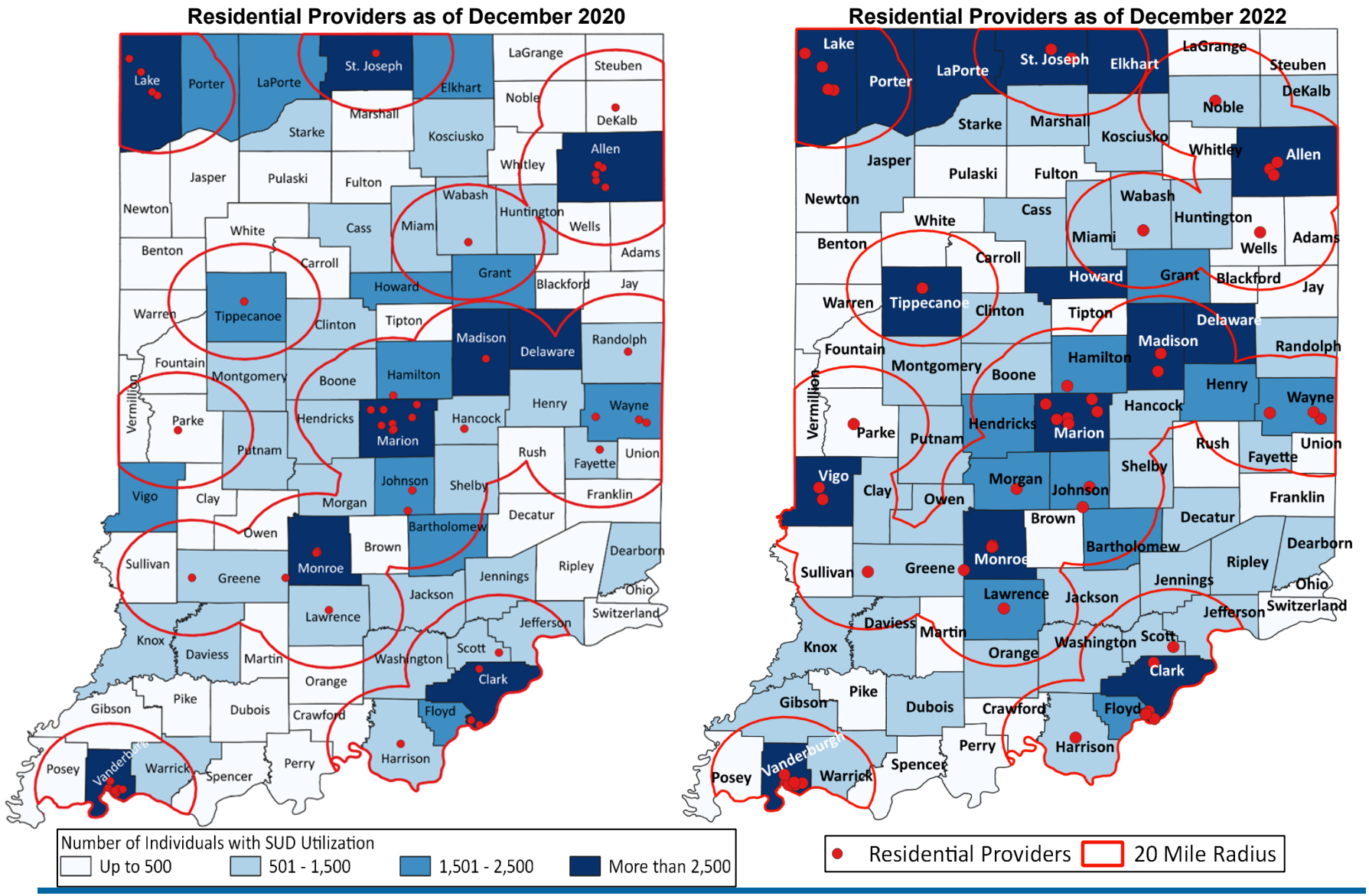


Exhibit C.21
Comparison of Residential Treatment Providers Under Contract with FSSA



Stakeholder Feedback

This section summarizes the feedback provided by the five Medicaid MCEs, fifty-two SUD providers, and two Medicaid beneficiaries. Themes mentioned by stakeholders are organized by each of the CMS milestones. A notation is given if the feedback reported is from the MCEs, from providers, and/or from beneficiaries.

Summary of Findings

Although providers expressed appreciation for the demonstration and improved access of SUD services to Medicaid beneficiaries, their feedback about the waiver, delivery of SUD services and more current day-to-day operations was mixed. HMA-Burns asked for specific examples of what was working well (or had improved during the current demonstration period) and where there were items that continue to be of concern.

Much of the concerns expressed by providers were related to their interactions with the MCEs. Many of the providers providing feedback through the online survey are contracted with all five of the MCEs. The positive and negative feedback about MCEs was not lopsided; that is, some providers had positive feedback about one of the MCEs while others had the opposite feedback.

Many of the topics that were covered by HMA-Burns in the provider interviews were also covered with the MCEs, but the feedback obtained was from the MCE perspective. The MCEs highlighted the varying levels of knowledge across the base of providers delivering SUD services. Challenges that the MCEs expressed were often not even specific to SUD; rather, it was re-educating SUD providers about working with Medicaid in areas such as seeking authorizations, billing requirements and ASAM level of care requirements. But even with the long-standing Medicaid providers in their network, some confusion came about due to changes in guidance resulting from the PHE that came from the FSSA.

The feedback from beneficiaries (Medicaid members) was obtained through a survey (offered online or hard copy to fill out) which was made available to them by their treating providers. The specific items asked of beneficiaries included:

1. Ease of finding treatment options or access to services;
2. Use of telehealth to access services;
3. Opinion on what could help others in the future who are seeking out SUD treatment; and
4. Identification of services not available (actual or perceived) to the client.

Exhibit C.22 on the next page summarizes the themes mentioned by stakeholders. The themes are mapped to the CMS Milestones. An indication is given as to which stakeholder (or stakeholders) mentioned the theme as well as how often the theme was mentioned.

Exhibit C.22
Summary of Themes Mentioned by Stakeholders

Theme Number	Description of Theme	Stakeholder Responding (P)rovider, (M)CE, (B)eneficiary	# Stakeholders Who Mentioned Theme (out of 59)
Milestone 1: Access to Critical Levels of Care for SUD Treatment			
1	Beneficiaries continue to not have a good understanding of the benefits offered by Medicaid.	M	5
2	Providers and MCEs noted improvements in residential, telehealth, outpatient and MAT but suggested improvements are still needed along the continuum.	P, M	57
3	Telehealth has improved access to services, primarily in rural areas.	P, M, B	49
Milestone 2: Use of Evidence-Based, SUD-specific Patient Placement Criteria			
4	Review processes and documentation requirements are inconsistent across MCEs.	P	19
5	The PHE contributed to the confusion on the part of providers regarding the ASAM treatment model and PA processes.	M	5
Milestone 3: Use of Nationally Recognized SUD Program Standards for Residential Treatment			
6	There is no ASAM licensure requirement for ASAM 3.7	P, M	11
7	PHE policies have meant reeducation of providers on authorization and ASAM level of care requirements.	M	5
8	There has been no change over the past year in issues with contracting, authorization and billing, with authorizations being the most difficult.	P	29
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care			
9	Some members had difficulties finding providers who would take Medicaid, yet others were able to access care immediately.	B	1
10	While there have been improvements over time, there has been little change over the past year in the provider network. Areas suggested for improvement include ASAM 3.7, ASAM 3.1, PHP, IOT, OTP and supportive housing.	P, M	37
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse			
11	Guidance from FSSA has been helpful, although providers and the MCEs asked for more opportunities to collaborate in advance of policy changes.	P, M	5
12	Beneficiaries continue to suggest multiple modes of communication around benefits and service location	B	1
13	Feedback on the Pregnancy Promise Program for members with OUD is largely positive.	P, M	29
14	The demonstration improved access but there is a need to level-set expectations around the demonstration, benefits and associated Medicaid processes.	P, M	34
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care Opioid Abuse			
15	Care coordination experiences have been variable and there are challenges in common understanding of the MCEs role.	P, M	28

Feedback on Milestone #1: Access to Critical Levels of Care for SUD Treatment

Understanding of benefits

- *(**MCEs**). Beneficiaries continue to not have a good understanding of the SUD benefits offered by Medicaid*. The MCEs felt that there continued to be a general lack of understanding of the benefits offered by members under the demonstration. This comment continues from the initial demonstration period.
- *(**beneficiaries**) Members find out about services from a variety of resources.* Many of the members interviewed in the initial demonstration period said that they found out about treatment primarily from a friend, family member, sponsor, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings, receiving other care from the provider, or as a result of going through the criminal justice system. The current Mid-Point feedback indicates this is still the case.

Access to services

- *(**MCEs**) Lack of ASAM 3.7-WM and limited numbers of Partial Hospitalization Program (PHP) and ASAM 3.1 providers is an issue.* While there have been improvements since the initial demonstration period, the MCEs continue to express concern with the lack of an ASAM 3.7 level of care and the limited number of PHP and ASAM 3.1 providers. The MCEs attributed the lack of 3.1 providers to low reimbursement levels.
- *(**providers**) Providers observed improved access over the past year, although there are some areas that have gotten worse.* Most providers commented that access improved with specific mentions regarding telehealth, outpatient and MAT. Providers commented that understanding processes, coverage, rates and staffing has gotten worse.

Telehealth improved access to services

- *(**MCEs**) Telehealth improved access to services during the PHE and in rural areas.* The MCEs were complimentary of the demonstration telehealth and felt that it improved access to services during the PHE and in rural areas, and IOP and PHP in particular, but expressed some concerns regarding privacy and monitoring.
- *(**providers**) Overall, providers responded that Telehealth had a positive impact on the adequacy of the provider network across the spectrum of ASAM levels of care.* Specifically, providers saw improved access in rural counties and mentioned that telehealth improved access most for outpatient services, intensive outpatient services and medication assisted treatment.
- *(**beneficiaries**) Reported accessing services via telehealth.* Specific services mentioned include outpatient and peer support.

Feedback on Milestone #2: Use of Evidence-Based, SUD-specific Patient Placement Criteria

Review processes and documentation requirements

- *(**providers**) Providers expressed concerns with the lack of a consistent review process and documentation requirements across the MCEs*. Providers specifically mentioned that the MCEs use their own form for authorization of Intensive Outpatient Treatment (IOT) services.
- *(**providers**) More than half (28 of 51) of responding providers indicated that the prior authorization (PA) process and use of a single form has been helpful*. Providers overwhelmingly (44 of 51) indicated that the single form has made PA easier or more understandable.

- *(**providers**) There is room for improvement to standardize authorization processes and forms across all applicable ASAM levels of care.* Comments provided indicate that while the process is improved, there is considerable room for improvement in standardizing processes including criteria and use of the single authorization form across applicable ASAM levels of care.
- *(**MCEs**) Peer to Peer options are underutilized by providers*. Providers are not taking advantage of the peer-to-peer option and go straight for an appeal.
- *(**MCEs**) Confusion regarding authorization requirements, billing and general knowledge of SUD demonstration*. All MCEs expressed that the PHE and staff turnover have contributed to provider confusion regarding authorization, billing and general knowledge of what the SUD demonstration is and the services offered.

Lack of understanding of ASAM treatment model and Medicaid processes

- *(**MCEs**) PHE changes contributed to provider confusion*. The MCEs overwhelmingly expressed concern that the PHE contributed to the confusion on the part of providers regarding the ASAM treatment model and PA processes.
- *(**providers**) Would like standardized training on ASAM interviews.* Providers suggested training on a standardized way of performing the ASAM interviews from a clinical perspective would be helpful to improve their understanding of the ASAM treatment model.

Feedback Related to Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment

ASAM licensure

- *(**providers and MCEs**) No licensure for ASAM 3.7*. Providers and MCEs question why there is not a licensure requirement for ASAM 3.7. This has not changed since the Summative Evaluation.

Reeducation of provider staff on ASAM levels

- *(**MCEs**). PHE policies have meant reeducation of providers on authorization and ASAM level of care requirements*. While supportive of the PHE policies designed to assure access, the MCEs overwhelmingly expressed concerns that they are essentially starting over on provider education regarding authorization and ASAM levels. They stated that some providers do not understand the PA form and ASAM ratings and requests are often scaled to what the provider offers and not the member's needs. This has not changed since the Summative Report.

Issues with contracting, authorizations and billing

- *(**providers**). No change in interactions with MCEs over the past year*. Providers are split, with less than half describing their interactions with the MCEs regarding SUD services as being neutral or easy with respect to contracting, authorizations or billing and that this has not changed over the past year. The most frequently mentioned area of difficulty is with authorizations.

Feedback on Milestone #4: Sufficient Provider Capacity at Critical Levels of Care

Ease of finding treatment options

- *(**beneficiaries**) Some members had difficulties finding providers who would take Medicaid, yet others were able to access care immediately*. While only one beneficiary provided

feedback on this item in the MidPoint, this theme continues to resonate during the current demonstration period.

Observations regarding provider network

- *(**providers**) Most providers thought there was no change in the adequacy of the provider network along ASAM levels of care with the waning of the pandemic*. Supportive housing, intensive outpatient services (ASAM 2.1) and opioid treatment programs mentioned most frequently as areas for improvement.
- *(**MCEs**) The MCEs expressed that while the availability of ASAM 3.5 providers is sufficient, the lack of ASAM level 3.7 availability, and limited ASAM 3.1 and PHP were areas of concern*.
- *(**providers**) The majority of providers (32 of 51) responded that they have considered expanding their scope of services to other ASAM levels*. Intensive Outpatient Services (ASAM 2.1) was mentioned most frequently, followed by Partial Hospitalization (ASAM 2.5) and Residential: Clinically Managed Low-Intensity (ASAM 3.1) as areas for expansion. Of those not considering expansion, the most common barriers mentioned by providers were workforce challenges followed by rates.

Feedback on Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse

Guidance from FSSA has been helpful but would like more collaboration in advance of policy changes

- *(**MCEs**) Feedback on guidance has been positive but want more advance notice*. In general, the MCEs had positive comments for FSSA with respect to guidance but would have appreciated more advance notice of policy changes.
- *(**providers**) Would like a more collaborative partnership and input into policy development*. Providers stated that they would like a more collaborative partnership with FSSA so that they could provide input into policy development as opposed to reacting after the fact.
- *(**providers**) Most providers felt FSSA could have done more related to some items*. 64.7% (33 of 51) stated that FSSA could have done more related to some items. Specifically, meetings with MCEs (21 providers) followed by Online Training (18 providers) and meetings with State staff (18 providers) were mentioned most frequently.
- *(**providers**) Most providers have attended the ASAM trainings*. The majority (37 of 51) providers have attended FSSA sponsored ASAM trainings and found them to be helpful. Providers reported sporadic attendance over the past several years, with some mentioning 2020 as the last training attended.
- *(**providers**) FSSA bulletins are helpful in supporting participation and provision of SUD services*. The majority of communication has been through bulletins and in general, most providers found the guidance to be somewhat helpful and supported their participation and provision of SUD services.
- *(**providers**) Provider bulletins and regular meetings were mentioned as most helpful*. Most (44 of 51) providers found the communications from FSSA or the MCEs to be helpful to somewhat helpful. Provider bulletins followed by regular meetings were mentioned as being most helpful.

Modes of communication

- *(**beneficiaries**) Beneficiaries suggested targeted outreach to teens and young adults via social media on the dangers of addiction and where to get help*. While only one beneficiary

provided feedback on this item in this Mid-Point Assessment, it was mentioned by beneficiaries during the prior demonstration period and is continued in this assessment.

- *(**beneficiaries**) Advertise provider services and locations*. Make communications real by showing pictures that illustrate the impact addictions has on you and your family. Members mentioned online, social media, radio, tv, print media, and billboards as examples. While only one beneficiary provided feedback on this item in the MidPoint, this theme continues to resonate during the current demonstration period.
- *(**beneficiaries**) Have more readily available pamphlets with information about what Medicaid covers, provider services, and locations on where to get treatment*. Suggested locations to place pamphlets: local WIC, welfare, offices; jails and parole offices; homeless shelters; AA/NA meeting sites; provider waiting rooms. While only one beneficiary provided feedback on this item in the MidPoint, this theme continues to resonate during the current demonstration period.

Feedback on the Pregnancy Promise Program for members with OUD

- *(**MCEs**) The guidance and support from state team on the Pregnancy Promise Program for members has been good and is well received by members*. In general, the MCEs feel like it is a true partnership, although they described implementation challenges including regarding knowledge of the program by providers, data and for what the MCEs could invoice. Would like to see the grant continue and if it does, more provider education.
- *(**providers**) Provider knowledge of the Pregnancy Promise Program is mixed*. Slightly more than half of providers responded that they did not know about the Pregnancy Promise Program. However, more than half of providers responded that the MCEs talked with them about the program.

Feedback on demonstration and suggested improvements

- *(**MCEs**). Dedicated training on the 1115 demonstration would be helpful*. With the waning of the pandemic, the MCEs are finding that dedicated training for new and existing providers on the 1115 demonstration would be beneficial to help reset provider expectations.
- *(**providers**). Improve consistency between state intentions and actual practice*. In general, providers would like there to be consistency between the state's intentions for the MCEs and actual practice. Consistency in authorization processes and decision making, followed by care coordination were mentioned most frequently.
- *(**providers**) Access has improved, specifically in telehealth, outpatient and MAT*. Most providers commented that access has improved with specific mentions regarding telehealth, outpatient and MAT.
- *(**providers**) Providers commented that understanding processes, coverage, rates and staffing have gotten worse and are areas for improvement*.

Feedback on Milestone #6: Improved Care Coordination and Transitions Between Levels of Care

Care coordination with the MCEs

- *(**providers**) Provider experiences were variable on their interactions with the MCEs on care coordination*. Many providers indicated that the MCEs assisted with care coordination but felt there was room for improvement. More than 74% (38 of 51) providers felt there was no change compared to the last year with respect to assistance with care coordination
- *(**MCEs**) The MCEs expressed that there are challenges with providers not having a good understanding of MCE care coordination processes*.

SECTION D: Assessment and Recommendations

Assessment of Overall Risk of Not Meeting Milestones

Exhibit D.1, which appears on the next six pages, summarizes the HMA-Burns team's assessment of FSSA's ability to meet the SUD milestones it agreed to in its demonstration waiver. To complete this assessment, the HMA-Burns team factored in the results to date of the critical metrics comparing results at the Mid-Point against the baseline, the status of FSSA's activities in its SUD Implementation Plan, a review of SUD provider availability, and feedback from stakeholders.

The HMA-Burns team met with FSSA on the results of this assessment and offered recommendations related to each CMS Milestone. The State's response to this assessment and the recommendations offered also appears in Exhibit D.1.

Assessment of State's Capacity to Provide SUD Services

Based on the assessment conducted, the HMA-Burns team believes that most community-based SUD services are available within reasonable proximity to most Medicaid beneficiaries. The exception to this is there appears to be a need for additional residential treatment services in the northern counties of the state at all ASAM levels. There has been little growth in licensed provider or bed capacity in this region of the state when compared to the central and southern regions. One option would be for the FSSA to build incentives within the existing residential provider network or providers new to Medicaid to enhance capacity for residential services in this region.

Next Steps Identified by the State

The FSSA has reviewed the Mid-Point Assessment prepared by HMA-Burns, focusing its review on the summary of progress-to-date, potential risks to future success, and recommendations. A response to each recommendation is found in Exhibit D.1 beginning on the following page and is organized by CMS Milestone and recommendation number.

The FSSA also carefully reviewed each of these recommendations against the approved Monitoring Protocol and Implementation Plan to determine if modifications were needed to either document. Based upon this review, it was determined that no Implementation Plan or Monitoring Protocol updates are required.

Lastly, the impact of the Coronavirus (COVID-19) public health emergency and the subsequent unwinding activities on SUD utilization patterns and delivery system needs continues to be evaluated. While the FSSA response has been prepared using the best information as of the date of this document, its approach to addressing recommendations will continue to be evaluated during CY 2024.

Exhibit D.1

Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Demonstration

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Completed	Total	Percent Complete	# Met Goal	Total	Percent Goal Met		
#1 Access to Critical Levels of Care for SUD Treatment	12	17	71%	6	7	86%	Beneficiaries continue to not have a good understanding of the benefits offered by Medicaid. Providers and MCEs noted improvements in residential, telehealth, outpatient and MAT but suggested improvements are still needed along the continuum. Telehealth has improved access to services, primarily in rural areas.	**Medium**

Independent Assessor Recommendations	
1	The FSSA is encouraged to work with its MCEs on the approach to authorizing intensive outpatient and partial hospitalization services statewide. Providers who have the capacity to deliver these services communicated to the evaluators that they forego delivering this service due to what are perceived as tight requirements for authorization approvals. (M1)
2	The evaluators saw little utilization for the billing of early intervention services. The FSSA is encouraged to understand the root cause for this, whether it is because the service is not being delivered or it is being billed under another service definition. Guidance to providers on the provision and billing of early intervention services is suggested, including a potential webinar or in-service education conducted by MCE Provider Relations staff. (M1)
State's Response	1. *Prior Authorization Processes for IOP and PHP:* During the PHE, FSSA relaxed prior authorization requirements to ensure services were continually rendered. With the unwinding of the PHE, FSSA worked closely with its MCE partners, providers and other stakeholders to provide regular communication and will evaluate the need for further education, and potential policy and process adjustments during CY 2024.
	2. *Conduct Root Cause Analysis of Low Early Intervention Billing:* During the PHE, FSSA adopted polices and procedures to encourage utilization of services. Indiana, not unlike other states, experienced disrupted utilization patterns. As the PHE unwinding activities phase down, FSSA will evaluate the need for further education, and potential policy and process adjustments during CY 2024.

Exhibit D.1 – continued

Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Demonstration

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Completed	Total	Percent Complete	# Met Goal	Total	Percent Goal Met		
#2 Use of Evidence-Based SUD-specific Patient Placement Criteria	4	4	100%	2	2	100%	Providers expressed concerns with the lack of a consistent review process and documentation requirements across the MCEs, and in particular with authorization of IOT services. The PHE contributed to the confusion on the part of providers regarding the ASAM treatment model and PA processes.	**Low**

Independent Assessor Recommendations	
3	The FSSA should consider a uniform method for providers to upload service authorization requests to the MCEs for inpatient hospital, residential treatment, intensive outpatient, and partial hospitalization services in an electronic format. The method would include required fields to ensure that relevant data is captured for completeness. It would also assist providers in the education process for what is required for SUD service authorization submissions and would streamline the submission requirements across the contracted MCEs.(M2)
4	The FSSA is encouraged to strengthen its oversight of the MCEs related to SUD service authorizations. In particular, an analysis of authorization approvals and denials at different ASAM levels of care. Additionally, there may be interest in understanding the trend in authorizations for SUD beneficiaries by type of SUD (e.g., alcohol, opioid, other).(M2)
5	The FSSA may want to consider another round of ASAM training focusing on level of care requirements and training on performing ASAM interviews from a clinical perspective. (M2)
State's Response	3. *Consider Uniform Method to Upload Prior Authorization Requests to the MCEs:* During the PHE, FSSA relaxed prior authorization requirements to ensure services were continually rendered. With the unwinding of the PHE, OMPP worked closely with its MCE partners, providers and other stakeholders to provide regular communication, and is using 2024 to evaluate the need for further education and process adjustments.
	4. *Strengthen Oversight of MCE SUD Service Authorizations:* During the PHE, FSSA relaxed prior authorization requirements to ensure services were continually rendered. With the unwinding of the PHE, OMPP worked closely with its MCE partners, providers and other stakeholders to provide regular communication, and is using 2024 to evaluate the need for further education, and potential policy and process adjustments.
	5. *Additional ASAM Trainings:* DMHA has held ASAM trainings every year since 2018. As ASAM recently came out with the 4th edition, live trainings will not be available until Spring of 2024. DMHA plans to have additional ASAM trainings in the Summer of 2024 to go over the new criteria.

Exhibit D.1 – continued

Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Demonstration

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Completed	Total	Percent Complete	# Met Goal	Total	Percent Goal Met		
#6 Improved Care Coordination and Transition Between Levels of Care	1	1	100%	6	7	86%	Provider experiences were variable on their interactions with the MCEs on care coordination. The MCEs expressed challenges with providers not having a good understanding of MCE care coordination processes.	**Low**
Independent Assessor Recommendations								
11	The FSSA is encouraged to strengthen its oversight of the MCEs related to the provision of care coordination or case management among SUD beneficiaries. (M6)							
12	The evaluators recommend that the FSSA create a SUD-specific Provider Manual with service requirements, authorization expectations, care coordination and HIPAA privacy, and billing guidance. This manual may also include examples of tools used by providers in the field today that are considered best practice for conducting SUD assessments. This could be a useful 'one-stop' method as a reference in lieu of compiling individual provider bulletins that have been released. (M6)							
State's Response	11. *Strengthen Oversight of MCE Care Coordination.* Indiana's MCEs are contractually required to track and coordinate the care of members receiving care in an IMD. This includes anticipating and planning for a member's successful discharge upon a member's entry into an IMD and coordination of physical and behavioral health care. To monitor the participation in and the effectiveness of the MCEs case management intervention activities, the OMPP requires that the MCEs submit a quarterly Care and Complex Case Management Report. This report allows the OMPP to monitor MCE outreach to beneficiaries with SUD for participation. In 2024, OMPP will update the MCE report to more accurately capture MCE outreach.							
	12. *A SUD Provider Specific Manual:* Indiana Medicaid has heard provider confusion around IHCP behavioral health policies and published an updated Behavioral Health Provider Refence Module February 2022. However, it is a combined manual for all behavioral health services (SUD, SMI, PRTF, etc.). OMPP will consider this request to better improve communication with our SUD providers. In the meantime, the OMPP will update the SUD FSSA website moving forward to track provider bulletins that apply to the SUD waiver.							

Exhibit D.1 – continued

Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Demonstration

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Completed	Total	Percent Complete	# Met Goal	Total	Percent Goal Met		
#4 Sufficient Provider Capacity at Critical Levels of Care	4	4	100%	2	2	100%	Some members had difficulties finding providers who would take Medicaid, yet others were able to access care immediately. While there have been improvements over time, there has been little change over the past year in the provider network. Areas suggested for improvement include ASAM 3.7, ASAM 3.1, PHP, IOT, OTP and supportive housing. Most providers (32 of 51) responded that they have considered expanding their scope of services to other ASAM levels.	**Low**

Independent Assessor Recommendations	
7	There appears to be a need for additional residential treatment services in the northern counties of the state at all ASAM levels. There has been little growth in licensed providers or bed capacity in this region of the state when compared to the central and southern regions. One option would be for the FSSA to build incentives within the existing residential provider network or providers new to Medicaid to enhance capacity for residential services in this region. (M4)
8	Feedback from providers, MCEs, and beneficiaries indicated that there is a greater need for IOT, PHP, ASAM 3.1 residential and supportive housing/sober living options. The FSSA issued two housing related request for funding grants in 2022 and is encouraged to continue its discussions with its existing provider base to expand their service array into this modality as well as to build the capacity from new providers as well. (M4)
9	Current state law limits the number of opioid treatment providers in the state. Absent a repeal of this law, the FSSA is encouraged to work with providers currently eligible to deliver MAT as per the legislation to expand this service particularly in rural portions of the state. Separately, the FSSA may consider ways to expand delivery of services of alternative MAT treatment. (M4)

State's Response	
	7. *Residential Treatment Services in Northern Counties:* OMPP and DMHA will explore the residential capacities in the northern counties in 2024.
	8. *3.1 and 3.5 ASAM Level of Care Combined Units:* The DMHA and OMPP have discussed and continue to consider options for providers to obtain dual certification for multiple ASAM residential levels of care, particularly if the provider can demonstrate a separation of the programs both physically and programmatically even if they are on the same campus.
	9. *Limits on Opioid Treatment Programs:* As of July 2023, OMPP has aligned itself with Medicare by end-dating the per diem OTP code and adopting the G-codes that are being used by Medicare. The SPA allowing Indiana to adopt the new OTP codes was approved in June 2023.

Exhibit D.1 – continued

Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Demonstration

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Completed	Total	Percent Complete	# Met Goal	Total	Percent Goal Met		
#5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse	2	3	67%	4	4	100%	With the waning of the pandemic, the MCEs are finding that dedicated training for new and existing providers on the 1115 demonstration would be beneficial to help reset provider expectations. In general, providers would like there to be consistency between the state's intentions for the MCEs and actual practice. Feedback on the Pregnancy Promise Program for members with OUD is largely positive. Beneficiaries suggested targeted outreach to teens and young adults via social media on the dangers of addiction and where to get help.	**Medium**
Independent Assessor Recommendations								
10	The evaluators recommend that the FSSA create a dedicated training for MCEs, providers and beneficiaries on the 1115 demonstration and its expectations to assist stakeholders with transitioning out of the PHE. (M5)							
State's Response	10. *Dedicated Training Regarding 1115 to Assist with Transitioning out of the PHE:* OMPP updates the MCEs twice per week on new provider bulletins and conducts callouts for urgent updates with the MCEs. OMPP started an MCE PHE Unwind Q&A document and sent it out to MCEs on a weekly basis when there were updatesand/or additions beginning January 27, 2023. Questions were collected directly from MCEs, during bi-weekly PHE Unwind meetings (which include MCEs, State staff from various divisions and sections, and systems contractors), stakeholder engagement meetings, and via email. OMPP held monthly Stakeholder engagement meetings to share information, progress, and updates regarding redetermination processes, the State's plans and timelines for PHE Unwind activities, and other related topics as appropriate, and to direct stakeholders to useful tools and resources available on the Indiana Medicaid website.							

Exhibit D.1 – continued

Assessment of State's Ability to Meet Milestones at Mid-Point of SUD Demonstration

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Completed	Total	Percent Complete	# Met Goal	Total	Percent Goal Met		
#6 Improved Care Coordination and Transition Between Levels of Care	1	1	100%	6	7	86%	Provider experiences were variable on their interactions with the MCEs on care coordination. The MCEs expressed challenges with providers not having a good understanding of MCE care coordination processes.	**Low**
Independent Assessor Recommendations								
11	The FSSA is encouraged to strengthen its oversight of the MCEs related to the provision of care coordination or case management among SUD beneficiaries. (M6)							
12	The evaluators recommend that the FSSA create a SUD-specific Provider Manual with service requirements, authorization expectations, care coordination and HIPAA privacy, and billing guidance. This manual may also include examples of tools used by providers in the field today that are considered best practice for conducting SUD assessments. This could be a useful 'one-stop' method as a reference in lieu of compiling individual provider bulletins that have been released. (M6)							
State's Response	11. *Strengthen Oversight of MCE Care Coordination.* Indiana's MCEs are contractually required to track and coordinate the care of members receiving care in an IMD. This includes anticipating and planning for a member's successful discharge upon a member's entry into an IMD and coordination of physical and behavioral health care. To monitor the participation in and the effectiveness of the MCEs case management intervention activities, the OMPP requires that the MCEs submit a quarterly Care and Complex Case Management Report. This report allows the OMPP to monitor MCE outreach to beneficiaries with SUD for participation. In 2024, OMPP will update the MCE report to more accurately capture MCE outreach.							
	12. *A SUD Provider Specific Manual:* Indiana Medicaid has heard provider confusion around IHCP behavioral health policies and published an updated Behavioral Health Provider Refence Module February 2022. However, it is a combined manual for all behavioral health services (SUD, SMI, PRTF, etc.). OMPP will consider this request to better improve communication with our SUD providers. In the meantime, the OMPP will update the SUD FSSA website moving forward to track provider bulletins that apply to the SUD waiver.							

ATTACHMENTS

Independent Assessor Description

The HMA-Burns team met with the leadership of FSSA on July 18, 2023 to discuss the requirements of the content of the Mid-Point Assessment report and to review a draft report outline. The FSSA team asked questions about the approach that the HMA-Burns team would take to conduct the assessment, but FSSA honored the independence of the assessment team and allowed the HMA-Burns team to conduct its work unhindered.

The HMA-Burns met with FSSA to gather information to conduct the Mid-Point Assessment over three subsequent meetings (August 15, September 19 and October 17), and presented a status report to the FSSA team on November 21, 2023 on the progress to date in conducting the assessment. At this time, the HMA-Burns team notified FSSA that they would be required to offer a response to the assessment and the recommendations put forth.

The draft version of the Mid-Point Assessment was delivered to FSSA on December 1, 2023. A meeting was held with FSSA leadership on December 4, 2023 to review the report contents, key findings, and recommendations. After this meeting, the FSSA convened internally to discuss how to write the state response to the findings and recommendations. Later, a follow-up meeting was held between FSSA and HMA-Burns to discuss the state response and to incorporate it into the body of the Mid-Point Assessment report. The State's response to this Mid-Point Assessment appears on page 38, "Next Steps Identified by the State" and in the green boxes that are shown in Exhibit D.1.

Attestation

As the Project Director of this engagement, I am providing assurances there is no conflict of interest between the team members that conducted this Mid-Point Assessment and FSSA or its contracted managed care organizations.

[redacted]

Debbie Saxe, Principal
Burns & Associates, a Division of Health Management Associates
December 31, 2023

Data Collection Tools

Refer to the pages that follow for the three collection tools utilized by the HMA-Burns team in this assessment:

1. Provider facilitated interview questions
2. Provider online interview questions
3. Medicaid beneficiary interview questions
4. MCE interview questions

Attachment 1: Provider facilitated interview questions

Facilitated Discussion with Provider Representatives for Indiana SUD Waiver Mid-Point Assessment

As the State's independent evaluator, Burns & Associates, a Division of Health Management Associates (HMA-Burns) will be completing the Mid-Point Assessment for Indiana's SUD second demonstration period from January 2021 through December 2025. This evaluation is due to CMS at the end of December 2023.

One of HMA-Burns' requirements for the Mid-Point Assessment is to obtain feedback from stakeholders specifically related to what they perceive to have/have not worked, what improved/what still needs to be improved, and the greatest successes/greatest challenges in the waiver. Stakeholders includes providers, actual beneficiaries receiving SUD services, and managed care entities (MCEs).

To that end, Debbie Saxe and Ryan Sandhaus from the HMA-Burns team will lead a facilitated discussion with providers who opt to provide feedback through an in-person (via Zoom) interview. We ask that you review the questions below to consider (a) who would be appropriate representatives from your organization to participate in this focus group and (b) be prepared to offer responses to these questions. All feedback provided will be verbal and will not be attributed to an individual or a provider organization by name.

CMS is also interested in obtaining feedback from Medicaid beneficiaries. To facilitate gathering Medicaid beneficiary feedback, HMA-Burns has developed three mechanisms for beneficiaries receiving SUD services to provide their input.

- ***Option 1: Online Survey***. The survey is only 5 questions and can be completed within five minutes. Survey respondents will be anonymous. **We would greatly appreciate it if you would consider offering the following link to your Medicaid clients to complete this survey**: *https://healthmanagement.qualtrics.com/jfe/form/SV_bDU5zjp9ptdR33U*, and if possible, allow clients to complete the survey while at the provider site. The survey will be open until **November 10, 2023**. A hardcopy of the online survey is available beginning on page 4 of this document.
- ***Option 2: Complete a Hardcopy of the Online Survey***. The survey is only 5 questions and can be completed within five minutes. Survey respondents will be anonymous. **We would greatly appreciate it if you would consider offering a hardcopy and place to complete the survey to your Medicaid clients.** HMA-Burns will supply a postage paid envelope to return completed surveys. The survey will be open until **November 10, 2023**. A hardcopy of the survey is available beginning on page 4 of this document.
- ***Option 3: Facilitated Beneficiary Discussion in Residential Treatment Settings***. For those residential providers opting for the in person (Zoom) facilitated discussion, if possible, if we were able to speak to a few individuals after our provider interview concludes, we would greatly appreciate it. The facilitated beneficiary discussion questions we would ask are available on page 6 of this document. We will not record the discussion. The input provided would be completely anonymous and would not be linked to any individual or organization.

Your feedback is greatly appreciated. Please note that in the Final Mid-Point Assessment report delivered to CMS and the State, individual provider names or participants in the facilitated discussion are never mentioned.

Facilitated Discussion with Provider Representatives for Indiana SUD Waiver Mid-Point Assessment

Provider Name:

How long have you been an SUD provider for FSSA:

Services provided by your organization. Check all that apply.

Opioid Treatment Program	❒
Early Intervention (ASAM 0.5)	❒
Outpatient Services (ASAM 1.0)	❒
Intensive Outpatient Services (ASAM 2.1)	❒
Partial Hospitalization (ASAM 2.5)	❒
Residential: Clinically Managed Low-Intensity (ASAM 3.1)	❒
Residential: Clinically Managed High-Intensity (ASAM 3.5)	❒
Medically Monitored Intensive Inpatient Services (ASAM 3.7)	❒
Medically Managed Intensive Inpatient (ASAM 4.0)	❒
Addiction Recovery Management Services	❒
Supportive Housing Services	❒
Medication Assisted Treatment	❒
Offer Telehealth	❒

Region(s) of the state where you offer services organization.

The counties assigned to each region are shown to the right. Check all that apply.

Northwest	❒ Lake, Porter, LaPorte, Newton, Jasper
North Central	❒ St. Joseph, Elkhart, Starke, Marshall, Pulaski, Fulton
Northeast	❒ LaGrange, Steuben, Noble, DeKalb, Kosciusko, Whitley, Allen, Miami, Wabash, Huntington, Wells, Adams
West Central	❒ Benton, White, Carroll, Warren, Tippecanoe, Clinton, Fountain, Montgomery, Vermillion, Parke, Vigo, Clay, Sullivan
Central	❒ Boone, Hamilton, Madison, Putnam, Hendrick, Marion, Hancock, Morgan, Johnson, Shelby, Rush
East Central	❒ Cass, Howard, Tipton, Grant, Blackford, Jay, Delaware, Randolph, Henry, Wayne, Fayette, Union
Southwest	❒ Owen, Monroe, Brown, Greene, Knox, Daviess, Martin, Lawrence, Orange, Gibson, Pike, Dubois, Posey, Vanderburgh, Warrick, Spencer, Perry
Southeast	❒ Bartholomew, Decatur, Franklin, Jackson, Jennings, Ripley, Dearborn, Ohio, Jefferson, Switzerland, Washington, Scott, Clark, Crawford, Harrison, Floyd

Medicaid Managed Care Entities (MCEs) that you contract with. Check all that apply.

Anthem	❒
CareSource	❒
MDwise	❒
MHS (Managed Health Services)	❒
UHC (United Healthcare)	❒

Facilitated Discussion with Provider Representatives for Indiana SUD Waiver Mid-Point Assessment

1. Beginning in January 2021, what is your opinion on the guidance provided to you by FSSA related to SUD services and how this impacted your participation in providing SUD services to Medicaid beneficiaries? In hindsight, could FSSA have done more related to some items? What specifically?

2. As the pandemic has waned, how would you characterize the adequacy of the provider network along the ASAM levels of care? Are there specific ASAM levels of care that are better? Which levels are worse? If you think improvements are needed, where specifically? (e.g., certain ASAM levels, certain regions of the state)?

3. Have you considered expanding your scope of services to other ASAM levels? If yes, which levels? If no, why not (e.g., rates, administrative burden, lack of clinicians or other workforce issues, etc.)?

4. What is your opinion of the impact of telehealth on the adequacy of the provider network across the spectrum of ASAM levels of care? Are there specific sectors of the ASAM continuum that experienced improved access as a result of the changes in telehealth?

5. Do you know about the Pregnancy Promise Program for members with OUD? Have the MCEs talked with you about it?

6. What is your opinion of the prior authorization process and use of a single form? Does the single form make prior authorization easy and more understandable? If you think improvements are needed, what specifically?

7. Did you or anyone on your staff attend any ASAM training sponsored by the FSSA? If yes, what was the last training you attended? Did you find the training helpful?

8. Other than the ASAM training, what is your opinion of other communications that you receive from the FSSA or the MCEs that you have contracts with about SUD services and processes? Examples could include provider bulletins or other training such as on billing procedures. What, if anything, has been most helpful? If you think improvements are needed, where specifically?

9. As the pandemic has waned, how would you assess your interactions with the MCEs regarding SUD services for contracting, authorization or billing <u>today</u>? How does this compare to last year ? Are some MCEs easier to work with than others? If there are differences, what are they?

10. How would you assess your interactions with the MCEs regarding care coordination for members <u>today</u>? Do the MCEs assist you with coordinating care for members? How does this compare to last year? If you think improvements are needed, where specifically?

11. What, in your opinion, has improved or gotten worse in the delivery of treatment for SUD in the last year?

12. Do you have recommendations related to the delivery of treatment for SUD that you would like communicated in the Mid-Point Assessment?

Online and Hardcopy Beneficiary Questionnaire

Hello. Our company, Health Management Associates, was hired by the State of Indiana to review services for people seeking treatment for alcohol and drugs. The State is trying to expand services available for treatment throughout Indiana. The federal government is providing money to Indiana to help them do that. In return, the federal government wants to hear from citizens of Indiana getting treatment and providers delivering treatment to see how that is going.

We wanted to ask you five questions to see what you think. This will take about 5 minutes for you to complete the questionnaire. **You do not need to give us your name or other personal details on the survey**. Your service provider will be giving you a link to submit this survey to us online. We wanted you to see this hard copy of the survey so that you know in advance the questions that you will be asked. We greatly appreciate that you have agreed to provide input and thank you for your time.

Place a ☑ in the boxes below that best matches your answer to each question.

1. How did you find out about where you could get treatment? Please check all that apply to you.
    a. Family member ❒
    b. Friend ❒
    c. Sponsor ❒
    d. Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings ❒
    e. Healthcare provider (doctor, nurse, physician assistant, hospital, clinic) ❒
    f. Court/jail/prison/law enforcement/parole office ❒
    g. Website ❒
    h. Homeless shelter ❒

2. Was it hard to figure out where to get treatment? ❒Yes ❒ No
   If you answered Yes, please check all of the reasons why that apply to you.
    a. Could not find a provider near my home ❒
    b. Found a provider, but they have a waiting list ❒
    c. Provider won't take Medicaid ❒

3. What do you think would help you or others who are seeking treatment about how they can find providers to help them? Please check all that you think would help.
    a. Social media ❒
    b. Radio or television ❒
    c. Billboards ❒
    d. AA/NA meeting locations ❒
    e. Healthcare provider (doctor, nurse, physician assistant, hospital, clinic) ❒
    f. Court/jail/prison/law enforcement/parole office ❒
    g. Targeted outreach (e.g., schools) ❒
    h. Government offices (e.g., WIC, welfare, county) ❒
    i. Homeless shelter ❒

4. Over the past 12 months, did you receive any alcohol and/or drug treatment services online or by phone? ❒Yes ❒ No

   If you answered Yes, please check all of the type or types of providers that you received services from online or by phone.

	Type of provider	Provided care online or by phone
a.	Primary Care Doctor	❑
b.	Psychiatrist or Psychologist	❑
c.	Counselor	❑
e.	Outpatient Clinic/Office (not residential)	❑
f.	Peer Support Professional	❑
g.	Peer Recovery Coach	❑

5. Are there services that you need but you cannot find help for? Please provide feedback for all services that apply to you and how much of a problem it is to find the type of provider.

	Type of provider	Big Problem	Small Problem	No Problem	Doesn't Apply to Me
a.	Primary Care Doctor	❑	❑	❑	❑
b.	Psychiatrist or Psychologist	❑	❑	❑	❑
c.	Counselor	❑	❑	❑	❑
e.	Residential treatment	❑	❑	❑	❑
f.	Treatment in an office setting (not residential)	❑	❑	❑	❑
g.	Methadone	❑	❑	❑	❑
h.	Suboxone/Subutex	❑	❑	❑	❑
i.	Transportation to/from services	❑	❑	❑	❑

Questions for Web-based focus group or individual sessions with beneficiaries

Introductory language for session:

Hello. I am xxxxxxx. I am from a company called Health Management Associates. Our company was hired by the State of Indiana to review services for people seeking treatment for alcohol and drugs. The State is trying to expand services available for treatment throughout Indiana. The federal government is providing money to Indiana to help them do that. In return, the federal government wants to hear from citizens of Indiana getting treatment and providers delivering treatment to see how that is going.

We wanted to ask you just a few questions to see what you think. You do not have to give us your name or other personal details. Our questions are more about how you found out about treatment. When we submit our report, we will not put anyone's name in the report. It is all anonymous.

1. How did you find out about where you could get treatment? Was it hard to figure out?

2. Did you receive any services by phone or through an online appointment? Did it make it easier for you to get treatment for alcohol and/or drugs?

3. What do you think would help you or others who are seeking treatment about how they can find providers to help them?

4. Are there services that you need but you cannot find help for? Can you provide examples?

We greatly appreciate that you have agreed to talk to us and thank you for your time.

Attachment 2: Provider online interview questions

Indiana 1115 SUD Summative Evaluation – Online Outreach to Provider Representatives

As the State's independent evaluator, Burns & Associates, a Division of Health Management Associates (HMA-Burns) will be completing the Mid-Point Assessment for Indiana's SUD second demonstration period from January 2021 through December 2025. This evaluation is due to CMS at the end of December 2023.

One of HMA-Burns' requirements for the Mid-Point Assessment is to obtain feedback from stakeholders specifically related to what they perceive to have/have not worked, what improved/what still needs to be improved, and the greatest successes/greatest challenges in the waiver. Stakeholders includes providers, actual beneficiaries receiving SUD services, and managed care entities (MCEs).

Your feedback is greatly appreciated. Please note that in the Final Mid-Point Assessment report delivered to CMS and the State, individual provider names are never mentioned.

Provider Name: [Optional fillable]

How long have you been an SUD provider for FSSA: [enter number of years]

Services provided by your organization. Check all that apply.

Opioid Treatment Program	❒
Early Intervention (ASAM 0.5)	❒
Outpatient Services (ASAM 1.0)	❒
Intensive Outpatient Services (ASAM 2.1)	❒
Partial Hospitalization (ASAM 2.5)	❒
Residential: Clinically Managed Low-Intensity (ASAM 3.1)	❒
Residential: Clinically Managed High-Intensity (ASAM 3.5)	❒
Medically Monitored Intensive Inpatient Services (ASAM 3.7)	❒
Medically Managed Intensive Inpatient (ASAM 4.0)	❒
Addiction Recovery Management Services	❒
Supportive Housing Services	❒
Medication Assisted Treatment	❒
Offer Telehealth	❒

Region(s) of the state where you offer services organization.
The counties assigned to each region are shown to the right. Check all that apply.

Northwest	❒ Lake, Porter, LaPorte, Newton, Jasper
North Central	❒ St. Joseph, Elkhart, Starke, Marshall, Pulaski, Fulton
Northeast	❒ LaGrange, Steuben, Noble, DeKalb, Kosciusko, Whitley, Allen, Miami, Wabash, Huntington, Wells, Adams
West Central	❒ Benton, White, Carroll, Warren, Tippecanoe, Clinton, Fountain, Montgomery, Vermillion, Parke, Vigo, Clay, Sullivan
Central	❒ Boone, Hamilton, Madison, Putnam, Hendrick, Marion, Hancock, Morgan, Johnson, Shelby, Rush
East Central	❒ Cass, Howard, Tipton, Grant, Blackford, Jay, Delaware, Randolph, Henry, Wayne Fayette, Union
Southwest	❒ Owen, Monroe, Brown, Greene, Knox, Daviess, Martin, Lawrence, Orange, Gibson, Pike, Dubois, Posey, Vanderburgh, Warrick, Spencer, Perry
Southeast	❒ Bartholomew, Decatur, Franklin, Jackson, Jennings, Ripley, Dearborn, Ohio, Jefferson, Switzerland, Washington, Scott, Clark, Crawford, Harrison, Floyd

Medicaid Managed Care Entities (MCEs) that you contract with. Check all that apply.

Anthem	❒
CareSource	❒
MDwise	❒
MHS (Managed Health Services)	❒
UHC (United Healthcare)	❒

Questions for the Online Survey

1. Beginning in January 2021, what is your opinion on the guidance provided to you by FSSA and how this impacted your participation in providing SUD services to Medicaid beneficiaries?
    a. Please select the response that most closely matches your opinion of the guidance.
        - Very helpful and encouraged participation/provision of SUD services ❒
        - Somewhat helpful and supported participation/provision of SUD services ❒
        - Not helpful but still able to participate/provide SUD services ❒
        - Not helpful and made it difficult to participate/provide SUD services ❒
        - Caused my organization to stop providing some SUD services ❒
        - Caused my organization to elect to not provide or expand some SUD services ❒

    b. In hindsight, could FSSA have done more related to some items? ❒Yes ❒ No

    c. If yes, what specifically? Select all that apply.
        - Provider Bulletins ❒
        - Online Training ❒
        - In Person Training ❒
        - Meetings with State Staff ❒
        - Meetings with MCEs ❒

2. As the pandemic has waned, how would you characterize the adequacy of the provider network along the ASAM levels of care? ❒ Improved ❒ No Change ❒ Somewhat Worse ❒ Worse

    a. Are there specific ASAM levels of care that are better? Select all that apply.

        - Opioid Treatment Program ❒
        - Early Intervention (ASAM 0.5) ❒
        - Outpatient Services (ASAM 1.0) ❒
        - Intensive Outpatient Services (ASAM 2.1) ❒
        - Partial Hospitalization (ASAM 2.5) ❒
        - Residential: Clinically Managed Low-Intensity (ASAM 3.1) ❒
        - Residential: Clinically Managed High-Intensity (ASAM 3.5) ❒
        - Medically Monitored Intensive Inpatient Services (ASAM 3.7) ❒
        - Medically Managed Intensive Inpatient (ASAM 4.0) ❒
        - Addiction Recovery Management Services ❒
        - Supportive Housing Services ❒
        - Medication Assisted Treatment ❒

b. Which levels are worse? Select all that apply.

Opioid Treatment Program	❒
Early Intervention (ASAM 0.5)	❒
Outpatient Services (ASAM 1.0)	❒
Intensive Outpatient Services (ASAM 2.1)	❒
Partial Hospitalization (ASAM 2.5)	❒
Residential: Clinically Managed Low-Intensity (ASAM 3.1)	❒
Residential: Clinically Managed High-Intensity (ASAM 3.5)	❒
Medically Monitored Intensive Inpatient Services (ASAM 3.7)	❒
Medically Managed Intensive Inpatient (ASAM 4.0)	❒
Addiction Recovery Management Services	❒
Supportive Housing Services	❒
Medication Assisted Treatment	❒

c. If you think improvements are needed in the regions where you serve clients, for which services? Select all that apply.

Opioid Treatment Program	❒
Early Intervention (ASAM 0.5)	❒
Outpatient Services (ASAM 1.0)	❒
Intensive Outpatient Services (ASAM 2.1)	❒
Partial Hospitalization (ASAM 2.5)	❒
Residential: Clinically Managed Low-Intensity (ASAM 3.1)	❒
Residential: Clinically Managed High-Intensity (ASAM 3.5)	❒
Medically Monitored Intensive Inpatient Services (ASAM 3.7)	❒
Medically Managed Intensive Inpatient (ASAM 4.0)	❒
Addiction Recovery Management Services	❒
Supportive Housing Services	❒
Medication Assisted Treatment	❒

3. Have you considered expanding your scope of services to other ASAM levels? ❒Yes ❒ No
   a. If yes, which ASAM levels? Select all that apply.

Opioid Treatment Program	❒
Early Intervention (ASAM 0.5)	❒
Outpatient Services (ASAM 1.0)	❒
Intensive Outpatient Services (ASAM 2.1)	❒
Partial Hospitalization (ASAM 2.5)	❒
Residential: Clinically Managed Low-Intensity (ASAM 3.1)	❒
Residential: Clinically Managed High-Intensity (ASAM 3.5)	❒
Medically Monitored Intensive Inpatient Services (ASAM 3.7)	❒
Medically Managed Intensive Inpatient (ASAM 4.0)	❒
Addiction Recovery Management Services	❒
Supportive Housing Services	❒
Medication Assisted Treatment	❒

   b. If no, why not? ❒ Rates ❒ Workforce Challenges ❒ Administrative Burden ❒ Other [fillable]

4. What is your opinion of the impact of telehealth on the adequacy of the provider network across the spectrum of ASAM levels of care? ❒Helpful ❒ Somewhat Helpful ❒ Not Helpful
    a. Are there specific sectors of the ASAM continuum that experienced improved access as a result of the changes in telehealth? Select all that apply.

Opioid Treatment Program	❒
Early Intervention (ASAM 0.5)	❒
Outpatient Services (ASAM 1.0)	❒
Intensive Outpatient Services (ASAM 2.1)	❒
Partial Hospitalization (ASAM 2.5)	❒
Residential: Clinically Managed Low-Intensity (ASAM 3.1)	❒
Residential: Clinically Managed High-Intensity (ASAM 3.5)	❒
Medically Monitored Intensive Inpatient Services (ASAM 3.7)	❒
Medically Managed Intensive Inpatient (ASAM 4.0)	❒
Addiction Recovery Management Services	❒
Supportive Housing Services	❒
Medication Assisted Treatment	❒

5. Do you know about the Pregnancy Promise Program? ❒Yes ❒ No
    a. Have the MCEs talked with you about it? ❒Yes ❒ No

6. What is your opinion of the prior authorization process and use of a single form? ❒Helpful ❒ Somewhat Helpful ❒ Not Helpful
    a. Does the single form make prior authorization easier and more understandable? ❒Yes ❒ No

    b. [optional] If you think improvements are needed, what specifically? [fillable]

7. Did you or anyone on your staff attend any ASAM trainings sponsored by FSSA? ❒Yes ❒ No
    a. [optional] If yes, what was the last training you attended? [fillable]

    b. Did you find the training helpful? ❒Yes ❒ No

8. Other than the ASAM training, what is your opinion of other communications that you receive from the FSSA or the Medicaid MCEs that you have contracts with about SUD services and processes? Examples could include provider bulletins or other trainings such as on billing procedures.
    ❒Helpful ❒ Somewhat Helpful ❒ Not Helpful

    a. [optional] What, if anything, has been most helpful? [fillable]

    b. [optional] If you think improvements are needed, where specifically? [fillable]

9. As the pandemic has waned, how would you assess your interactions with the MCEs regarding SUD services for contracting, authorization or billing <u>today</u>? ❒ Easy ❒ Neutral ❒ Somewhat Difficult ❒ Difficult
    a. How does this compare to last year? ❒ Improved ❒ No Change ❒ Somewhat Worse ❒ Worse

    b. If you contract with more than one MCE, are some MCEs easier to work with than others? ❒Yes ❒No ❒I only contract with one MCE

c. What areas have you had difficulties with any MCE? Check all that apply.
   - ❒ Contracting
   - ❒ Authorizations
   - ❒ Billing
   - ❒ None of the above

10. How would you assess your interactions with the MCEs regarding care coordination for members today? ❒ Easy ❒ Neutral ❒ Somewhat Difficult ❒ Difficult

    a. Do the MCEs assist you with coordinating care for members? Please check the box that best applies.

Anthem	❒ Yes	❒ No
CareSource	❒ Yes	❒ No
MDwise	❒ Yes	❒ No
MHS	❒ Yes	❒ No
UHC	❒ Yes	❒ No

    b. How does this compare to last year? ❒ Improved ❒ No Change ❒ Somewhat Worse ❒ Worse

11. What, in your opinion, has improved or gotten worse in the delivery of treatment for SUD in the last year?
    [fillable]

12. Do you have recommendations related to the delivery of treatment for SUD that you would like communicated in the Mid-Point Assessment?
    [fillable]

Attachment 3: Medicaid beneficiary interview questions

Indiana SUD Waiver Mid-Point Assessment Member Questionnaire

Online and Hardcopy Beneficiary Questionnaire

Hello. Our company, Health Management Associates, was hired by the State of Indiana to review services for people seeking treatment for alcohol and drugs. The State is trying to expand services available for treatment throughout Indiana. The federal government is providing money to Indiana to help them do that. In return, the federal government wants to hear from citizens of Indiana getting treatment and providers delivering treatment to see how that is going.

We wanted to ask you five questions to see what you think. This will take about 5 minutes for you to complete the questionnaire. **You do not need to give us your name or other personal details on the survey**. Your service provider will be giving you a link to submit this survey to us online. We wanted you to see this hard copy of the survey so that you know in advance the questions that you will be asked. We greatly appreciate that you have agreed to provide input and thank you for your time.

Place a ☑ in the boxes below that best matches your answer to each question.

1. How did you find out about where you could get treatment? Please check all that apply to you.
    a. Family member ❒
    b. Friend ❒
    c. Sponsor ❒
    d. Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings ❒
    e. Healthcare provider (doctor, nurse, physician assistant, hospital, clinic) ❒
    f. Court/jail/prison/law enforcement/parole office ❒
    g. Website ❒
    h. Homeless shelter ❒

2. Was it hard to figure out where to get treatment? ❒Yes ❒ No
   If you answered Yes, please check all of the reasons why that apply to you.
    a. Could not find a provider near my home ❒
    b. Found a provider, but they have a waiting list ❒
    c. Provider won't take Medicaid ❒

3. What do you think would help you or others who are seeking treatment about how they can find providers to help them? Please check all that you think would help.
    a. Social media ❒
    b. Radio or television ❒
    c. Billboards ❒
    d. AA/NA meeting locations ❒
    e. Healthcare provider (doctor, nurse, physician assistant, hospital, clinic) ❒
    f. Court/jail/prison/law enforcement/parole office ❒
    g. Targeted outreach (e.g., schools) ❒
    h. Government offices (e.g., WIC, welfare, county) ❒
    i. Homeless shelter ❒

4. Over the past 12 months, did you receive any alcohol and/or drug treatment services online or by phone? ❒Yes ❒ No

   If you answered Yes, please check all of the type or types of providers that you received services from online or by phone.

	Type of provider	Provided care online or by phone
a.	Primary Care Doctor	❑
b.	Psychiatrist or Psychologist	❑
c.	Counselor	❑
e.	Outpatient Clinic/Office (not residential)	❑
f.	Peer Support Professional	❑
g.	Peer Recovery Coach	❑

5. Are there services that you need but you cannot find help for? Please provide feedback for all services that apply to you and how much of a problem it is to find the type of provider.

	Type of provider	Big Problem	Small Problem	No Problem	Doesn't Apply to Me
a.	Primary Care Doctor	❑	❑	❑	❑
b.	Psychiatrist or Psychologist	❑	❑	❑	❑
c.	Counselor	❑	❑	❑	❑
e.	Residential treatment	❑	❑	❑	❑
f.	Treatment in an office setting (not residential)	❑	❑	❑	❑
g.	Methadone	❑	❑	❑	❑
h.	Suboxone/Subutex	❑	❑	❑	❑
i.	Transportation to/from services	❑	❑	❑	❑

Questions for Web-based focus group or individual sessions with beneficiaries

Introductory language for session:

Hello. I am xxxxxxx. I am from a company called Health Management Associates. Our company was hired by the State of Indiana to review services for people seeking treatment for alcohol and drugs. The State is trying to expand services available for treatment throughout Indiana. The federal government is providing money to Indiana to help them do that. In return, the federal government wants to hear from citizens of Indiana getting treatment and providers delivering treatment to see how that is going.

We wanted to ask you just a few questions to see what you think. You do not have to give us your name or other personal details. Our questions are more about how you found out about treatment. When we submit our report, we will not put anyone's name in the report. It is all anonymous.

1. How did you find out about where you could get treatment? Was it hard to figure out?

2. Did you receive any services by phone or through an online appointment? Did it make it easier for you to get treatment for alcohol and/or drugs?

3. What do you think would help you or others who are seeking treatment about how they can find providers to help them?

4. Are there services that you need but you cannot find help for? Can you provide examples?

We greatly appreciate that you have agreed to talk to us and thank you for your time.

Attachment 4: MCE interview questions

Facilitated Discussion with MCE Representatives for SUD Waiver Mid-Point Assessment

Meeting via Zoom September 21, 2023

As the State's independent evaluator, Burns & Associates, a Division of Health Management Associates (HMA-Burns) will facilitate this MCE stakeholder group discussion to gain feedback that can be included in the Mid-Point Assessment of Indiana's SUD waiver for the second demonstration period from January 2021 through December 2025. The Mid-Point Assessment is due to CMS at the end of December 2023.

One of HMA-Burns' requirements for the Mid-Point Assessment is to obtain feedback from stakeholders specifically related to what they perceive to have/have not worked, what improved/what still needs to be improved, and the greatest successes/greatest challenges in the waiver. Stakeholders includes managed care entities (MCEs), providers, and actual beneficiaries receiving SUD services.

To that end, Debbie Saxe, Ryan Sandhaus and Lilia Teninty from the HMA-Burns team will lead a facilitated discussion. We ask that you review the questions below to consider (a) who would be appropriate representatives from your organization to participate in this focus group and (b) be prepared to offer responses to these questions. All feedback provided will be verbal and will not be attributed to an individual or an MCE by name.

CMS is also interested in obtaining feedback from Medicaid beneficiaries. To facilitate gathering Medicaid beneficiary feedback, HMA-Burns has developed a brief set of questions and three mechanisms for beneficiaries receiving SUD services to provide their input. Each method should take no longer than a few minutes to complete.

- Option 1: Online Survey.
- Option 2: Complete a Hardcopy of the Online Survey.
- Option 3: Facilitated Beneficiary Discussion in Residential Treatment Settings.

While the MCEs are not obligated to assist HMA-Burns with collecting beneficiary feedback, we are interested in your opinion on how we are proposing to gather Medicaid beneficiary input from those receiving SUD services.

- Are there other mechanisms that may be more effective in gathering feedback from beneficiaries?
- Are there specific providers or provider types that would be more helpful in assisting HMA-Burns with collection of Medicaid beneficiary feedback?
- Are there other venues/opportunities that are you are aware of that could assist us with gathering feedback? For example, existing focus groups or venues for members to provide feedback?

We greatly appreciate your feedback and input and thank you in advance for your time.

Facilitated Discussion with MCE Representatives for SUD Waiver Mid-Point Assessment

Meeting via Zoom September 21, 2023

1. Beginning in January 2021, what is your opinion on the guidance provided to you by FSSA related to SUD services during the pandemic and how this impacted your (the MCE's) responsibilities for implementing waiver activities? In hindsight, could FSSA have done more related to some items? What specifically?

2. Is there anything that you believe the FSSA could still do to improve guidance related to SUD waiver implementation efforts?

3. Do you perceive that the expectations of the MCEs related to the SUD waiver have changed over time? If yes, how so?

4. As the pandemic has waned, how would you characterize the adequacy of the provider network along the ASAM levels of care? Are there specific ASAM levels of care that are better? Which levels are worse? If you think improvements are needed, where specifically? (e.g., certain ASAM levels, certain regions of the state)?

5. What is your opinion of the impact of telehealth on the adequacy of the provider network across the spectrum of ASAM levels of care? Are there specific sectors of the ASAM continuum that experienced improved access as a result of the changes in telehealth?

6. How would you characterize the guidance about and the impact of the Pregnancy Promise Program for members with OUD?

7. As the pandemic has waned, how would you assess provider compliance and their general understanding of contracting, authorization or billing rules today? How does this compare to last year? If you think improvements are needed, where specifically?

8. How would you assess your interactions with providers regarding care coordination for members today? How does this compare to last year? Are some provider types easier to work with than others? If there are differences, what are they?

9. Do you perceive that there is still confusion on the part of providers about covered services for SUD? If yes, what specifically?

10. What, in your opinion, has improved or gotten worse in the delivery of treatment for SUD in the last year?

11. Do you have recommendations to the evaluators related to the delivery of treatment for SUD that you would like communicated in the Mid-Point Assessment?