Eric Holcomb, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

August 30, 2019

Calder Lynch, Acting Deputy Administrator and Director
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Amendment Request
Healthy Indiana Plan (HIP) Section 1115 Waiver (Project No. 11-W-00296/5)

Dear Director Lynch,

The Indiana Family and Social Services Administration (FSSA) is pleased to submit this request to amend its §1115 waiver seeking federal authority to reimburse for acute inpatient stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED).

This request is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and is intended to improve access to acute care for Medicaid enrollees with SMI and SED. It builds upon Indiana's current authority to reimburse IMDs for short term stays for Medicaid beneficiaries receiving substance use disorder treatment. Further, the waiver will ensure comparable access to IMDs for Indiana Medicaid enrollees regardless of delivery system and eliminate the current inconsistency between fee-for-service and managed care coverage.

FSSA looks forward to continuing our partnership with the Centers for Medicare & Medicaid Services to ensure the delivery of comprehensive behavioral health services to Indiana Medicaid enrollees. Thank you for the opportunity to submit this waiver amendment request.

Sincerely,

[redacted]

Allison Taylor
Indiana Medicaid Director

cc: Judith Cash, Director State Demonstrations Group
Shanna Janu, Project Officer
Ruth Hughes, Associate Regional Administrator
Jennifer Walthall, Secretary, Indiana Family and Social Services Administration

Indiana Family and Social Services Administration

SMI/SED Amendment Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver (Project Number 11-W-00296/5)

August 30, 2019

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Overview

In 2018, the Indiana Family and Social Services Administration (FSSA) received authority from the Centers for Medicare and Medicaid Services (CMS) to reimburse institutions for mental diseases (IMDs) for Medicaid eligible individuals ages 21-64 with substance use disorders (SUD). Through this waiver amendment, FSSA seeks to expand this authority to reimburse for acute inpatient stays in IMDs for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED). Reimbursement will not be extended to IMDs for residential stays; additionally, state mental health hospitals will not be classified as IMDs eligible for reimbursement under this waiver. A 2015 report to the Indiana General Assembly highlighted the need for expanded crisis services, access to inpatient psychiatric beds, and improved coordination for individuals transitioning from inpatient services back into the community. Specifically, the report indicated that there is a need for increased options for individuals in psychiatric crises with survey results suggesting that Indiana residents rely heavily on general hospital emergency rooms to handle individuals in acute crisis.[1] This request is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and is intended to improve access to acute care for Medicaid enrollees with SMI and SED. Further, it will ensure comparable access to IMDs for Indiana Medicaid enrollees regardless of delivery system and eliminate the current inconsistency between fee-for-service and managed care coverage. The State requests an amendment effective date of January 1, 2020.

Indiana's Behavioral Health System of Care

System Overview

Indiana's publicly funded behavioral health (both mental health and addiction) system of care supports access to prevention, early intervention and recovery-oriented services and supports in all 92 counties, blending federal, state and local funding streams to a provider network of agencies and individual practitioners. Indiana's FSSA and specifically its Office of Medicaid Planning and Policy (OMPP) and Division of Mental Health and Addiction (DMHA) partner to provide policy oversight and primary funding of services and supports for individuals in need of behavioral health services. OMPP includes a robust continuum of behavioral health services as a benefit to enrollees in its fee-for service and Medicaid managed care programs. DMHA leverages its block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and state appropriations to compliment the Medicaid service array, with a focus on serving adults with SMI, youth with SED and individuals with SUD of any age, and that are at or below 200% of the federal poverty level (FPL). OMPP and DMHA also partner with the Department of Child Services (DCS) and Department of Corrections (DOC) in supporting access to and oversight of behavioral services for Indiana's most vulnerable Hoosiers.

[1] DMHA distributed the Psychiatric and Addiction Crisis Survey in December 2014 and January 2015. Tailored surveys went out to respondent groups including mental health and addiction providers, hospital emergency department staff, first responders, consumer and family advocates, and probation and parole officers.

Estimates on the prevalence of serious mental illness and serious emotional disturbance are provided in the attached Mental Health Services Availability Assessment Template.

Provider Network

As further delineated in the attached Mental Health Services Availability Assessment Template[2], OMPP maintains a large network of behavioral health providers including hospitals, psychiatric residential treatment facilities (PRTF), SUD residential providers, and community-based agencies and individual practitioners. Individual practitioners are certified and/or licensed by the Indiana Professional Licensing (IPLA). While IPLA is a separate and independent agency from FSSA, both OMPP and DMHA maintain a strong collaborative relationship. DMHA is responsible for certification and licensure for SUD provider agencies, free-standing psychiatric hospitals, and community mental health centers (CMHCs). Indiana Administrative Code (IAC) outlines provider requirements that assist in assuring quality and program integrity. Addiction residential, CMHC, and Clubhouse providers participating within the Medicaid program must be certified/licensed by DMHA prior to provider enrollment with OMPP.

Community Mental Health Centers

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

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

[2] Please note, FSSA has provided statewide versus county-level data on this template. Because licensure data for clinicians is based on their county of residence versus the county(s) in which they practice, it is impossible to accurately compare numbers at the county level as outlined in the template. The State looks forward to finalizing a methodology with CMS post waiver approval to more accurately represent the robust provider network in the state.

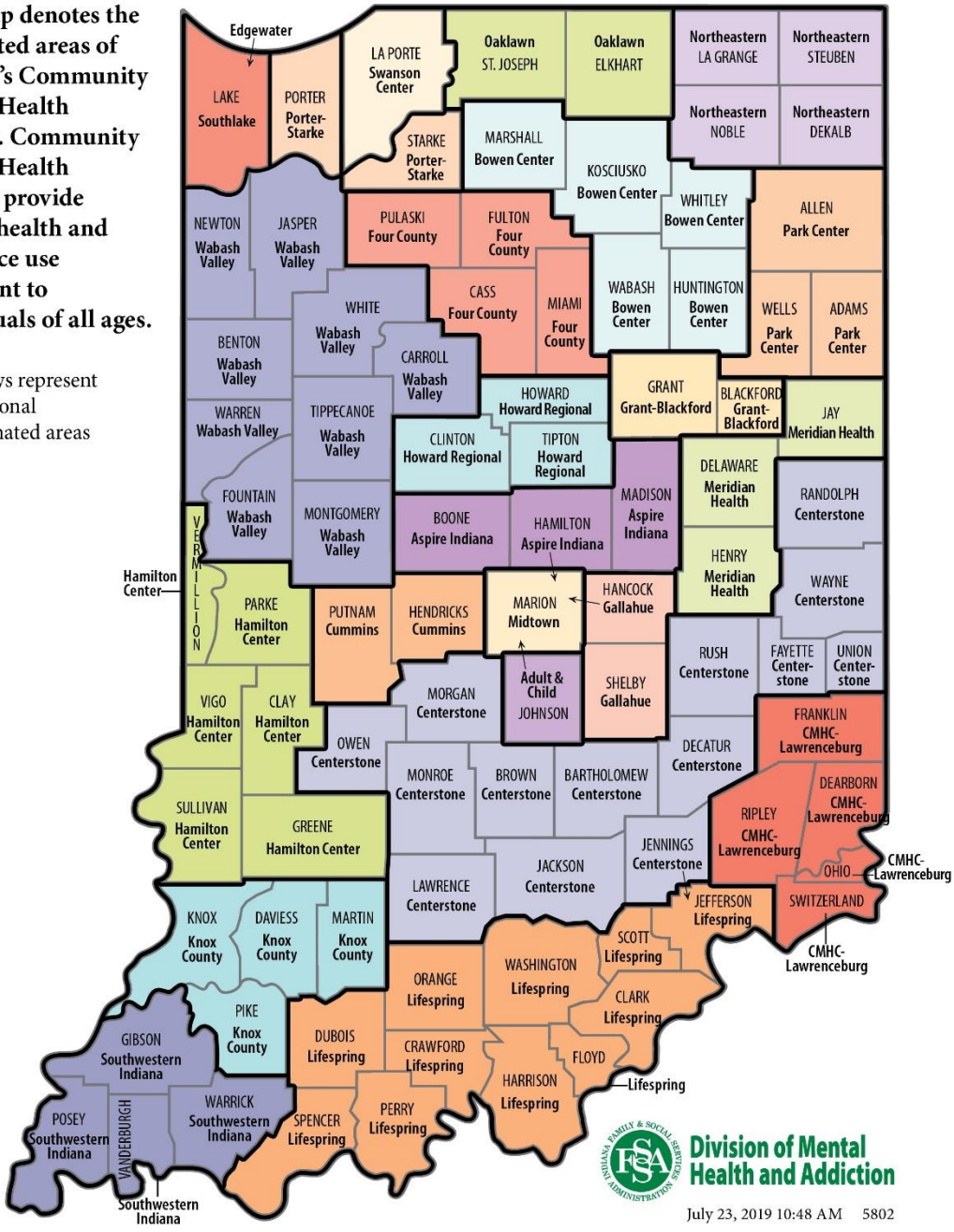
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

Many of these services are part of the state plan Medicaid Rehabilitation Option (MRO) services under which service need is identified through an assessment that confirms need for services with an eligible diagnosis and level of care determination using the Child and Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA).

Community Mental Health Centers

This map denotes the designated areas of Indiana's Community Mental Health Centers. Community Mental Health Centers provide mental health and substance use treatment to individuals of all ages.

→ Arrows represent additional designated areas



Current Service Continuum

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

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

The IHCP covers **outpatient mental health services** provided by a licensed medical doctor, doctor of osteopathy, psychologist endorsed as a health service provider in psychology (HSPP), psychiatric hospitals, psychiatric wings of acute care hospitals, and outpatient mental health facilities. Reimbursement is also available for services provided by mid-level practitioners when services are supervised by a physician or a HSPP. The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and supervising the treatment plan.

Adult Mental Health Habilitation Services. Effective November 1, 2014, Indiana implemented the §1915(i) Adult Mental Health Habilitation (AMHH) services program. The AMHH services program was adopted by Indiana to provide community-based opportunities for the care of adults with SMI who may most benefit from keeping or learning skills to maintain a healthy safe lifestyle in the community.

AMHH services are provided for individuals and their families, or groups of adult persons who are living in the community and who need help on a regular basis with SMI or co-occurring mental illness and addiction disorders. AMHH services are intended for individuals who meet all of the following core target group criteria: enrolled in Medicaid, age 35 or older, reside in a setting which meets federal setting requirements for home and community-based services (HCBS) and has an AMHH-eligible, DMHA-approved diagnosis.

An eligible AMHH enrollee will be authorized to receive specific requested AMHH services, according to an individualized care plan, approved by the State Evaluation Team. The following are the AMHH services:

- Adult day services

- Home- and Community-Based Habilitation and Support Services
- Respite care
- Therapy and behavioral support services
- Addiction counseling
- Supported community engagement services
- Care coordination
- Medication training and support

Initial eligibility in the program is for one year and can be extended if medical need remains.

Inpatient (acute). Prior authorization is required for all inpatient psychiatric admissions, rehabilitation, and substance abuse inpatient stays. Each Medicaid-eligible patient admitted to an acute psychiatric facility or unit must have an individually developed plan of care (POC). For members between 22 and older, a POC must be developed by the attending or staff physician. For members under 21 years old, POCs must be developed by a physician and interdisciplinary team. All POCs must be developed within 14 days of the admission date, regardless of the member's age. For a patient who becomes eligible for Medicaid after admission to a facility, the POC must be prepared to cover all periods for which Medicaid coverage is claimed. The following components must be documented in each member's POC:

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

The POC is developed as a result of a diagnostic evaluation that includes an examination of the medical, psychological, social, and behavioral aspects of the member's presenting problem and previous treatment interventions. The POC is reviewed by the attending or staff physician to ensure that appropriate services are being provided and that they continue to be medically necessary. The attending or staff physician also recommends necessary adjustments in the plan, as indicated by the member's overall adjustment as an inpatient. The POC must be in writing and must be part of the member's record.

State Hospital (longer term stays/forensic). Indiana's six state psychiatric hospitals provide intermediate and longer term inpatient psychiatric stays for adults who have co-occurring mental health and addiction issues, who are deaf or hearing impaired, and who have forensic involvement; as well as youth with SED. Individuals are admitted to a state hospital only after a screening by a CMHC. CMHCs, as the state hospital gate-keepers, are responsible for providing

case management to the individual in both the hospital and their transition to the community following discharge. The state psychiatric hospitals are accredited by the Joint Commission (JC). To maintain JC accreditation, all hospitals are required to participate in a performance measurement program. This is accomplished through participation in the National Research Institute Performance Measurement System, which provides a framework within which the state psychiatric hospitals can identify and implement consistent measures of performance and outcomes.

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

Amendment Goals

The State's goals are aligned with those of CMS for this demonstration waiver and are part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services, including:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

The State has multiple initiatives intended to support achievement of these goals that include cross-collaboration between the OMPP and DMHA.

State Strategies for Addressing Waiver Milestones

Current Oversight of Institutions for Mental Disease (IMDs)

In order to operate in the state of Indiana, all free-standing psychiatric hospitals must be licensed as a private mental health institution (PMHI) by DMHA. 440 IAC 1.5 currently requires PMHIs to be accredited by an accrediting body approved by the Division. This list only includes accrediting agencies also approved by CMS for deeming authority for Medicare requirements under 42 CFR 488.5 or 42 CFR 488.6. PMHI licensure must be renewed annually. DMHA currently conducts annual visits to ensure requirements are being met. In SFY 2019, all PMHI renewal site visits were unannounced. DMHA utilizes a site visit checklist that crosswalks with licensure requirements. The site visit checklist includes confirmation that individuals receive a physical within twenty-four (24) hours of admission as well as an initial emotional, behavioral, social and legal assessment per IAC requirements. This includes screening for chronic health conditions and substance use disorders. Prior authorization is currently required for inpatient psychiatric care under both managed care and for fee for service enrollees. This would include IMD admissions should Indiana receive a waiver of the current exclusion for reimbursement to these providers. There are currently 28 free-standing psychiatric hospitals licensed in the state of Indiana with a capacity of 1,010 beds. Thirteen (13) of the 28 PMHIs have more than 16 beds. DMHA is in the process of reviewing the IAC related to PMHIs with attention to quality assurance and monitoring for these providers based on the most recent cycle of onsite reviews and compliance with the goals and milestones of this 1115 waiver application.

Improving Integration and Care Coordination, including Transitions to Community-Based Care

Indiana has several initiatives, leveraging different authorities outside this 1115 waiver, to promote and expand care coordination and integrated delivery of behavioral health and primary care. These efforts focus on both youth with SED and adults with SMI and include cross collaboration with Indiana's DMHA and State Department of Health (ISDH).

Indiana's Primary Care and Behavioral Health Integration

FSSA in partnership with ISDH launched an initiative in 2012 to develop a statewide strategic plan to integrate primary and behavioral health care services in Indiana. Indiana's Primary Care and Behavioral Health Integration (PCBHI) efforts include the formation of a statewide stakeholder group, formalized definition for integration for Indiana, and the original creation of five subcommittees that spearheaded research and collaboration in the following areas that support integrated care:

- Data/Technology
- Education/Training
- Funding/Reimbursement

- Health Homes/Care Coordination
- Policy Development

In addition, FSSA applied for and was awarded the SAMHSA and National Association of State Mental Health Program Directors (NASHMHPD) Transformation Transfer Initiative (TTI) Grant which allowed Indiana to complete the following initiatives toward integration:

- Offered eight (8) integration educational training events in 2013.
- Completed a statewide integration survey.
- Offered Cross training for Community Health Workers (CHW) and Certified Recovery Specialists.
- Established process for state approved integrated care CHW certification.
- Established PCBHI Guiding Principles.

FSSA and ISDH established a process by which CMHCs, Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs) and Rural Health Clinics (RHCs) could become a state certified integrated care entity (ICE). ICE providers are required to provide care coordination that includes partnering with physicians, nurses, social workers, discharge planners, pharmacists, representatives in the education system, representatives of the legal system, representatives of the criminal justice system and others during any transition of care. The goals of this coordination include reducing unnecessary inpatient and emergency room use and increasing consumer and family members ability to manage their own care and live safely in the community. OMPP plans to submit a state plan amendment in 2019 to transition the ICE model to a health home program.

Behavioral and Primary Healthcare Coordination Service Program

Conceived under a separate §1915(i) state plan amendment, the Behavioral and Primary Healthcare Coordination (BPHC) program offers a service that consists of the coordination of healthcare services to manage the mental health/addiction and physical healthcare needs of eligible recipients. This includes logistical support, advocacy and education to assist individuals in navigating the healthcare system and activities that help recipients gain access necessary to manage their physical and behavioral health conditions.

BPHC service activities may include support in adhering to health regimens, scheduling and keeping medical appointments, obtaining and maintaining a primary medical provider and facilitating communication across providers. In addition, BPHC includes: direct assistance in gaining access to services; coordination of care within and across systems; oversight of the entire case; and linkage to appropriate services; needs based assessment of the eligible recipient to identify service needs; development of an individualized integrated care plan (IICP); referral and related activities to help the recipient obtain needed services; monitoring and follow-up; and evaluation.

Child Mental Health Wraparound (CMHW) Services

The §1915(i) Child Mental Health Wraparound (CMHW) Services Program is authorized through Medicaid state plan authority. The §1915(i) CMHW Services are outlined in 405 IAC 5-21.7. CMHW services provide youth with SED with intensive home and community-based wraparound services provided within a system of care (SOC) philosophy and consistent with wraparound principles. Services are intended to augment the youth's existing or recommended behavioral health treatment plan. The State's purpose for providing CMHW services is to serve eligible participants who have SED and enable them to benefit from receiving intensive wraparound services within their home and community with natural family/caregiver supports and provided sustainability of these services which were originally offered under the CMS Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) demonstration. Under the demonstration, Indiana was able to provide quicker and more seamless transition of youth from PRTF placement as well as prevent some youth from placement within a PRTF setting. The CMHW services available to the eligible participant include wraparound facilitation, habilitation, respite care, and training and support for the unpaid caregiver.

Increasing Access to Continuum of Care Including Crisis Stabilization Services

On March 18, 2019, CMS approved a state plan amendment that expands crisis intervention services, intensive outpatient program services, and peer recovery services to all Indiana Medicaid programs. Previously, these services were limited to the Medicaid Rehabilitation Option program. This change expands the potential number of providers eligible to deliver these services to Indiana enrollees. This SPA has an effective date of July 1, 2019.

This expansion of the crisis continuum specifically began in 2014. DMHA partnered with the National Alliance on Mental Illness of Indiana (NAMI Indiana), Mental Health America of Indiana (MHAI), the Indiana Hospital Association (IHA), Key Consumer, and the Indiana Council on Community Mental Health Centers (ICCMHC) to conduct a review of Indiana's mental health and substance use crisis services. The review was in response to Indiana Senate Enrolled Act No. 248 of 2014, which mandated DMHA to conduct a psychiatric crisis intervention study ("crisis study") and report the results to the legislative council by September 2015. The crisis study included a review of psychiatric and addiction crisis services available in Indiana, a survey of professionals and individuals in Indiana who have experience with the current state of Indiana's crisis response, and a review of crisis services and models implemented by other states that could improve outcomes for individuals who experience psychiatric or addiction crises.

In response to recommendations from the report, DMHA plans to pilot two Crisis Stabilization Units (CSU) in the northern and southern parts of the state. The goals for these units are to provide an alternative to crisis evaluations within emergency departments and divert admissions to inpatient psychiatric units. The state initially proposes to fund these services with Mental Health Block Grant funding. In addition to the CSUs, FSSA's OMPP, DMHA, and Division of Disability and Rehabilitative Services (DDRS) are partnering with the Department of Child

Services (DCS) and Juvenile Justice agencies to explore piloting mobile response stabilization services (MRSS), adapting a model utilized in New Jersey. MRSS would provide community-based crisis intervention including short term follow-up and support for the youth and family to prevent reescalation, emergency department utilization and/or inpatient admission.

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

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

Some of the State's CMHCs are providing the following additional crisis services:

- Mobile crisis teams
- Assertive community treatment (ACT)
- 23-hour crisis stabilization units
- Short-term crisis residential
- Peer crisis services

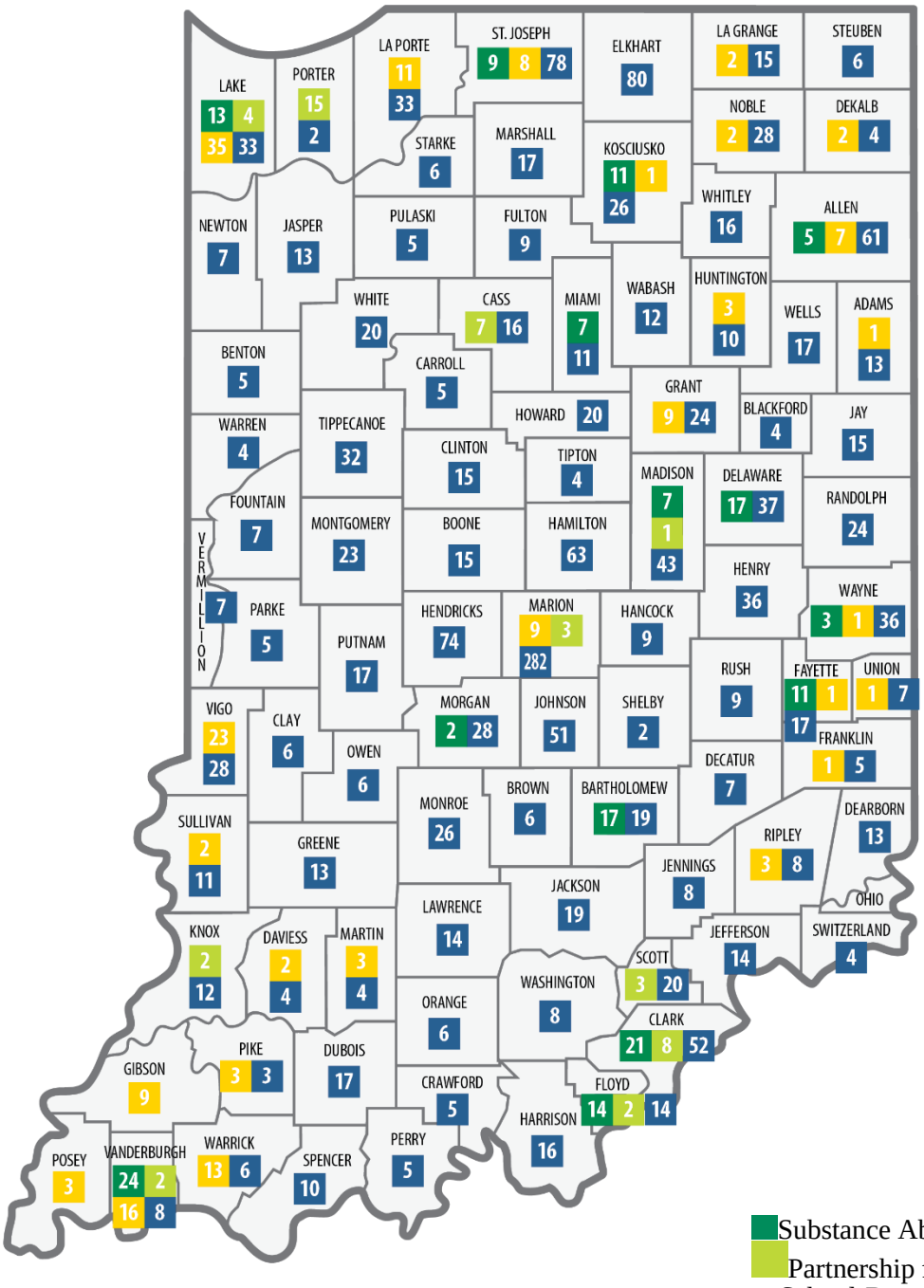
Additionally, Hoosier Care Connect MCOs, who serve the State's aged, blind and disabled Medicaid population are contractually required to ensure the availability of behavioral health crisis intervention services 24/7.

Earlier Identification and Engagement in Treatment

Indiana has expanded coverage for mental health and substance use disorder screening and referral under Medicaid. In 2014, OMPP expanded provider types eligible for reimbursement of screening and brief intervention for SUD to include midlevel licensed individuals under the supervision of a physician, including nurse practitioners (NP), health service providers in

psychology (HSPP), licensed clinical social workers (LCSW), licensed mental health counselors (LMHC), and licensed marriage and family therapists (LMFT). In October 2016, OMPP began coverage for annual depression screening. Providers are expected to use validated standardized tests for the screening. These tests include, but are not limited to, the Patient Health Questionnaire (PHQ), Beck Depression Inventory, Geriatric Depression Scale, and Edinburgh Postnatal Depression Scale (EPDS). Coverage applies to all Indiana Health Coverage Programs (IHCP) programs under Medicaid.

The State has also focused on school-based initiatives to increase behavioral health integration. Indiana Medicaid allows enrolled school corporations reimbursement for Medicaid-covered services in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Medicaid-covered IEP services include occupational, physical, speech and applied behavior analysis therapy, hearing, nursing and behavioral health evaluation and treatment services as well as IEP-required specialized transportation. In addition, CMHCs across the State work in close collaboration with Indiana schools. Currently 85% of school districts have partnerships with the CMHC in their area. Through these partnerships behavioral health staff are co-located within the schools and providing behavioral health services to youth and their families.



Substance Abuse Prevention Block Grant

Partnership for Success Grant School-Based

Child Psychiatric Services Fund

Certified Community Mental Health Center: School-Based Services

Mental health services in schools reported by CMHCs include alternative, charter, pre-K, public, non-public and private schools.

Number within box indicates the number of schools in the county with services

Additionally, the MCOs are contractually required to plan for, develop and/or enhance relationships with school-based health centers (SBHC) with the goal of providing accessible services to school-aged enrolled members. SBHCs provide on-site comprehensive preventive and primary health services including behavioral health, oral health, ancillary and enabling services.

Program Description

Demonstration Eligibility

All enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and between the ages of 21 – 64, would be eligible for acute inpatients stays in an IMD under the waiver. Only the eligibility groups outlined in Table 1 below will not be eligible for stays in an IMD as they receive limited Medicaid benefits only.

Table 1: Eligibility Groups Excluded from the Demonstration

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

Demonstration Cost Sharing

All cost-sharing for services provided through this waiver will be consistent with the Medicaid State Plan applicable to an enrollee's specific eligibility category. No modifications are proposed through this amendment.

Delivery System and Payment Rates for Services

Through this amendment, the State seeks a waiver of the IMD exclusion for all Medicaid beneficiaries ages 21-64, regardless of delivery system. No modifications to the current Indiana Medicaid fee-for-service or managed care arrangements are proposed through this amendment; all enrollees will continue to receive services through their current delivery system. Additionally, payment methodologies will be consistent with those approved in the Medicaid State Plan.

Program Evaluation

Evaluation of the impact of the IMD waiver for enrollees with SMI will be incorporated into the State's current SUD Evaluation Design. The evaluation will be submitted by June 30, 2022, in

alignment with the State's approved STCs. The State understands CMS intends to release evaluation design requirements for this initiative. Following receipt of this guidance, the State will review for applicability to Indiana's proposed approach and align where appropriate. Pending receipt of this guidance, below are draft evaluation parameters based on CMS guidance provided in Appendix B of State Medicaid Director Letter #18-011.

Table 2: Draft Evaluation Parameters

Hypothesis	Potential Measure(s)
Goal 1: Reduced utilization and lengths of stay in emergency departments (EDs) among Medicaid beneficiaries with SMI or SED while awaiting treatment in specialized settings.	
The IMD waiver will reduce ED utilization and ED boarding among beneficiaries with SMI or SED.	ED use among Medicaid beneficiaries with SMI or SED and their lengths of stay in the ED
Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings.	
The IMD waiver will reduce preventable psychiatric readmissions to acute care hospitals and residential settings.	Readmissions to inpatient psychiatric or crisis residential settings
Goal 3: Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.	
The IMD waiver will improve the availability of crisis stabilization services.	Rates of involuntary admissions to treatment settings
	Suicide or overdose death within 15 days of discharge from an inpatient facility or residential setting for treatment for an SMI or SED
Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.	
The IMD waiver will improve access to community-based behavioral health services, including through increased integration of primary and behavioral health care.	Use of first-line psychosocial care for children and adolescents on antipsychotics (NQF#2801, Child Core Set)
	Patient referral into treatment by specified care setting (school, community, criminal justice, faith communities)
	Access to preventive/ambulatory health services for Medicaid beneficiaries with SMI or SED
	Evidence of availability of community-based services and alternatives to inpatient and residential services in each geographic region of the state (e.g., maps of provider availability and provider agreements)
Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	
The IMD waiver will improve care coordination.	Medication continuation following discharge (Medicare IPF Reporting Requirement)
	Follow up after ED visit for mental illness or alcohol and other drug abuse or dependence (NQF# 2605, Adult Core Set)

Demonstration Financing and Budget Neutrality

Budget Neutrality Impact

Please refer to the attached documentation prepared by the State's actuary for a detailed analysis of the budget neutrality impact.

CHIP Allotment

This requirement is not applicable to this amendment request, as the amendment does not make any changes to the CHIP program.

Maintenance of Effort

In accordance with the November 13, 2018, CMS State Medicaid Director Letter, the State understands this waiver request is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of outpatient treatment for these conditions.

Table 3 details the SFY 2019 outpatient community-based mental health expenditures by population and stratified into federal share, state share general funding, and state share county-level funding. The populations are:

- Healthy Indiana Plan (HIP) serves most non-dual non-disabled adults, including the new adult group
- Hoosier Care Connect (HCC) serves non-dual disabled adults and children
- Hoosier Healthwise (HHW) serves most non-disabled children and pregnant women who are not eligible for HIP
- Fee-for-service (FFS): Dual eligibles (those with Medicare eligibility), members who require long term services and supports (LTSS), and those with retroactive eligibility, presumptive eligibility, or limited benefits (for example emergency services only or family planning services only) are served on a fee-for-service basis

Table 3: Outpatient Community-Based Mental Health Expenditures ($ in Millions)[i]

POPULATION	TOTAL	FEDERAL	STATE - GENERAL FUNDS	STATE - COUNTY FUNDS
HIP	$ 77.0	$ 61.5	$ 14.7	$ 0.8
HCC	98.3	64.8	27.0	6.5
HHW	140.4	101.3	30.8	8.2
FFS	169.9	112.1	45.6	12.2
Total	**$ 485.6**	**$ 339.8**	**$ 118.1**	**$ 27.8**

While the State is committed to maintaining or improving access to community-based mental health services, the following are concerns with strictly using funding data to measure MOE:

- If the State is successful in improving physical/behavioral health integration, reporting may become difficult as reimbursement for services may become intertwined.
- Movement to managed care may affect expenditures, as managed care companies may negotiate different levels of reimbursement or apply different criteria for treatment.
- If the State transitions to more value-based reimbursement, costs may decline slightly without any loss of access or quality.
- Any potential future program changes may affect expenditures.
- County and local funding does not necessarily fall under the purview of the State.

During previous technical assistance discussions between CMS and FSSA, CMS has indicated the possibility of using other measures to ensure consistent, ongoing effort on behalf of the State. While this amendment request provides funding data to meet CMS' current MOE requirement, in light of the concerns outlined above, we look forward to continued conversation about feasible alternatives. We offer two suggestions below:

1. Maintaining the **number** of outpatient mental health **recipients** (i.e., those who do not also receive institutional mental health care) during the state fiscal year.
2. Maintaining the **percentage** of mental health service **recipients** who only receive community-based services (again, those who do not receive institutional mental health care).

Given the potential for future cost uncertainty to result in a *perceived* decline in effort, a recipient-based methodology may be a more accurate indication of MOE. We would be happy to discuss with CMS and continue collaborating on the development of a mutually satisfactory MOE measure.

Requested Waivers & Expenditure Authorities

The State requests expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD. No additional waivers of Title XIX or Title XXI are requested through this amendment application.

Public and Tribal Notice

In accordance with 42 CFR §431.408, the public had an opportunity to comment on this waiver amendment through a public notice and comment period that ran from July 24, 2019 through August 23, 2019. The public notice and all waiver documents were posted on the FSSA website and made available for review at the FSSA offices. An abbreviated notice was also published on July 24, 2019 in the State's administrative record, the Indiana Register. Additionally, FSSA sent email notification regarding the amendment to stakeholders via DMHA and OMPP list servs. Finally, the State held two public hearings on July 30, 2019 (Medical Care Advisory Committee that operates in accordance with 42 CFR §431.12) and July 31, 2019 (open forum for interested

parties to learn about the contents of the application and to comment on its content). Statewide accessibility was assured through web conference capabilities at the MAC meeting.

Summary of Public Comments

Six comments regarding the amendment were received at the MAC meeting. All four of the State's MCOs spoke regarding their support of the amendment indicating this will increase access to critical behavioral health services. Additionally, the Indiana Hospital Association and Mental Health America of Indiana also provided their support.

The Arc of Indiana spoke at the second public hearing. They discussed the importance of educating behavioral health providers that they "are allowed to treat people who also have an intellectual development disability." Further, they wanted to ensure programmatic changes did not unintentionally cause an individual to have to choose between treating mental illness and addressing their developmental disability. They also discussed the importance of addressing mental health issues before they become a crisis and ensuring adequate provider capacity.

Four written comments were also received. A letter was submitted on behalf of several UHS of Delaware, Inc. operated hospitals that would be directly impacted by the amendment, including: Bloomington Meadows Hospital, Michiana Behavioral Health Center, Valle Vista Health System, and Wellstone Regional Hospital. UHS indicated full support for the amendment, indicating it would facilitate greater access to acute inpatient services. They noted the importance of establishing clear service definitions and ensuring consistent application of prior authorization requirements across payors (i.e., fee-for-service and the State's four MCOs). Additionally, CareSource voiced support via written comment, indicating they are committed to working with the State, providers and community partners to connect patients to care in the most appropriate setting. Further, the National Alliance on Mental Illness (NAMI) Indiana expressed support for the waiver application, indicating it would address key gaps in coverage for essential behavioral health services. However, they expressed concerns that HIP's Gateway to Work program, cost sharing requirements and lock out policies will have unintended consequences for enrollees with mental illness and impact their ability to access IMD services. The final written comment was received from Options Behavioral Health Systems, which provided its "full support" of the waiver and indicated it will expand access to services and "reduce bounce back" to hospitals.

Response to Comments Received

The State appreciates the commenter's support of the waiver amendment. Comments related to the Healthy Indiana Plan policies are taken under consideration but are out of the scope of this amendment. No modifications were made to the waiver in response in regard to this comment. In response to the comment received regarding operational considerations, as FSSA works with its MCOs and utilization management vendor on implementation of the waiver, it will ensure efforts are undertaken to assure consistency in application of prior authorization guidelines and service definitions.

Tribal Notice

In accordance with 42 CFR §431.408, notice of the waiver amendment was provided to Indiana's federally recognized tribe, the Pokagon Band of Potawatomi Indians, on June 28, 2019. The State received no comment in response.

Appendix 1: Public Notice

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION

Notice of Public Comment Period to Reimburse Short Term Stays in an Institution for Mental Disease

Pursuant to 42 CFR § 431.408, notice is hereby given that the Indiana Family and Social Services Administration (FSSA) will provide the public the opportunity to review and provide input on a proposed amendment to the State's Section 1115 demonstration waiver. This notice provides details about the waiver amendment submission and serves to open the 30-day public comment period, which closes on August 23, 2019.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the FSSA via US postal service or email, the FSSA will host two hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

1) **Tuesday, July 30, 2019**
   Indiana State Government Center South
   Conference Room C
   302 West Washington St.
   Indianapolis, IN 46204
   10:00 a.m. – 12:00 p.m. EST
   Webcast available at https://indiana.adobeconnect.com/hearing/

2) **Wednesday, July 31, 2019**
   Indiana State Library
   Author's Room
   315 West Ohio St.
   Indianapolis, IN 46202
   8:30 a.m. – 11:30 a.m. EST

Prior to finalizing the proposed waiver amendment, the FSSA will consider all written and verbal public comments received. The comments will be summarized and addressed in the final draft of the waiver amendment to be submitted to the Centers for Medicare and Medicaid Services (CMS).

AMENDMENT PROPOSAL SUMMARY

Through this amendment, FSSA is seeking federal authority to reimburse for acute inpatient stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbances (SED). This request is part of broader efforts

within the FSSA to ensure a comprehensive continuum of behavioral health services and is intended to improve access to acute care for Medicaid enrollees with SMI and SED. The proposed effective date of the amendment is January 1, 2020, pending CMS approval.

GOALS AND OBJECTIVES

In pursuing this waiver amendment, FSSA seeks to achieve the following goals:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

ELIGIBILITY

All Medicaid enrollees ages 21-64, eligible for full Medicaid benefits, and with a diagnosed SMI or SED requiring an acute, inpatient level of care would be eligible for short term stays in an IMD under this waiver amendment.

ENROLLMENT & FISCAL PROJECTIONS

The waiver amendment will have no impact on annual Medicaid enrollment. Further, it is expected to be budget neutral as outlined in the table below.

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2019	**2020**	**2021**	**2022**	**2023**	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$2,588,542	$2,742,539	$2,905,687	$3,078,544	$3,261,682	$14,576,993
IMD Services MEG 2 (Fee-for-Service Residential)	$282,517	$299,324	$317,131	$335,997	$355,986	$1,590,954
IMD Services MEG 3 (Managed Care)	$7,851,066	$8,318,142	$8,812,953	$9,337,255	$9,892,704	$44,212,120
TOTAL	$10,722,125	$11,360,005	$12,035,771	$12,751,795	$13,510,372	$60,380,068

With-Waiver Total Expenditures

	2019	2020	2021	2022	2023	TOTAL
IMD Services MEG 1 (Fee-for-Service Inpatient)	$2,588,542	$2,742,539	$2,905,687	$3,078,544	$3,261,682	$14,576,993
IMD Services MEG 2 (Fee-for-Service Residential)	$282,517	$299,324	$317,131	$335,997	$355,986	$1,590,954
IMD Services MEG 3 (Managed Care)	$7,851,066	$8,318,142	$8,812,953	$9,337,255	$9,892,704	$44,212,120
TOTAL	$10,722,125	$11,360,005	$12,035,771	$12,751,795	$13,510,372	$60,380,068
Net Overspend	$0	$0	$0	$0	$0	**$0**

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

No modifications to the current Indiana Medicaid fee-for-service or managed care arrangements are proposed through this amendment; all enrollees will continue to receive services through their current delivery system. Additionally, this amendment does not propose any changes in the cost sharing requirements for any enrollees.

HYPOTHESES & EVALUATION

The State proposes to align its evaluation design with forthcoming CMS requirements. Pending receipt of this guidance, below are draft evaluation parameters.

Hypothesis	Potential Measure(s)
Goal 1: Reduced utilization and lengths of stay in emergency departments (EDs) among Medicaid beneficiaries with SMI or SED while awaiting treatment in specialized settings.	
The IMD waiver will reduce ED utilization and ED boarding among beneficiaries with SMI or SED.	ED use among Medicaid beneficiaries with SMI or SED and their lengths of stay in the ED
Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings.	
The IMD waiver will reduce preventable psychiatric readmissions to acute care hospitals and residential settings.	Readmissions to inpatient psychiatric or crisis residential settings
Goal 3: Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.	
The IMD waiver will improve the availability of crisis stabilization services.	Rates of involuntary admissions to treatment settings
	Suicide or overdose death within 15 days of discharge from an inpatient facility or residential setting for treatment for an SMI or SED
Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.	

Hypothesis	Potential Measure(s)
The IMD waiver will improve access to community-based behavioral health services, including through increased integration of primary and behavioral health care.	Use of first-line psychosocial care for children and adolescents on antipsychotics (NQF#2801, Child Core Set)
	Patient referral into treatment by specified care setting (school, community, criminal justice, faith communities)
	Access to preventive/ambulatory health services for Medicaid beneficiaries with SMI or SED
	Evidence of availability of community-based services and alternatives to inpatient and residential services in each geographic region of the state (e.g., maps of provider availability and provider agreements)
Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	
The IMD waiver will improve care coordination.	Medication continuation following discharge (Medicare IPF Reporting Requirement)
	Follow up after ED visit for mental illness or alcohol and other drug abuse or dependence (NQF# 2605, Adult Core Set)

WAIVER & EXPENDITURE AUTHORITY

Through this amendment, the State is requesting expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD. No additional waivers of Title XIX or Title XXI are requested through this amendment application.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the submission, including the public notice, the waiver amendment, and other documentation regarding the proposal are available for public review at the FSSA, Office of Medicaid Policy and Planning, 402 W. Washington Street, Room W374, Indianapolis, Indiana 46204. These documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments regarding the waiver amendment will be accepted through 5:00 pm on August 23, 2019, and may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Gabrielle Koenig or via email at spacomment@fssa.IN.gov.

Jennifer Walthall, M.D., MPH
Secretary
Family and Social Services Administration

Appendix 2: Abbreviated Public Notice

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF PUBLIC HEARING

In accordance with 42 CFR §431.408, the Indiana Family and Social Services Administration (FSSA) will be holding public hearings on its Section 1115 demonstration waiver amendment that will be submitted to the Centers for Medicare and Medicaid Services (CMS). Through this amendment, FSSA is seeking federal authority to reimburse for acute inpatient stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbances (SED). This request is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and is intended to improve access to acute care for Medicaid enrollees with SMI and SED. The proposed effective date of the amendment is January 1, 2020, pending CMS approval.

Hearings will be held as follows:

3) **Tuesday, July 30, 2019**
   Indiana State Government Center South
   Conference Room C
   302 West Washington St.
   Indianapolis, IN 46204
   10:00 a.m. – 12:00 p.m. EST
   Webcast available at https://indiana.adobeconnect.com/hearing/
4) **Wednesday, July 31, 2019**
   Indiana State Library
   Author's Room
   315 West Ohio St.
   Indianapolis, IN 46202
   8:30 a.m. – 11:30 a.m. EST

All information regarding the submission, including the public notice, the waiver amendment, and other documentation regarding the proposal are available for public review at the FSSA, Office of Medicaid Policy and Planning, 402 W. Washington Street, Room W374, Indianapolis, Indiana 46204. These documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments regarding the waiver amendment will be accepted through 5:00 pm on August 23, 2019, and may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Gabrielle Koenig or via email at spacomment@fssa.IN.gov.

Jennifer Walthall, M.D., MPH
Secretary
Family and Social Services Administration

Appendix 3: Tribal Notice

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF TRIBAL COMMENT PERIOD TO REIMBURSE SHORT TERM STAYS IN AN INSTITUTION FOR MENTAL DISEASE

In accordance with 42 CFR § 431.408(b), notice is hereby given to the Pokagon Band of the Potawatomi that the Indiana Family and Social Services Administration (FSSA) will be submitting an amendment to the State's Section 1115 demonstration waiver to the Centers for Medicare and Medicaid Services (CMS).

This notice also serves to open the **30-day tribal comment period, which closes July 29, 2019 at 5:00 pm.**

AMENDMENT PROPOSAL SUMMARY

Through this amendment, FSSA is seeking federal authority to reimburse for acute inpatient stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED). This request is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and is intended to improve access to acute care for Medicaid enrollees with SMI and SED. The proposed effective date of the amendment is January 1, 2020, pending CMS approval.

GOALS AND OBJECTIVES

In pursuing this waiver amendment, FSSA seeks to achieve the following goals:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

TRIBAL IMPACT

Members of the Pokagon Band of the Potawatomi located in Indiana and enrolled in full Medicaid benefits will have access to acute inpatient stays in an IMD. Currently, Medicaid is prohibited from reimbursing for psychiatric stays in an IMD for individuals ages 21-64. No modifications to the current Indiana Medicaid fee-for-service or managed care arrangements are proposed through this amendment; all enrollees will continue to receive services through their

current delivery system. Additionally, this amendment does not propose any changes in the cost sharing requirements for any enrollees.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Gabrielle Koenig or via electronic mail at gabrielle.koenig@fssa.in.gov **through July 29, 2019**. Additionally, we would be happy to schedule a phone or in-person consultation to discuss the program in further detail.

Appendix 4: Budget Neutrality Documentation

MILLIMAN CLIENT REPORT

1115 Waiver – Healthy Indiana Plan

Budget Neutrality

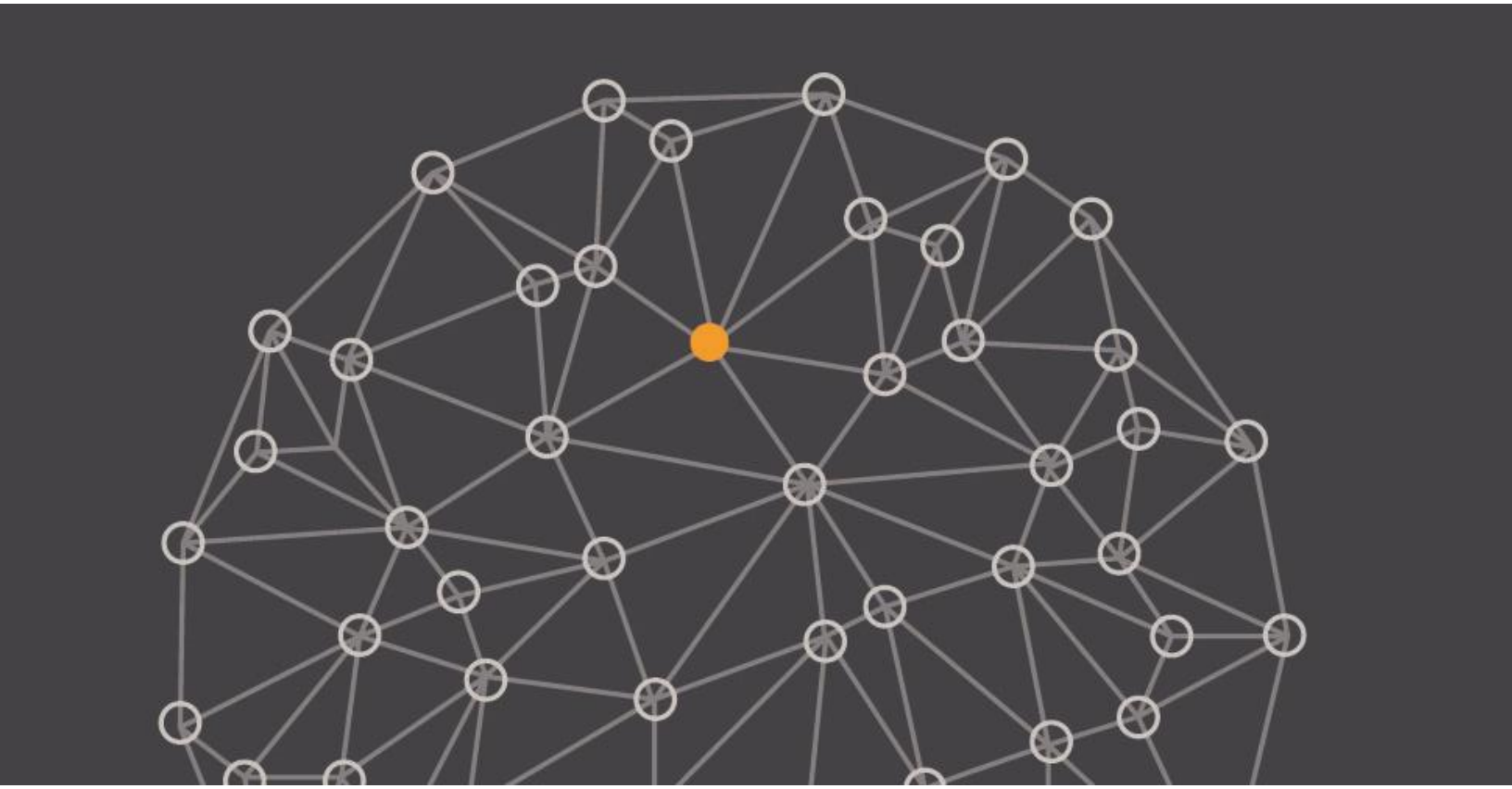
Expenditure authority for members with a substance use disorder or serious mental illness

Draft

State of Indiana

Family and Social Services Administration

Andrew Dilworth, FSA, MAAA
Renata Ringo, FSA, MAAA
Christine Mytelka, FSA, MAAA



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BACKGROUND

The state of Indiana's current 1115 Healthy Indiana Plan (HIP) waiver, No. 11-W-00296/5, requests expenditure authority for adults who receive Substance Use Disorder (SUD) services delivered in an Institution for Mental Disease (IMD). Budget neutrality documentation for this Medicaid Eligibility Group (MEG) was provided in a report titled "*22-1115 Waiver Renewal – IMD only.pdf*" dated January 21, 2018.

The MEG for the currently approved 1115 waiver is described below:

1. **SUD IMD**:
    a. Inpatient services: all member months for an adult aged 21-64, receiving services described by the American Society of Addiction Medicine (ASAM) criteria as occurring in Level 4.0 settings for up to 15 days,
    b. Residential services: all member months for any individual receiving services described by the ASAM criteria as occurring in Level 3.1 or 3.5 settings, limited to an average length of 30 days

Based on the CMS letter[3] to State Medicaid Directors dated November 13, 2018, the state wishes to revise the waiver to include Serious Mental Illness (SMI) services as well. The remainder of this report details the budget neutrality projections for this proposed waiver amendment.

EXECUTIVE SUMMARY

This report has been developed for the state of Indiana, Family and Social Services Association (FSSA) to document budget neutrality projections for the HIP 1115 waiver amendment.

The current waiver has been approved for the period February 1, 2018 through December 31, 2020. These projections reflect the state's intention to transition from one MEG to three, effective January 1, 2020.

Indiana had previously demonstrated budget neutrality for a single SUD IMD MEG, as described in the "Background" section above. In subsequent discussions with CMS, a preference was indicated for separating out managed care and fee-for-service (FFS) into two MEGs. In addition, an analysis of expenditures showed significant variation between the location of care for the FFS recipients. Managed care recipients did not exhibit the same variation, as the majority of their relevant expenditures pertain to the capitation rate, which does not vary by care setting for these individuals.

The proposed MEGs are:

1. **FFS intensive inpatient** – FFS member months for an adult aged 21-64 with a SUD or SMI intensive inpatient stay (ASAM level 4.0)
2. **FFS residential treatment** – FFS member months for an individual of any age with a SUD or SMI residential treatment (ASAM level 3.1 to 3.5)
3. **Managed care** – managed care member months for an adult aged 21-64 with a SUD or SMI intensive inpatient stay or an individual with a SUD or SMI residential treatment (ASAM level 3.1 to 4.0)

The state has chosen not to avail itself of the in lieu of authority for managed care under 42 CFR 438.6(e). As under the current waiver, 1115 expenditure authority is requested for costs associated with all allowable IMD admissions, for one day stays through 15 days for intensive inpatient admissions, and from one day up to an average length of 30 days for residential treatment.

We summarized CY 2018 expenditures for each proposed population described above, including all Medicaid-funded expenses. For the managed care group, this includes capitation payments plus any carved out services administered under the FFS delivery system.

For purposes of completing the budget neutrality template provided by CMS, we populated a placeholder assumption of 4.9% for the president's budget trend and a 1.0% enrollment trend rate for each MEG. However, it is our understanding that since the "IMD Without Waiver" and "IMD With Waiver" calculations are the same in the template, the CY 2018 PMPM values for each MEG are the primary information desired. This is also consistent with guidance communicated by CMS in various phone calls.

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

Refer to the Excel file named "*02-SMI IMD Budget Neutrality Template.xlsx*" included with the delivery of this report to see the completed budget neutrality template. The remainder of this report details the data and methodology used to populate the template.

DATA, ASSUMPTIONS, AND METHODOLOGY

DATA

CY 2018 member months and expenditures were developed based on enrollment, capitation payment, and claims data reported through the state of Indiana's Enterprise Data Warehouse (EDW), and originally provided by the fiscal agent. Enrollment and expenditure data reflects services reported as of June 30, 2019.

METHODOLOGY AND ASSUMPTIONS

The methodology used to determine the CY 2018 member months and expenditures is described below:

Fee-for-service methodology

FFS member months represent those individuals receiving residential treatment or intensive inpatient services in an IMD. Residential treatment was determined by procedure code, either H0010 or H2034. Intensive inpatient recipients were identified according to the IMD provider IDs included in Figure 1 below, and limited to adults ages 21-64. Individuals were accordingly assigned to either the residential treatment or intensive inpatient MEG. In the case where a recipient had both types of services in the same month, they were assigned to the intensive inpatient MEG.

FIGURE 1: INSTITUTIONS FOR MENTAL DISEASE (IMD) – INDIANA HEALTH COVERAGE PROGRAM

Billing Provider ID*	Provider Name
100273400	Valle Vista Health System
100273450	Fairbanks Hospital
100273680	Bloomington Meadows Hospital
200029610	Northern Indiana Hospital, Plymouth
200240620	Deaconess Cross Pointe, Evansville
200484350	Michiana Behavioral Health
200813230	Wellstone Regional Hospital
200903750	Harsha Behavioral Center Inc
200968000	Brentwood Meadows LLC
201050770	Options Behavioral Health System
201110540	Sycamore Springs LLC
201292260	Assurance Health Psychiatric Hospital

*AIM billing provider ID. In CORE, a location code may be appended.

Once the eligible recipient-months were identified as described above, we calculated all of their FFS expenditures for those months in which they received residential treatment or intensive inpatient services. We included all expenditures, not just the applicable SUD/SMI expenditures, because without the waiver these members would not be eligible for Medicaid during months in which they received treatment in an IMD.

Managed care methodology

Managed care member months were identified in the same manner as FFS. The only distinction is that there is only one managed care MEG for residential treatment and intensive inpatient services combined.

Once the eligible recipient-months were identified as described above, we summarized all expenditures for those months in which they received residential treatment or intensive inpatient services. Again, we included all expenditures, not just the applicable SUD/SMI expenditures, because without the waiver these members would not be eligible.

The expenditures for the managed care recipients consist of two components: capitation payments and services administered under the FFS delivery system.

Capitation payments

Capitation payments were calculated for each member based on their managed care rate cell. The capitation rates currently included in the EDW do not correspond to the latest CY 2018 capitation rates that will ultimately be paid. As such, we adjusted the capitation payments to include the impact of CY 2018 rate amendments that are not yet reflected in the EDW.

When reviewing these expenses by the setting of care, we confirmed there was no major variation according to whether an individual was treated in a residential or inpatient setting, unlike FFS. Since the capitation payments represent the significant majority of expenses for these individuals, this was the rationale for our decision to only include one managed care MEG.

Services administered under FFS

While capitation payments represent the bulk of expenditures for the managed care population, there are some services carved out of managed care that are administered via the FFS delivery system that also must be included. Examples of these carve-outs include some high-cost drugs, such as Hepatitis C therapies, and Medicaid Rehabilitation Option (MRO). The carved out claims expenditures for the applicable member months were added to the capitation payments to reflect the comprehensive total cost for this MEG.

Hospital presumptive eligibility

As of January 1, 2019, hospital presumptive eligibility (PE) members began enrolling in FFS, rather than managed care. Due to this program change, there will be a significant shift in enrollment and expenditures from the managed care MEG to FFS in CY 2019. Given the emphasis on the CY 2018 starting point only, we have summarized the PE experience as is, but we did wish to note this upcoming change for future waiver reporting.

Limitations

The information contained in this report has been prepared for the state of Indiana, Family and Social Services Administration (FSSA) to assist with the development of budget neutrality for the HIP 1115 waiver amendment to be submitted to the Centers for Medicaid and Medicare Services (CMS). The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this correspondence is provided to any third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for FSSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the state of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and FSSA approved December 5, 2018.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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[i] **DATA**

SFY 2019 maintenance of effort expenditures were developed based on enrollment and fee-for-service claims data reported through the state of Indiana's Enterprise Data Warehouse (EDW) and originally provided by the fiscal agent. Enrollment and claims data reflects services reported as of June 30, 2019.

In addition, managed care capitation rates for CY 2018 and CY 2019 were also referenced. The enrollment and claims data used in the development of the capitation rates was also from the state's EDW, reported as of January 1, 2018 and September 30, 2018, respectively.

HIP manual MRO expenditures were provided to Milliman by FSSA. Similarly, aggregate county-level MRO funding was also provided by FSSA.

METHODOLOGY AND ASSUMPTIONS

The methodology used to determine the SFY 2019 maintenance of effort expenditures is described below:

Fee-for-service population

Outpatient mental health expenditures for the FFS population reflect the following two categories of service:

1. Medicaid Rehabilitation Option (MRO), and
2. Other Mental Health services (MHO)

These FFS expenditures are labeled as category of service 2610 or 2620.

Total expenditures on a paid basis were then split into federal and state shares according to the FMAP for each subpopulation, e.g., standard FMAP or CHIP.

Managed care populations

Outpatient mental health expenditures for the managed care populations consist of two components: capitation payments and services administered under the FFS delivery system.

Capitation payments

First, the portion of the capitation rates attributable to outpatient mental health was determined for each managed care rate cell. This was done separately for the January through July 2018, August through December 2018, and CY 2019 rates. The applicable monthly benefit costs were then multiplied by the July 2018 through June 2019 managed care member months from the EDW, reported through June 30, 2019.

The resulting total expenditures were then split into federal and state shares according to the applicable FMAP for each rate cell, e.g., standard, CHIP, or expansion.

Note that the capitation rates used in the outpatient mental health benefit cost calculations do not correspond to the capitation payments currently included in the EDW, but rather reflect the capitation rates expected to ultimately be paid for these time periods.

Services administered under FFS

In addition to capitation payments, there are some services carved out of managed care that are administered via the FFS delivery system that also must be included for the managed care populations.

Similar to the FFS population described above, the managed care populations include expenditures for the following two categories of service:

1. Medicaid Rehabilitation Option (MRO), and
2. Other Mental Health services (MHO)

Furthermore, the Healthy Indiana Plan (HIP) population includes manual MRO payments for which the state bore 100% responsibility. These expenditures represent approximately $6.2 million of the total state share in SFY 2019, and were provided by FSSA.

County-level funding allocation

FSSA also determined that $27.8 million of MRO expenditures in SFY 2019 were funded from outside of the general state allocation. That is, county and local level funding accounts for $27.8 million of the MRO state share. This amount was allocated to each population based on the proportion of state MRO expenditures in each population. State general funding and the county-level funds in the overall state share are split out separately to further illustrate the portion over which FSSA can exert control.

Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

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Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

> ***State Response:*** **In accordance with Indiana's approved Medicaid State Plan, the Office of the Secretary of the Family and Social Services Administration (FSSA) is the single state agency. The Division of Mental Health and Addiction (DMHA) is within the FSSA; therefore, no MOU is applicable to this waiver request.**

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Kelly Flynn
Director Policy and Program Development Section, Indiana Medicaid
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1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Indiana*
Demonstration name	*Healthy Indiana Plan – Project Number 11-W-00296/5*
Approval date	*TBD – Amendment submitted August 30, 2019*
Approval period	*January 1, 2020 – December 31, 2020*
Implementation date	*January 1, 2020*

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2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *Through these section 1115 SMI/SED demonstrations, FFP is only available for services provided to beneficiaries during short term stays for acute care in IMDs (See top of p. 12 in the State Medicaid Director Letter (SMDL). As part of their implementation plan, states should propose to CMS how they are defining a short term acute stay in an IMD for purposes of these demonstrations. This definition should include a length of stay (e.g., up to 60 days) that will enable the state to demonstrate that FFP is only being claimed for services provided to beneficiaries during short term stays for acute care and the statewide average length of stay meets the expectation of 30 days (stated at the bottom of p. 12 in the SMDL). States may not claim FFP for services provided to beneficiaries who require long lengths of stay beyond a short term stay for acute care as defined by the state. However, states should provide coverage of services during longer stays in these settings for those beneficiaries who need them, but with other sources of funding than FFP. States should avoid imposing a hard cap or limit on coverage of services provided to beneficiaries residing in IMDs which may not be in compliance with federal parity requirements.* *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	

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Prompts	Summary
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status:* In accordance with Indiana Administrative Code (440 IAC 1.5), all free-standing psychiatric hospitals must be licensed as a private mental health institution (PMHI)[1] by the Indiana Division of Mental Health and Addiction (DMHA). PMHI licensure must be renewed annually. Additionally, all entities must be accredited by an agency approved by DMHA, which currently include the following: • National Committee for Quality Assurance (NCQA) • CARF – The Rehabilitation Accreditation Commission • Joint Commission on Accreditation of Healthcare Organizations (JCAHO) The following general components are required for licensure: • A governing board • Medical or professional staff organization • A quality assessment and improvement program • Dietetic service • Infection control program • Medical record services • Nursing service • Physical plan, maintenance and environmental services • Intake and treatment services • Discharge planning services • Pharmacy services • A plan for special procedures An entity seeking a license as a PMHI must file an application with DMHA which includes, at minimum: • A description of the organizational structure and mission of the applicant • The location of all operational sites of the applicant • The consumer population to be served and program focus • A list of governing board members and executive staff

[1] Defined as an inpatient hospital setting, including inpatient and outpatient services provided in that setting, for the treatment and care of individuals with psychiatric disorders or chronic addictive disorders, or both, that is physically, organizationally, and programmatically independent of any hospital or health facility licensed by the Indiana State Department of Health.

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	• A copy of the applicant's procedures to ensure protection of consumer rights and confidentiality • Written evidence of an onsite review and inspection by the Indiana Department of Health and Department of Homeland Security Division of Fire and Building Safety and the correction of any deficiencies identified • Proof of accreditation including site survey recommendations from the accrediting agency and the applicant's response to such recommendations To maintain licensure, a PMHI must meet the following conditions: • Maintain accreditation from a DMHA approved accrediting agency • Maintain compliance with required health, building, fire and safety codes as prescribed by federal, state and local law • Have written policies and enforce these policies to support and protect the fundamental human, civil, constitutional and statutory rights of each consumer • Comply with requirements for providing, posting and documenting consumer statement of rights under Indiana Code 12-27 • Respond to complaints from the consumer service line in a timely manner
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A –milestone requirements already met.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* DMHA currently conducts annual unannounced site visits of each PMHI. Site visits are conducted using a checklist which crosswalks with all licensure requirements.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A –milestone requirements already met.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and	*Current Status:* In accordance with 405 IAC 5-3-13, all inpatient psychiatric, substance abuse and rehabilitation admissions require prior authorization to ensure the appropriate level of care. Medical necessity reviews are completed by Indiana's managed care organizations (MCOs) and the State's fee-for-service prior authorization (PA) entity, based on the individual's enrollment. The PA entity utilizes Milliman Care

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Prompts	Summary
types of care and to provide oversight on lengths of stay	Guidelines and OMPP reviews the MCO's UM practices; effective 7/1/19 all entities will utilize Milliman Care Guidelines. As described in the Indiana Medicaid Medical Policy Manual, acute psychiatric inpatient admissions are available for enrollees with a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following: • Danger to the individual • Danger to others • Death of the individual Reimbursement is available for inpatient care only when the need for admission has been certified. Emergency and nonemergency admissions require telephonic precertification review. The precertification review must be followed by a written certification of need through completion of State Form 44697 – Certification of the Need for Inpatient Psychiatric Hospital Services (1216A form) along with a written plan of care. This form documents the enrollee's: • Psychiatric and medical evaluation • Functional capacity • Prognoses • Recommendations • Certification by an interdisciplinary team that based upon physical, mental and social evaluations the individual requires inpatient psychiatric treatment and available alternative community resources do not meet the patient's mental health care needs All requests for PA are reviewed on a case-by-case basis. The MCO or PA entity reviews each State Form 44697 to determine whether the requested acute inpatient services meet medical necessity. Reimbursement is denied for any days the facility cannot justify a need for inpatient care. If the provider fails to complete a telephone PA precertification, reimbursement will be denied from the admission to the actual date of notification. Additionally, in accordance with 440 IAC 1.5-3-9, all PMHIs must have policies and procedures that govern the intake and assessment process to determine eligibility for services. Each admitted Medicaid enrollee must

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Prompts	Summary
	have a preliminary treatment plan formulated within 60 hours of admission on the basis of the intake assessment at admission, which must specify the services necessary to meet the consumer's needs and contain discharge or release criteria and the discharge plan. Further, progress notes must be entered daily and the consumer's treatment plan must be reviewed at least every seven days.
	Future Status: OMPP will develop a report to monitor average length of stay (ALOS) for all Medicaid programs. All reporting will follow CMS monitoring guidance. Additionally, OMPP will review timeline requirements for submission of the 1216A form.
	Summary of Actions Needed: The Quality and Outcomes section of OMPP, in coordination with the evaluation vendor and MCOs, will develop reporting specifications to implement monitoring by 1/1/2020. OMPP will make necessary updates to the provider manuals to reflect any changes by 1/1/2020.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* In order to receive reimbursement under Medicaid, participating psychiatric hospitals must be enrolled to participate in Indiana Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. As MCOs have been reimbursing IMDs as an in lieu of service and are only permitted to contract with Indiana Medicaid screened and enrolled providers, the State is currently screening and revalidating this provider type.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A –milestone requirements already met.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* Indiana Administrative Code (440 IAC 1.5-3-9) details a series of required policies and procedures for intake and assessment processes. This includes, but is not limited to completion of the following assessments: • Physical examination by a licensed physician, advance practice nurse or physician's assistant • Emotional, behavioral, social and legal assessment Compliance with these requirements, including screening for SUD, is reviewed during annual site reviews conducted by the DMHA.
	Future Status: Compliance will continue to be monitored via the annual unannounced site visits of hospitals as part of their recertification.
	Summary of Actions Needed: N/A –milestone requirements already met.

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Prompts	Summary
1.f Describe the state's approach to defining a 'short term stay for acute care in an IMD', as described above and as referenced in the SMDL (page 12).	Current available data regarding managed care beneficiary stays in an IMD through the in-lieu of service authority indicates an average length of stay of less than 15 days. Additionally, the State is proposing to utilize this waiver authority solely for acute inpatient stays in an IMD for individuals with SMI, and will not extend reimbursement to IMDs for residential stays. Therefore, a short term stay in an IMD for purposes of this demonstration will be defined as 15 days. The State is not proposing to impose a "hard stop" on approved lengths of stay. Rather, stays will be approved based on medical necessity. It is anticipated a minority of enrollees may meet medical necessity for acute inpatient stays longer than 15 days; for example, pending transfer to a state operated facility. However, as evidenced by the current managed care data, the 15 day length of stay appears appropriate for the majority of enrollees and will permit the State to meet an average statewide length of stay in accordance with CMS requirements.
1.g Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* DMHA conducts the Mental Health Statistical Improvement Project Survey for Adults and Youth (MHSIP), an annual consumer satisfaction surveys for all individuals who have been served by DMHA contracted providers. In addition, the MCOs conduct annual consumer assessment of healthcare providers and systems (CAHPS) surveys which provide insight into the consumer experience with their healthcare providers. Findings from these surveys are utilized in quality assurance and improvement activities as needed.
	Future Status: Continued operation of current consumer satisfaction surveys.
	Summary of Actions Needed: N/A –milestone requirements already met.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status:* Indiana Administrative Code (440 IAC 1.5-3-10) outlines minimum requirements for discharge planning. Hospitals are required to initiate discharge planning at admission that includes the following: • Facilitates the provision of follow-up care. • Transfers or refers consumers, along with necessary medical information and records, to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care. Required minimum information to be transferred includes: o Medical history o Current medications o Available social, psychological and educational services

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Prompts	Summary
	o Nutritional needs o Outpatient service needs o Follow-up care needs Additionally, in accordance with the Indiana Medicaid Medical Policy Manual, all plans of care must document a post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the member's community to ensure continuity of care when the patient returns to his or her family and community upon discharge. Community mental health centers (CMHCs) are required, as codified in Indiana Administrative Code (440 IAC 9-2-4), to be involved in the planning of treatment for and the discharge of consumers during the time a consumer is in inpatient care, to maintain continuity of care. Additionally, MCOs are contractually required to provide case management services for any member discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 calendar days following discharge. MCO contracts also require case managers to contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization and must schedule an outpatient follow-up appointment to occur no later than seven calendar days following the inpatient behavioral health hospitalization discharge. If a member misses an outpatient follow-up or continuing treatment, the MCO is contractually required to ensure that a behavioral health care provider or the MCO's behavioral health case manager contacts that member within three business days of notification of the missed appointment.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A –milestone requirements already met.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* MCOs are contractually required to provide case management services for any member at risk for or discharged from an inpatient psychiatric or substance abuse hospitalization. Case managers must contact members during an inpatient hospitalization and as a component of case management, must make every effort to assist members in navigating community resources and linking members with community based services such as Connect2Help211, food pantries, housing and housing supports, legal, employment and disaster services.

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	Additionally, CMHCs are required, in accordance with IAC 440 IAC 9-2-10, as a component of case management, to provide advocacy and referral including helping individuals access entitlement and other services, such as Medicaid, housing, food stamps, educational services, recovery groups, and vocational services.
	Future Status: Indiana Medicaid Provider Manual will be updated to explicitly require psychiatric hospitals have protocols in place to assess for housing insecurity as part of the social work assessment and discharge planning processes and to refer to appropriate resources. Compliance will be monitored via the annual unannounced site visits of hospitals as part of their recertification. Post-discharge follow-up will continue to be provided by MCOs and providers eligible to deliver case management services.
	Summary of Actions Needed: Provider Manual will be updated by OMPP by 1/1/2020. The State will issue provider communication materials detailing the requirements concurrent with the change in the Manual.
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* MCOs currently undertake the primary responsibility for assuring enrollees access follow-up care post-discharge. They are contractually required to schedule an outpatient follow-up appointment to occur no later than seven calendar days following an inpatient behavioral health hospitalization discharge. If a member misses an outpatient follow-up appointment, the MCO must ensure that a behavioral health provider or the MCO's case manager contacts that member within three business days of notification of the missed appointment. Additionally, Indiana Medicaid provides coverage for bridge appointments, which are follow-up appointments after inpatient hospitalization for behavioral health issues, when no outpatient appointment is available within seven days of discharge. The goal of the bridge appointment is to provide proper discharge planning while establishing a connection between the member and the outpatient treatment provider. During the bridge appointment, the provider ensures, at minimum, the following: • The member understands the medication treatment regimen as prescribed. • The member has ongoing outpatient care. • The family understands the discharge instructions for the member. • Barriers to continuing care are addressed. • Any additional questions from the member or family are answered.
	Future Status: Indiana Medicaid Provider Manual will be updated to explicitly require psychiatric hospitals have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary

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	within 72 hours of discharge and follow-up care is accessed. Compliance will be monitored via the annual unannounced site visits of hospitals as part of their recertification.
	Summary of Actions Needed: Provider Manual will be updated by OMPP by 1/1/2020. The State will issue provider communication materials detailing the requirements concurrent with the change in the Manual.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* MCOs are required to identify high utilizers of ED services and ensure members are coordinated and participating in the appropriate disease management or care management services. Any member with ED utilizations at least three standard deviations from the mean are referred to care coordination.
	Future Status: OMPP, in collaboration with its Provider Relations contractor, will monitor provider network capacity on an annual basis and identify underserved areas for targeted provider recruitment. Additionally, DMHA plans to pilot two Crisis Stabilization Units (CSU) in the northern and southern parts of the state. The goals for these units are to provide an alternative to crisis evaluations within emergency departments and divert admissions to inpatient psychiatric units. FSSA's OMPP, DMHA, and Division of Disability and Rehabilitative Services (DDRS) are partnering with the Department of Child Services (DCS) and Juvenile Justice agencies to explore piloting mobile response stabilization services (MRSS). MRSS would provide community-based crisis intervention including short term follow-up and support for the youth and family to prevent reescalation, emergency department utilization and/or inpatient admission.
	Summary of Actions Needed: OMPP will annually identify geographic shortage areas and Provider Enrollment will conduct targeted outreach to non-Medicaid enrolled providers in those areas. The CSU is proposed for implementation in SFY2020. The timeline for a potential MRSS is currently under review.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* Please refer to previous sections.
	Future Status: N/A
	Summary of Actions Needed: N/A
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute	

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Prompts	Summary
symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment	*Current Status:* Indiana provides a comprehensive statewide service array inclusive of: • Outpatient behavioral health services currently delivered by providers across the State, as delineated in the attached Mental Health Services Availability Assessment Template. • Medicaid rehabilitation option (MRO) delivered by the State's 24 CMHCs. All 92 counties in Indiana have at least one CMHC delivering care in the geographical area and most counties in the state, other than very rural ones, have more than one CMHC offering services within a county. • Three §1915(i) programs serving individuals with behavioral health needs. • Expanded SUD services in accordance with the State's approved SUD waiver. • Partial hospitalization programs which are time-limited medical services intended to provide a transition from inpatient psychiatric hospitalization to community-based care or, in some cases, substitute for an inpatient admission. Indiana Administrative Code and DMHA contracts require CMHCs to provide a defined continuum of care directly, or through subcontract which includes: • Individualized treatment planning to increase patient coping skills and symptom management • 24/7 crisis intervention • Case management to fulfill individual patient needs, including assertive case management • Outpatient services, including intensive outpatient services, substance abuse services, counseling and treatment • Acute stabilization, including detoxification services • Residential services • Day treatment • Family support services • Medication evaluation and monitoring • Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

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	Additionally, effective July 1, 2019, in accordance with the CMS approval of SPA TN 18-012, Indiana Medicaid expanded crisis intervention services, intensive outpatient program services and peer recovery services to all Indiana Medicaid programs; these services were previously limited to the MRO option. This change will expand the available provider base from the Indiana's CMHCs to all Medicaid enrolled providers meeting the applicable criteria. OMPP and DMHA continually assess access and availability of behavioral health services. For example, in accordance with the State's approved §1915(b)(4) waivers for MRO services and §1915(i) programs, FSSA utilizes information gathered from analysis of Indiana's MMIS, site reviews, and recipient reports and complaints to evaluate the need to expand provider agencies and/or provide training and/or corrective actions to assist provider agencies in increasing efficiencies for timely access to services. When "timely access" is identified as a provider agency issue, the State uses a request for corrective action and provides technical assistance and training in order to assist the agency in correcting the issue. If the issue is not remediated satisfactorily, further sanctions are applied, up to and including decertification of the agency as an MRO or §1915(i) provider. Further, OMPP's Provider Relations contractor identifies underserved areas by calculating the ratio of providers to members by county. Recruiting efforts are intensified in counties that are identified as not meeting HRSA provider-to-member ratio standards. Utilizing the results of this analysis, the Provider Relations team outreaches to behavioral health providers not currently Medicaid enrolled. Provider Relations employs the following strategy to reach out to potential providers: ● Analyze the provider-to-population report to prioritize the geographic areas to be targeted. ● Analyze NPI reports to determine which specialties are underrepresented in the selected geographic region. ● Collaborate with residency programs to educate graduating classes about the benefits of providing services to the Medicaid population and encourage enrollment in Medicaid when residents graduate. ● Contact providers by telephone or via on-site visit. During the contact, Provider Relations will: ○ Invite the provider to consider Medicaid enrollment. ○ Explain the benefits of Medicaid enrollment. ○ Educate the provider regarding any misconceptions about Medicaid.

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	○ Mitigate the provider's objections. ○ Offer to make an on-site visit to discuss enrollment and help the provider complete the online enrollment application, if applicable. ○ Ascertain the reasons the provider chooses not to enroll, if applicable. Additionally, MCOs are contractually required to meet network adequacy standards for behavioral health providers in accordance with 42 CFR §438.68. Corrective action is implemented when standards are not met.
	Future Status: OMPP will continue to monitor provider network capacity on an annual basis. Additionally, DMHA plans to pilot two Crisis Stabilization Units (CSU) in the northern and southern parts of the state. The goals for these units are to provide an alternative to crisis evaluations within emergency departments and divert admissions to inpatient psychiatric units. FSSA's OMPP, DMHA, and Division of Disability and Rehabilitative Services (DDRS) are partnering with the Department of Child Services (DCS) and Juvenile Justice agencies to explore piloting mobile response stabilization services (MRSS). MRSS would provide community-based crisis intervention including short term follow-up and support for the youth and family to prevent reescalation, emergency department utilization and/or inpatient admission.
	Summary of Actions Needed: OMPP will annually identify geographic shortage areas and Provider Enrollment will conduct targeted outreach to non-Medicaid enrolled providers in those areas. The CSU is proposed for implementation in SFY2020. The timeline for MRSS is currently under review.
3.b Financing plan – See additional guidance in Attachment A	*Current Status:* Please refer to Financing Plan below.
	Future Status: Please refer to Financing Plan below.
	Summary of Actions Needed: Please refer to Financing Plan below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* In March 2018, FSSA implemented a new tool to help Hoosiers seeking treatment for SUD immediately connect with available inpatient or residential treatment services. This new tool is made possible by a partnership between the State, OpenBeds, a software platform that manages health services, and Indiana 2-1-1, a non-profit organization that provides health care and other resource referrals to those in need.

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	This service allows treatment facilities to list their vacancies in a real-time, broadly connected database and offers a comprehensive suite of information technology functionalities specific to mental health and SUD, and provides capability for: • Transparency regarding the capacity of inpatient services, including recovery housing and community services, to provide an immediate and accurate inventory of available resources • Secure and HIPAA-compliance digital communication for referrals with email and text notifications, including the ability to transmit client data, along with consent • Digital registration and authentication for health systems and organizations • Real-time analytics to track utilization and referral patterns across the region • Patient marketplace or "pull referral" functionality to expedite patient placement • Mobile platform
	Future Status: FSSA is currently in the process of expanding use of OpenBeds beyond SUD to include tracking availability of psychiatric inpatient and crisis stabilization beds.
	Summary of Actions Needed: Expansion of OpenBeds contract in Fall 2019 to include psychiatric bed capacity.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* Every individual served by a DMHA contracted provider receives a Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA) to inform individualized treatment planning and level of care decision making. Individuals are reassessed every six months with adjustments to level of care and/or treatment plan being made accordingly. Further, as stated in Indiana Administrative Code 405 IAC 5-21.5, IHCP reimbursement for MRO services is available for members who meet specific diagnosis and level of need (LON) criteria under the approved DMHA assessment tool (ANSA or CANS). Additional MRO services beyond what is available for the assigned service package may be added with prior authorization (PA). MRO services are clinical behavioral health services provided to members and families of members living in the community who need aid intermittently for emotional disturbances, mental illness, and addiction. The CANS/ANSA also inform individual service needs and level of care that could include inpatient and/or residential services. In addition to use of the CANS and ANSA, determinations of medical necessity for behavioral health services are based on utilization management criteria implementation by the State's MCOs and utilization management vendor.
	Future Status: Effective July 1, 2019, all Indiana Medicaid MCOs and the utilization management vendor are utilizing Milliman Care Guidelines to determine appropriate level and care and length of stay for behavioral health diagnoses.

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Prompts	Summary
	Summary of Actions Needed: N/A
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* Please refer to previous sections.
	Future Status: N/A
	Summary of Actions Needed: N/A
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment	*Current Status:* The Vocational Rehabilitation Services (VRS) is a program of FSSA's Division of Disability and Rehabilitative Services (DDRS). VRS are available statewide, in all regions of the state. Eligibility for VRS is determined in accordance with federal requirements at 34 CFR 361.42(a). Accordingly, eligibility for VRS includes a determination that an applicant meets the following conditions: • Has a physical or mental impairment • This impairment constitutes or results in a substantial impediment to employment • VRS are required to prepare for, enter, engage in, or retain an employment outcome consistent with his or her abilities, capacities, career interests, and informed choice. Additionally, all applicants determined eligible for Social Security for Social Security Disability (SSDI) or Supplemental Security Income (SSI) are presumed eligible for VRS. Individuals receiving VRS have an Individualized Plan for Employment (IPE) based on the requirements at 34 CFR 361.45, following an assessment for determining vocational rehabilitation needs. VRS are provided in accordance with the IPE and may include: • Vocational counseling and guidance • Medical treatment to correct or modify the physical or mental impairment • Training (including vocational school, college or university, on-the-job, and other training) • Rehabilitation technology (assistive devices and services) • Placement assistance and follow-up (including supported employment)

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	• Other planned goods and services determined to be necessary to address an identified substantial impediment to employment and to be required to enable the individual to prepare for, enter, engage in, or retain an employment outcome Supportive employment (SE) is available as a VRS. Through this service, individuals with the most severe disabilities are placed in competitive jobs with qualified job coaches/trainers to provide individualized, ongoing support services needed for each individual to retain employment. The employer is contacted monthly and the employee is visited twice monthly, either at or away from the workplace, to address any issues that may threaten the individual's ability to remain on the job. Additionally, several of Indiana's CMHCs provide supportive employment services, an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illness. These programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client to staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: N/A
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* In 2012, FSSA in partnership with the Indiana State Department of Health (ISDH) launched the Primary Care and Behavioral Health Integration (PCBHI) initiative, to develop a statewide strategic plan to integrate primary and behavioral health care services in Indiana. As an outgrowth of this initiative, the State was awarded the SAMHSA and National Association of State Mental Health Program Directors (NASHMHPD) Transformation Transfer Initiative (TTI) Grant which allowed the State to implement a series of initiatives aimed at increased integration. Additionally, a process was established by which Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs) and Rural Health Clinics (RHCs)

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	could become a state certified integrated care entity (ICE). Currently, there are 13 ICE sites operating within the State. ICE core requirements include: • Core assessments for behavioral and physical health • Integrated care plans • Interdisciplinary team meetings • Real-time physician/pharmacy consults • Leadership support • Evidence based practice and training • Electronic health records and data sharing • Quality outcome measures The State has also focused on school-based initiatives to increase behavioral health integration. For example, CMHCs across the State work in close collaboration with Indiana schools. Currently, 85% of school districts have CMHCs providing services within their schools. Additionally, DMHA released an RFP in June 2019 to contract with no more than three regionally diverse social services providers to implement an evidence-based program that partners with school corporations, charter schools, and accredited nonpublic schools to provide social work services and evidence-based prevention programs to children, parents, caregivers, teachers, and the community to prevent substance abuse, promote healthy behaviors, and maximize student success. Further, the MCOs are contractually required to plan for, develop and/or enhance relationships with school-based health centers (SBHC) with the goal of providing accessible services to school-aged enrolled members. SBHCs provide on-site comprehensive preventive and primary health services including behavioral health, oral health, ancillary and enabling services. Additionally, Indiana encourages the integration of primary and behavioral health care services through the use of an alternative payment methodology (APM) for federally qualified health centers (FQHCs) which consists of: (1) an adjustment to the FQHC's prospective payment system (PPS) rate; and (2) performance incentive payments limited to an established annual amount for each participating FQHC. To qualify for an APM, the FQHC must implement a care plan that fully integrates primary care and behavioral health at the FQHC through an integration plan approved by OMPP and DMHA which includes the following components: • Incorporation of screening and evaluation processes to identify targeted patient population • Establishment of appropriate levels of behavioral health staffing

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	• Physical integration of the provision of primary and behavioral health care together at the same FQHC location • Performance of medical and behavioral health care services by the staff at the FQHC • Full integration of medical records, billing and other data relating to primary and behavioral health care services • Ongoing monitoring of the integration plan through data collection and evaluation
	Future Status: To ensure the financial sustainability of the current ICE model following the end of the current grant funding, the State intends to implement a Medicaid health homes model, through state plan authority.
	Summary of Actions Needed: OMPP plans to submit a health homes state plan amendment by the end of 2019.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* The State's review of the crisis continuum confirmed the following crisis services are being provided in addition to the CMHC mandated 24/7 crisis services: mobile crisis teams (5), assertive community treatment (ACT) (6), 23-hour crisis stabilization units (7), short-term crisis residential (2) and peer crisis services (2).
	Future Status: DMHA plans to pilot two Crisis Stabilization Units (CSU) in the northern and southern parts of the state. The goals for these units are to provide an alternative to crisis evaluations within emergency departments and divert admissions to inpatient psychiatric units. FSSA's OMPP, DMHA, and Division of Disability and Rehabilitative Services (DDRS) are partnering with the Department of Child Services (DCS) and Juvenile Justice agencies to explore piloting mobile response stabilization services (MRSS). MRSS would provide community-based crisis intervention including short term follow-up and support for the youth and family to prevent reescalation, emergency department utilization and/or inpatient admission.
	Summary of Actions Needed: The CSU is proposed for implementation in SFY2020. The timeline for MRSS is currently under review.
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* Please refer to previous sections.
	Future Status: N/A
	Summary of Actions Needed: N/A
SMI/SED.Topic_5. Financing Plan	

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State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status:* The State's review of the crisis continuum confirmed the following crisis services are being provided in addition to the CMHC mandated 24/7 crisis services: mobile crisis teams (5), assertive community treatment (ACT) (6), 23-hour crisis stabilization units (7), short-term crisis residential (2) and peer crisis services (2).
	Future Status: The State will annually monitor access to non-residential crisis stabilization services through an agreed upon methodology. DMHA plans to pilot two Crisis Stabilization Units (CSU) in the northern and southern parts of the state. The goals for these units are to provide an alternative to crisis evaluations within emergency departments and divert admissions to inpatient psychiatric units. FSSA's OMPP, DMHA, and Division of Disability and Rehabilitative Services (DDRS) are partnering with the Department of Child Services (DCS) and Juvenile Justice agencies to explore piloting mobile response stabilization services (MRSS). MRSS would provide community-based crisis intervention including short term follow-up and support for the youth and family to prevent reescalation, emergency department utilization and/or inpatient admission.
	Summary of Actions Needed: The CSU is proposed for implementation in SFY2020. The timeline for MRSS is currently under review.
F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care	*Current Status:* As described throughout this template, and as outlined in the attached "Overview of the Assessment of the Availability of Mental Health Services" template, Indiana offers a comprehensive continuum of community-based services.
	Future Status: The State will annually monitor access to community-based services through an agreed upon methodology.

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<tr><td>settings such as the Certified Community Behavioral Health Clinic model.</td><td>Summary of Actions Needed: OMPP will annually identify geographic shortage areas and Provider Enrollment will conduct targeted outreach to non-Medicaid enrolled providers in those areas.</td></tr>
<tr><td colspan="2">SMI/SED. Topic_6. Health IT Plan</td></tr>
<tr><td colspan="2">As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”[2] The HIT Plan should also describe, among other items, the:
Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and
Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.
Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</td></tr>
<tr><td colspan="2">Statements of Assurance</td></tr>
<tr><td>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period</td><td>As outlined in Indiana’s State Medicaid Health Information Technology Plan (SMHP), Indiana’s HIT environment is active with multi-faceted efforts to support provider HIT capacity and foster the sharing of clinical and administrative data to improve health care and support system improvements. The State has taken an active role through its state health agencies and Medicaid program to promote HIT adoption and HIE development, building upon its private health care marketplace.

As outlined in the table below, the State is home to four well-established health information exchange networks operated by Health Information Organizations (HIOs), each functioning in different capacities for community partners.

<table>
<tr><th>Regional HIO</th><th>June 2019 Status</th></tr>
<tr><td>HealthBridge (includes greater Cincinnati tristate area)</td><td>Utilization of the Health Collaborative’s HealthBridge Suite (hb/suite):
58 hospitals</td></tr>
</table>
</td></tr>
</table>

[2] See SMDL #18-011, “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.” Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

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<tr><td></td><td>• 8,901 providers
• 160 million clinical results processed
• 15 million monthly messages</td></tr>
<tr><td>HealthLINC</td><td>• Delivers more than 175,000 medical results per month among hospitals, office and clinic practices and under-served clinics
• Health service directory that includes more than 350 physicians and other providers</td></tr>
<tr><td>Indiana Health Information Exchange (IHIE)</td><td>• Connection to 117 hospitals representing 38 health systems
• Over 17,055 practices
• Over 47,452 providers
• Over 14,847,271 patients
• Over 12,510,420,163 clinical data elements</td></tr>
<tr><td>Michiana Health Information Network (MHIN)</td><td>• Over 576 data sources
• 3.9 million transactions inbound per month
• 20,304 providers connected</td></tr>
</table>

However, a March 2019 assessment of Indiana’s health information sharing (HIS), conducted based on capability maturity guidance from CMS and the Office of the National Coordination for Health Information Technology (ONC), revealed opportunities for increased electronic documentation and standardization among settings and providers not previously addressed through Meaningful Use, including behavioral health providers. Through this HIT Plan, the State intends to drive improvements in this area.</td></tr>
<tr><td>Statement 2: Please confirm that your state’s SUD Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.</td><td>This HIT Plan is aligned with the State’s broader State Medicaid Health IT Plan (SMHP). The State is in the process of completing an updated SMHP with targeted completion by the end of calendar year 2019. Through this update process, areas of prioritization will take into consideration the milestones of this waiver.</td></tr>
</table>

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Prompts	Summary
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[3] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Indiana will review the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B for potential inclusion into our MCO contracts. The following standards are currently utilized by our MCOs: • Documenting and Sharing Care Plans – The MCOs are contractually obligated to share care plans with primary medical providers (PMPs) and behavioral health providers with appropriate consent. • The MCOs have agreements with health information exchanges, such as the Indiana Health Information Exchange (IHIE) and the Michiana Health Information Network (MHIN). • Clinical Quality Measurement and Reporting – The MCEs report on the following HEDIS quality measures related to behavioral health: o Follow-up care for children prescribed ADHD medication, initiation phase o Follow-up care for children prescribed ADHD medication, maintenance phase o 30-day follow-up after hospitalization for mental illness o 7-day follow-up after hospitalization for mental illness o Use of multiple concurrent antipsychotics in children and adolescents up to age 17 o Use of first-line psychosocial care for children/adolescents on antipsychotics up to age 17 o Antidepressant medication management, acute phase o Antidepressant medication management, continuation phase o 30-day follow-up after emergency department (ED) visit for mental illness o 7-day follow-up after ED visit for mental illness
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [4] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States*	

[3] Available at https://www.healthit.gov/isa/.
[4] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

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Prompts	Summary
may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."[5]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* The State does not have readily accessible data on the exact number of Medicaid-enrolled behavioral health providers who have adopted certified EHRs and are utilizing them for e-referrals and/or closed loop referrals. With multiple HIEs and large health systems that have been able to exchange effectively via EHR and prescription software vendors, it is difficult to accurately assess participation. Each HIE is able to easily report on its participants but the extent to which non-participating organizations are identified and assessed individually is meticulous work. It is known that certain hospital, facility, and provider types that were not eligible for Meaningful Use (Promoting Interoperability) are not participating due to lagging technology and/or regulatory barriers, such as with CFR 42 Part 2. The aforementioned March 2019 HIS Assessment did reveal provider tracking of referrals may be facilitated by tools within the EHR but most still struggle with closing the referral loop.
	Future State: The State will conduct a survey to identify the volume of providers utilizing closed loop referrals and e-referrals to identify the baseline of current activity and identify options for increasing provider uptake.
	Summary of Actions Needed: The provider survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* The State does not have readily accessible data on the exact number of Medicaid-enrolled behavioral health providers who have adopted certified EHRs and are utilizing them for e-referrals and/or closed loop referrals. The aforementioned March 2019 HIS Assessment did reveal provider tracking of referrals may be facilitated by tools within the EHR but most still struggle with closing the referral loop.
	Future State: The State will conduct a survey to identify the volume of providers utilizing closed loop referrals and e-referrals to identify the baseline of current activity and identify options for increasing provider uptake.
	Summary of Actions Needed: The provider survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.

[5] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

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1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State:* The State does not have readily accessible data on the exact number of Medicaid-enrolled behavioral health providers who have adopted certified EHRs and are utilizing them for e-referrals and/or closed loop referrals. The aforementioned March 2019 HIS Assessment did reveal provider tracking of referrals may be facilitated by tools within the EHR but most still struggle with closing the referral loop.
	Future State: The State will conduct a survey to identify the volume of providers utilizing closed loop referrals and e-referrals to identify the baseline of current activity and identify options for increasing provider uptake.
	Summary of Actions Needed: The provider survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* The aforementioned March 2019 HIS Assessment revealed that while electronic care plans are utilized they are not standardized. HIEs receive what the provider delivers via continuity of care documents (CCD) but content and format are variable.
	Future State: The State will work toward compliance with the forthcoming CMS Interoperability and Patient Access final rule. Additionally, FSSA will survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.
	Summary of Actions Needed: FSSA will monitor for CMS release of the final rule and determine required steps and timeline for compliance accordingly. The IMD survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* Indiana contracts with the Indiana Health Information Exchange (IHIE) to aggregate Medicaid claims with medical and pharmacy data in its repository to create a continuity of care (CCD) record that can be shared between Medicaid providers. The aforementioned March 2019 HIS Assessment indicates some MCOs and providers are receiving admit-discharge-transfer (ADT), CCDs or other clinical data points and incorporating directly into their work flow for care coordination and quality management. Additionally, the majority of community mental health centers have certified EHRs and utilize Viewpoint, a referral portal, to communicate among entities.
	Future State: As previously described, OMPP plans to submit a health homes state plan amendment. A key component of this initiative will include leveraging HIT for enhanced integration and coordination. OMPP is currently in the process of developing HIT standards and requirements for participating providers. Additionally, the State will work toward compliance with the forthcoming CMS Interoperability and Patient Access final rule. FSSA will also survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.

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	Summary of Actions Needed: OMPP plans to submit a health homes state plan amendment by the end of 2019. FSSA will monitor for CMS release of the final rule and determine required steps and timeline for compliance accordingly. The IMD survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* State psychiatric hospitals utilize one EHR system which permits tracking of records as youth transition to adulthood.
	Future State: The State will work toward compliance with the forthcoming CMS Interoperability and Patient Access final rule. Additionally, FSSA will survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.
	Summary of Actions Needed: FSSA will monitor for CMS release of the final rule and determine required steps and timeline for compliance accordingly. The IMD survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* State psychiatric hospitals utilize one EHR system which permits tracking of care plans as youth transition to adulthood.
	Future State: The State will work toward compliance with the forthcoming CMS Interoperability and Patient Access final rule. FSSA will also survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.
	Summary of Actions Needed: FSSA will monitor for CMS release of the final rule and determine required steps and timeline for compliance accordingly. The IMD survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.

2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* In 2017, DMHA released an RFP to procure a new EHR system to be used collectively by all state psychiatric hospitals. The State's expectation is that a modern EHR will facilitate interoperability. The required HIE functionality put forth in FSSA's statement of work for this project include:
	• Admission, discharge and transfer (ADT) and census
	  o Collecting and updating patient demographic information, family contact data, alerts, insurance coverage, management of room and bed, census activities, and leave-of-absence
	  o Fully integrating the aforementioned data across the other core functions
	• Clinical documentation: Includes assessments, treatment, treatment plans, and nursing care plans, including, but not limited to, historical patient data, patient risk criteria, electronic document system

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	capturing interdisciplinary Plans of Care and reporting, automated work lists, clinical decision support, and patient education tracking. The system must support multiple modes of data entry including, but not limited to, template notes, third-party dictation, and voice recognition. This also includes fully integrating this data across the other core functions. • Interfaces, data sharing and interoperability: o Using common standards and implementation specifications for electronic exchange of information in accordance with MU Stage 2 guidance. o Actual electronic exchange of clinical information with acute care hospitals, CMHCs, Public Health registries, LTC facilities, private practitioners, pharmacies, correctional facilities, judicial bodies, laboratories, and healthcare payers (e.g., Medicaid, Medicare, commercial insurance, Social Security Administration [SSA], private pay, etc.) • Case management: Functionality includes, but is not limited to, the ability for designated staff to track, manage, document, and receive alerts for case management activities. Having the State Psychiatric Hospitals interface with an HIE will give the Medicaid providers operating within the SPHs the capability to exchange health information with adjacent acute care facilities/hospitals, CMHCs, and other healthcare partners along the continuum of care. This specifically will allow Medicaid providers the capability to meet MU stage 3. More specifically the SPHs will be capable of bi-directionally exchanging summary of care records and CCDs when referring or receiving a Medicaid patient to or from another care setting. In addition, SPHs interfacing with the HIE will be capable of sending and receiving ADT notifications. These activities allow Medicaid providers within the SPHs to fulfill the objectives and enables them to report measures in accordance with MU stage 3 for HIE.
	Future State: FSSA will survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.
	Summary of Actions Needed: The IMD survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless	*Current State:* Consent/privacy is managed in a multitude of mechanisms across the Medicaid Health Information Sharing Enterprise, many still very manual, non-standardized and not electronically transmitted. HIEs rely on the participants to manage what information is delivered to them. Substance abuse disorder laws (42 CFR Part 2) require explicit patient consent and therefore typically are only shared in a one-off manual manner. Consent, segregation of highly sensitive records, and secure transport are difficult to implement and

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<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td rowspan="3">sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)</td><td>manage and therefore infrequently done electronically. Indiana is an opt-out state for HIE. Responsibility is on provider to communicate with patients. Patient data can be shared with HIE unless the patient explicitly requests it not to be.</td></tr>
<tr><td>Future State: To be determined based on prioritization of initiatives during the aforementioned SMHP update process.</td></tr>
<tr><td>Summary of Actions Needed: To be determined based on prioritization of initiatives during the aforementioned SMHP update process.</td></tr>
<tr><td colspan="2">Interoperability in Assessment Data (Section 4)</td></tr>
<tr><td rowspan="3">4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem</td><td>Current State: Within the integrated care entities (ICE), core assessments and adjudicated Medicaid claims data are aggregated and available via the Relias ProAct Tool. This tool exclusively houses Medicaid patients and an external facing interface is provided for each ICE and applies 400+ measures to Medicaid claims and non-claims data. It provides individual patient history, as well as population demographics and associated costs of diagnoses, medications and utilization.</td></tr>
<tr><td>Future State: The State will work toward compliance with the forthcoming CMS Interoperability and Patient Access final rule.</td></tr>
<tr><td>Summary of Actions Needed: FSSA will monitor for CMS release of the final rule and determine required steps and timeline for compliance accordingly.</td></tr>
<tr><td colspan="2">Electronic Office Visits – Telehealth (Section 5)</td></tr>
<tr><td>5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care</td><td>Current State: Indiana received $16 million from the Federal Communications Commission's (FCC's) Rural Health Care Pilot Program, and as a result, created the Indiana Telehealth Network (ITN). ITN formed an FCC Rural Health Care Steering Committee, which was made up of representatives from healthcare providers, telecommunication companies, representatives from the Indiana Office of Community & Rural Affairs, and representatives from the Indiana Rural Health Association, the lead entity for the ITN. The five year project was divided into three phases and the work successfully concluded in 2015. The table below presents a summary of the project phases.
<table>
<tr><th>Phase 1</th><th>Phase 2</th><th>Phase 3</th></tr>
<tr><td>Reduced bandwidth costs
Reduced Primary Rate Interface (PRI) costs
Doubled the speed of existing broadband connections</td><td>Expanded ability to conduct Telehealth encounters over a dedicated health care network
Disaster Recovery
E-Learning
Internet Access</td><td>Seamless interfaces with the Indiana Health Information Organizations (HIOs)</td></tr>
</table></td></tr>
</table>

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<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td></td><td>
<table>
<tr><td>• 85% funding for construction of fiber to their hospitals
• Completed ability to transmit images
• Improved economic opportunities</td><td>• Videoconferencing</td><td></td></tr>
</table>

As of December 2016, ITN’s healthcare participants included 153 critical access hospitals, rural hospitals, urban partner hospitals, rural health clinics, urban partner hospitals, rural health clinics, federally qualified health centers, community mental health centers and data centers.

Additionally, as part of the 21st Century Cures Act, a portion of Indiana’s awarded funding is being utilized to implement Project-ECHO-Extension for Community Healthcare Outcomes. The primary goal of ECHO is to enable rural and traditionally underserved populations to receive high-quality care, when they need it, close to home. This low-cost, high-impact intervention is achieved by leveraging technology to connect expert mentors and multiple local primary care providers in online video-conferencing TeleECHO clinics.
Future State: Continued operation of current programing.
Summary of Actions Needed: N/A</td></tr>
<tr><td>Alerting/Analytics (Section 6)</td><td></td></tr>
<tr><td rowspan="3">6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of</td><td>Current State: Some providers may have this capability, but the current volume is unknown.</td></tr>
<tr><td>Future State: As previously described, OMPP plans to submit a health homes state plan amendment. A key component of this initiative will include leveraging HIT for enhanced integration and coordination. OMPP is currently in the process of developing HIT standards and requirements for participating providers.</td></tr>
<tr><td>Summary of Actions Needed: OMPP plans to submit a health homes state plan amendment by the end of 2019.</td></tr>
</table>

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Prompts	Summary
patients stop engaging after 6 months of treatment[6])	
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* Some providers may have this capability, but the current volume is unknown.
	Future State: As previously described, OMPP plans to submit a health homes state plan amendment. A key component of this initiative will include leveraging HIT for enhanced integration and coordination. OMPP is currently in the process of developing HIT standards and requirements for participating providers.
	Summary of Actions Needed: OMPP plans to submit a health homes state plan amendment by the end of 2019.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* The State's eligibility and enrollment system can link children and parents on the same case.
	Future State: To be determined based on prioritization of initiatives during the aforementioned SMHP update process.
	Summary of Actions Needed: To be determined based on prioritization of initiatives during the aforementioned SMHP update process.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* The aforementioned March 2019 assessment of Indiana's HIS indicates patient/client identification is inconsistent between entities. Patient matching is an issue for all entities. Health systems employ entire departments to deal with multiple issues surrounding the record integrity that include duplicate records or documenting on the wrong patient record. Resolving a merged record and identifying who may have received erroneous information may take many hours of work per case. Additionally, Indiana is currently participating in the National Governor's Association "Harnessing the Power of Data to Achieve State Policy Goals: The Foundation for State Success in Improving Quality and Reducing Costs" initiative, intended to address governance, cross-sector data sharing and systems capabilities.
	Future State: The State will work toward compliance with the forthcoming CMS Interoperability and Patient Access final rule.
	Summary of Actions Needed: FSSA will monitor for CMS release of the final rule and determine required steps and timeline for compliance accordingly.

[6] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

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Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

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IMD Overview

How To Use This Spreadsheet:

Consult the tables below for a overview of the "IMD Services Limit" and "Non-IMD reporting requirements for monitoring. The notes below the table provide additi details of estimation and expenditure reporting. For states proposing to include IM comprehensive budget neutrality spreadsheet, STCs and expenditure monitoring separately tabulated by, for example, diagnosis-type (see glossary below for defin

Scenario 1

Situation: Demonstration CNOM is limited to expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD, SMI and/or SED who are residents in facilities that meet the definition of an IMD (i.e., IMD exclusion related MA).
Without Waiver (i.e., budget neutrality limit)
With Waiver

Scenario 2

Situation: Demonstration CNOM include both CNOM for IMD exclusion related MA to *and* CNOM for additional hypothetical services that can be provided outside the IMD.
Without Waiver (i.e., budget neutrality limit)
With Waiver

Glossary of Abbreviations

CNOM = expenditure authority (cost not otherwise matchable)
Hypo = hypothetical, i.e., optional services that could be included in the state plar
IMD = institution for mental diseases
MA = medical assistance
MM = member month
SUD = substance abuse disorder
SMI = serious mental illness
SED = serious emotional disturbance

Notes

1. Date of service for capitation payments is the month of coverage f
2. The IMD Services Limit and Non-IMD Services CNOM Limit are inte
3. Services provided in an IMD "in lieu of" other allowable settings are
4. Some specific unallowable costs are detailed below (see STCs for ad

Estimation for the IMD Services Limit

The IMD Services Limit represents the projected cost of medical assistance during

- States should present their most recent represenative year of historical dat
- The per user per month cost(s) are then projected forward using the Presid
- If the state has an existing comprehensive Medicaid demonstration with alr
- States may also "top off" IMD Services Limit PMPMs with an additional estir
- State may use Alternate PMPM Development in Historical tab for estimating

Trends

PMPM trend rates will generally be the smoothed trend from the most recent Pre

- The President's Budget trends should be for the eligibility groups that are pa
- The per user per month costs are then projected forward using the Presider
- The projected per user per month costs will become the PMPMs for the IMI

Multiple MEGs

There should be one set of MEGs for the current Medicaid state plan IMD Service

- States may also develop single, or multiple, PMPMs for SUD, SMI and/or SEI

Member Month Non-Duplication

IMD Services Limit member month must be non-duplicative of Non-IMD Services

- This means that month of Medicaid eligibility for an individual cannot appea
- IMD Services CNOM Limit member months can be duplicative of general co

State Data Inputs

States must add their data to the yellow highlighted cells for CMS review and disc

- CMS will provide template instructions with this spreadsheet.

"In Lieu of" Services

States must not report expenditures for a capitation payment to a risk-based MC

- This flexibility is referred to in the regulations as "in-lieu-of" services or setti
- For more information on "in leu of" servies, see "Medicaid and CHIP Manag

Unallowable Costs

In addition to other unallowable costs and caveats outlined in the STCs, the state

- Room and board costs for residential treatment service providers unless the

- Costs for services provided in a nursing facility as defined in section 1919 of
- Costs for services provided to inmates of a public institution, as defined in 4
- Costs for services provided to beneficiaries under age 21 residing in an IMD

Supplemental Methodology Document

The 'Historical Spending Data' and/or 'Alternate PMPM Development' in the IMD

- There should also be sections/headings in the methodology document whic

D Services CNOM Limit" in Scenarios 1 and 2. The tables provide basic concepts an
onal information related to allowable IMD medical assistance services, estimation
MD services as a component of their broader 1115 demonstrations, the limits esta
tool (see State Medicaid Director Letter #18-009). The limits established may be u
ıition of abbreviations).

IMD Services Limit
PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day BN Expenditure Limit · PMPM cost × IMD MMs
Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs

IMD Services Limit
PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day · *Can* exclude months with ≤ 15 IMD inpatient days under managed care BN Expenditure Limit · PMPM cost × IMD MMs
Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report:

- IMD MMs separate from other Medicaid months of eligibility
- MA costs during IMD MMs separate from other MA costs

ı but are instead being authorized in the 1115 using CNOM

or which the capitation is paid.
nded to be two distinct budget neutrality tests separately and independently enfc
excluded from this budget neutrality test (see below).
ldditional exceptions and caveats).

ş months in which Medicaid eligible are patients at the IMD. These are the accept
a on overall MA costs for individuals with a SUD, SMI and/or SED diagnosis (or pro
ent's Budget PMPM cost trend--and the projected per user per month costs will b
eady calculated without waiver PMPMs, CMS will incorporate the PMPMs establis
nated amount representing any additional CNOM services that affected individual
ş expenditures (see 'Supplemental Methodology Document' requirement below).

esident's Budget Medicaid trends and will be supplied to states by CMS.
articipating in the IMD demonstration; most often, these will be the Current Adult
ıt's Budget PMPM cost trend.
D Services Limit.

s Limit(s) with associated PMPMs and member months, and one for the Non-IMD
D.

CNOM Limit member months, and must also be non-duplicative of general compr
ar as both an IMD Services Limit member month and a Non-IMD Services CNOM Li
mprehensive demonstration budget neutrality limit member months.

ussion - and choose the appropriate drop-downs corresponding to their data inpu

O or PIHP for an enrollee with a short-term stay in an IMD for inpatient psychiatric
ings and is effectuated through the contract between the state and the MCO or PI
ed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438

may not receive FFP under any expenditure authority approved under this demon
ey qualify as inpatient facilities under section 1905(a) of the Act.

the Act that qualifies as an IMD.
2 CFR 435.1010 and clause A after section 1905(a)(29), except if the individual is a
) unless the IMD meets the requirements for the “inpatient psychiatric services for

Historical tab must be accompanied by a supplemental methodology and data sou
h describe all other state data inputs (see 'State Data Inputs' above).

d frameworks for establishing the budget neutrality limits--and expenditure
of the various budget neutrality limits, trend rates, "in lieu of" services and other
ıblished in this spreadsheet--once approved by CMS--will be included in the
ısed as an upper limit for all medical assistance services provided in an IMD--or

Non-IMD Services CNOM Limit

Non-IMD Services CNOM Limit
PMPM Cost · Estimate of average CNOM service cost during Non-IMD MMs · Est. total CNOM service cost ÷ est. Non-IMD MMs · CNOM service cost can include capitated cost of IMD services Member Months · Non-IMD MM: Any month of Medicaid eligibility in which a person *could* receive a CNOM service that is not an IMD MM BN Expenditure Limit · PMPM cost × Non-IMD MMs
Expenditures Subject to Limit · All CNOM service costs with dates of service during Non-IMD MMs Reporting Requirements State must be able to identify and report:

- Non-IMD MMs separate from IMD MMs
- IMD CNOM costs separate from other MA costs

ɔrced.

able ways for the state to determine the PMPMs for the IMD Services Limit.
xy) who received inpatient treatment those diagnoses (or could have received inpatient treatment if such services were availab
ecome the PMPMs for the IMD Services Limit.
hed in this workbook.
s may also receive during IMD months.

s, New Adults, or a blend of Current and New Adults, to determine average MA cost per user of SUD, SMI and/or SED inpatient

Services CNOM Limit and/or Non-Hypothetical CNOM Limit, as applicable.

ehensive demonstration budget neutrality limit member months.
mit member month; it has to be one or the other, and likewise for IMD Services Limit member month and general comprehens

ıts.

: or substance use disorder services of no more than 15 days within the month for which the capitation payment is made is perr
HP.
3.6(e)" (August 2017).

ıstration for any of the following :

ıdmitted for at least a 24 hour stay in a medical institution (see SMI/SED SMDL, p. 13).
r individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G .

ırces document that fully describes, for each MEG, a complete break-out of all SUD, SMI and/or SED services--with descriptions

le), to determine projected MA cost per user of SUD, SMI and/or SED inpatient services for each historical year.

services for each historical year.

ive demonstration budget neutrality limit member months.

nissible under the regulation at §438.6(e) for MCOs and PIHPs to use the IMD as a medically appropriate and cost eff

of accompanying expenditures and caseloads.

ective alternative setting to those covered under the State plan or ABP.

IMD Historical

Representative Data Year:	2018
Type of State Years:	Calendar

IMD Services MEG 1	2018
TOTAL EXPENDITURES	$2,443,192
ELIGIBLE MEMBER MONTHS	1,078
PMPM COST	$2,266.41

FFS Intensive Inpatient Expenditures

IMD Services MEG 2	
TOTAL EXPENDITURES	$266,654
ELIGIBLE MEMBER MONTHS	68
PMPM COST	$3,921.38

FFS Residential Expenditures

IMD Services MEG 3	
TOTAL EXPENDITURES	$7,410,254
ELIGIBLE MEMBER MONTHS	7,243
PMPM COST	$1,023.09

Managed Care Capitation + FFS Expenditures

Continue MEGs from Above, As Needed

Alternate Development: IMD Services + Non-IMD & Non-Hypo CNOMs	Estimated Total Expenditures for Medical Assistance Provided in an IMD that are:	
IMD Services	Currently State Plan FFS (e.g. Carved Out) or Not Currently State Plan but Otherwise Approvable (Including Pending SPAs)	Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or "Costs Not Otherwise Matchable" ("Non-IMD" or "Non-Hypo" CNOMs)
Service 1		
Service 2		
Service 3		
Service 4		
Service 5		
Service 6		
Service 7		
Service 8		
Service 9		
Service 10		
Service 11		
Service 12		
Add additional services, as necessary		

Totals	

s

Managed Care PMPM (Replicate Column, as Necessary)			
			C
Capitated PMPM for Currently Approved, non-IMD, State Plan or Other Title XIX Services	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost for All Services Provided in an IMD	IMD Services MEG 1
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
$0		#DIV/0!	
			$0.00

2018			
Choose "Included" from Drop-Down(s) to Link Services with MEG(s)			
CURRENT State Plan Service(s)		NOT CURRENT State Plan Svc(s)	
IMD Services MEG 2	IMD Services MEG 3	Non-IMD Services CNOM Limit MEG	Non-Hypothetical Services CNOM MEG
$0.00	$0.00	$0.00	$0.00

IMD Without Waiver

PB Trend Rate(s) Used:

IMD Services MEG 1	4.90%
IMD Services MEG 2	4.90%
IMD Services MEG 3	4.90%
Non-IMD Services CNOM Limit MEG	

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR
IMD Services MEG 1			
Eligible Member Months	n.a.	n.a.	1078
PMPM Cost	4.9%	12	$ 2,266
Total Expenditure			
IMD Services MEG 2			
Eligible Member Months	n.a.	n.a.	68
PMPM Cost	4.9%	12	$ 3,921
Total Expenditure			
IMD Services MEG 3			
Eligible Member Months	n.a.	n.a.	7243
PMPM Cost	4.9%	12	$ 1,023
Total Expenditure			

Continue MEGs from Above, As Needed

Non-IMD Services CNOM Limit MEG			
Eligible Member Months	n.a.	n.a.	n.a.
PMPM Cost	0.0%	12	$ -
Total Expenditure			

Start DY

DEMONSTRATION YEARS (DY)					TOTAL
2019	2020	2021	2022	2023	WOW
1,089	1,100	1,111	1,122	1,133	
$ 2,377	$ 2,494	$ 2,616	$ 2,744	$ 2,879	
$ 2,588,542	$ 2,742,539	$ 2,905,687	$ 3,078,544	$ 3,261,682	$ 14,576,993
69	69	70	71	71	
$ 4,114	$ 4,315	$ 4,527	$ 4,748	$ 4,981	
$ 282,517	$ 299,324	$ 317,131	$ 335,997	$ 355,986	$ 1,590,954
7,315	7,389	7,462	7,537	7,612	
$ 1,073	$ 1,126	$ 1,181	$ 1,239	$ 1,300	
$ 7,851,066	$ 8,318,142	$ 8,812,953	$ 9,337,255	$ 9,892,704	$ 44,212,120
0	0	0	0	0	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	$ -

IMD With Waiver

ELIGIBILITY GROUP	LAST HISTORIC YEAR	PB TREND RATE	DEM	
			2019	2020
IMD Services MEG 1				
Eligible Member Months			1,089	1,100
PMPM Cost	$ 2,266	4.9%	$ 2,377	$ 2,494
Total Expenditure			$ 2,588,542	$ 2,742,539
IMD Services MEG 2				
Eligible Member Months			69	69
PMPM Cost	$ 3,921	4.9%	$ 4,114	$ 4,315
Total Expenditure			$ 282,517	$ 299,324
IMD Services MEG 3				
Eligible Member Months			7,315	7,389
PMPM Cost	$ 1,023	4.9%	$ 1,073	$ 1,126
Total Expenditure			$ 7,851,066	$ 8,318,142

Continue MEGs from Above, As Needed

Non-IMD Services CNOM Limit MEG

Eligible Member Months	n.a.		0	0
PMPM Cost	$ -	0.0%	$ -	$ -
Total Expenditure			$ -	$ -

Main Budget Neutrality Test (i.e. NOT Hypothetical)

Non-Hypothetical Services CNOM MEG

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	
				DY 01
Eligible Member Months	n.a.	n.a.	n.a.	0
PMPM Cost	0.0%		$ -	$ -
Total Expenditure				$ -

ONSTRATION YEARS (DY)			TOTAL WW
2021	2022	2023	
1,111	1,122	1,133	
$ 2,616	$ 2,744	$ 2,879	
$ 2,905,687	$ 3,078,544	$ 3,261,682	$ 14,576,993
70	71	71	
$ 4,527	$ 4,748	$ 4,981	
$ 317,131	$ 335,997	$ 355,986	$ 1,590,954
7,462	7,537	7,612	
$ 1,181	$ 1,239	$ 1,300	
$ 8,812,953	$ 9,337,255	$ 9,892,704	$ 44,212,120
0	0	0	
$ -	$ -	$ -	
$ -	$ -	$ -	$ -

DEMONSTRATION YEARS (DY)				TOTAL
DY 02	DY 03	DY 04	DY 05	WOW
0	0	0	0	
$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -

IMD Summary

Supplemetal Test #1: IMD Services Cost Limit
Without-Waiver Total Expenditures

	2019
IMD Services MEG 1	$2,588,542
IMD Services MEG 2	$282,517
IMD Services MEG 3	$7,851,066
Continue MEGs from Above, As Needed	
TOTAL	$10,722,125

With-Waiver Total Expenditures

	2019
IMD Services MEG 1	$2,588,542
IMD Services MEG 2	$282,517
IMD Services MEG 3	$7,851,066
Continue MEGs from Above, As Needed	
TOTAL	$10,722,125
Net Overspend	$0

Supplemental Test #2: Non-IMD Services CNOM Limit
Without-Waiver Total Expenditures

	2019
Non-IMD Services CNOM Limit MEG	$0
TOTAL	$0

With-Waiver Total Expenditures

	2019
Non-IMD Services CNOM Limit MEG	$0
TOTAL	$0
Net Overspend	$0

Main Budget Neutrality Test (i.e. NOT Hypothetical)
With-Waiver Total Expenditures

	2019
Non-Hypothetical Services CNOM MEG	$0
TOTAL	$0

Add Trend Rates & PMPMs from Table Below to 'SUD IMD Supplemental Budget Neu

SUD MEG(s)	Trend Rate
IMD Services MEG 1	4.9%
IMD Services MEG 2	4.9%
IMD Services MEG 3	4.9%
Continue MEGs from Above, As Needed	
Non-IMD Services CNOM Limit MEG	0.0%

Main Test: With Waiver "Coster(s)" (Amendments Only)

Non-Hypothetical Services CNOM MEG	0.0%

DEMONSTRATION YEARS (DY)			
2020	2021	2022	2023
$2,742,539	$2,905,687	$3,078,544	$3,261,682
$299,324	$317,131	$335,997	$355,986
$8,318,142	$8,812,953	$9,337,255	$9,892,704
$11,360,005	$12,035,771	$12,751,795	$13,510,372

2020	2021	2022	2023
$2,742,539	$2,905,687	$3,078,544	$3,261,682
$299,324	$317,131	$335,997	$355,986
$8,318,142	$8,812,953	$9,337,255	$9,892,704
$11,360,005	$12,035,771	$12,751,795	$13,510,372

$0	$0	$0	$0

DEMONSTRATION YEARS (DY)			
2020	2021	2022	2023
$0	$0	$0	$0
$0	$0	$0	$0

2020	2021	2022	2023
$0	$0	$0	$0
$0	$0	$0	$0

$0	$0	$0	$0

DEMONSTRATION YEARS (DY)			
2020	2021	2022	2023
$0	$0	$0	$0
$0	$0	$0	$0

ıtrality Test(s)' STC

2019	2020	2021	2022
$2,377	$2,494	$2,616	$2,744
$4,114	$4,315	$4,527	$4,748
$1,073	$1,126	$1,181	$1,239
$0	$0	$0	$0

$0	$0	$0	$0

TOTAL
$14,576,993
$1,590,954
$44,212,120
$60,380,068

TOTAL
$14,576,993
$1,590,954
$44,212,120
$60,380,068
$0

TOTAL
$0
$0

TOTAL
$0
$0
$0

TOTAL
$0
$0

2023
$2,879
$4,981
$1,300
$0

$0

IMD Caseloads

Projected IMD Member Months/Caseloads

	Trend Rate	2019
IMD Services MEG 1	1.0%	1,089
IMD Services MEG 2	1.0%	69
IMD Services MEG 3	1.0%	7,315
Non-IMD Services CNOM Limit MEG		
Non-Hypothetical Services CNOM MEG		

DEMONSTRATION YEARS (DY)			
2020	2021	2022	2023
1,100	1,111	1,122	1,133
69	70	71	71
7,389	7,462	7,537	7,612
0	0	0	0
0	0	0	0

Overview of the Assessment of the Availability of Mental Health Services

CMS developed this draft template for use (1) at application and (2) in annual monitoring reports. As described in SMD #18-011:

1. CMS strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, particularly crisis stabilization services;
2. CMS expects states to conduct annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services, and provide updates on steps taken to increase service availability.

The template is intended to guide states in conducting a thorough assessment of availability across various components of a state's mental health system. Suggested data elements describe the following providers and service settings:

- Providers
  - -Psychiatrists and other providers authorized to prescribe
  - -Other practitioners authorized to treat mental illness
- Community mental health centers (CMHCs)
- Intensive outpatient/Partial hospitalization
- Residential treatment facilities and beds
- Inpatient facilities and beds
- Crisis stabilization services
- Federally Qualified Health Centers offering behavioral health services

Instructions for Completing the Assessment of the Availability of Mental Health Services ("Availability Assessment" tab)

Note: Instructions for completing each cell of the availability assessment will be included in an instruction tab and in pop-up comments within the body of the assessment template. See below for an example of what such instructions will include.

Each state will submit multiple availability assessments. The state will submit an initial assessment at the time of application and annual assessments thereafter. The state will select a consistent month in each year to populate the information in the template (e.g. provide initial information based on counts covering April 2019, and update the information based on counts covering April 2020, April 2021, April 2022, and April 2023).

Enter the state name, data entry date(s), and time period reflected in the assessment in cells C1-3.

In column B, enter each geographic designation starting in cell B7. Add rows as needed to capture all geographic designations. The state should select and input geographic units of analysis. The state should consider how it divides its mental health system into smaller units or catchment areas to select geographic designations that will yield meaningful, actionable information. For example, the geographic designations could be counties, regions, or human services districts.

In column C, starting in cell C8, enter the total number of adult Medicaid beneficiaries in each geographic designation ever enrolled in the most recent 12 month period for which data are available.

In column D, starting in cell D8, enter the number of adults with SMI in each geographic designation. As defined on page 1 of the SMDL, adults with SMI are those age 21 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. Major life activities include activities of daily living (e.g., eating, bathing, dressing), instrumental activities of daily living (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication), and functioning in social, family, and vocational/educational contexts.

In column E, starting in cell E8, the inventory will automatically calculate the percent of adult Medicaid beneficiaries who have SMI in each geographic designation. The state should not input any values into this column or modify the formulas in this column.

In column F, starting in cell F8, enter the total number of Medicaid beneficiaries under the age of 21 in each geographic designation ever enrolled in the most recent 12 month period for which data are available.

In column G, starting in cell G8, enter the number of beneficiaries under the age of 21 with SED in each geographic designation. As defined on page 2 of the SMDL, individuals with SED are those who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment" is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills.

In column H, starting in cell H8, the inventory will automatically calculate the percent of beneficiaries under the age of 21 who have SED in each geographic designation. The state should not input any values into this column or modify the formulas in this column.

Additional rows will be added with instructions for completing the remaining columns of the "Availability Assessment" tab of the template.

State Name	Indiana
Date of Assessment	7/1/19
Time Period Reflected in Assessment	06/01/2019

Geographic Distribution	**Beneficiaries**									
	Adult			**Under 21**			**Total**			
Geographic designation	Number of Medicaid beneficiaries (Adult)	Number of Medicaid beneficiaries with SMI (Adult)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (Under 21)	Number of Medicaid beneficiaries with SED (Under 21)	Percent with SED (Under 21)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)	Beneficiary Category Notes
1. Statewide	761825	44943	6%	698360	39100	6%	1460185	84043	6%	SMI & SED prevalence is based on Medicaid enrollees accessing a DMHA certified provider. SED data is captured for those under 18.
2.			-			-	0	0	-	
3.			-			-	0	0	-	
4.			-			-	0	0	-	
5.			-			-	0	0	-	
6.			-			-	0	0	-	
7.			-			-	0	0	-	
8.			-			-	0	0	-	
9.			-			-	0	0	-	
10.			-			-	0	0	-	
Total	**761825**	**44943**	**6%**	**698360**	**39100**	**6%**	**1460185**	**84043**	**6%**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

	Geographic Distribution	Providers						
		Psychiatrists or Other Practitioners Who Are Authorized to Prescribe						
	Geographic designation	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Total Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatrists or Other Prescribers	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Category Notes
1.	Statewide	433	336	265	0.003997953	0.775981524	0.788690476	This data currently includes only psychiatrists. In Indiana, advanced practice nurses who complete a certification are also authorized to prescribe psychotropic medications. This data is not readily available for this submission; the State will work toward a methodology for gathering for future submissions.
2.					-	-	-	
3.					-	-	-	
4.					-	-	-	
5.					-	-	-	
6.					-	-	-	
7.					-	-	-	
8.					-	-	-	
9.					-	-	-	
10.					-	-	-	
	Total	**433**	**336**	**265**	**0.003997953**	**0.775981524**	**0.788690476**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution — Providers

Other Practitioners Authorized to Treat Mental Illness

	Geographic designation	Number of Other Types of Practitioners Authorized to Treat Mental Illness	Number of Medicaid-Enrolled Other Types of Practitioners Authorized to Treat Mental Illness	Number of Medicaid-Enrolled Other Types of Practitioners Authorized to Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness to Medicaid Beneficiaries with SMI/ SED	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness to Total Practitioners Authorized to Treat Mental Illness	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness Accepting New Patients to Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness	Other Practitioner Category Notes
1.	Statewide	966	1212	604	0.014421189	1.254658385	0.498349835	Midlevel behavioral health practitioners do not independently enroll in Indiana Medicaid; they must bill under the supervision of an HSPP or psychiatrist. Therefore, only HSPPs are included. Additionally, the number of Medicaid enrolled appears larger than number licensed as the number of Medicaid enrolled providers include those in out-of-state border cities treated as in-state providers and also includes individuals practicing at multiple service locations. The number accepting new patients is based on MCO data. To avoid duplication of practitioners enrolled in multiple MCOs, data from the MCO with the largest network is included. The number accepting new patients may therefore be higher if there are providers enrolled in a different MCO. The state will work toward a methodology to improve for future submissions.
2.					-	-	-	
3.					-	-	-	
4.					-	-	-	
5.					-	-	-	
6.					-	-	-	
7.					-	-	-	
8.					-	-	-	
9.					-	-	-	
10.					-	-	-	
	Total	**966**	**1212**	**604**	**0.014421189**	**1.254658385**	**0.498349835**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Community Mental Health Centers

	Geographic designation	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled CMHCs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled CMHCs to Total CMHCs	Ratio of Medicaid-Enrolled CMHCs Accepting New Patients to Medicaid-Enrolled CMHCs	CMHC Category Notes
1.	Statewide	24	24	24	0.000285568	1	1	
2.					-	-	-	
3.					-	-	-	
4.					-	-	-	
5.					-	-	-	
6.					-	-	-	
7.					-	-	-	
8.					-	-	-	
9.					-	-	-	
10.					-	-	-	
	Total	**24**	**24**	**24**	**0.000285568**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Intensive Outpatient or Partial Hospitalization Providers						
	Number of Intensive Outpatient/Partial Hospitali-zation Providers	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitali-zation Providers Accepting New Medicaid Patients	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitali-zation Providers Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Intensive Outpatient/ Partial Hospitali-zation Providers to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Intensive Outpatient/Partial Hospitali-zation Providers to Total Partial Hospitali-zation/Day Treatment Providers	Ratio of Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers Accepting New Medicaid Patients to Medicaid-Enrolled Partial Hospitalization/ Day Treatment Providers	Intensive Outpatient/ Partial Hospitali-zation Category Notes
Geographic designation							
1. Statewide	N/A	N/A	N/A	N/A	N/A	N/A	The # of IOP/PHP providers in the state/Medicaid enrolled is not collected as this is not a specific license or provider type.
2.				-	-	-	
3.				-	-	-	
4.				-	-	-	
5.				-	-	-	
6.				-	-	-	
7.				-	-	-	
8.				-	-	-	
9.				-	-	-	
10.				-	-	-	
Total	**0**	**0**	**0**	**0**	**-**	**-**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Residential Mental Health Treatment Facilities					
	Residential Mental Health Treatment Facilities (Adult)					
Geographic designation	Number of Residential Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) to Total Residential Treatment Facilities (Adult)	Ratio of Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) Accepting New Patients to Medicaid-Enrolled Residential Treatment Facilities (Adult)
1. Statewide	N/A	N/A	N/A		-	-
2.				-	-	-
3.				-	-	-
4.				-	-	-
5.				-	-	-
6.				-	-	-
7.				-	-	-
8.				-	-	-
9.				-	-	-
10.				-	-	-
Total	**0**	**0**	**0**	**0**	**-**	**-**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities (Adult)

	Geographic designation	Total Number of Residential Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Treatment Beds (Adult)	Total Number of Medicaid-Enrolled Residential Treatment Beds Accepting New Adult Medicaid Patients	Number of Residential Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients
1.	Statewide	N/A	N/A	N/A	N/A	N/A	N/A
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
	Total	**0**	**0**	**0**	**0**	**0**	**0**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Residential Mental Health Treatment Facilities						
	Residential Mental Health Treatment Facilities (Adult)						
Geographic designation	Ratio of Medicaid-Enrolled Residential Treatment Beds to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Beds to Total Residential Treatment Beds	Ratio of Medicaid-Enrolled Residential Treatment Beds Accepting New Medicaid Patients to Medicaid-Enrolled Residential Treatment Beds	Ratio of Medicaid-Enrolled Residential Treatment Facilities that Qualify as IMDs to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs to Total Residential Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients to Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs	Residential Treatment Facility Category Notes (Adult)
1. Statewide	-	-	-	-	-	-	Adult SMI residential treatment facilities are not an applicable provider type in the state.
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	
Total	**0**	**-**	**-**	**0**	**-**	**-**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Residential Mental Health Treatment Facilities					
	Psychiatric Residential Treatment Facilities					
Geographic designation	Number of Psychiatric Residential Treatment Facilities (PRTF) (Under 21)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled PTRFs to Medicaid Beneficiaries with SED (Under 21)	Ratio of Medicaid-Enrolled PRTFs to Total PTRFs	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Number of Medicaid-Enrolled PRTFs
1. Statewide	12	12	12	0.000306905	1	1
2.				-	-	-
3.				-	-	-
4.				-	-	-
5.				-	-	-
6.				-	-	-
7.				-	-	-
8.				-	-	-
9.				-	-	-
10.				-	-	-
Total	**12**	**12**	**12**	**0.000306905**	**1**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Psychiatric Residential Treatment Facilities

	Geographic designation	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Number of Medicaid-Enrolled PRTF Beds Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid Beneficiaries with SED	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Total Number of PRTFs	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Number of Medicaid-Enrolled PRTFs	Psychiatric Residential Treatment Facility (Under 21) Category Notes
1.	Statewide	377	377	377	0.009641944	1	1	
2.					-	-	-	
3.					-	-	-	
4.					-	-	-	
5.					-	-	-	
6.					-	-	-	
7.					-	-	-	
8.					-	-	-	
9.					-	-	-	
10.					-	-	-	
	Total	**377**	**377**	**377**	**0.009641944**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient
	Psychiatric Hospitals

	Geographic designation	Number of Public Psychiatric Hospitals	Number of Private Psychiatric Hospitals	Number of Medicaid-Enrolled Public Psychiatric Hospitals	Number of Medicaid-Enrolled Private Psychiatric Hospitals	Medicaid-Enrolled Public Psychiatric Hospitals Accepting New Medicaid Patients	Medicaid Enrolled Private Psychiatric Hospitals Accepting New Medicaid Patients
1.	Statewide	6	28	6	23	6	23
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
	Total	**6**	**28**	**6**	**23**	**6**	**23**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient						
	Psychiatric Hospitals						
Geographic designation	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals to Public Psychiatric Hospitals	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals to Private Psychiatric Hospitals	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Public Psychiatric Hospitals	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Private Psychiatric Hospitals	Psychiatric Hospital Category Notes
1. Statewide	7.1392E-05	0.000273669	1	0.821428571	1	1	
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	
Total	**7.1392E-05**	**0.000273669**	**1**	**0.821428571**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient					
	Psychiatric Hospitals That Qualify As IMDs					
Geographic designation	Number of Public Psychiatric Hospitals that qualify as IMDs	Number of Private Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients	Number of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients
1. Statewide	6	13	6	13	6	13
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Total	**6**	**13**	**6**	**13**	**6**	**13**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient						
	Psychiatric Hospitals That Qualify As IMDs						
Geographic designation	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs to Public Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs to Private Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients to Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients to Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs	Psychiatric Hospitals That Qualify As IMDs Category Notes
1. Statewide	7.1392E-05	0.000154683	1	1	1	1	
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	
Total	**7.1392E-05**	**0.000154683**	**1**	**1**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient					
	Psychiatric Units					
Geographic designation	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients
1. Statewide	32	2	28	2	28	2
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Total	**32**	**2**	**28**	**2**	**28**	**2**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient						
	Psychiatric Units						
Geographic designation	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Psychiatric Units in Critical Access Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatric Units in Critical Access Hospitals	Psychiatric Unit Category Notes
1. Statewide	0.000333163	2.37973E-05	0.875	1	1	1	
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	
Total	**0.000333163**	**2.37973E-05**	**0.875**	**1**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient						
	Psychiatric Beds						
Geographic designation	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Medicaid-Enrolled Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Medicaid-Enrolled Licensed Psychiatric Hospital Beds Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds Accepting New Medicaid Patients to Medicaid-Enrolled Licensed Psychiatric Hospital Beds	Psychiatric Beds Category Notes
1. Statewide	2982	2752	2752	458.6666667	0.922870557	1	
2.				-	-	-	
3.				-	-	-	
4.				-	-	-	
5.				-	-	-	
6.				-	-	-	
7.				-	-	-	
8.				-	-	-	
9.				-	-	-	
10.				-	-	-	
Total	**2982**	**2752**	**2752**	**458.6666667**	**0.922870557**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

	Geographic Distribution	Crisis Stabilization Services								
	Geographic designation	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Coordinated Community Crisis Response Teams	Ratio of Crisis Call Centers to Medicaid Beneficiaries with SMI/SED	Ratio of Mobile Crisis Units to Medicaid Beneficiaries with SMI/SED	Ratio of Crisis Observation/ Assessment Centers to Medicaid Beneficiaries with SMI/SED	Ratio of Coordinated Community Crisis Response Teams to Medicaid Beneficiaries with SMI/SED	Crisis Stabilization Services Category Notes
1.	Statewide	24	5	7	N/A	0.000285568	5.94934E-05	8.32907E-05	-	
2.						-	-	-	-	
3.						-	-	-	-	
4.						-	-	-	-	
5.						-	-	-	-	
6.						-	-	-	-	
7.						-	-	-	-	
8.						-	-	-	-	
9.						-	-	-	-	
10.						-	-	-	-	
	Total	**24**	**5**	**7**	**0**	**0.000285568**	**5.94934E-05**	**8.32907E-05**	**0**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

	Geographic Distribution	Federally Qualified Health Centers		
	Geographic designation	Number FQHCs that Offer Behavioral Health Services	Ratio of FQHCs that Offer Behavioral Health Services to Medicaid Beneficiaries with SMI/SED	FQHC Category Notes
1.	Statewide	23	0.000273669	
2.			-	
3.			-	
4.			-	
5.			-	
6.			-	
7.			-	
8.			-	
9.			-	
10.			-	
	Total	**23**	**0.000273669**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.