MID-POINT ASSESSMENT OF INDIANA'S SECTION 1115 SUBSTANCE USE DISORDER WAIVER

FINAL VERSION
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Abbreviations List

Abbreviation	Meaning	Abbreviation	Meaning
AA	Alcoholics Anonymous	IHCDA	Indiana Housing and Community Development Authority
ANSA	Adult Needs and Strengths Assessment	IMD	Institution for Mental Diseases
AOD / AODD	Alcohol or Other Drug Dependence	INSPECT	Indiana Prescription Drug Monitoring Program
APR-DRG	All Patient Refined Diagnostic Related Grouping	IOP	Intensive Outpatient Program
ASAM	American Society of Addiction Medicine	IOT	Intensive Outpatient Treatment
B&A	Burns & Associates, Inc.	IPLA	Indiana Professional Licensing Agency
BT	Numbering of provider bulletins	ISDH	Indiana State Department of Health
CANS	Child and Adolescent Needs and Strengths	IT	Information Technology
CMCS	Cooperative Managed Care Services	LCAC	Licensed Clinical Addiction Counselors
CMS	Centers for Medicare and Medicaid Services	MAT	Medication assisted treatment
Core MMIS	Core Medicaid Management Information System	MCE	Managed Care Entity
CY	Calendar Year	MHS	Managed Health Services
Demo	Demonstration Year	Model	Model or Managed Care Population
DMHA	Division of Mental Health and Addiction	MRO	Medicaid Rehabilitation Option
DRG	Diagnosis-Related Group	NA	Narcotics Anonymous
Dual	Dual Eligible for Medicare and Medicaid	NPI	National Provider Identifier
DY	Demonstration Year	OBOT	Office-Based Opioid Treatment
EBT	Electronic benefit transfer	OMPP	Office of Medicaid Policy and Planning
ED	Emergency Department	OTP	Opioid Treatment Program
FAQ	Frequently Asked Question(s)	OUD	Opioid Use Disorder
FFS	Fee-For-Service	PDMP	Prescription Drug Monitoring Program
FSSA	Family and Social Services Administration	PH/PHP	Partial Hospitalization Progam
HCPCS	Healthcare Common Procedure Coding System	PMPM	Per-Member-Per-Month
HEALTH IT	Health Information Technology	SAMHSA	Substance Abuse and Mental Health Services Administration
HIP	Healthy Indiana Plan 2.0	SPA	State Plan Amendment
HIT	Health Information Technology	STC	Special Terms and Conditions
IAC	Indiana Administrative Code	SUD	Substance Use Disorder
IDOC	Indiana Department of Corrections	WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

EXECUTIVE SUMMARY

Background

On February 1, 2018, Indiana's Family and Social Services Administration (FSSA) received approval of its Substance Use Disorder (SUD) Implementation Protocol as required by special terms and conditions of the state's section 1115 Healthy Indiana Plan (HIP) demonstration. As set forth in the Implementation Plan, the FSSA is focusing on three areas specifically:

1. Expanded SUD treatment options for as many of its members as possible;
2. Stronger, evidence-based certification standards for its SUD providers, particularly its residential treatment providers; and
3. Consistency with prior authorization criteria and determinations among its health plans (called managed care entities, or MCEs, in Indiana).

In support of these focus areas, Indiana's FSSA and the Centers for Medicare and Medicaid Services (CMS) identified six key milestones, as described in their approved Implementation and Monitoring Plan, which include:

1. Access to critical levels of care for SUD treatment;
2. Use of evidence-based SUD-specific patient placement criteria; prior-authorization, providers, payers; matching need to capacity;
3. Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities;
4. Sufficient provider capacity at critical levels of care, including medication assisted treatment for opioid use disorder (OUD);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transition between levels of care.

The FSSA's Office of Medicaid Policy and Planning (OMPP) has responsibility for the administration and oversight of Indiana's Medicaid program under waiver and state plan authorities. With the OMPP, the FSSA Division of Mental Health and Addiction (DMHA) has played a key role in the implementation activities identified in the approved SUD Implementation Protocol. In addition to the FSSA, the Indiana State Department of Health (ISDH), Indiana Department of Corrections (IDOC), and Indiana Professional Licensing Agency (IPLA) are all participating in aspects of implementing the SUD waiver.

Indiana's SUD Health Information Technology (HIT) Plan was approved by CMS on June 6, 2018. The plan builds upon the State's prescription drug monitoring program (INSPECT). The IPLA has responsibility for oversight of INSPECT and its functionality. The IPLA is also responsible for development and implementation of the approved SUD HIT plan. Key components of the HIT plan include the following:

- Prescription Drug Monitoring Program (PDMP) Functionalities
- Current and future PDMP query capabilities
- Use of PDMP – supporting clinicians with changing office workflows / business processes
- Overall objective for enhancing PDMP functionality and interoperability

The FSSA amended its SUD Monitoring Protocol after CMS released its guidance to states regarding a standardized monitoring approach. Indiana's SUD Monitoring Protocol now mirrors the CMS protocol. In particular, Indiana is reporting on 31 of 36 CMS-recommended or required SUD measures and intends to report on two additional measures related to overdose deaths when the data becomes available.

Burns & Associates, Inc. (B&A) serves as the independent evaluator of Indiana's SUD waiver. In addition, B&A provides technical assistance to the FSSA in the computation of the 31 SUD measures submitted either quarterly or annually to CMS. For this Mid-Point Assessment, B&A utilized data computed and trended to date on many of these measures to inform our assessment. Additional sources used in the assessment include the following:

- A review of the State's progress against tasks it enumerated in its SUD Implementation Plan;
- One-on-one interviews with 20 SUD providers during November and December, 2019;
- One-on-one interviews with 21 Medicaid beneficiaries of SUD treatment; and
- Feedback from an interview session attended by the four MCEs under contract with FSSA.

Activities Already Completed by the FSSA in its SUD Implementation Protocol

The FSSA identified 31 specific activities in its protocol that it has been working to complete. These activities are organized in areas related to access to service, patient placement criteria, program standards for provider contracting, provider capacity, treatment and prevention, care coordination and transitions between levels of care.

To date, 22 of the 31 activities have been completed. Some of the notable activities completed include obtaining federal and legislative changes to clarify and expand coverage for SUD treatment; developing communications with providers on new benefits and coverage policies; developing criteria for licensure of residential treatment providers; making systems-related changes to accommodate the policy changes; educating stakeholders on authorization requests and determinations and standardize some aspects; and educating stakeholders on American Society of Addiction Medicine (ASAM) criteria.

Areas that continue to be worked on by the FSSA in its Implementation Protocol include making changes to Indiana Administrative Code related to SUD coverage; development of a supportive housing solution; development of criteria or tools to be used in patient placement that align with ASAM; and integrating all hospitals in Indiana with INSPECT.

Assessment of Progress Toward FSSA Milestones

B&A compiled the results of our review of the status of action items in the FSSA's Implementation Protocol, the review of trends on metrics tabulated on a regular basis, and the qualitative feedback from providers, beneficiaries and MCEs to make assessment of the FSSA's progress toward meeting each of the six milestones it identified in its Implementation and Monitoring Plan. B&A assigned a risk level of "low", "medium" or "high" that FSSA would not achieve success in reaching each milestone by the end of the waiver period. For each milestone, B&A offers recommendations to the FSSA for potential modifications to its Implementation Plan or Monitoring Protocol to better equip the State to achieve each milestone. A summary of this information appears in the table on the next two pages. More details on the results of trends in monitoring metrics appear in Section III of this report. Additional feedback from stakeholders appears in Section IV. A summary of progress and potential risks are shown for each milestone along with the recommendations from B&A for each milestone in Section V.

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Fully Completed	Total	Percent Completed	Desired to Date	Total	Percent As Desired		
#1 Access to Critical Levels of Care for SUD Treatment	11	17	65%	7	12	58%	1. Beneficiaries do not have a good understanding of benefits or where to access services. 2. The waiver has provided ability to treat in settings previously not covered by Medicaid. 3. The waiver allows ability to deal with relapses that are common in SUD treatment. 4. Providers expressed concerns from beneficiaries if Medicaid will cover their treatment.	**Medium**
Recommendations for Potential Modifications to Implementation Plan or Monitoring Protocol	1	FSSA should develop a mechanism for periodic review (e.g. annual or every two years) of the method used by high-volume SUD providers to determine how they assess patient need for SUD services.						
	2	FSSA should develop a compendium of tools used by providers with more experience in the field that can be shared to educate newer-contracted providers.						
	3	FSSA clinical team is encouraged to facilitate an educational session with the providers and the MCEs on the application of the tools commonly used to assess patient need for substance use treatment and how these tools align with ASAM.						
	4	The FSSA should outreach to the existing provider base about its capacity and interest to be licensed as ASAM 3.7 providers.						
	5	The FSSA should outreach to existing providers and potential other entities about options to build a supportive housing network of providers statewide.						
	6	The FSSA, in coordination with MCEs, should conduct a root cause analysis of why early intervention services and withdrawal management are not being reported.						
	7	The FSSA should convene its MCEs and FFS counterparts to determine if it is possible to allow some standardization of the amount and duration of intensive outpatient service sessions.						
	8	The FSSA, in coordination with its MCEs, should conduct a root cause analysis to determine the reason for the reduction of total days in ASAM level 4.0 during the waiver period.						
#2 Use of Evidence-Based SUD-specific Patient Placement Criteria	3	4	75%	none to report			1. Differing interpretations/results of authorization decisions by MCEs. 2. Authorization process differs by MCEs (e.g. documentation, concurrent review process). 3. Improvements seen in authorizations with FSSA assistance, but more clarification needed. 4. Some unintended consequences since introduction of the waiver (e.g., denials for alcohol detoxification, denials for treatment for justice-involved population).	**Low**
Recommendations for Potential Modifications to Implementation Plan or Monitoring Protocol	9	The FSSA should require reporting by each of its MCEs of inter-rater reliability testing conducted on its clinical staff to review SUD-related authorization requests.						
	10	The FSSA should conduct its own inter-rater reliability test of clinicians across the MCEs.						
#3 Use of Nationally-Recognized SUD-specific Program Standards for Residential Treatment	1	2	50%	none to report			1. Need for licensure at ASAM level 3.7. 2. Concern from providers about some requirements for ASAM 3.1/3.5 combo settings. 3. Some issues early on with onboarding new providers at the MCEs.	**Low**
Recommendation for Potential Modifications	11	The FSSA should consider either a removal of the physical location requirement between ASAM 3.1 and 3.5 programs or allow for waivers of this requirement, particularly for programs that were in place prior to the waiver						

Milestone	Action Items in Implementation Protocol			Monitoring Metric Goals			Key Themes from Stakeholder Feedback	Risk Level
	Fully Completed	Total	Percent Completed	Desired to Date	Total	Percent As Desired		
#4 Sufficient Provider Capacity at Critical Levels of Care	4	4	100%	2	2	100%	1. Concern from beneficiaries accessing treatment nearby (i.e. w/in 60 miles of their home). 2. Concern from beneficiaries about access across continuum (e.g. supportive housing, IOP). 3. Concern from MCEs with provider supply at lower ASAM levels.	**Medium**
Recommendations for Potential Modifications to Implementation Plan or Monitoring Protocol	12	The FSSA should track diagnoses for authorization requests by region of the state to better understand trends and potentially develop provider outreach or other policies specific to the needs of different communities in the state.						
	13	The FSSA should consider financial and/or non-financial incentives (e.g., reduced administrative requirements) to incentivize providers to develop residential treatment programs specifically for adolescents.						
	14	The FSSA may want to consider piloting a bundled payment model for selected residential programs to encourage participation.						
#5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse	2	3	67%	5	11	45%	1. Initial FSSA guidance (lack of clarity) caused confusion for providers and MCEs. 2. Ongoing FSSA-led joint providers/MCE meetings since start have been very helpful. 3. Written communications (e.g. provider bulletins) from FSSA could be improved. 4. Some improvements from FSSA (e.g. common prior auth form) but also some new confusion (e.g. MRO services now delivered by MCEs).	**Medium**
Recommendations for Potential Modifications to Implementation Plan or Monitoring Protocol	15	The FSSA should consider making either Initiation and Engagement of AOD Treatment or Follow-up After Discharge from an Emergency Department for AOD as one of its pay-for-outcomes measures in its contracts with the MCEs.						
	16	The FSSA should encourage or require a SUD-specific quality improvement program from each of its MCEs that focuses on one or more of the SUD-related measures.						
	17	The FSSA should determine the barriers for emergency responders to bill Medicaid for naloxone.						
	18	The FSSA should track access to both OTP and OBOT and identify strategies to support the increased use of OBOT and buprenorphine waivered clinicians.						
	19	The State's IPLA needs to develop a plan to either report on the measures that have been specified in the SUD Health IT Plan or develop replacement						
	20	The plan to get 100% compliance among in-state hospitals to integrate with INSPECT by the end of CY 2020 needs to be developed, shared and enforced.						
#6 Improved Care Coordination and Transition Between Levels of Care	1	1	100%	4	7	57%	1. Providers cited that care coordination activities with each MCE varies. 2. MCEs cited communication challenges with some providers regarding early discharges. 3. Beneficiaries interviewed who received inpatient or residential services sometimes stated it was not long enough.	**Medium**
Recommendations for Potential Modifications to Implementation Plan or Monitoring Protocol	21	The FSSA should consider both incentives and penalties for providers who do not participate with the MCEs in transitions of members across ASAM levels.						
	22	The FSSA should add accountability standards in its MCE contracts to ensure a higher level of documented transitions of its members across ASAM levels.						
	23	The FSSA should implement common billing guidelines for SUD services across FFS and managed care.						
	24	The FSSA should provide either a summary of changes at the start of provider bulletins that are updates or replacements of other bulletins.						
	25	The FSSA should provide more specific language and terminology to avoid different interpretations of the same policy statement.						

SECTION I: BACKGROUND

Indiana, along with a number of states, is in the midst of a substantial drug abuse epidemic. The magnitude of the epidemic is demonstrated by the following facts:

- Nearly six times as many Hoosiers died from drug overdoses in 2014 as did in 2000, and the number of heroin overdose deaths increased by nearly 25 times between 2000 and 2014.[1]
- In 2014, Indiana had the 16th highest drug overdose death rate in the nation, which represented a statistically significant increase in the rate from 2013.[2]
- Since 2009, more Hoosiers have lost their lives due to a drug overdose than in automobile accidents on state highways.[3]
- The State's Medicaid population has been particularly impacted by the crisis with nearly 100,000 individuals treated for a diagnosis of substance use disorder in 2016.[4]

As an outgrowth of recommendations made by the State's Taskforce on Drug Enforcement, Treatment, and Prevention, the Indiana Family and Social Services Administration (FSSA) requested a waiver from the Centers for Medicare and Medicaid (CMS) under the authority of section 1115(a) of the Social Security Act. The waiver request was to add new evidence-based substance use disorder (SUD) treatment services and to expand access to qualified providers through a waiver of the Institution for Mental Diseases (IMD) exclusion. As proposed, the SUD services would be available to all Medicaid beneficiaries, not just those eligible as a result of the demonstration waiver. The waiver application was submitted on January 31, 2017 and amended on July 20, 2017. The waiver request was subsequently approved on February 1, 2018.

Primary Goals of Indiana's Section 1115 SUD Demonstration Waiver

On February 1, 2018, Indiana also received approval of its SUD Implementation Protocol as required by special terms and conditions (STC) X.10 of the state's section 1115 Healthy Indiana Plan (HIP) demonstration. As set forth in the Implementation Plan, Indiana is aligning the six goals for the SUD waiver component with the milestones outlined by CMS as follows: [5]

[1] Indiana State Department of Health, Indiana: Special Emphasis Report, Drug Overdose Deaths, 1999-2013 (2016), available at http://www.in.gov/isdh/files/2016_SER_Drug_Deaths_Indiana.pdf.

[2] R. Rudd et al., Increases in drug and opioid overdose deaths — United States, 2000–2014, 64(50) Morbidity and Mortality Weekly Report 1378 (2016).

[3] Indiana State Department of Health, Indiana: Special Emphasis Report, Drug Overdose Deaths, 1999-2013 (2015), available at http://www.in.gov/isdh/files/2015_SER_Drug_Deaths_Indiana_Updated.pdf

[4] State of Indiana 1115 SUD Waiver Implementation Plan, page 4, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-sud-implementation-prtcl-appvl-02012018.pdf

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

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

To accomplish these six goals, Indiana Medicaid is focusing on the three following areas: [6]

- Expanded SUD treatment options for as many of its members as possible;
- Stronger, evidence-based certification standards for its SUD providers, particularly its residential addiction providers; and
- Consistency with prior authorization criteria and determinations among its health plans.

In support of these focus areas, Indiana Medicaid and CMS identified six key milestones, as described in their approved Implementation and Monitoring Plan, which include:[7]

1. Access to critical levels of care for SUD treatment;

2. Use of evidence-based SUD-specific patient placement criteria; prior-authorization, providers, payers; matching need to capacity;

3. Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities;

4. Sufficient provider capacity at critical levels of care, including medication assisted treatment for opioid use disorder (OUD);

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and

6. Improved care coordination and transition between levels of care.

State Agency Collaboration to Conduct Its SUD Implementation Protocol

The FSSA's Office of Medicaid Policy and Planning (OMPP) has responsibility for the administration and oversight of Indiana's Medicaid program under waiver and state plan authorities. With the OMPP, the FSSA Division of Mental Health and Addiction (DMHA) has played a key role in the implementation activities identified in the approved SUD Implementation Protocol. In addition to the FSSA, the Indiana State Department of Health (ISDH), Indiana Department of Corrections (IDOC), and Indiana Professional Licensing Agency (IPLA) are all participating in aspects of implementing the SUD waiver. Two agencies

[6] Indiana 1115 SUD Waiver Implementation Plan, Updated January 2018, page 4, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-sud-implementation-prtcl-appvl-02012018.pdf

[7] Indiana 1115 SUD Waiver Implementation Plan, Updated January 2018, pages 4 – 30, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-sud-implementation-prtcl-appvl-02012018.pdf

are providing data—the ISDH is the source for reporting overdose deaths and the IDOC is the source for identifying the criminally involved subpopulation. An overview of each agency's role by milestone in SUD implementation can be found in Exhibit I.1.

Exhibit I.1
Indiana State Agencies by SUD Implementation Protocol Activity

	FSSA		ISDH	IDOC	IPLA
	OMPP	DMHA			
Access to Critical Levels of Care for SUD Treatment	X	X			
Use of Evidence-Based SUD-Specific Patient Placement Criteria	X	X			
Use of Nationally Recognized SUD-Specific Program Standards for Residential Treatment	X	X			
Sufficient Provider Capacity at Critical Levels of Care	X	X			
Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse	X	X	X	X	X
Improved Care Coordination and Transitions Between Levels of Care	X	X			

In addition to the state agencies, FSSA began a partnership linking Open Beds and Indiana 211 to help individuals in need of addiction treatment find resources for treatment.

Beginning in September 2018, OMPP and DMHA began a cross-divisional SUD Work Group to identify and address improvement opportunities in the SUD delivery system and to continue the State's efforts to engage and support SUD stakeholders representing all areas of the SUD continuum of care. During its first year, the workgroup focused on improvements in prior authorization, transitions to care, and state communications. The SUD Workgroup meets on a bi-weekly basis internally. It uses the feedback obtained from providers, managed care entities (MCEs) and other key stakeholders to identify and address challenges in the SUD delivery system. Additional information about the SUD Work Group can be found at: https://www.in.gov/medicaid/providers/1020.htm. Key initiatives coming out of the SUD Workgroup include:

- Develop a common prior authorization form for inpatient and residential SUD services;
- Host quarterly listening sessions for contracted MCEs and providers;
- Create a provider-focused SUD webpage to publish and collate information for providers (https://www.in.gov/medicaid/providers/1020.htm);
- Host three American Society of Addiction Medicine (ASAM) training sessions with national ASAM trainers in three different regions (north, central, south) of the state;
- Host a meeting with SUD inpatient providers where the DMHA Medical Director shares best practices for using ASAM to determine level of care.
- Host a combined MCE and SUD provider meeting. The Independent Evaluator presents results of its independent prior authorization review.
- In partnership with the MCEs, host a training for SUD inpatient and residential providers to learn best practices for prior authorizations and how to access other resources at the MCEs including care coordination.

Key Elements of the SUD Implementation Protocol

The FSSA submitted its SUD Implementation Protocol to CMS in January 2018. The protocol was approved by CMS simultaneous to approval of the SUD waiver itself on February 1, 2018. Key components of the SUD Implementation Protocol include the following:

- Access to critical levels of care for SUD treatment
- Use of evidence-based SUD-specific patient placement criteria
- Use of nationally recognized SUD-specific program standards for residential treatment
- Sufficient provider capacity at critical levels of care
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse
- Improved care coordination and transition between levels of care

FSSA identified 31 specific activities in its protocol that it has been working to complete. In Section II of this report, Burns & Associates, Inc. (B&A) assesses progress on the State's activities as outlined in its SUD Implementation Protocol specifically.

Key Elements of the SUD Health Information Technology Plan

Indiana's SUD Health Information Technology (HIT) Plan was approved by CMS on June 6, 2018. The plan builds upon the State's prescription drug monitoring program (INSPECT). The IPLA has responsibility for oversight of INSPECT and its functionality. The IPLA is also responsible for development and implementation of the approved SUD HIT plan. Key components of the HIT plan include the following:

- Prescription Drug Monitoring Program (PDMP) Functionalities
- Current and future PDMP query capabilities
- Use of PDMP – supporting clinicians with changing office workflows / business processes
- Overall objective for enhancing PDMP functionality and interoperability

The SUD HIT plan identifies seven milestones and 11 specific implementation activities that the State has been working towards. In addition to the HIT implementation activities the FSSA, in conjunction with IPLA, developed three SUD HIT monitoring metrics. In Section III, B&A will assess progress toward meeting the HIT outcome measures in the SUD Monitoring Protocol.

Measures Collected in the SUD Monitoring Protocol

The FSSA submitted a draft SUD Monitoring Protocol to CMS where monitoring aligned with many of the tasks in the State's Implementation Protocol. The State of Indiana was one of the first states to receive SUD waiver approval. As a result, the standardized monitoring approach developed by CMS had yet to be released when Indiana received its SUD waiver approval. Subsequently, Indiana resubmitted its SUD Monitoring Protocol to align with the CMS framework provided to states to focus on the six key milestones.

Exhibit I.2, which appears on the next two pages, lists the metrics that the FSSA is reporting to CMS in its SUD quarterly or annual waiver updates.

Exhibit I.2
Tracking of CMS SUD Monitoring Protocol Metrics Being Reported by Indiana FSSA

CMS Milestone / Metric name	CMS Metric #	Indiana Report-ing?	If Yes, Populations Reporting using CMS Periodicity Schedule						
			Demon-stration	Model	OUD	Age Group	Dual Status	Pregnant	Criminally Involved
Milestone 1: Access to critical levels of care for OUD and other SUDs									
Assessed for SUD Treatment Needs Using a Standardized Screening Tool	1	N	N	N	N	N	N	N	N
Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	2	Y	Y	Y	Y	Y	Y	Y	Y
Medicaid Beneficiaries with SUD Diagnosis (monthly)	3	Y	Y	Y	Y	Y	Y	Y	Y
Medicaid Beneficiaries with SUD Diagnosis (annually)	4	Y	Y	Y	Y	N	N	N	N
Medicaid Beneficiaries Treated in an IMD for SUD	5	Y	Y	Y	Y	N	N	N	N
Utilization of Any SUD Treatment	6	Y	Y	Y	Y	Y	Y	Y	Y
Utilization of Early Intervention	7	Y	Y	Y	Y	Y	Y	Y	Y
Utilization of Outpatient Services	8	Y	Y	Y	Y	Y	Y	Y	Y
Utilization of Intensive Outpatient and Partial Hospitalization Services	9	Y	Y	Y	Y	Y	Y	Y	Y
Utlization of Residential and Inpatient Services	10	Y	Y	Y	Y	Y	Y	Y	Y
Utilization of Withdrawal Management	11	Y	Y	Y	Y	Y	Y	Y	Y
Utilization of Medication Assisted Treatment (MAT)	12	Y	Y	Y	Y	Y	Y	Y	Y
Average Length of Stay in IMDs	36	Y	Y	Y	Y	Y	Y	Y	Y
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria									
There are no CMS-provided metrics related to milestone 2.									
Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities									
There are no CMS-provided metrics related to milestone 3.									
Milestone 4: Sufficient provider capacity at critical levels of care including for medication assisted treatment for OUD									
SUD Provider Availability	13	Y	Y	Y	not applicable				
SUD Provider Availability - MAT	14	Y	Y	Y	not applicable				

Exhibit I.2 (continued)
Tracking of CMS SUD Monitoring Protocol Metrics Being Reported by Indiana FSSA

CMS Milestone / Metric name	CMS Metric #	Indiana Report-ing?	If Yes, Populations Reporting using CMS Periodicity Schedule						
			Demon-stration	Model	OUD	Age Group	Dual Status	Pregnant	Criminally Involved
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD									
Initiation of Alcohol and Other Drug Dependence (AOD) Treatment	15	Y	Y	Y	Y	Y	Y	Y	Y
Engagement of Alcohol and Other Drug Dependence (AOD) Treatment	15	Y	Y	Y	Y	Y	Y	Y	Y
Use of Opioids at High Dosage in Persons Without Cancer	18	Y	Y	Y	N	N	N	N	N
Use of Opioids from Multiple Providers in Persons Without Cancer	19	Y	Y	Y	N	N	N	N	N
Use of Opioids at High Dosage & from Multiple Providers Persons w/o Cancer	20	Y	Y	Y	N	N	N	N	N
Concurrent Use of Opioids and Benzodiazepines	21	Y	Y	Y	N	N	N	N	N
Continuity of Pharmacotherapy for Opioid Use Disorder	22	Y	Y	Y	N	N	N	N	N
Access to Preventive Health Services for Adult Medicaid Benef with SUD	32	Y	Y	Y	N	N	N	N	N
Number of prescribers accessing INSPECT	S.1	intend to	intend to	not applicable					
Number of patient requests made into INSPECT	S.2	Y	Y	not applicable					
Number of prescribers making patient requests through an integrated system	S.3	intend to	intend to	not applicable					
Milestone 6: Improved care coordination and transitions between levels of care									
ED Utilization for SUD per 1,000 Medicaid Beneficiaries	23	Y	Y	Y	Y	Y	N	N	N
Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	24	Y	Y	Y	Y	Y	N	N	N
Readmissions Among Beneficiaries with SUD	25	Y	Y	Y	N	N	N	N	N
AOD Treatment Provided/Offered (metric 1) or Treated (metric 2) at Discharge	16	N	N	N	N	N	N	N	N
Follow-up after Discharge from the ED for AOD (7 days)	17	Y	Y	Y	N	N	N	N	N
Follow-up after Discharge from the ED for AOD (30 days)	17	Y	Y	Y	N	N	N	N	N
Grievances Related to SUD Treatment Services	33	Y	Y	Y	not applicable				
Appeals Related to SUD Treatment Services	34	Y	Y	Y	not applicable				
Critical Incidents Related to SUD Treatment Services	35	N	N	N	not applicable				
Other SUD-related metrics									
Overdose Deaths (count)	26	intend to	intend to	N	intend to	intend to	N	N	N
Overdose Deaths (rate)	27	intend to	intend to	N	intend to	intend to	N	N	N
SUD Spending	28	Y	Y	Y	N	N	N	N	N
SUD Spending within IMDs	29	Y	Y	Y	N	N	N	N	N
Per Capita SUD Spending	30	Y	Y	Y	N	N	N	N	N
Per Capita SUD Spending within IMDs	31	Y	Y	Y	N	N	N	N	N

Independent Evaluator

Burns & Associates, Inc. (B&A) was awarded a contract through competitive bid to serve as the Independent Evaluator of Indiana's SUD waiver. B&A's scope of work includes the following:

- Providing technical assistance related to computing metrics that the FSSA reports on a quarterly and annual basis to CMS as required in the waiver terms and conditions;
- Developing the evaluation design;
- Conducting tasks related to the development of and actual drafting of the Interim Evaluation;
- Conducting tasks related to the development of and actual drafting of the Mid-Point Assessment;
- Conducting tasks related to the development of and actual drafting of the Summative Evaluation.

B&A met with the FSSA SUD Core Team to review the elements required in the Mid-Point Assessment as per the waiver terms and conditions. We described our approach and timeline to meeting each of these requirements. Although the FSSA asked questions of B&A related to certain techniques that would be used, the FSSA did not direct B&A during the preparation of the Mid-Point Assessment. The FSSA did provide B&A with materials to assist us in our work, for example, contact information to outreach to SUD providers. As part of the work related to the evaluation overall, B&A developed an arrangement with the FSSA to receive monthly files from the State's Enterprise Data Warehouse that contain information related to beneficiary enrollment, provider enrollment, and service utilization (fee-for-service claims and managed care encounters). The data used to report results in this Mid-Point Assessment came from the same data used for quarterly reporting and to produce the Interim Evaluation.

An attestation signed by B&A's Principal Investigator appears in Appendix A of this report.

SECTION II: ASSESSMENT OF PROGRESS IN COMPLETING ACTIVITIES IN THE SUD IMPLEMENTATION PROTOCOL

Introduction

The FSSA submitted its SUD Implementation Protocol to CMS in January 2018. The protocol was approved by CMS simultaneous to approval of the SUD waiver itself on February 1, 2018. Key components of the SUD Implementation Protocol include the following:

- Access to critical levels of care for SUD treatment
- Use of evidence-based SUD-specific patient placement criteria
- Use of nationally recognized SUD-specific program standards for residential treatment
- Sufficient provider capacity at critical levels of care
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse
- Improved care coordination and transition between levels of care

FSSA identified 31 specific activities in its protocol that it has been working to complete. In Section II of this report, B&A assesses progress on the State's activities as outlined in its SUD Implementation Protocol specifically. In Section III, B&A will assess progress toward meeting outcome measures in the SUD Monitoring Protocol.

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

FSSA identified 17 specific items in its Implementation protocol related to access to critical levels of care. Among these, 11 have been completed. Six of the 11 items were completed in the timeframe that the State imposed upon itself in its protocol.

Examples of items that have been completed are Indiana Administrative Code (IAC) and State Plan Amendment (SPA) changes related to service coverage. Other examples relate to provider communications and systems changes.

Although some IAC changes have occurred, others in the protocol have yet to be completed. Other items that have not been completed include system changes to convert inpatient SUD stays to a per diem methodology and the development of a supportive housing solution.

Refer to Exhibit II.1 on the next page for additional details.

Exhibit II.1
Tracking Completion of Action Items Cited in the FSSA Approved SUD Implementation Plan
Access to Critical Levels of Care for SUD Treatment

	Action	Implementation Timeline	Was Action Completed?	If Yes, Date Completed	Completed on Time?
1	Pursue Indiana Administrative Code (IAC) change for coverage and reimbursement of OTPs	Will be filed by 12/31/18; completed prior to protocol approval	Yes	9/1/2017	Yes
2	Pursue IAC amendments to Mental Health Services Rule	Will be filed by 12/31/18	No		
3	Pursue IAC change to remove Intensive Outpatient Treatment (IOT) from MRO	Will be filed by 12/31/18	No		
4	Pursue State Plan Amendment (SPA) to move IOT coverage from MRO	Will be filed by 6/30/18	Yes	10/3/2018	No
5	Pursue amendment to 1915(b)(4) waiver	Will be filed by 6/30/18	Yes	2/22/2019	No
6	Make necessary system changes to CoreMMIS to remove IOT from MRO	Will be completed by 6/30/18	Yes	7/1/2019	No
7	Develop provider communication over new benefits- billing for IOT/IOP	Contingent upon approval of SPA	Yes	5/30/2019 BT201929	Yes
8	Make necessary system change to CoreMMIS to enroll residential addiction facilities and to reimburse for residential treatment	Will be completed by 3/1/18	Yes	3/1/2018	Yes
9	Develop provider communication over new benefits- residential treatment	Ongoing and as part of roll-out	Yes	Initial 1/4/2018	Yes
10	Determine final action and necessary system changes to CoreMMIS to allow reimbursement for inpatient SUD stays on a per diem basis	Fall 2018	No		
11	Develop provider communication over new benefits- inpatient SUD stays	Ongoing and as part of roll-out	Yes	Initial 1/4/2018 BT201801	Yes
12	Make necessary system changes to allow reimbursment for Addiction Recovery Management Services	Spring 2018	Yes - excludes Recovery-Focused Case Management	7/1/2019	No
13	Pursue SPA to add coverage and reimbursement of Addiction Recovery Management Services	Spring 2018	Yes	10/3/2018	No
14	Pursue IAC changes to add coverage of Addiction Recovery Management Services	Will be filed by 12/31/18	No		
15	Develop provider communication over new benefits Addiction Recovery Management Services	Ongoing and as part of roll-out	Yes - excludes Recovery-Focused Case Management	Initial 5/30/2019 BT201929	
16	Invite representatives from each of the MCEs, the Indiana Housing and Community Development Authority (IHCDA) and other interested stakeholders towards developing a supportive housing solution	No specific date- implied some time in 2018	No		
17	Establish allowed criteria to use for authorizing inpatient detoxification	February 1, 2018	Yes	8/1/2016 BT01632 & 5/22/2018 BT201821	Yes

Note: Notations with "BT" are the numbering of provider bulletins/communications.

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

Four specific items were identified by FSSA related to evidence-based patient placement criteria (refer to Exhibit II.2 below). Among these, three have been completed. The contracts with each MCE and the FFS program authorization vendor (DXC) were reviewed to ensure operational functions and reporting for SUD were accounted for. This included the addition of reporting starting in January 2019 by the MCEs for SUD-related grievance and appeals, authorization requests and complex case/care management.

The FSSA sponsored provider education on ASAM criteria first through written materials in CY 2018 and later through in-person training in the Spring of CY 2019. A standard authorization request form to be used by each MCEFFS program was implemented in March 2019.

The fourth item in the protocol was not completed and FSSA has decided to abandon the project, at least for the foreseeable future. The FSSA hired researchers to review the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) tools to identify ways to better align these with ASAM criteria. A revised tool was developed and piloted in the field that attempted to consolidate the ANSA and ASAM screening tools into one. It was ultimately decided that the consolidated tool would not be feasible for Indiana, because it was not adequately addressing the screening criteria from each of the separate tools based on testing in the field. At this time, Indiana has decided to not pursue a consolidated screening tool, and providers will continue to use either the ANSA or CANS tool along with the ASAM screening tool.

Exhibit II.2
Tracking Completion of Action Items Cited in the FSSA Approved SUD Implementation Plan
Use of Evidence-Based SUD-specific Patient Placement Criteria

	Action	Implementation Timeline	Was Action Completed?	If Yes, Date Completed	Completed on Time?
18	Provider education on ASAM criteria	Ongoing throughout 2018	Yes	Initial 5/22/2018 BT201821	Yes
19	Development of standard prior authorization SUD treatment form	Completed by 7/1/18	Yes	3/15/2019	No
20	Review MCE and FFS vendor contracts and pursue amendments, where necessary	Filed by 7/1/18	Yes	2/24/2018	Yes
21	Review CANS/ANSA for alignment with ASAM crtieria	Completed by 12/31/18	No		

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

Two items related to SUD-specific program standards for residential treatment. The item related to provisional ASAM designation was completed. Since then, the FSSA has developed a more formal licensure process for ASAM residential levels 3.1 and 3.5 which has been in place since July 2018. The task related to IAC language has yet to be completed.

Exhibit II.3
Tracking Completion of Action Items Cited in the FSSA Approved SUD Implementation Plan
Use of Nationally Recognized SUD-Specific Program Standards for Residential Treatment

	Action	Implementation Timeline	Was Action Completed?	If Yes, Date Completed	Completed on Time?
22	Finalize process for provisional ASAM designation	Completed by 12/31/17	Yes	1/4/2018 BT201801	Yes
23	Insert permanent certification language in IAC	Completed by 12/31/18	No		

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

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

Exhibit II.4
Tracking Completion of Action Items Cited in the FSSA Approved SUD Implementation Plan
Sufficient Provider Capacity at Critical Levels of Care

	Action	Implementation Timeline	Was Action Completed?	If Yes, Date Completed	Completed on Time?
24	Create new provider specialty for residential addictions facilities	Completed by 3/1/18	Yes	3/1/2018	Yes
25	Data reporting by provider specialty and ASAM level of care	Completed by 3/31/18	Yes	Q1 2018 report	Yes
26	New training materials on 1115-approved services as well as provider enrollment for residential facilities	Completed by early 2018	Yes	Initial 1/4/2018	Yes
27	Assessment of ASAM providers and services (by level of care, includes MAT)	Completed by 12/31/18	Yes	Q3 2018 report	Yes

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

Two of the three items in the Implementation Protocol related to treatment and prevention strategies for opioid abuse have been completed. These relate to emergency responder reimbursement of naloxone and expanded coverage of peer recovery coaches, crisis intervention, and intensive outpatient treatment (IOT). Peer recovery coaches, crisis intervention, and IOT services are now available as part of state plan services effective July 1, 2019.

Emergency responder reimbursement of naloxone, as envisioned, would require providers to report usage for Medicaid members to their local health departments and these entities will then bill Indiana Medicaid for the naloxone used and resupply the emergency responders. At this time, the state is continuing to work with two counties, Ripley and Montgomery, and the ISDH to develop a mechanism to reimburse for these services.

During 2018, Indiana was notified that it was awarded a second 21st Century Cures Act grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Part of the funding is to provide naloxone kits to first responders and law enforcement. The initial grant period was May 1, 2017

through April 30, 2018. During that time period, 6,566 kits were issued. For the second grant period beginning May 1, 2018 through April 30, 2019, the state issued 7,147 kits.

The ISDH has several projects to improve access to naloxone including: Naloxone distribution programs for local health departments and first responders (https://www.in.gov/isdh/27616.htm); training programs including statewide training opportunities (https://www.in.gov/isdh/27386.htm); and a dedicated naloxone workgroup. In addition, Indiana Public Law 32 (Senate Bill 406) created the opportunity effective on April 17, 2015 for health care prescribers to prepare a standing order for an overdose prevention drug.

The expanded use of INSPECT (Indiana's prescription drug monitoring program) across all hospitals in the State continues through the present time, but it is not fully integrated in all hospitals. The State gave itself a target completion for this to occur by January 31, 2021.

Exhibit II.5
Tracking Completion of Action Items Cited in the FSSA Approved SUD Implementation Plan
Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse

	Action	Implementation Timeline	Was Action Completed?	If Yes, Date Completed	Completed on Time?
28	Consider options for emergency responder reimbursement of naloxone	Completed by early 2018	Yes	Q1 2018 report	Yes
29	Integrate all Indiana hospitals with INSPECT (the State's prescription drug monitoring program)	Completed "within 3 years"	No		
30	Expand coverage of peer recovery coaches	No specific date	Yes	7/1/2019	Yes

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

One activity was included in the protocol related to expanding MCE case management services for individuals transitioning from residential treatment facilities. A contract amendment was completed to clarify this requirement with the MCEs. B&A conducted an assessment of SUD-related case and care management at each MCE during CY 2018. This is discussed further in Section III.

Exhibit II.6
Tracking Completion of Action Items Cited in the FSSA Approved SUD Implementation Plan
Improved Care Coordination and Transitions Between Levels of Care

	Action	Implementation Timeline	Was Action Completed?	If Yes, Date Completed	Completed on Time?
31	Extend MCE case management to individuals transitioning from residential treatment facilities	No specific date	Yes	2/24/2018	Yes

SECTION III: ASSESSMENT OF PROGRESS TOWARD OUTCOME MEASURES IN THE SUD MONITORING PROTOCOL

Introduction

The FSSA submitted a draft SUD Monitoring Protocol to CMS where monitoring aligned with many of the tasks in the State's Implementation Protocol. The State of Indiana was one of the first states to receive SUD waiver approval. As a result, the standardized monitoring approach developed by CMS had yet to be released when Indiana received its SUD waiver approval. Subsequently, Indiana resubmitted its SUD Monitoring Protocol to align with the CMS framework provided to states.

The key components of Indiana's current SUD Monitoring Protocol follow CMS's suggested guidance:

- Assessment of need and qualification for SUD treatment services
- Access to critical levels of care for OUD and other SUDs (Milestone #1)
- Use of evidence-based, SUD-specific patient placement criteria (Milestone #2)
- Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (Milestone #3)
- Sufficient provider capacity at critical levels of care including for medication assisted treatment for OUD (Milestone #4)
- Implementation of comprehensive treatment and prevention strategies to address opioid use and OUD (Milestone #5)
- Improved care coordination and transitions between levels of care (Milestone #6)
- SUD health information technology (Health IT)
- Other SUD-related metrics, such as grievances and appeals
- Budget neutrality

The FSSA is submitting results on most all of the metrics that CMS recommends in its SUD Monitoring Protocol at the periodicity requested by CMS (either monthly, quarterly or annually). Additionally, the FSSA is reporting results at the subpopulation level when requested by CMS for almost all metrics. B&A is providing technical assistance in the computation of these measures for the FSSA.

The Indiana FSSA chose to submit an amendment to its Section 1115 waiver with a proposed effective date of January 1, 2020. As a result, an Interim Evaluation of the SUD component of the waiver was required to be submitted with this waiver amendment application. B&A submitted this Interim Evaluation of the SUD waiver on October 31, 2019, earlier than what had been expected for the SUD waiver component.

Because the SUD waiver has only been in place since February 1, 2018, B&A used simple tests to measure the statistical significance where data was available to do so. Elsewhere in the report, B&A reported on trends using directional indicators (i.e., increase, decrease or neutral) for the measures that are reported to CMS. Where sufficient data was available, B&A's assessment compared results of each metric for the period just prior to the waiver (Calendar Year 2017) to the initial year of the post-waiver period (Calendar Year 2018).[8] Results were reported for each metric for the demonstration population as well as the sub-populations requested by CMS for review. Additionally, B&A added an additional sub-

[8] Although the effective date of the SUD waiver was February 1, 2018, B&A used the full calendar year of CY 2018 data to define the post-waiver period in order to have a comparable duration to the 12-month pre-waiver period of CY 2017.

population in its review representing individuals who are eligible for the State's Medicaid Rehabilitation Option (MRO). For the Summative Evaluation, stronger tests of statistical significance will be utilized when more data points over time will be available.

For this Mid-Point Assessment, B&A has categorized the metrics currently being tracked into each of the six milestones defined by the State. Some metrics do not map to a specific milestone but are tracked under "Other SUD-related metrics", e.g. cost metrics. A summary of the trends appears in Exhibit III.1 beginning on the next page. B&A built dashboards of the results of each metric for both the demonstration and the sub-populations. Exhibit III.1 uses a mix of red, yellow and green coloring to indicate whether the observed trend in the CY 2017 period compared to the trend in CY 2018 is as desired for the demonstration population and sub-populations. Specifically, the green shading indicates that the observed trend between years was as expected, yellow is neutral, and red is not as expected.

Exhibit III.1
Trends in the Metrics Being Reported by Indiana FSSA by Milestone

Color Coding indicates finding for the trend compared to desired result desired neutral not desired
Text inside the box indicates the actual trend (note that sometimes a decrease is the desired trend and an increase is not a desired trend)

CMS Milestone / Metric name	CMS Metric #	Results by Subpopulation						
		Demon-stration	Model	OUD	Dual Status	Pregnant	Criminally Involved	MRO
Milestone 1: Access to critical levels of care for OUD and other SUDs								
Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	2	Increase	Increase	Increase	Increase	Increase	Decrease	Increase
Medicaid Beneficiaries with SUD Diagnosis (monthly)	3	Increase	Increase	Increase	Increase	Increase	Decrease	Increase
Medicaid Beneficiaries with SUD Diagnosis (annually)	4	Increase	Increase	Increase	Increase	Increase	Decrease	Increase
Medicaid Beneficiaries Treated in an IMD for SUD	5	Decrease	Decrease	Decrease	Decrease	Increase	Decrease	Decrease
Utilization of Any SUD Treatment	6	Increase	Increase	Increase	Increase	Increase	Decrease	Increase
Utilization of Early Intervention	7	Decrease	Decrease	Decrease	Increase	Increase	Neutral	Decrease
Utilization of Outpatient Services	8	Increase	Increase	Increase	Increase	Increase	Decrease	Increase
Utilization of Intensive Outpatient and Partial Hospitalization Services	9	Decrease	Decrease	Decrease	Decrease	Increase	Decrease	Decrease
Utlization of Residential and Inpatient Services	10	Increase	Increase	Increase	Increase	Increase	Increase	Increase
Utilization of Withdrawal Management	11	Increase	Increase	Decrease	Decrease	Increase	Increase	Increase
Utilization of Medication Assisted Treatment (MAT)	12	Increase	Increase	Increase	Increase	Increase	Decrease	Increase
Average Length of Stay in IMDs	36	Decrease	Decrease	Decrease	Increase	Increase	Decrease	Decrease
Milestone 4: Sufficient provider capacity at critical levels of care including for medication assisted treatment for OUD								
SUD Provider Availability	13	Increase	Increase	not applicable				
SUD Provider Availability - MAT	14	Increase	Increase	not applicable				

Exhibit III.1 (continued)
Trends in the Metrics Being Reported by Indiana FSSA by Milestone

Color Coding indicates finding for the trend compared to desired result desired neutral not desired
Text inside the box indicates the actual trend (note that sometimes a decrease is the desired trend and an increase is not a desired trend)

CMS Milestone / Metric name	CMS Metric #	Results by Subpopulation						
		Demon-stration	Model	OUD	Dual Status	Pregnant	Criminally Involved	MRO
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD								
Initiation of Alcohol and Other Drug Dependence (AOD) Treatment	15	Decrease	Decrease	Decrease	Increase	Increase	Increase	Decrease
Engagement of Alcohol and Other Drug Dependence (AOD) Treatment	15	Increase	Increase	Increase	Decrease	Increase	Increase	Decrease
Use of Opioids at High Dosage in Persons Without Cancer	18	Increase	Increase	Decrease	Increase	Neutral	Increase	Decrease
Use of Opioids from Multiple Providers in Persons Without Cancer	19	Decrease	Decrease	Decrease	Decrease	Decrease	Increase	Decrease
Use of Opioids at High Dosage & from Multiple Providers Persons w/o Cancer	20	no results yet						
Concurrent Use of Opioids and Benzodiazepines	21	Decrease	Decrease	Decrease	Decrease	Decrease	Decrease	Decrease
Continuity of Pharmacotherapy for Opioid Use Disorder	22	Increase	Decrease	Decrease	Neutral	Increase	Decrease	Decrease
Access to Preventive Health Services for Adult Medicaid Benef with SUD	32	Increase	Increase	Increase	Decrease	Increase	Decrease	Increase
Number of prescribers accessing INSPECT	S.1	no results	not applicable					
Number of patient requests made into INSPECT	S.2	Increase	not applicable					
Number of prescribers making patient requests through an integrated system	S.3	no results	not applicable					
Milestone 6: Improved care coordination and transitions between levels of care								
ED Utilization for SUD per 1,000 Medicaid Beneficiaries	23	Increase	Increase	Decrease	Increase	Increase	Increase	Decrease
Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	24	Increase	Decrease	Decrease	Increase	Increase	Increase	Decrease
Readmissions Among Beneficiaries with SUD	25	Increase	Increase	Increase	Decrease	Decrease	Increase	Decrease
Follow-up after Discharge from the ED for AOD (7 days)	17	Increase	Increase	Increase	Increase	Increase	Increase	Increase
Follow-up after Discharge from the ED for AOD (30 days)	17	Increase	Increase	Increase	Decrease	Increase	Increase	Increase
Grievances Related to SUD Treatment Services	33	Decrease	Decrease	not applicable				
Appeals Related to SUD Treatment Services	34	Decrease	Decrease	not applicable				

In the remainder of this section, B&A provides additional information on selected metrics under each milestone. For the metrics that are reported here that are also reported to CMS in quarterly waiver update reports, the specifications as outlined by CMS are used, unless otherwise noted. The data used to compute the results shown are from the FSSA's Enterprise Data Warehouse. The data used is as reported through fee-for-service (FFS) claims or as managed care encounters through October 31, 2019.

Whereas the Interim Evaluation examined trends for each sub-population defined, for this Mid-Point Assessment B&A is focusing on our review on results found in the model population (i.e., the managed care enrolled population) and results found for the remaining population outside of the model population (i.e., the FFS enrolled population).

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

B&A is assessing the results between the pre-waiver and post-waiver period. The entire period of CY 2017 serves as the baseline to define the pre-waiver period. In Exhibits III.2 and III.3 that appear on the next page, the black line going across each exhibit represents the value that is the average for all of CY 2017 for the demonstration population. The light blue line going across each exhibit represents the value that is the average for all of CY 2017 for the model population only.

In both exhibits, these baseline values are then compared to month-by-month results in the post-waiver period. In the post-waiver period, the time period of January 2018 through June 2019 is examined. Although this 18-month time period allows for additional assessment than the 12-month period that was used in the Interim Evaluation, B&A offers caution in interpreting results for the first six months of CY 2019 because there may still be data not yet reported by the FSSA's managed care entities (MCEs) in the model population. The blue portion of the stacked bars represents results from the model population. The yellow portion of the bar represents the FFS population.

Exhibit III.2 shows the count of Medicaid beneficiaries identified with a SUD diagnosis by month. In the entire demonstration, this value in the first six months of CY 2019 has remained steady at close to 100,000 individuals compared to the average of 82,686 in CY 2017. For the model population specifically, the count of beneficiaries in the first six months of CY 2019 has remained steady near 77,000 compared to the average of 66,664 in CY 2017. Both the demonstration population overall and the model population have seen an increase since the pre-waiver period of the number of beneficiaries identified with a SUD diagnosis. The demonstration population has grown 20.9 percent while the model population has grown 15.5 percent.

Exhibit III.3 is shown in the same format as Exhibit III.2, but this exhibit trends the count of Medicaid beneficiaries identified with newly initiated SUD treatment or diagnosis, by month. In the demonstration population overall, the average in CY 2017 was 6,761. In the post-waiver 18-month period reported, the value has been higher than the pre-waiver period in all but three months. The greatest monthly value was 7,858 in May 2019. There has been more variability in the model population. The average number of newly initiated in CY 2017 was 5,548. In the post-waiver 18-month period reported, the value was higher than the pre-waiver period in nine of the months. The count has been below the pre-waiver average, however, in all months of CY 2019 reported thus far.

Exhibit III.2
Count of Medicaid Beneficiaries Identified with a SUD Diagnosis, by Month (CMS Metric #3)
For Demonstration Population Overall Divided between Members in and out of the Model Population

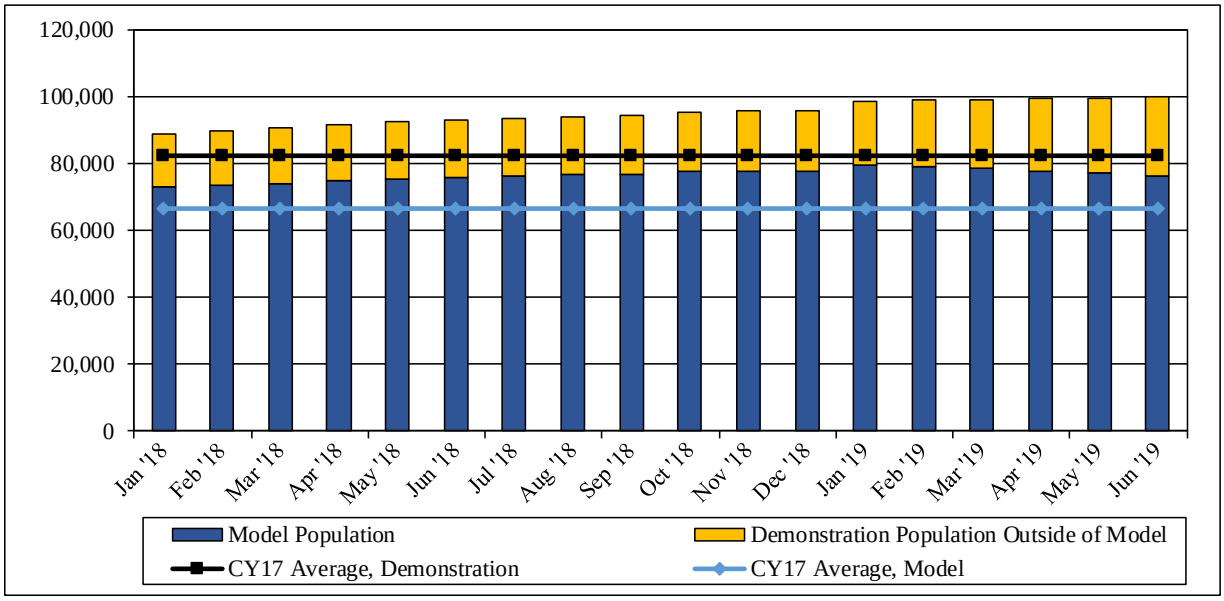
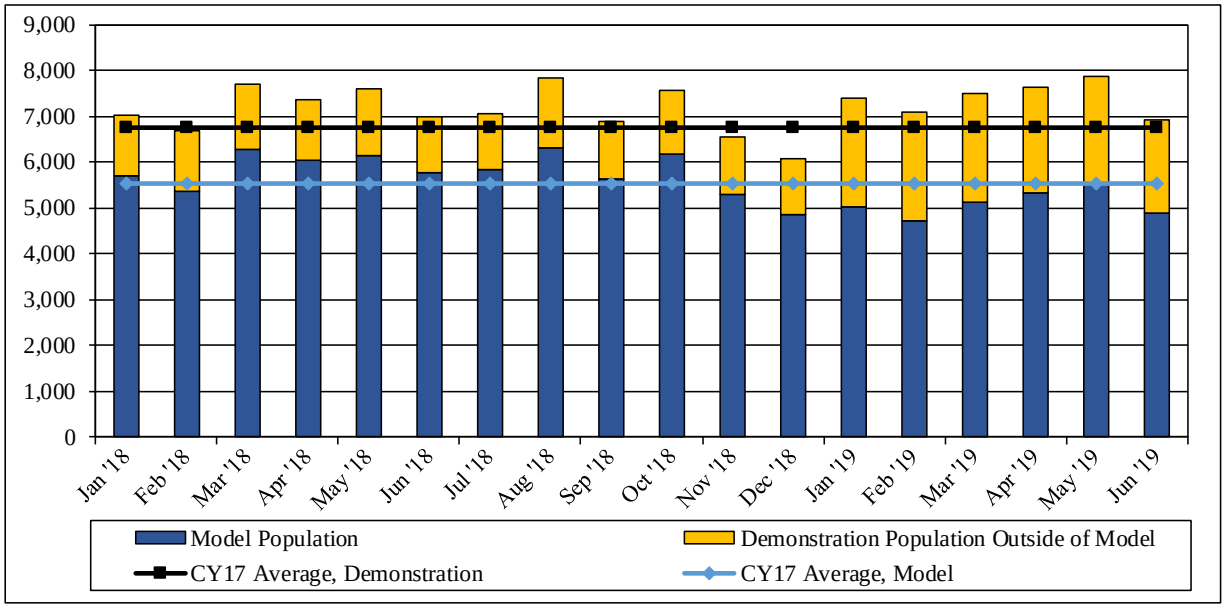


Exhibit III.3
Count of Medicaid Beneficiaries Identified with Newly Initiated SUD Treatment or Diagnosis, by Month (CMS Metric #2)
For Demonstration Population Overall Divided between Members in and out of the Model Population

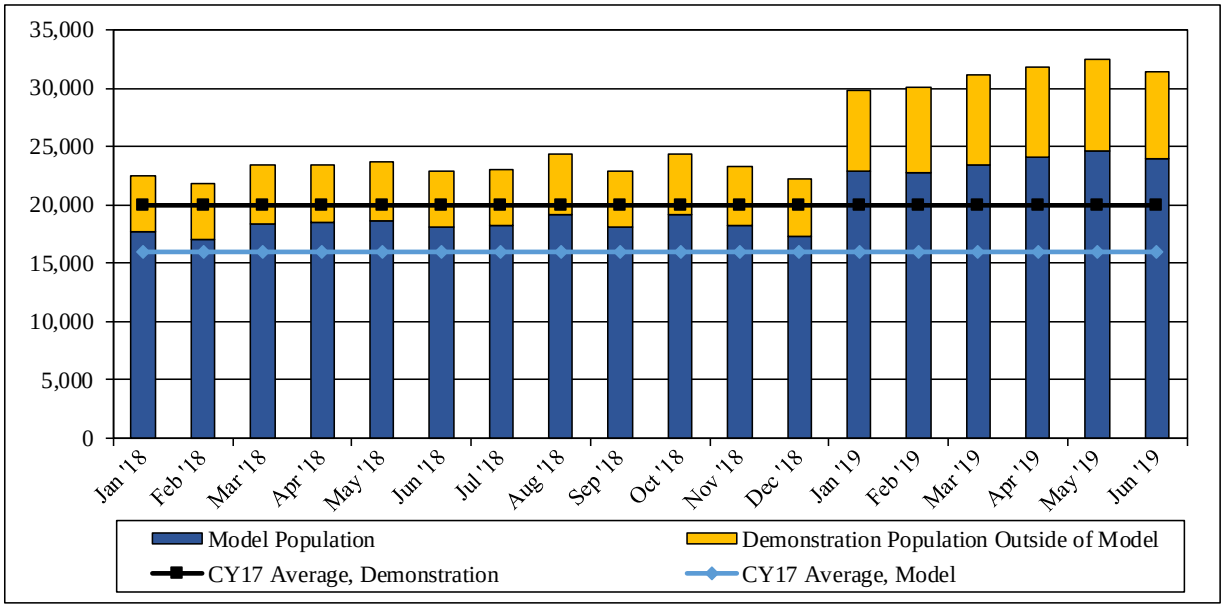


Exhibits III.4 through III.9 are displayed in the same manner as the exhibits just reviewed. In each exhibit, B&A reports on the trends in the counts of beneficiaries using different types of SUD treatment. The terms used in each exhibit and the method of counting members is what is suggested by CMS in the SUD Monitoring Protocol.

Exhibit III.4 below shows the results of the month-by-month count of Medicaid beneficiaries with any SUD treatment. In the pre-waiver period, the average in CY 2017 was just under 20,000 beneficiaries at 19,969. In the model population, this average was 15,991.

As the exhibit shows, in each month reported thus far in the post-waiver period, the number of beneficiaries that have received any SUD treatment is greater than the pre-waiver average in the demonstration population overall and the model population specifically. In particular, the growth in CY 2019 thus far is more than 50 percent from the pre-waiver period as more than 30,000 beneficiaries in the demonstration received some type of SUD treatment in the months of January to June 2019. In the model population, the growth in SUD beneficiaries from January to June 2019 was 42 to 54 percent higher than the model average in the pre-waiver period of CY 2017.

Exhibit III.4
Count of Medicaid Beneficiaries with Any SUD Treatment, by Month (CMS Metric #6)
For Demonstration Population Overall Divided between Members in and out of the Model Population



Although there has been significant growth in the number of beneficiaries receiving any SUD treatment during the waiver thus far, this is not true for early intervention treatment specifically (refer to Exhibit III.5). The count of beneficiaries receiving early intervention treatment (as defined by the CMS measure specification) was low even in the pre-waiver. In most months post-waiver, the number was less than the pre-waiver period in both the demonstration population overall and in the model population specifically. Exhibit III.6 shows that there has been a modest increase in the number of beneficiaries receiving outpatient treatment in each month of the waiver period compared to the pre-waiver period average.

Exhibit III.5
Count of Medicaid Beneficiaries with Early Intervention Treatment, by Month (CMS Metric #7)
For Demonstration Population Overall Divided between Members in and out of the Model Population

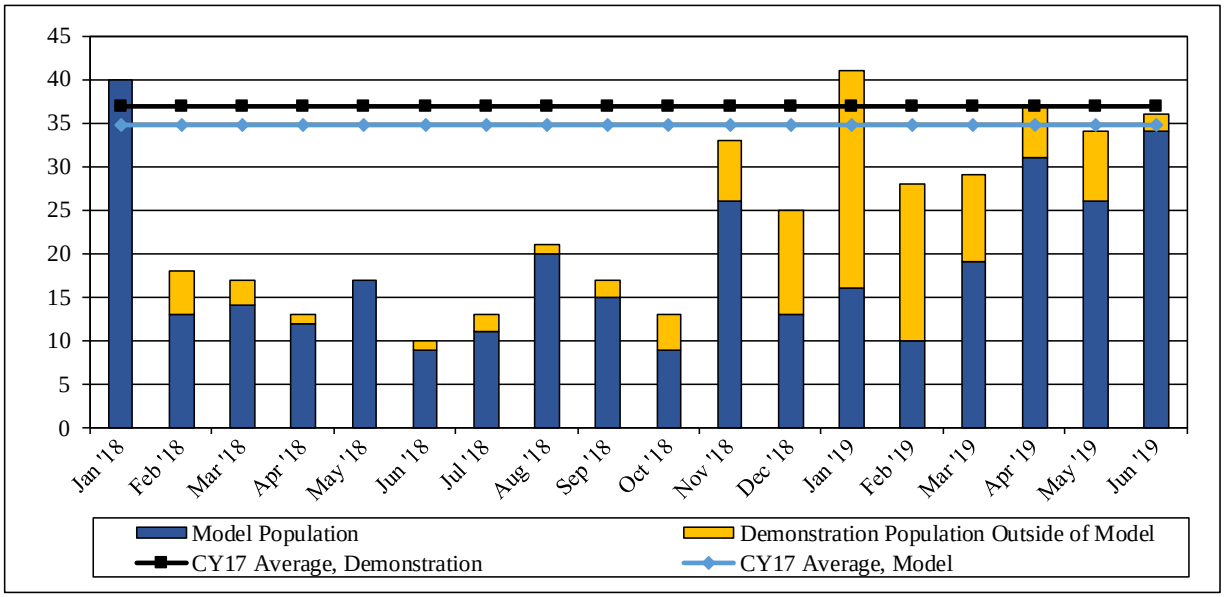
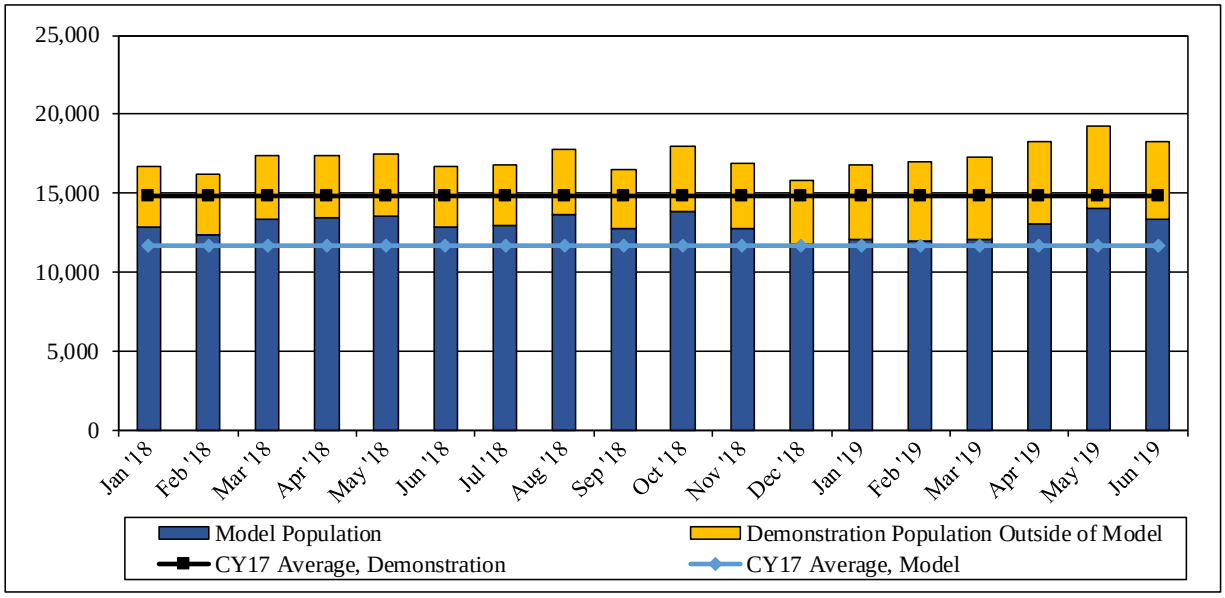


Exhibit III.6
Count of Medicaid Beneficiaries with Outpatient Treatment, by Month (CMS Metric #8)
For Demonstration Population Overall Divided between Members in and out of the Model Population



The count of beneficiaries receiving intensive outpatient and partial hospitalization during the waiver period is a bit lower than the pre-waiver period average in all but the most recent months of CY 2019 for the demonstration population. For the model population, it is always a bit lower (refer to Exhibit III.7). In face-to-face meetings with providers conducted by B&A, the providers stated that the MCEs are now requiring prior authorization of intensive outpatient treatment. This is a result of an FSSA change in policy effective July 1, 2019 whereby intensive outpatient treatment is no longer carved out of managed care. Prior to this, the individuals shown in the model population in Exhibit III.7 were enrolled in managed care, but the intensive outpatient benefit was not managed by their MCE.

Exhibit III.8 shows that beneficiaries utilizing withdrawal management was greater in the CY 2018 waiver period compared to the pre-waiver period. But starting in CY 2019, the total demonstration count is above the pre-waiver average, but the model population count is below its pre-waiver average.

Exhibit III.7
Count of Medicaid Beneficiaries with Intensive Outpatient and Partial Hospitalization, by Month
(CMS Metric #9)
For Demonstration Population Overall Divided between Members in and out of the Model Population

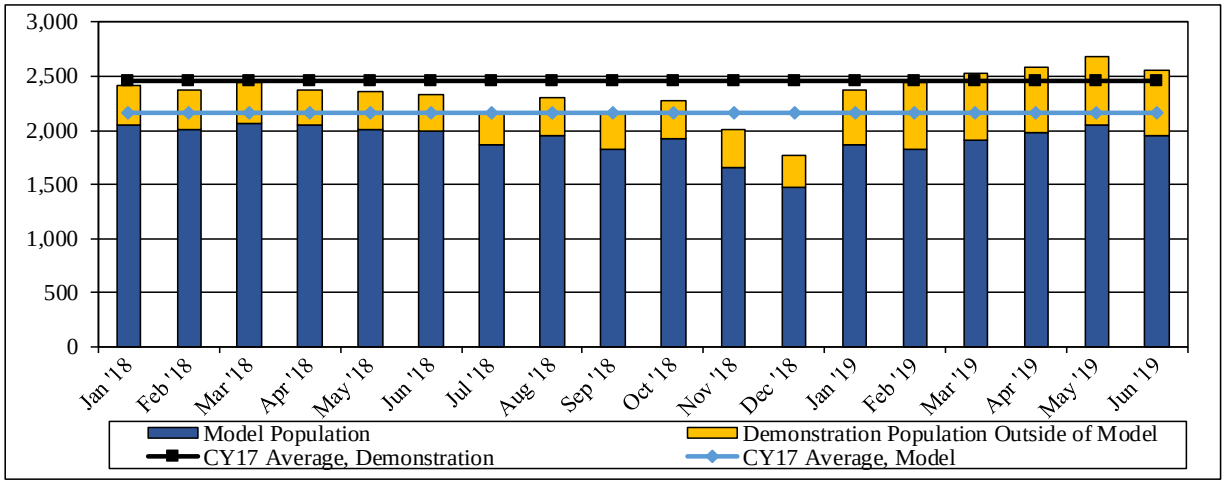
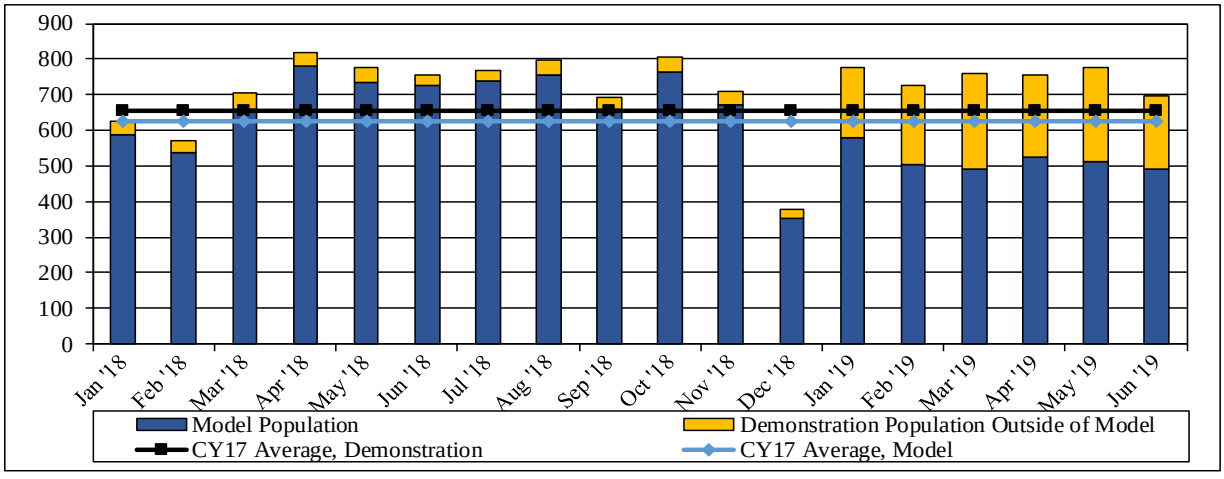
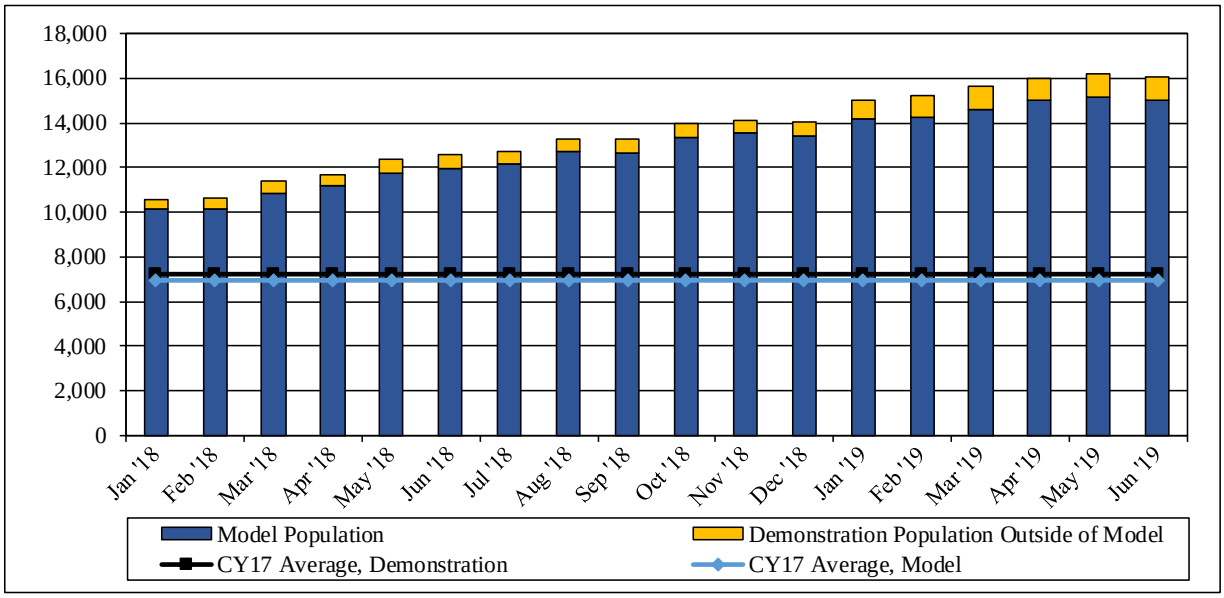


Exhibit III.8
Count of Medicaid Beneficiaries with Withdrawal Management, by Month
(CMS Metric #11)
For Demonstration Population Overall Divided between Members in and out of the Model Population



The count of beneficiaries receiving medication assisted treatment has been gradually increasing during the waiver period. In the pre-waiver period of CY 2017, the average number of beneficiaries receiving this service was 7,246. Of these, 96 percent of the beneficiaries were in the model population. In each month reported thus far in CY 2019, the count of beneficiaries receiving medication assisted treatment is between 15,000 and 16,200 which is more than double the average in the pre-waiver period of CY 2017.

Exhibit III.9
Count of Medicaid Beneficiaries with Medication Assisted Treatment, by Month (CMS Metric #12)
For Demonstration Population Overall Divided between Members in and out of the Model Population

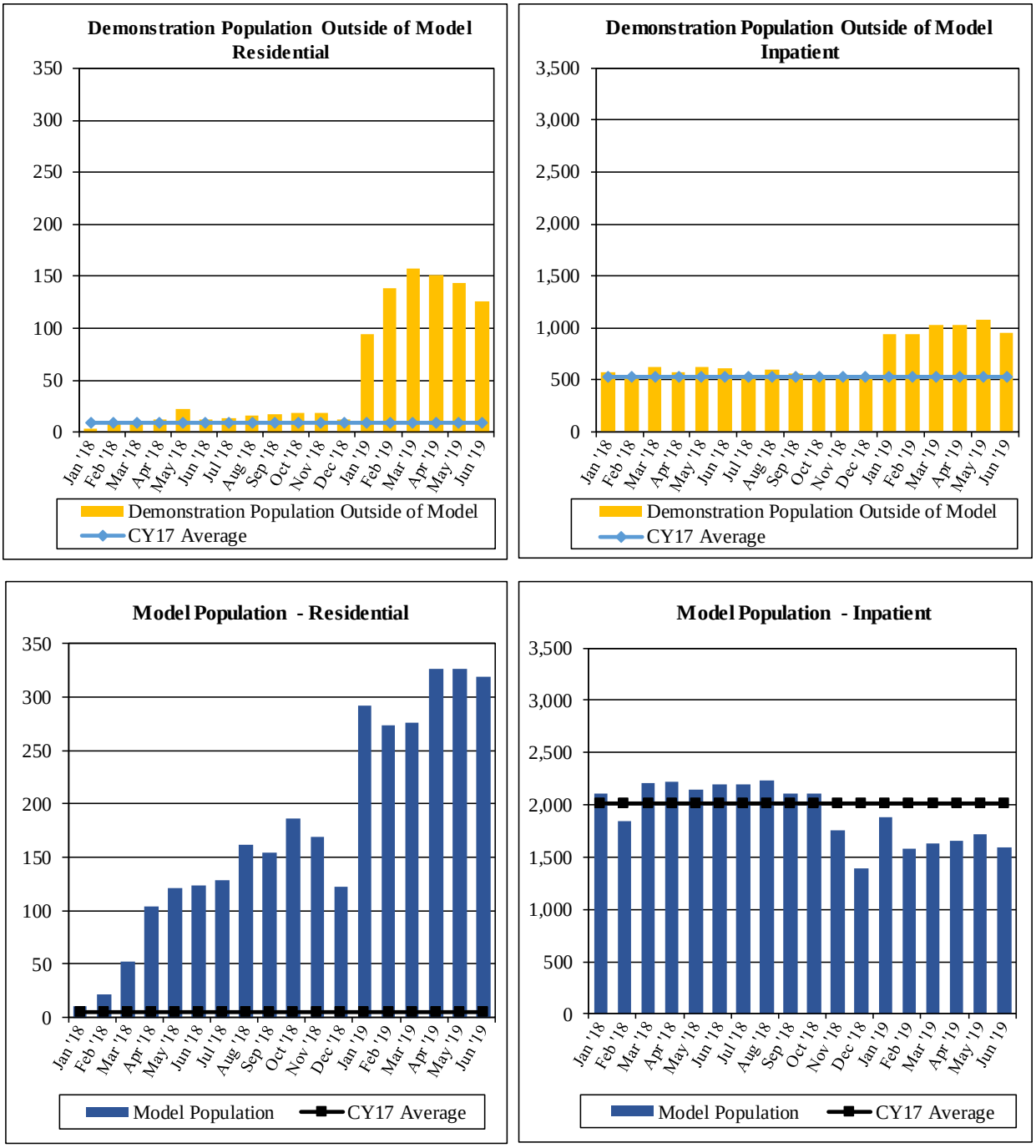


Exhibits III.10 through III.13, which appear on the next four pages, examine trends in the utilization of residential treatment and inpatient services. It should be noted that one of the key activities undertaken by the FSSA at the start of the waiver was to identify and contract with residential treatment providers. Within its provider enrollment and claims systems, these providers are now identified with their own provider type and specialty. The residential treatment providers were encouraged by the FSSA to contract with each of the four MCEs serving the model population, and vice versa. This is why, when reviewing these four exhibits, the average utilization for residential treatment pre-waiver in the model population was zero because these providers had not been enrolled with the MCEs in the pre-waiver period. Further, most of the providers had not been enrolled in FFS either. This is why the pre-waiver average values shown for residential treatment in the demonstration overall are near zero.

Exhibit III.10 displays the count of Medicaid beneficiaries receiving residential treatment (left side) and inpatient treatment (right side). The top boxes represent the FFS population and the bottom boxes represent the model population.

There has been significant growth in the count of beneficiaries receiving residential treatment, particularly in the first six months of CY 2019. This is true for the demonstration overall and for the model population. Inpatient users, however, were steady in CY 2018 among the FFS population but have risen in CY 2019 above the pre-waiver average of 535. In the model population, the number of users is usually less than the pre-waiver average of 2,010 in each month. The reduction in CY 2019 could be due to tighter authorization criteria imposed by the MCEs and/or incomplete encounter submissions.

Exhibit III.10
Count of Medicaid Beneficiaries with Residential Treatment or Inpatient Stays, by Month
(CMS Metric #10)
For Demonstration Population Overall Divided between Members in and out of the Model Population



In Exhibit III.11, B&A deviated from the CMS reporting measure which considers all Medicaid beneficiaries. Instead, we considered only the approximately 100,000 beneficiaries identified with SUD to compute a days paid per 1,000 Medicaid beneficiaries. The rationale is that these would be the users of each service. Similar to what was observed in Exhibit III.10, the residential treatment service is increasing significantly, particularly in CY 2019. Days paid per 1,000 SUD members for residential was 50-70 for the demonstration overall and 40-50 for the model population. Inpatient days, however, are increasing for the demonstration population overall in CY 2019 but decreasing for the model population.

Exhibit III.11
Days Paid Per 1,000 SUD-identified Medicaid Beneficiaries, by Month
(Using same data as CMS Metric #10)
For Demonstration Population Overall Divided between Members in and out of the Model Population

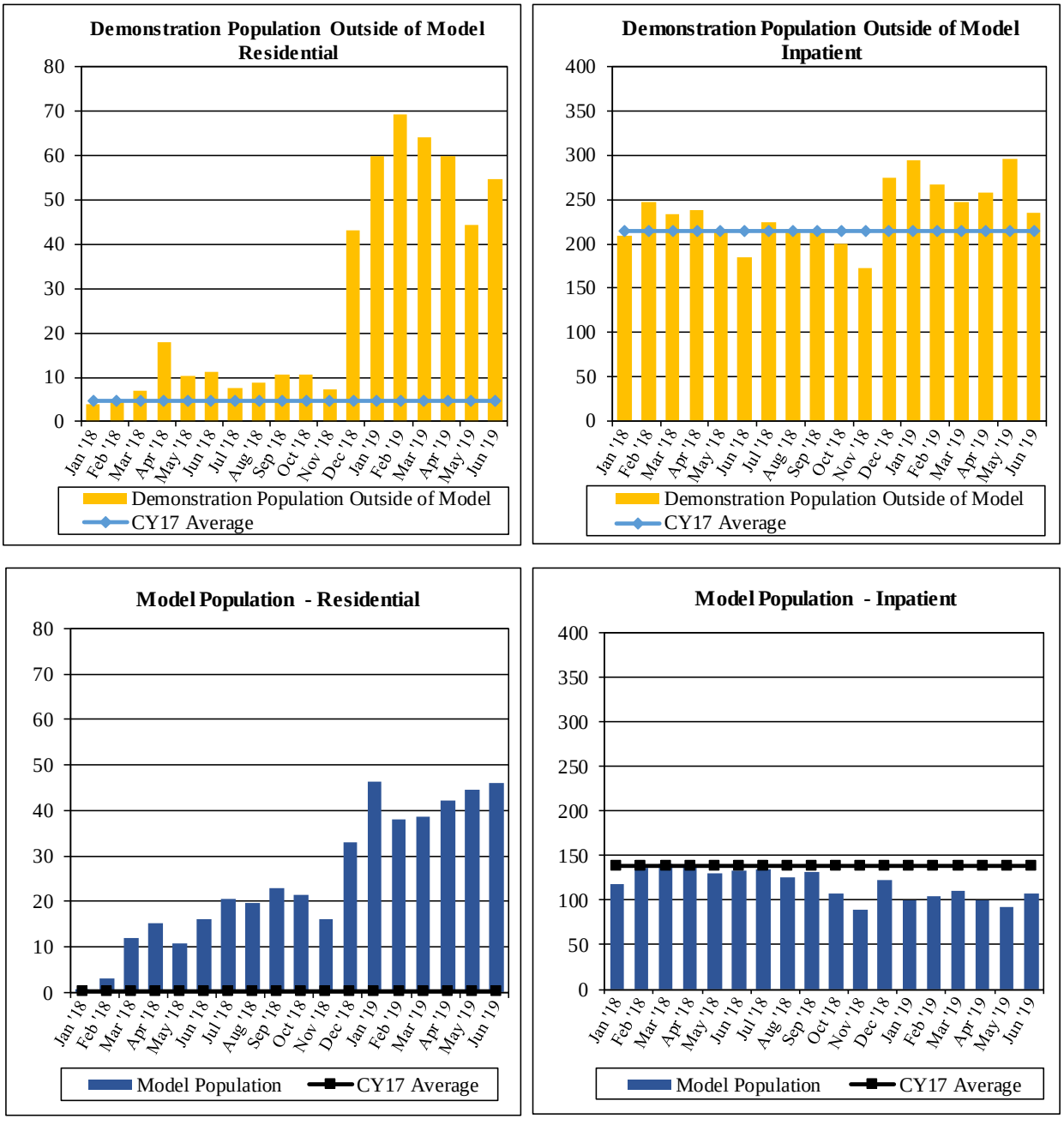


Exhibit III.12 examines residential days paid per 1,000 SUD Medicaid beneficiaries by each of the four MCEs within the model population. For each MCE, B&A uses the SUD Medicaid beneficiaries enrolled with the MCE as its denominator. Whereas the overall model population value was between 40 and 50 days in the first six months of CY 2019, there is some variation at the MCE level, particularly by month. However, each MCE was within the overall model result in the first six months of CY 2019.

Exhibit III.12
Residential Days Paid Per 1,000 SUD-identified Medicaid Beneficiaries, by Month
(Using same data as CMS Metric #10)
By MCE

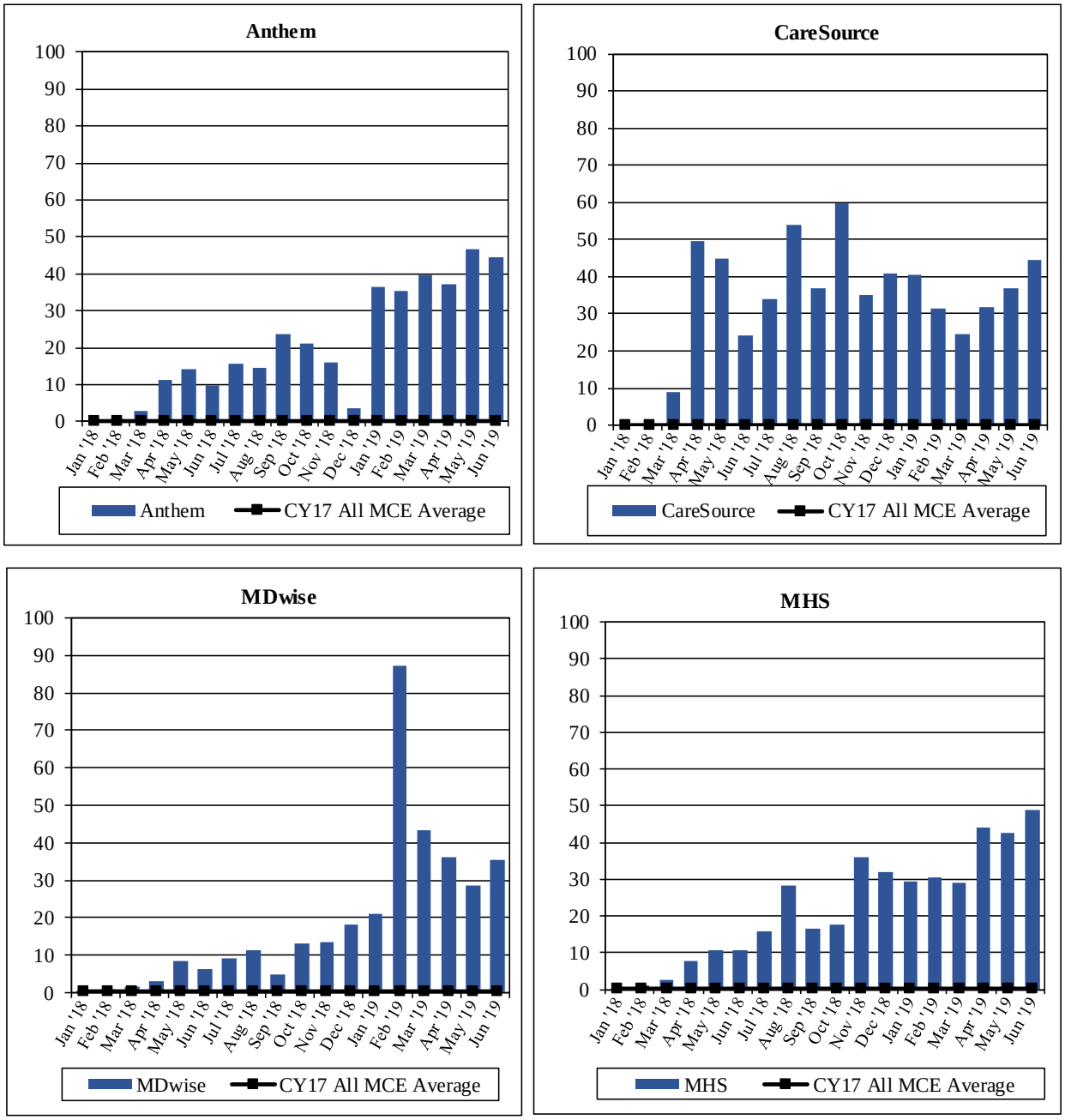
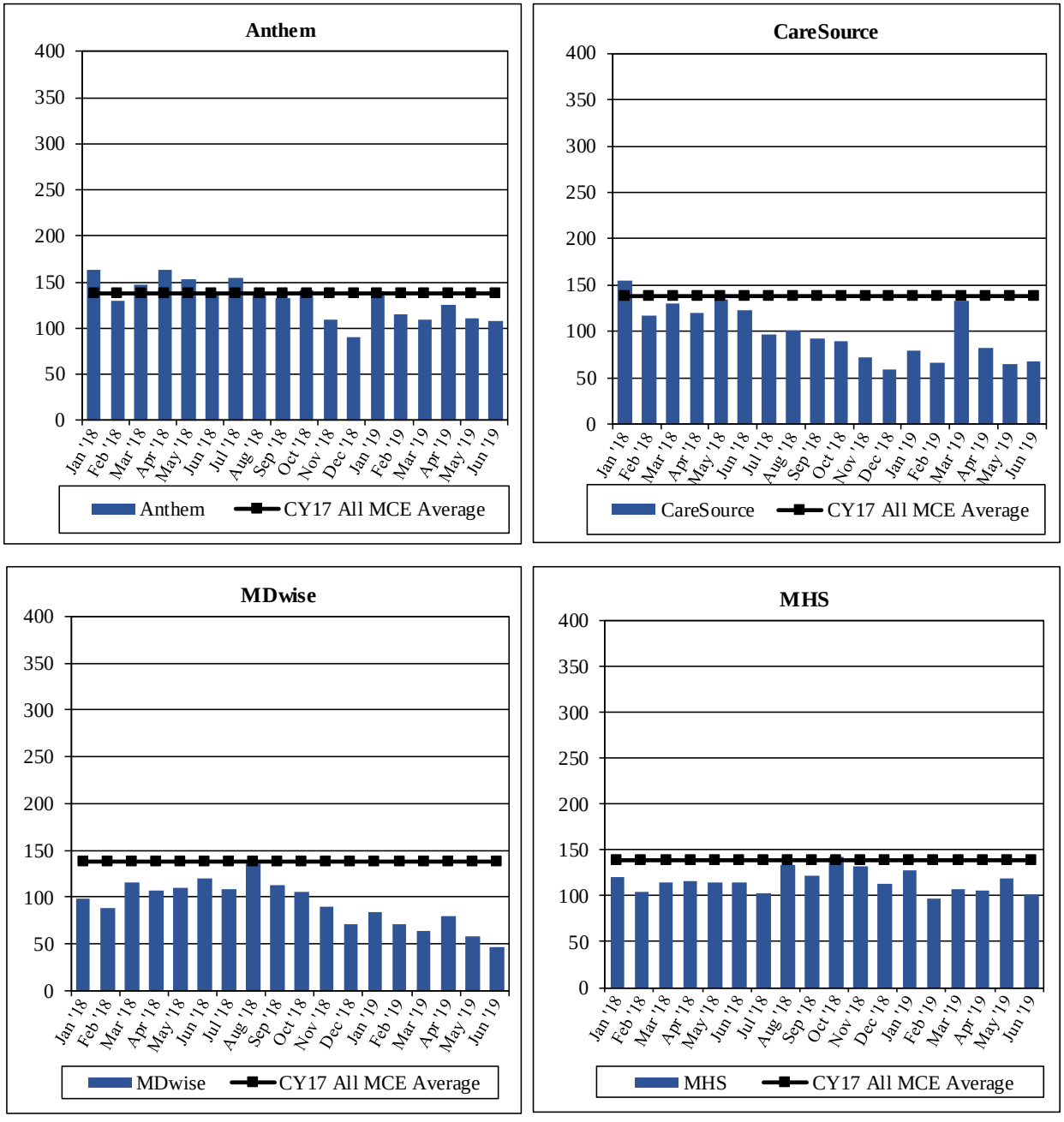


Exhibit III.13 displays results in the same manner as Exhibit III.12, but this time for inpatient days paid. Exhibit III.11 showed that the results in the model population overall in the first six months of CY 2019 was near 100 days per 1,000. As seen below, this is generally true for Anthem and MHS, but CareSource and MDwise are both significantly lower than this overall average.

Exhibit III.13
Inpatient Days Paid Per 1,000 SUD-identified Medicaid Beneficiaries, by Month
(Using same data as CMS Metric #10)
By MCE



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

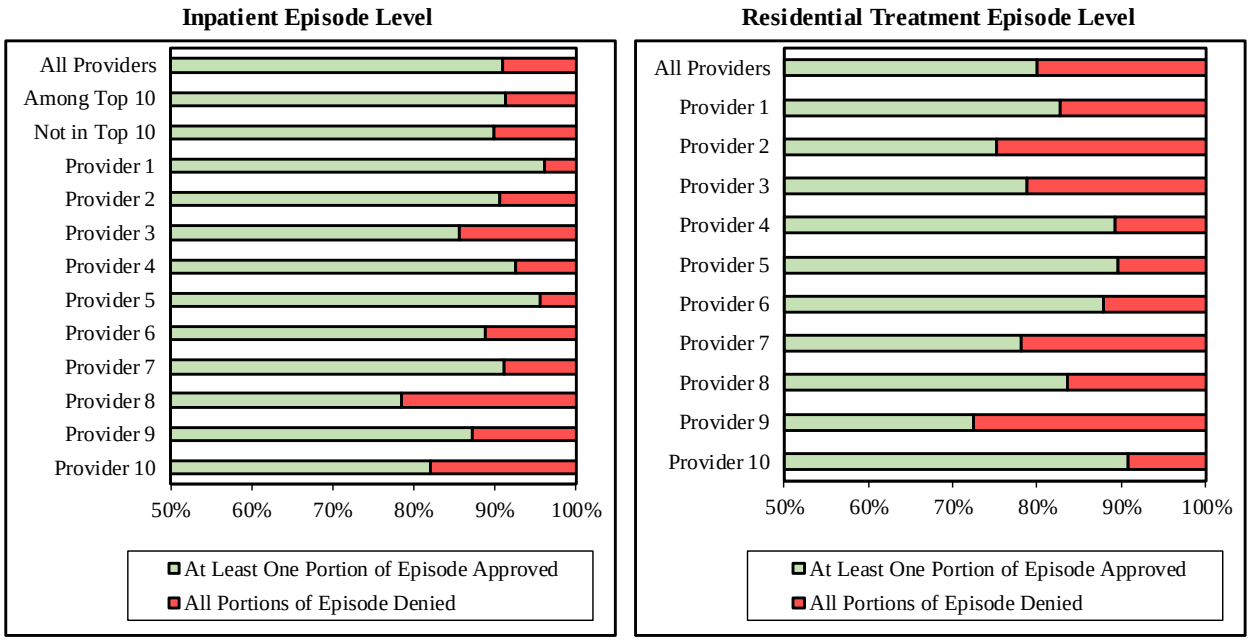
In Milestone #1, there are many CMS-defined measures that can be used to assess progress. CMS has not defined any measures for Milestone #2. Further, as previously stated in Section II (Exhibit II.2), the FSSA has chosen to abandon the initial project undertaken to align the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) tools with ASAM criteria.

FSSA has, however, provided training sessions for both MCE and SUD provider staff on ASAM criteria using ASAM trainers. The FSSA has also held multiple meetings with both the MCEs and providers to both educate and come to a common understanding of the use of ASAM criteria, particularly as it relates to service authorization requests. This has resulted in a new standardized authorization form used by all MCEs and specific to SUD that leverages ASAM concepts to help guide providers to make authorization requests to the MCEs. The new authorization form was implemented March 15, 2019.

B&A conducted a focus study of authorization requests made by providers to the MCEs for inpatient and residential treatment in the first year of the waiver (CY 2018). Results from this study are used by B&A to make its assessment on this topic to date. It should be noted, however, that because of the form change made in March 2019 and the ASAM training held in the Spring of 2019, B&A will be conducting another study in CY 2020 of authorization requests made in the second half of CY 2019.

B&A accumulated all authorization requests for a beneficiary over the course of a single stay, or episode. We computed the percent of beneficiaries for which the MCE approved at least some portion of the episode. For example, a majority of the days requested may have been approved but the last few days requested by the provider were denied. B&A then tabulated the results for each of the top 10 inpatient and residential providers separately. Exhibit III.14 shows that, in 91 percent of inpatient episodes overall, at least some portion of the stay was approved by the MCE. This approval rate varied, however, from 78 to 96 percent across the top 10 providers. In 79 percent of residential episodes overall, at least some portion of the stay was approved by the MCE. This approval rate varied, however, from 56 to 91 percent across the top 10 providers.

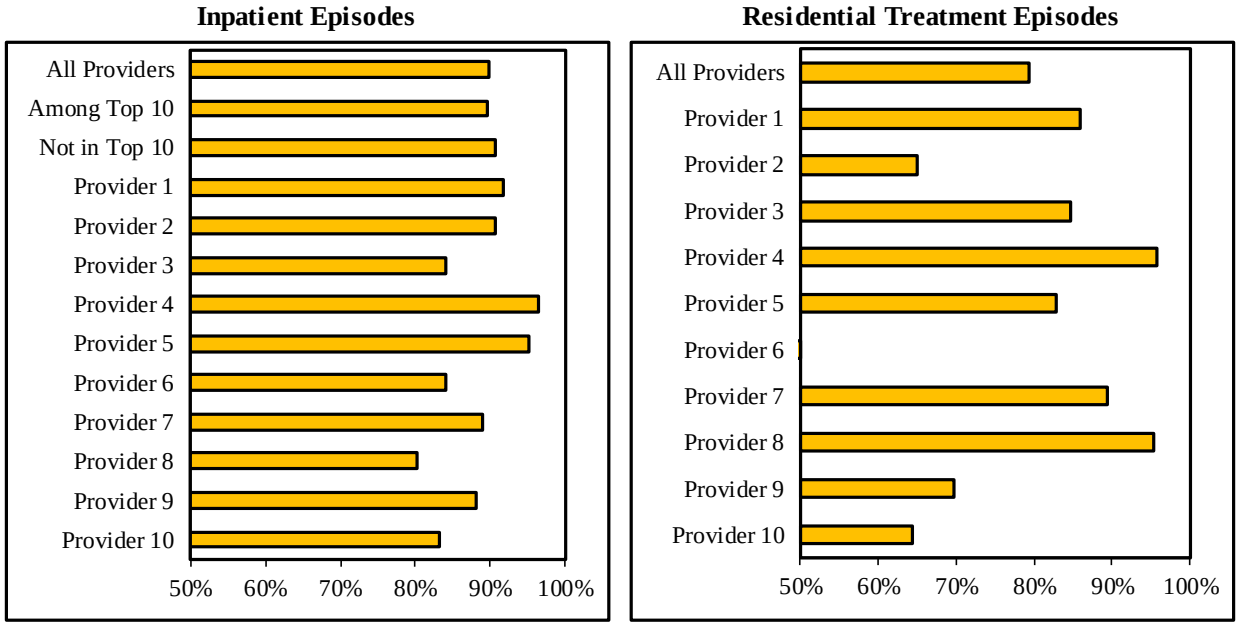
Exhibit III.14
Authorizations Approved and Denied



For inpatient episodes, 90 percent of all inpatient days requested were approved. For residential treatment, 79 percent of days were approved. (Refer to the top row of each box in Exhibit III.15.)

The range of days approved among the top 10 inpatient providers was 80 to 96 percent; for residential providers, from 70 to 98 percent.

Exhibit III.15
Ratio of Requested Days to Approved Days



Exhibits III.16 and III.17 on the next page examine the rate of approved episodes among the same top 10 providers of inpatient and top 10 providers of residential treatment. In these exhibits, the circles represent each of the MCEs. A provider may, but is not required to, contract with all four (or some subset of) MCEs. The circles show the variation in the approval rate of episodes for the same provider across the MCEs for which the provider contracts.

Exhibit III.16 at the top of the page focuses on the high-volume inpatient SUD providers. As can been seen, there is wide variation in the approval rates for an individual provider across MCEs. In some cases, 100 percent of a provider's client episodes had at least some days approved. The same provider may have an approval rate closer to 80 percent with another MCE. It should be noted that the circles showing 100 percent approval are not the same MCE with each provider.

Exhibit III.17 at the bottom of the page focuses on the high-volume residential treatment SUD providers. Once again, almost every high-volume provider experienced 100 percent approval on at least some days from at least one of the MCEs in CY 2018. There is greater variation, however, in the individual approval rates from MCEs to a residential provider than was observed among the inpatient providers.

Exhibit III.16
Examination of Approval Rates for Inpatient Services by MCE, Top 10 Providers Requesting Authorization

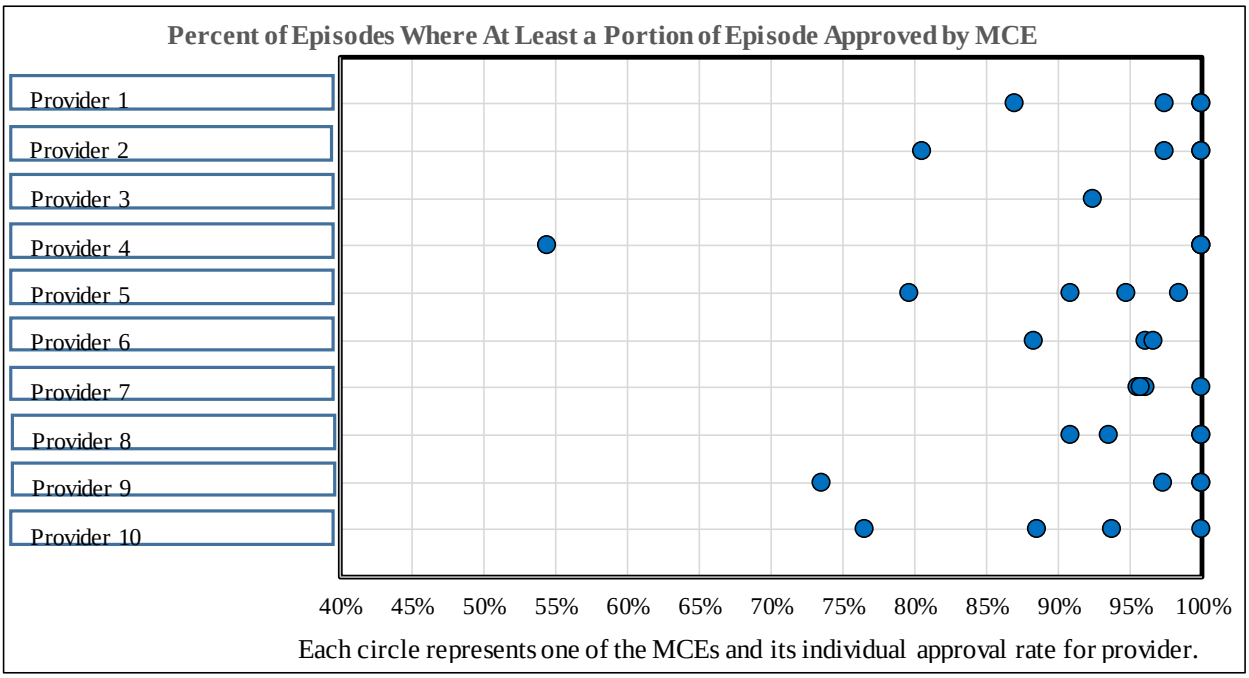
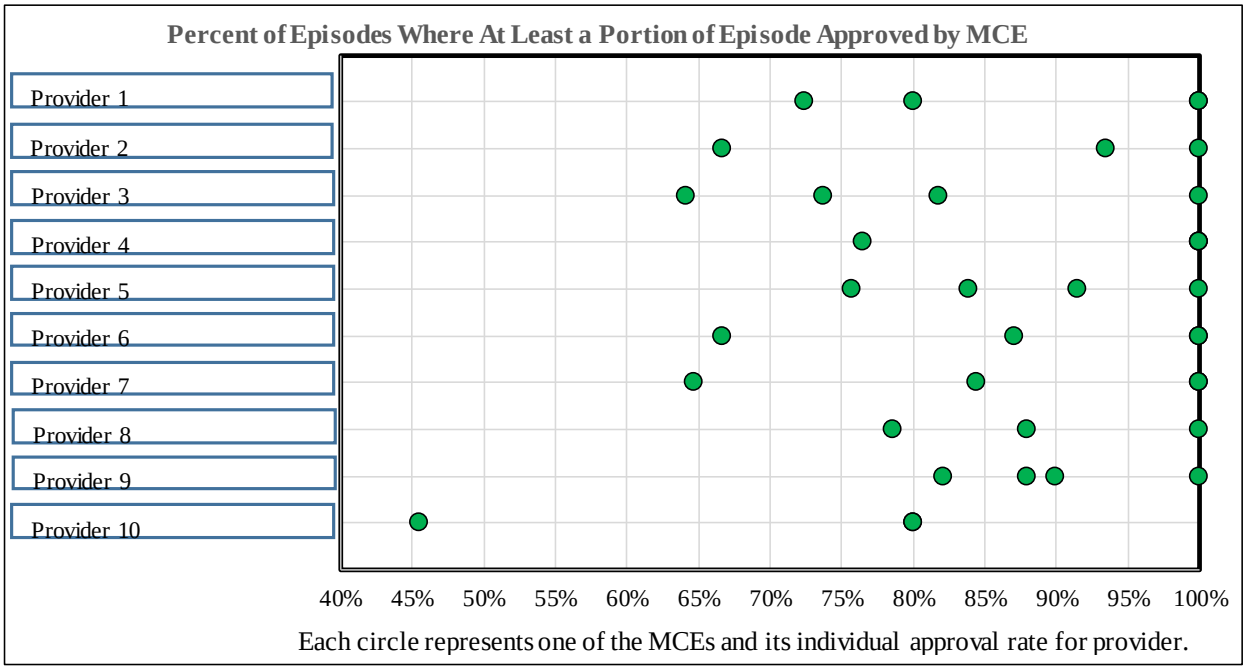


Exhibit III.17
Examination of Approval Rates for Residential Services by MCE, Top 10 Providers Requesting Authorization



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

For Milestone #3, CMS has not established any standardized measures. The FSSA, through its DMHA, established criteria to issue licenses to providers for ASAM 3.1 and 3.5 levels of care. By the fifth month after the waiver effective date (July 1, 2018), only providers with a DMHA license for 3.1 or 3.5 were authorized to bill for each of these levels of care.

Exhibit III.18 shows the growth in the number of beds and number of providers eligible to bill for Medicaid beneficiaries receiving ASAM levels 3.1 and 3.5 treatment. For level 3.1, the number of beds available has grown from 118 to 286 in the last year. For level 3.5, the beds have grown from 541 to 625 during this time period. There has been growth in the number of 3.1 providers as well, but the number of 3.5 providers has remained steady.

Exhibit III.18
Number of Beds (bars) and Number of Providers (line)
Residential Treatment ASAM Levels 3.1 and 3.5

Source: Indiana Division of Mental Health and Addiction

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

In order to assess provider capacity at different level of care, B&A plotted the physical location of where SUD treatment may be delivered for a variety of provider specialties:

- Institutions for Mental Disease (IMD)
- Inpatient hospital
- Residential treatment
- Outpatient
- Medication Assisted Treatment (MAT)

Exhibits III.19 through III.21 appear on each of the next three pages. Each exhibit (and page) represents a region of the state. The FSSA has customarily mapped its 92 counties into eight regions. On page III-20, the three northern regions of the state are shown. On page III-21, the three central regions are shown. On page III-22, the two southern regions are shown.

Because the volume of outpatient providers is much more significant than all of the other provider categories, the outpatient providers are plotted on their own map at the bottom of the page. The other providers are plotted together at the top of the page.

Key observations from each of the three exhibits include the following:

- Inpatient and outpatient providers are located in every region of the state and are fairly spread out within the regions.
- Although MAT providers are located in every region as well, they tend to be concentrated in the major cities within each region.
- Residential treatment providers are more limited, particularly in the North Central, West Central and Southern regions outside of the major cities in these regions.

It was previously found in Exhibit III.18 that the number of residential treatment beds has been growing significantly in the last year. It appears, however, that this growth is concentrated in areas that already had some beds already, not new areas. In Exhibit III.22 which appears on page III-23, B&A plotted the location of each residential treatment center online as of October 31, 2018 and November 30, 2019. A 20-mile radius was drawn around each center to identify coverage areas for residential treatment. The left map in the exhibit shows the results for the October 2018 period; the right map is the November 2019 period.

The two maps show that the actual coverage area is almost identical between the two time periods. So, although more residential beds have come online in CY 2019, they are not located in areas that previously did not have residential treatment beds.

It should also be noted that, among the 911 beds online as of November 30, 2019, only 59 are targeted for the adolescent population. The remainder are for adults only. There are nine beds for adolescents in Connersville (East Central Region) and 51 beds in Wabash (Northeast Region).

Exhibit III.19
Location of SUD Providers in the Northwest, North Central and Northeast Regions of the State

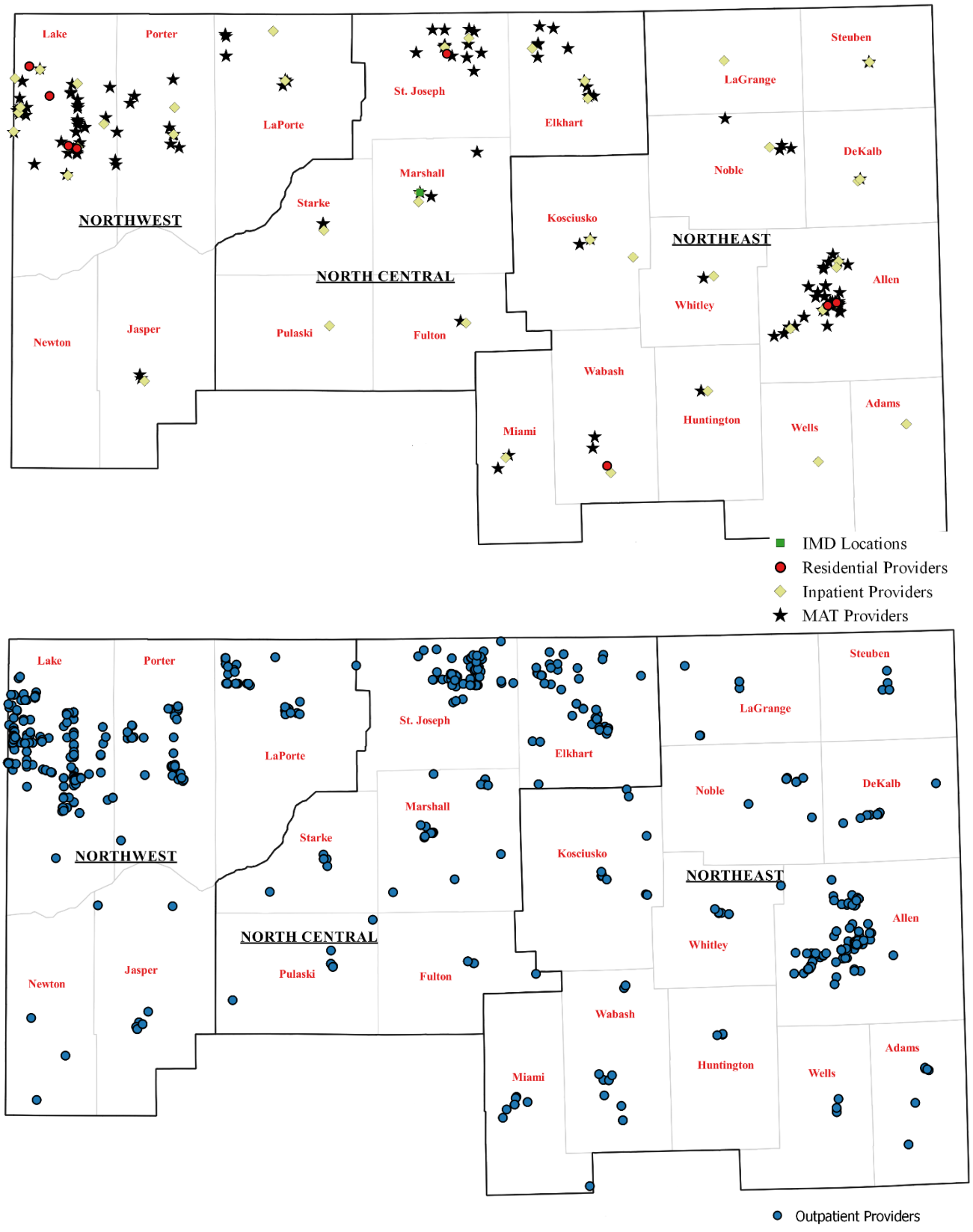
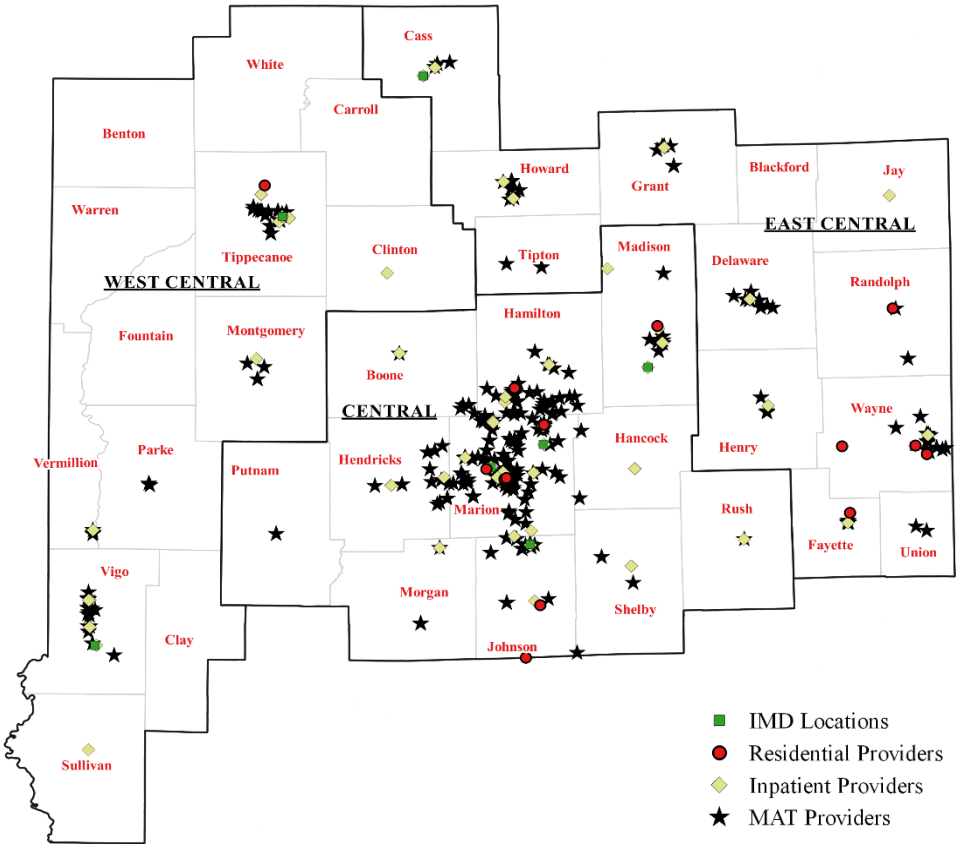


Exhibit III.20
Location of SUD Providers in the West Central, Central and East Central Regions of the State



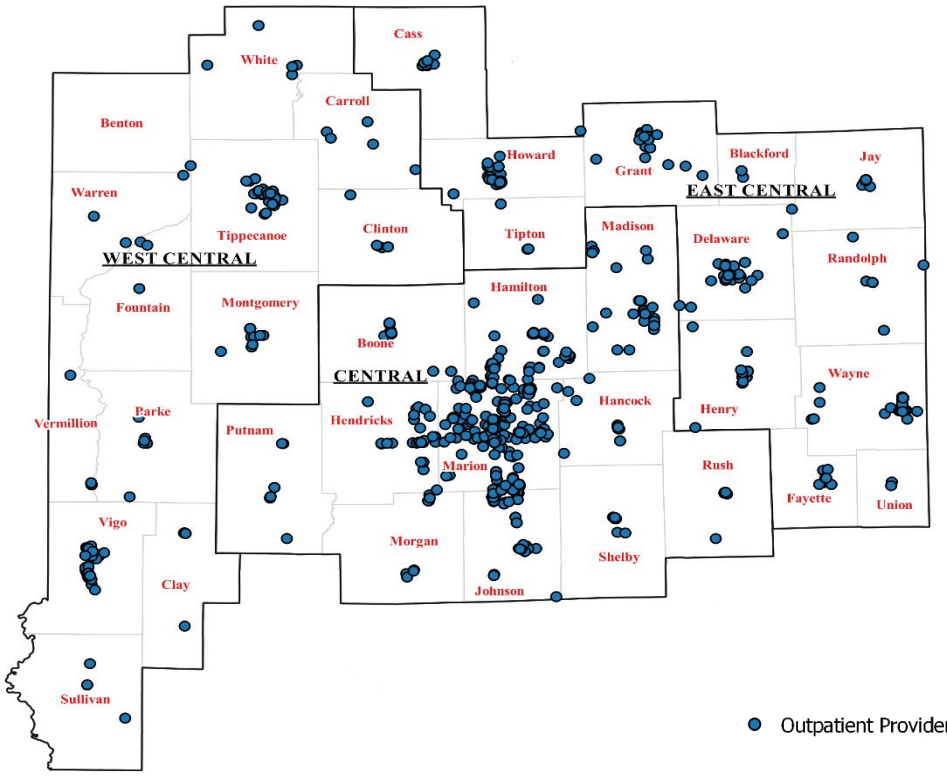
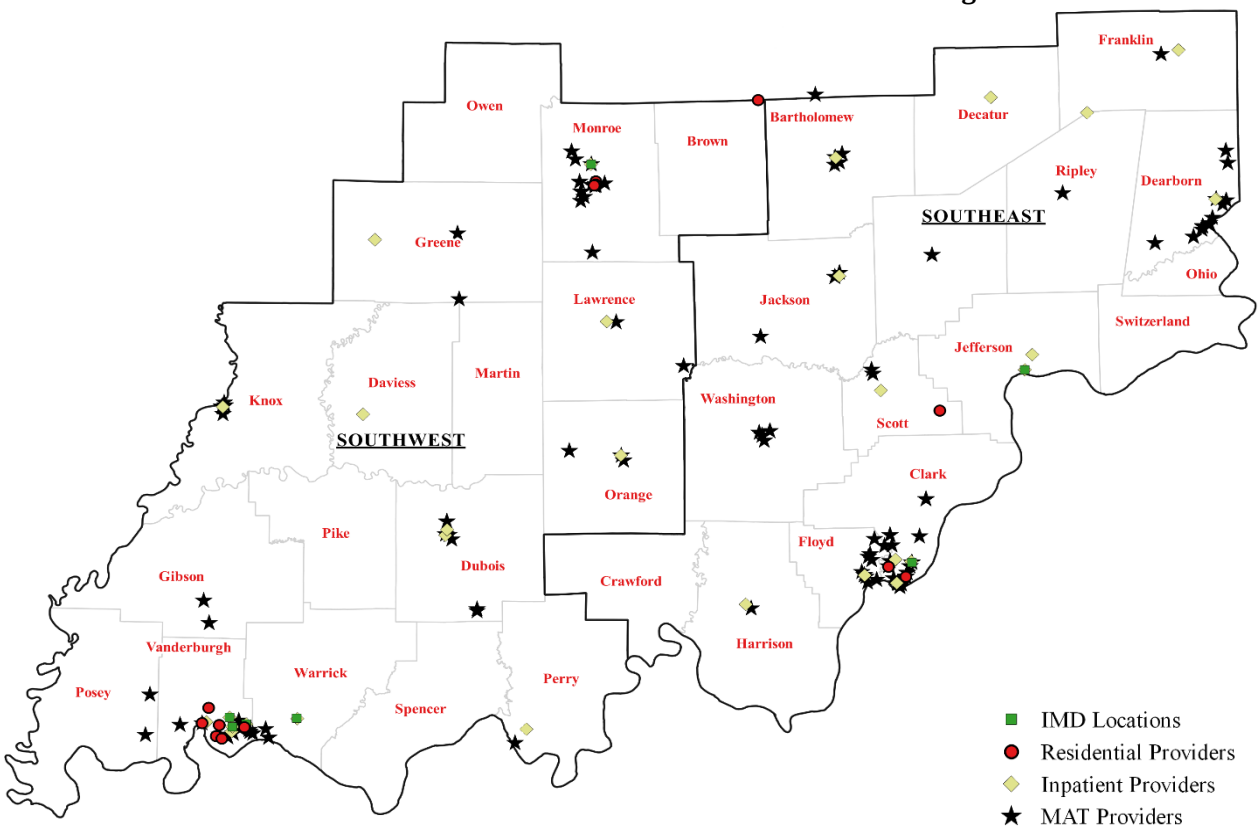


Exhibit III.21
Location of SUD Providers in the Southwest and Southeast Regions of the State



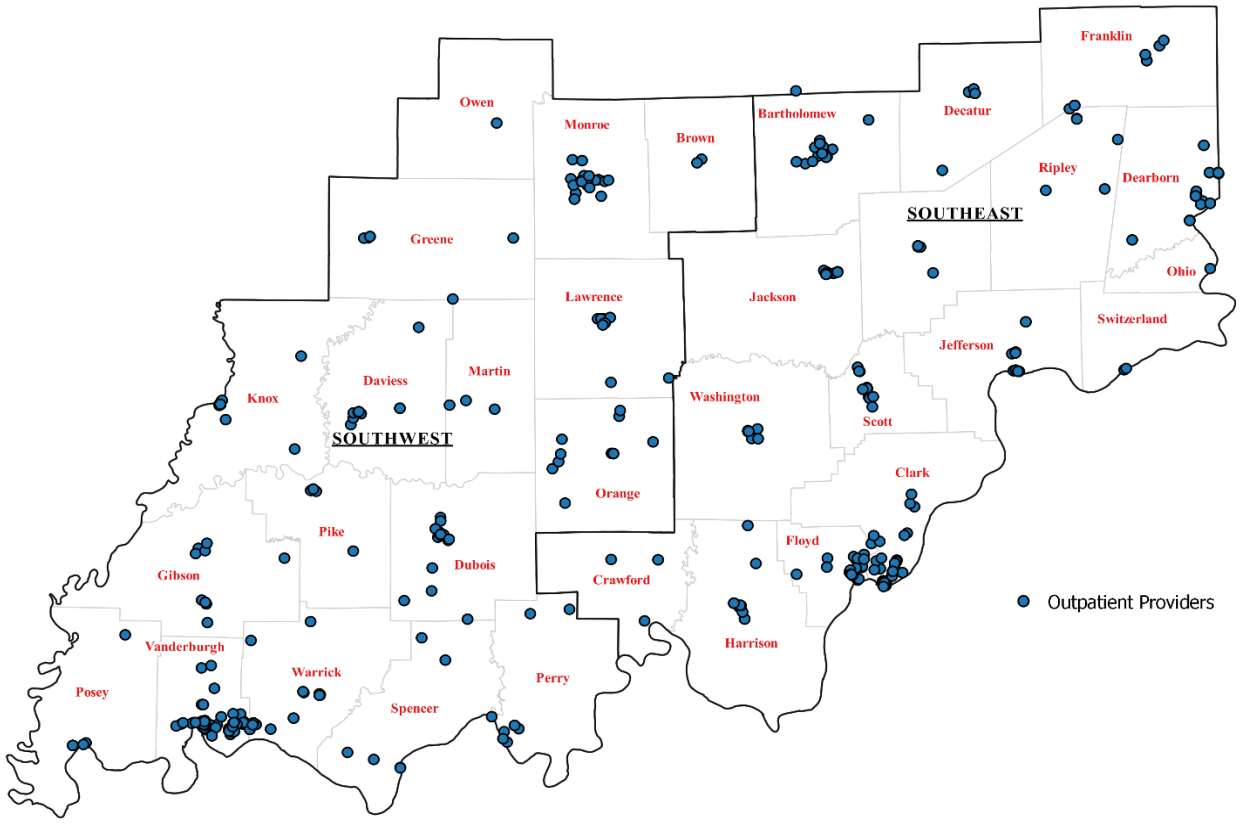
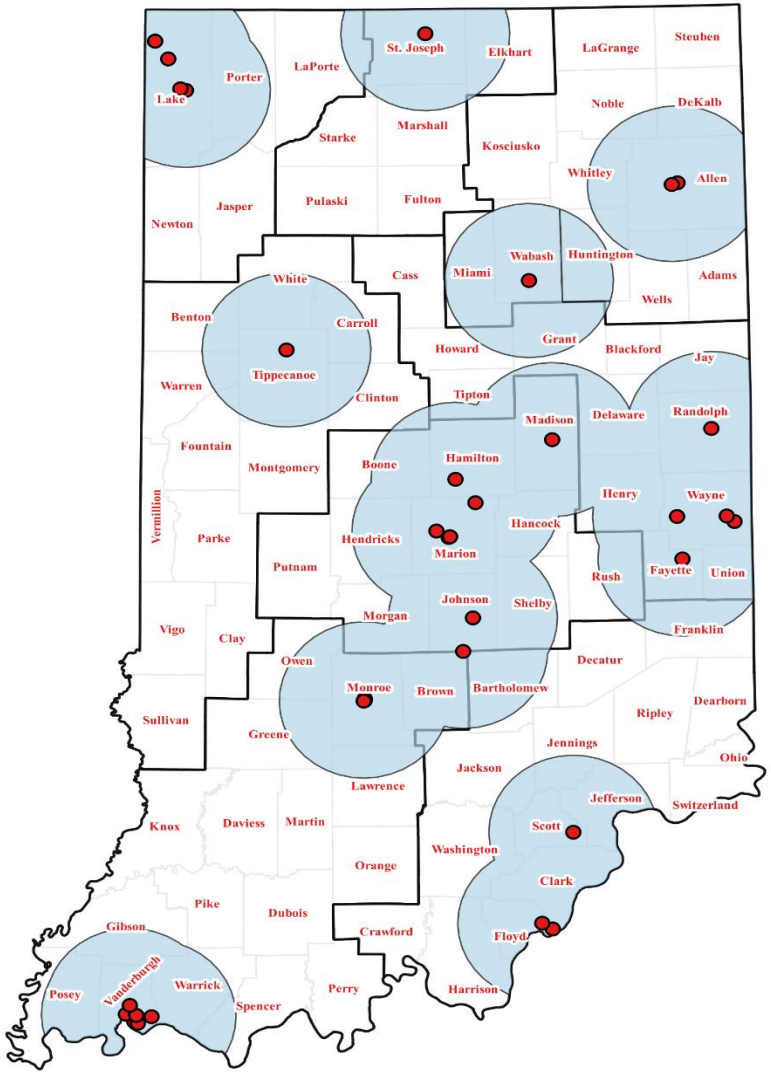
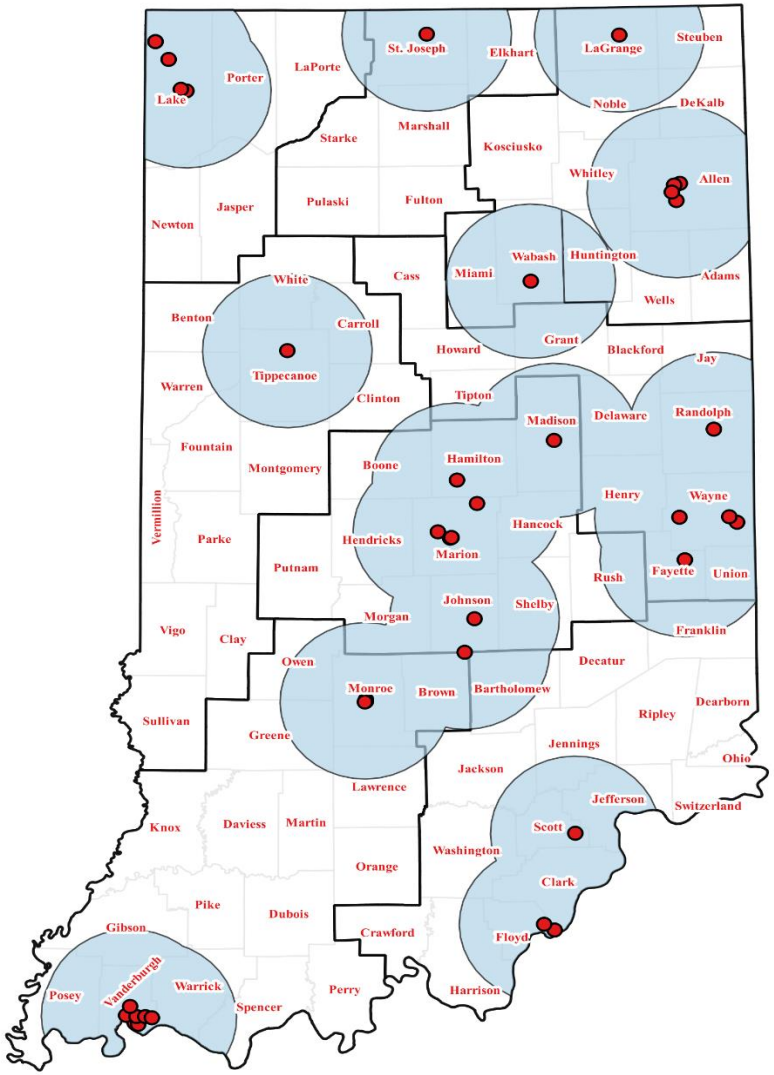


Exhibit III.22
Comparison of Residential Treatment Providers Under Contract with FSSA, October 31, 2018 and November 30, 2019

Residential Providers as of October 31, 2018



Residential Providers as of November 30, 2019



Residential Providers

20 Mile Radius

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

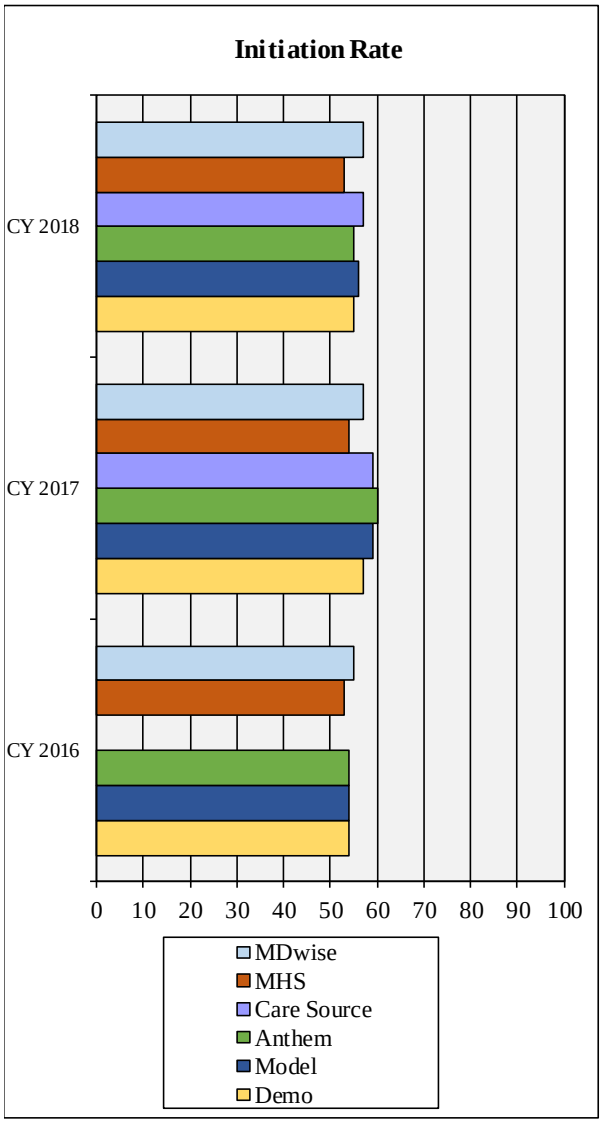
To assess the FSSA's progress in Milestone #5, B&A used four of the CMS-defined measures that are reported annually by states in the SUD Monitoring Protocol. Because these measures are only reported annually and the FSSA's waiver only has data available from the first year of the waiver, B&A is using two pre-waiver periods (CY 2016 and CY 2017) to assess progress.

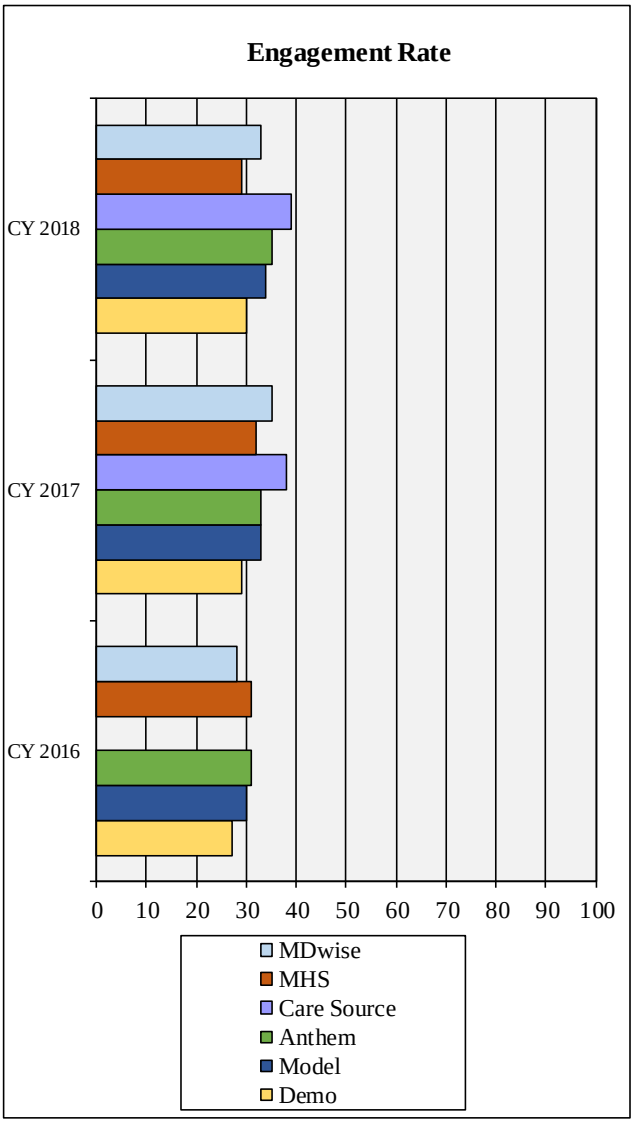
The exhibits in this section are formatted in the same manner. Exhibit III.23, that appears on the next page, assesses trends in the rate of initiation (left box) and engagement (right box) of SUD treatment. Results are shown for the demonstration population overall, the model population, and each MCE under the model population. The percentage rate for each cohort population are plotted as bars in the exhibit. The color of each bar represents one of the cohort population (e.g., the blue bar always represents the total model population whereas the green bar always represents Anthem specifically). The newest MCE, CareSource, began contracting with the State in January 2017, and has results for only one year in the pre-waiver period.

With respect to the initiation rate, there has been a slight decrease in the waiver period (CY 2018) when compared to the pre-waiver period of CY 2017 for the demonstration overall and the model population specifically. The overall rate in the waiver period is 55 percent. Three of the four MCEs also saw a decrease during this time period. MDwise remained steady. All four MCEs have initiation rates similar to the all-MCE model population average rate.

With respect to the engagement rate, there has been a slight increase in the waiver period when compared to the pre-waiver period of CY 2017 for the demonstration overall and the model population specifically. The overall rate in the waiver period is 30 percent; for the model population specifically, 34 percent. Two of the four MCEs (Anthem, CareSource) also saw an increase during this time period, but MHS and MDwise saw a decrease. The four MCEs have engagement rates that are more varied from the all-MCE model population average rate than what was seen for the initiation rates.

Exhibit III.23
Rate of Initation and Engagement of Alcohol and Other Drug Dependence Treatment (percent)
(CMS Metric #15)





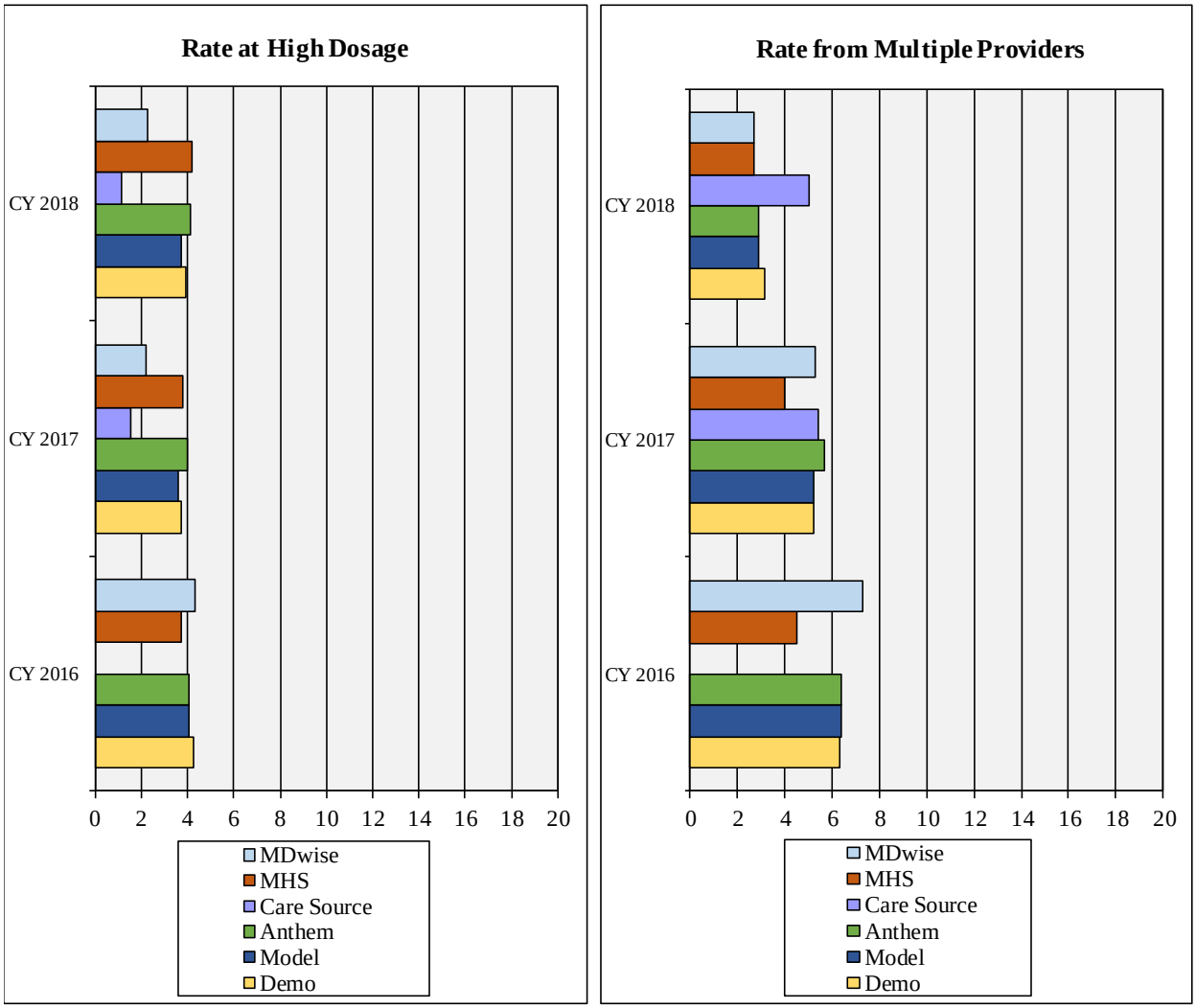
Initiation	Demo	Model	Anthem	Care Source	MHS	MDwise
CY 2016	54	54	54		53	55
CY 2017	57	59	60	59	54	57
CY 2018	55	56	55	57	53	57

Engagement	Demo	Model	Anthem	Care Source	MHS	MDwise
CY 2016	27	30	31		31	28
CY 2017	29	33	33	38	32	35
CY 2018	30	34	35	39	29	33

Exhibit III.24 shows the rates of the use of opioids at high dosage (left box) and from multiple providers (right box). There has been little change since the waiver began on the rate at high dosage (near 4.0%), but the rate from multiple providers has decreased (from 5.2% to 3.2%) which is the desired result. For the rate at high dosage, CareSource and MDwise do have a slightly lower rate than their peers. For the rate from multiple providers, three of the four MCEs are the same but CareSource is higher.

B&A used the CMS definitions for each of these measures.

Exhibit III.24
Rate of Use of Opioids in Persons Without Cancer (percentage)
(CMS Metric #18)

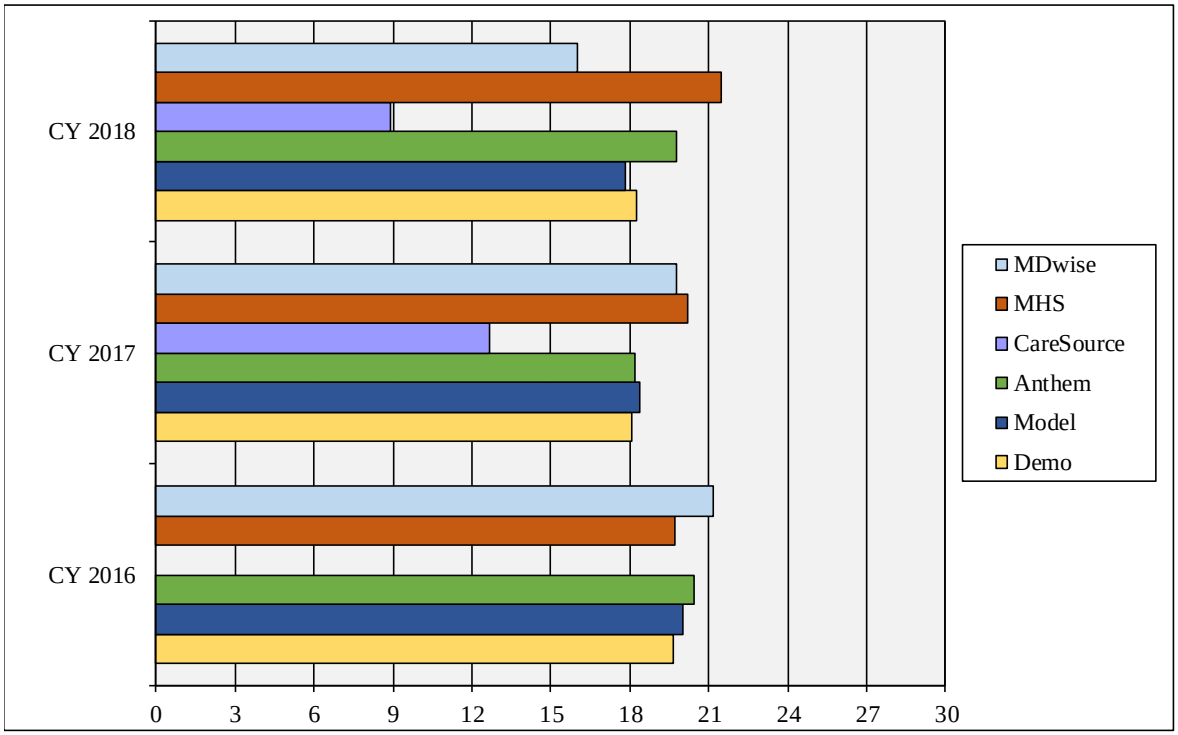


High Dose	Demo	Model	Anthem	Care Source	MHS	MDwise
CY 2016	4.2	4.0	4.1		3.7	4.3
CY 2017	3.8	3.6	4.0	1.5	3.8	2.2
CY 2018	4.0	3.7	4.1	1.2	4.2	2.3

Multiple	Demo	Model	Anthem	Care Source	MHS	MDwise
CY 2016	6.3	6.4	6.4		4.5	7.3
CY 2017	5.2	5.2	5.7	5.4	4.0	5.3
CY 2018	3.2	2.9	2.9	5.0	2.7	2.7

Exhibit III.25 shows results for the rate of continuity of pharmacotherapy for opioid use disorder. The rate has remained steady so far between the pre-waiver and waiver periods at 18.3 percent. The rate for the model population overall is similar to the demonstration population as a whole, but there is some variation at the individual MCE level within the model population.

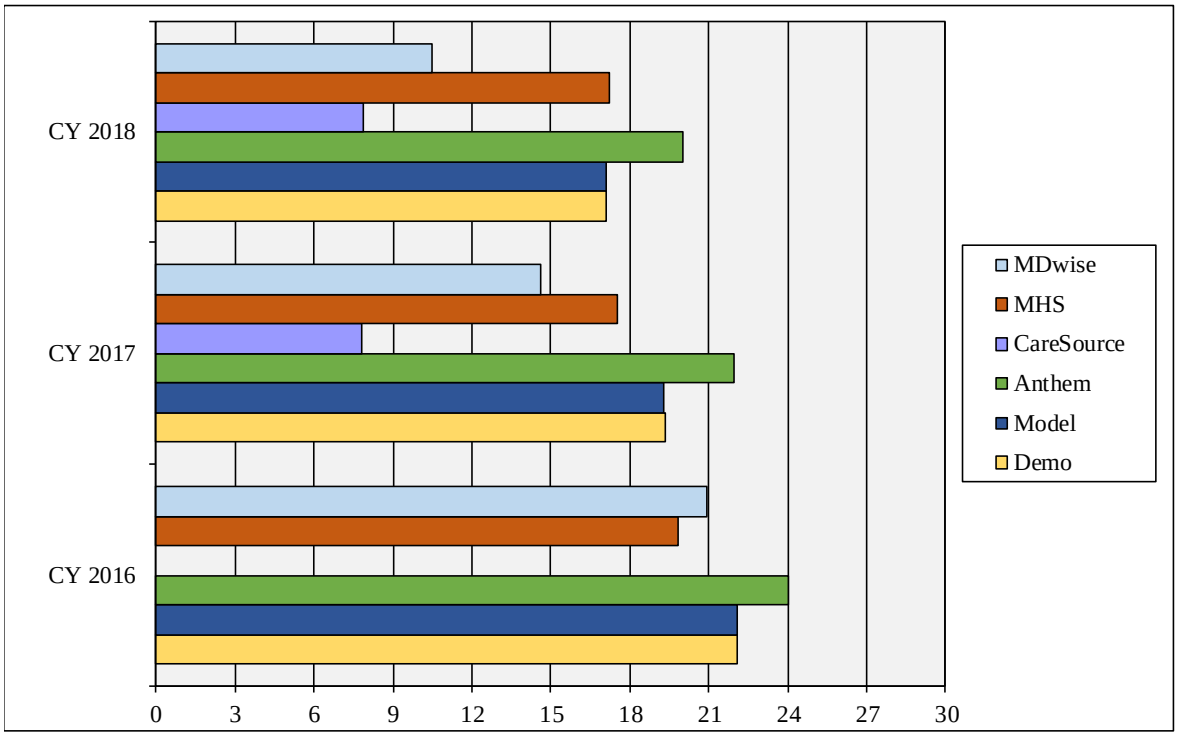
Exhibit III.25
Rate of Continuity of Pharmacotherapy for Opioid Use Disorder (percentage)
(CMS Metric #22)



	Demo	Model	Anthem	CareSource	MHS	MDwise
CY 2016	19.6	20.0	20.4		19.7	21.2
CY 2017	18.1	18.4	18.2	12.7	20.2	19.8
CY 2018	18.3	17.9	19.8	8.9	21.5	16.0

For the rate of concurrent use of opioids and benzodiazepines, there has been some improvement during the first year of the waiver period, from 19.3 percent in the pre-waiver period of CY 2017 to 17.1 percent in CY 2018. There was also a reduction from CY 2016 to CY 2017. There is variation, however, in this rate across the MCEs. But three of the four MCEs (CareSource is the exception) have seen a reduction in the waiver period.

Exhibit III.26
Rate of Concurrent Use of Opioids and Benzodiazepines (percentage)
(CMS Metric #21)



	Demo	Model	Anthem	CareSource	MHS	MDwise
CY 2016	22.1	22.1	24.0		19.8	20.9
CY 2017	19.3	19.3	22.0	7.8	17.6	14.6
CY 2018	17.1	17.1	20.0	7.9	17.2	10.5

SUD Health Information Technology (Health IT)

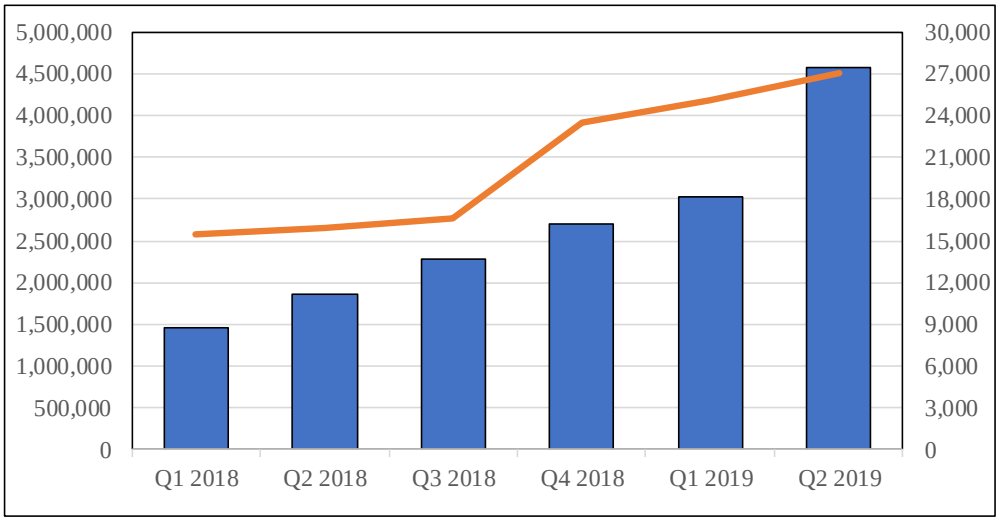
The FSSA has identified three measures in its SUD Health Information Technology Plan:

- Number of prescribers accessing INSPECT (the State's prescription drug monitoring program software);
- Number of patient requests made into INSPECT; and
- Number of prescribers making patient requests through an integrated system solution

As of the date of this report, the State has been able to track and report on the number of registered INSPECT prescribers and registered users but not the number that are actually accessing INSPECT routinely (measure #1). The State can also track the number of patient prescription requests either through an integrated system or not through one, but it cannot track the number of unique prescribers making these requests (measure #3).

Exhibit III.27 below, therefore, reports on the total patient requests made into INSPECT (measure #2) as well as the number of registered users (which may or may not be indicative of the number actually accessing INSPECT). There has been considerable growth in the total number of requests, from near 1.5 million in the first quarter of the waiver period to over 4.5 million in the latest quarter available (Q2 2019). The number of registered users has grown from 15,418 in Quarter 1 2018 to 27,045 in Quarter 2 2019.

Exhibit III.27
Requests Made by Prescribers (bars) and Number of Registered Users (line)
Indiana's Prescription Drug Monitoring Program



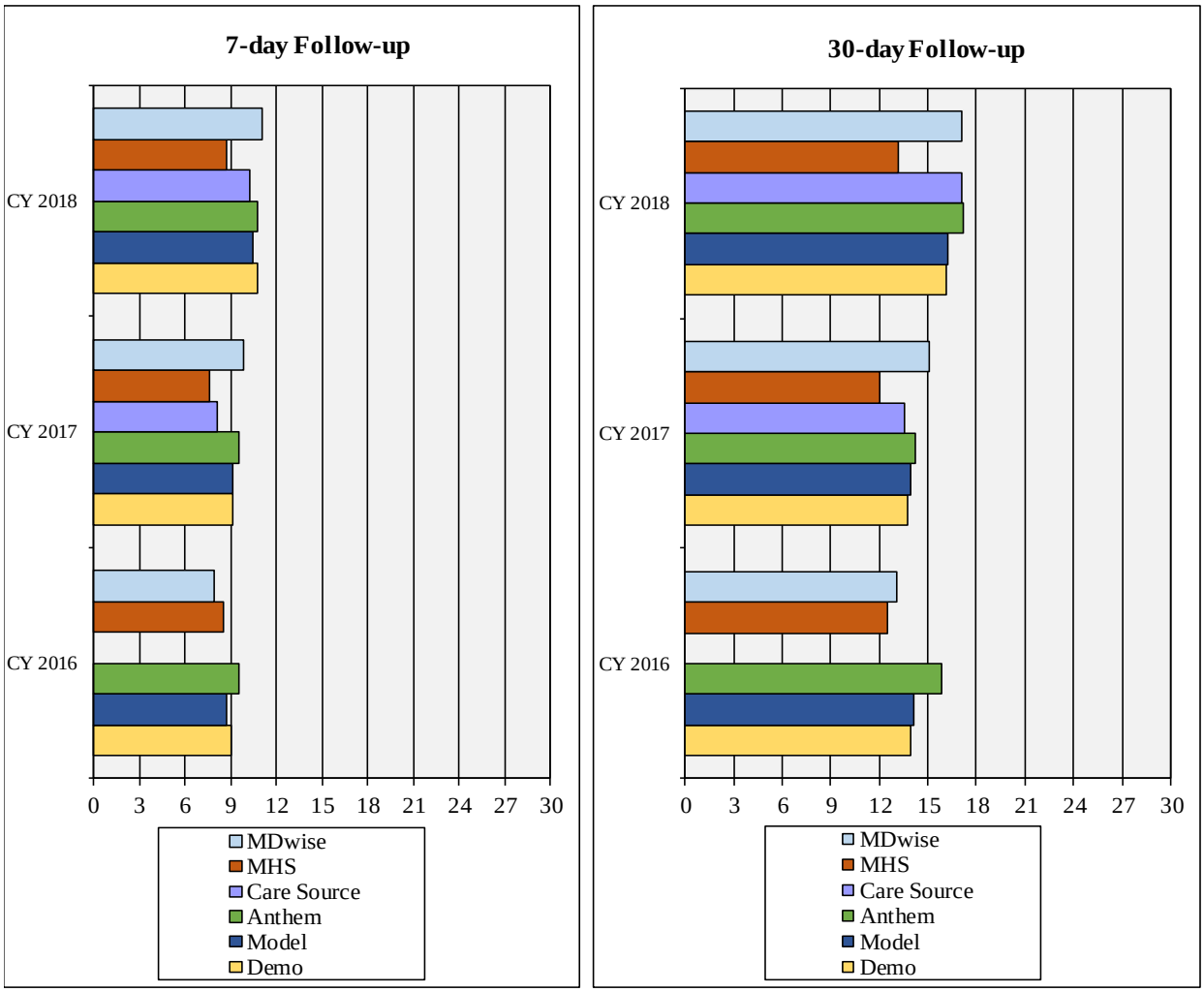
Source: Indiana Professional Licensing Agency

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

For Milestone #6, B&A uses one CMS measure as well as measures defined by B&A in a focus study to assess improvements in care coordination or transitions between levels of care.

First, Exhibit III.28 shows the results of the CMS-defined measure for follow-up after discharge from the emergency department for a mental health or alcohol or drug abuse/dependence issue. There has been slight improvement in both the 7-day follow-up (left box) and 30-day follow-up (right box) in the waiver period when compared to the pre-waiver period. On both measures, three of the MCEs are near the all-MCE model average, but MHS is slightly lower than its peers.

Exhibit III.28
Rate of Follow-up After an ED Visit for Alcohol or Drug Abuse or Dependence (percent)
(CMS Metric #17)



7-day	Demo	Model	Anthem	Care Source	MHS	MDwise
CY 2016	9.0	8.7	9.5		8.5	7.9
CY 2017	9.2	9.1	9.5	8.1	7.6	9.8
CY 2018	10.7	10.4	10.8	10.3	8.8	11.0

30-day	Demo	Model	Anthem	Care Source	MHS	MDwise
CY 2016	14.0	14.1	15.9		12.5	13.1
CY 2017	13.8	13.9	14.3	13.5	12.1	15.0
CY 2018	16.1	16.3	17.2	17.1	13.1	17.1

To assess transitions of care, B&A used encounters submitted by each of the MCEs to the FSSA as of June 30, 2019 for a study of anchor events that were identified to create an episode of care for each member based on admission. Anchor events included in the study were those that occurred between July 1, 2018 and December 31, 2018. The episodes were defined by the ASAM level of care:

- ASAM 4.0 (inpatient) was defined using diagnosis related groupings (Indiana uses 3M's APR-DRG grouper)
    - Inpatient, alcohol dependency, was defined by DRG 775 (Alcohol Abuse & Dependence)
    - Inpatient, drug dependency, was defined by DRGs 773 (Opioid Abuse & Dependence), 774 (Cocaine Abuse & Dependence) and 776 (Other Drug Abuse & Dependence)
    - Inpatient, alcohol and drug dependency, was defined by DRG 770 (Drug & Alcohol Abuse or Dependence, Left Against Medical Advice) and 772 (Alcohol & Drug Dependence with Rehab or Rehab/Detox Therapy)
- ASAM 3.5 (residential treatment) was defined by the presence of HCPCS H2034 (as directed by the State for billing purposes)
- ASAM 3.1 (residential treatment) was defined by the presence of HCPCS H0010 (as defined by the State for billing purposes)

B&A created a person-specific episode for each member. The individual was assigned to an MCE and region based on the admission date of their anchor event. A 12-week time period was defined counting backwards from the admission date of the anchor event. A 12-week time period was also defined counting forward from the discharge date of the anchor event.

The individuals in the study were further segmented into two study groups. The first group contains all 3,808 individuals originally considered in the study. The second group contains 2,708 individuals which is the subset of individuals from the 3,808 who were enrolled with the same MCE for the entire 12-week period *after* discharge from their anchor event.

Exhibit III.29, which appears on the next page, examines the percentage of individuals in the 2,708 cohort that had an inpatient anchor events and then utilized residential (ASAM levels 3.1 or 3.5), intensive outpatient or partial hospitalization (IOP/PH) or MAT in the 12 weeks after their discharge. Results are shown at the regional level. Members are assigned to one of the regions based on their home address.

The exhibit shows that the utilization of residential is near the statewide average for all regions with the exception of members with an inpatient anchor for alcohol only in the West Central region of the state (6.5% of individuals used residential compared to 1.1% statewide). The sample in this region, however, is the lowest of any region.

The percentage of members utilizing IOP/PH in the Central region is higher compared to the rest of the state, particularly for members with an inpatient anchor event for alcohol treatment only or drug treatment only. Further, for members with an anchor for alcohol treatment only, the utilization of IOP/PH is lower in the North Central, Northeast and West Central regions. These findings may be a result of access to IOP/PH providers in regions of the state.

The utilization of MAT also had some variation across regions of the state. Members in the Central and North Central regions were higher utilizers than other regions of the state.

Exhibit III.29
Utilization of Residential (ASAM 3.1 or 3.5), Intensive Outpatient or Partial Hospitalization, and Medication Assistance Treatment
For Individuals in Study with an Anchor Event for Inpatient (ASAM 4.0)

	Percent of Members using Service Some Time In 12 Weeks After Inpatient Stay											
	Sample with Minimum Enrollment with an MCE 12 Weeks After Discharge											
	DRG = Alcohol Only				DRG = Drugs Only				DRG = Alcohol and Drugs			
	Total in Sample	Pct with 3.1 / 3.5	Pct with IOP/PH	Pct with MAT	Total in Sample	Pct with 3.1 / 3.5	Pct with IOP/PH	Pct with MAT	Total in Sample	Pct with 3.1 / 3.5	Pct with IOP/PH	Pct with MAT
Any Program	742	1.1%	9.0%	18.3%	592	0.8%	15.5%	30.2%	949	1.9%	10.1%	43.6%
Northwest	95	0.0%	5.3%	17.9%	30	3.3%	6.7%	20.0%	64	0.0%	9.4%	32.8%
North Central	43	2.3%	0.0%	14.0%	18	0.0%	11.1%	44.4%	71	0.0%	15.5%	56.3%
Northeast	112	0.9%	1.8%	14.3%	57	0.0%	0.0%	14.0%	49	0.0%	0.0%	30.6%
West Central	34	8.8%	0.0%	5.9%	40	0.0%	2.5%	17.5%	70	4.3%	5.7%	41.4%
Central	215	0.9%	18.6%	23.3%	219	1.4%	27.9%	42.0%	421	0.7%	12.1%	49.2%
East Central	67	0.0%	3.0%	19.4%	66	1.5%	7.6%	31.8%	123	3.3%	3.3%	37.4%
Southwest	105	1.0%	9.5%	17.1%	82	0.0%	17.1%	23.2%	81	3.7%	17.3%	28.4%
Southeast	71	0.0%	11.3%	19.7%	80	0.0%	8.8%	22.5%	70	7.1%	8.6%	47.1%

Exhibit III.30 shows a similar display, but this time for the use of IOP/PH or MAT in the 12 weeks after an ASAM 3.5 residential stay. The first notable finding is the volume of ASAM 3.5 anchor events themselves across the regions. Almost two-thirds of all ASAM 3.5 anchor events are in the Northwest, Southwest and Southeast regions Even though these regions do not represent that percentage of the statewide population. The Central region of the state comprises almost one-third of the state's population, yet very few ASAM 3.5 anchor events were identified in this region.

Exhibit III.30
Utilization of Intensive Outpatient or Partial Hospitalization and Medication Assistance Treatment
For Individuals in Study with an Anchor Event for Residential (ASAM 3.5)

	Percent of Members using Service Some Time In 12 Weeks After Residential Stay				
	Sample with Minimum Enrollment with an MCE 12 Weeks After Discharge				
	Total in Sample	Pct with IOP/PH Prior to 3.5	Pct with IOP/PH After 3.5	Pct with MAT Prior to 3.5	Pct with MAT After 3.5
Any Program	394	19.8%	17.3%	35.5%	32.2%
Northwest	90	22.2%	28.9%	30.0%	24.4%
North Central	12	16.7%	0.0%	50.0%	33.3%
Northeast	29	13.8%	0.0%	31.0%	41.4%
West Central	5	0.0%	0.0%	60.0%	0.0%
Central	40	25.0%	10.0%	45.0%	45.0%
East Central	52	5.8%	5.8%	34.6%	23.1%
Southwest	76	19.7%	23.7%	25.0%	26.3%
Southeast	90	26.7%	18.9%	44.4%	43.3%

In the three regions with the most ASAM 3.5 anchor events, there was a higher percentage of members in the Northwest and Southwest regions who used IOP/PH after their ASAM 3.5 residential stay than before their stay. The opposite was true in the Southeast region.

For MAT, the only region that had members who used more MAT after their ASAM 3.5 stay than before their anchor stay was the Southwest region. This region, however, had one of the lowest percentages of MAT users overall.

For the total 3,808 individuals included in our study, B&A requested rosters from each MCE for their members who were enrolled in complex case or care management at some time in CY 2018. These rosters were cross-tabulated to the individuals identified in the study. Overall, 15.6% of members in B&A's study were enrolled in case or care management with the MCEs. However, there was wide variation among the MCEs on this statistic. MHS reported 86.0% of its members in the B&A study were enrolled in case or care management, whereas the other three MCEs each reported under 2.5% of their members enrolled.

Exhibit III.31
SUD Member Enrollment in Case or Care Management in CY 2018, by MCE

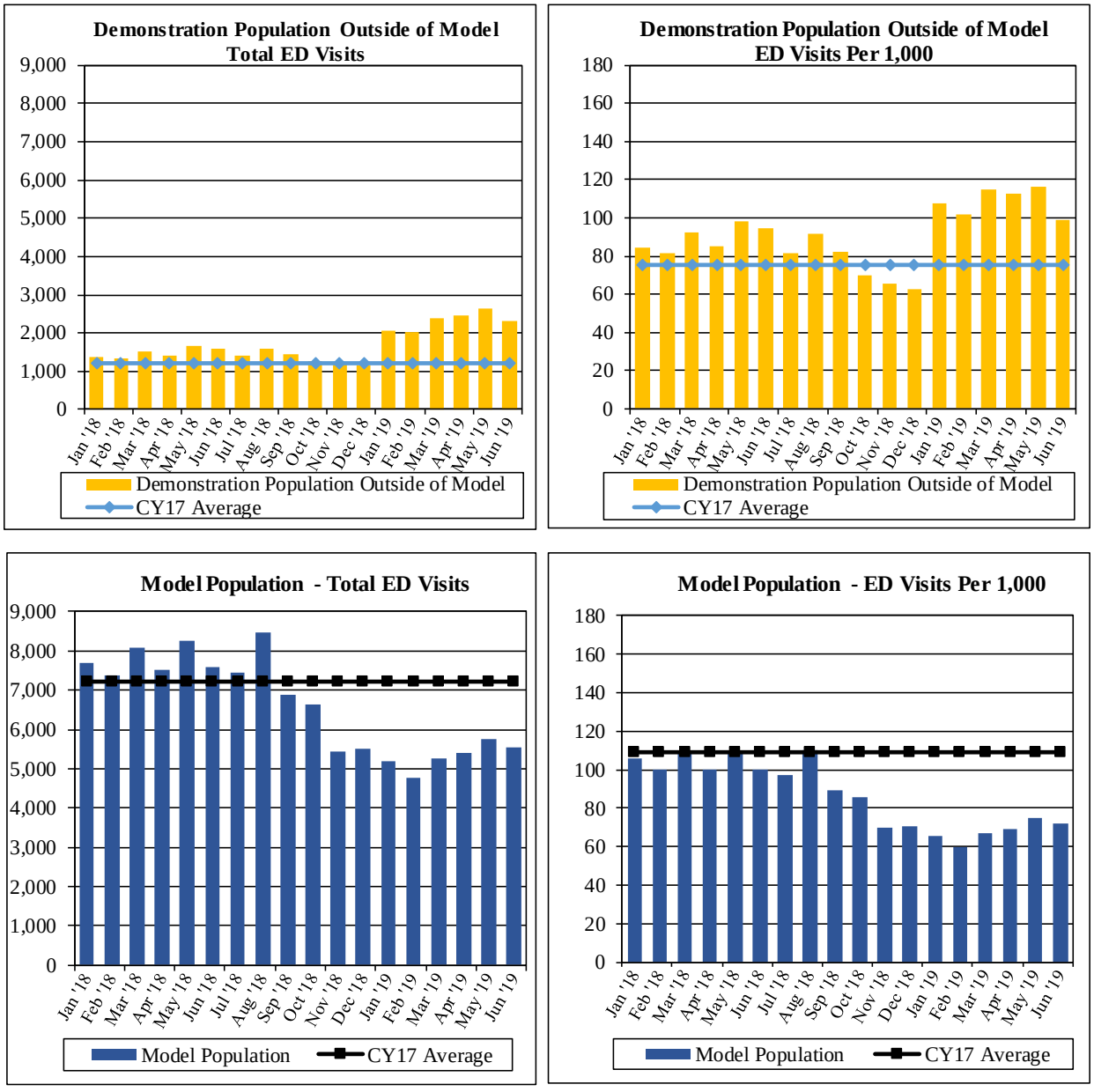
MCE	Members in the Transitions of Care Study	Number of Individuals in Case or Care Management	Percent in Case or Care Management
Anthem	1,907	12	0.6%
CareSource	384	9	2.3%
MDwise	858	7	0.8%
MHS	659	567	86.0%
Total	**3,808**	**595**	**15.6%**

The individuals in the Transitions of Care study are those members in each MCE that had a stay in either an ASAM 4.0, 3.5 or 3.1 level of care.

Other SUD-Related Metrics

In this section, B&A provides an assessment-to-date on two other measures requested in the SUD Monitoring Protocol. Exhibit III.32 shows the total ED visits (left boxes) and ED visits per 1,000 SUD Medicaid beneficiaries (right boxes) by month since the start of the waiver. The FSSA has seen improvement through a reduction of overall ED utilization for SUD beneficiaries particularly among the model population (bottom left box). The ED visits per 1,000 SUD beneficiaries in the model population has been lower in every month of the waiver than the pre-waiver period average in CY 2017. For the FFS population, however, the post-waiver results have generally exceeded the pre-waiver average.

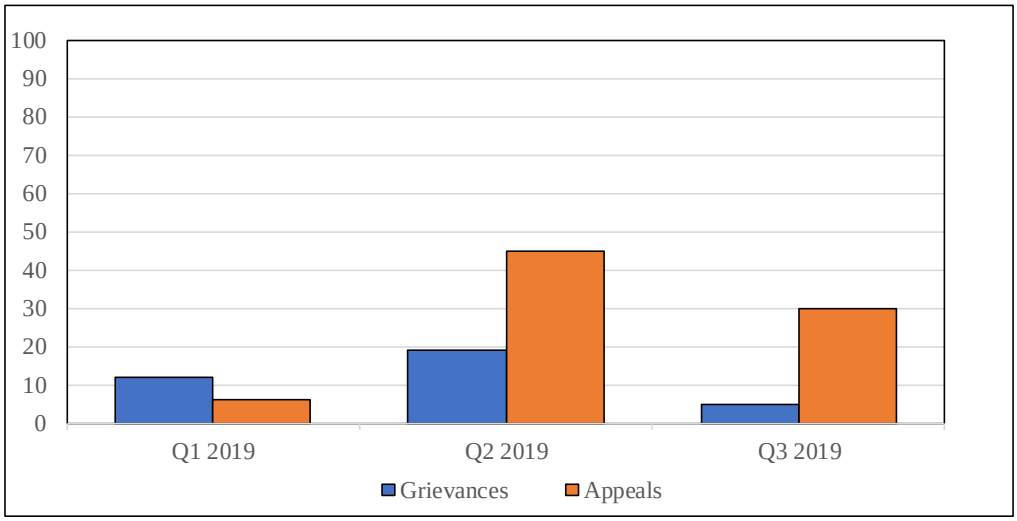
Exhibit III.32
ED Utilization, Total Visits and Visits Per 1,000 SUD-identified Medicaid Beneficiaries, by Month
For Demonstration Population Overall Divided between Members in and out of the Model Population



The FSSA required its MCEs to start reporting on grievances and appeals specific to the SUD population beginning with the experience period that began January 1, 2019. As a result, only three quarters of data are available to report at this time.

To date, there have been 20 or less grievances reported each quarter for all four MCEs combined. Appeals have been more sporadic with six in Quarter 1, 45 in Quarter 2 and 30 in Quarter 3.

Exhibit III.33
Number of SUD-Related Grievances and Appeals Reported (Member or Provider)
For the Model Sub-population (Managed Care)



Source: Data self-reported by the MCEs to the Indiana Office of Medicaid Policy and Planning

It should be noted that the FSSA is currently not tracking another SUD-related metric suggested by CMS related to critical incidents related to SUD treatment services.

Budget Neutrality

To date, the FSSA does not appear to have any issues meeting its waiver budget neutrality requirements for the SUD population. Exhibit III.38 summarizes the latest information available which is tabulated by the Medicaid agency's external actuary. In the first demonstration year when the SUD benefits were a part of the FSSA's 1115 waiver (DY4), the with waiver per member per month (PMPM) did exceed the agreed-upon target by 0.9 percent, or $62.66. The projections for the final two years of the waiver (DY5 and DY6) is that the SUD PMPM during the waiver will be 3.0 percent below the without waiver estimate after accounting for the agreed-upon 4.9 percent trend rate allowed in the waiver terms and conditions.

Exhibit III.34
Summary of Budget Neutrality Calculations to Date
For Medicaid Eligibility Group = SUD

	DY4	DY5	DY6
Without Waiver PMPM (1)			
4.90% trend rate allowed	$6,834.71	$7,169.61	$7,520.92
With Waiver PMPM (2)			
Actual + Projected Expenditures	$74,381,238	$96,879,581	$102,642,947
Actual + Projected Member Months	10,784	13,938	14,077
Per Member Per Month Calculation	$6,897.37	$6,950.75	$7,291.54
Difference	**-$62.66**	**$218.86**	**$229.38**

(1) Source: Indiana's approved waiver terms and conditions, page 49
(2) Source: Indiana's Q3 2019 waiver monitoring report

SECTION IV: STAKEHOLDER FEEDBACK OF INDIANA'S SUD WAIVER IMPLEMENTATION ACTIVITIES TO DATE

Introduction

The B&A team collected feedback from a variety of stakeholders to gain perceptions about the initial implementation of activities related to the SUD waiver as well as ongoing activities. Most of the feedback was collected through in-person interviews, but some was collected telephonically.

B&A requested from the FSSA the current list of providers licensed to provide ASAM 4.0, 3.5 and 3.1 services as of September 30, 2019 with their contact information. B&A outreached to each of the 38 providers on this list to request participation in an interview one-on-one with each provider at their location (when the interview was conducted in-person). A total of 20 providers agreed to participate. All but a few interviews were conducted in-person, but a few were conducted by phone due to scheduling logistics. All of the interviews were completed between November 18 and December 5, 2019.

Appointments were set in advance so that the appropriate provider representatives could be present. Each provider was sent the same set of questions in advance of their interview. The B&A Review Team requested that the topics covered in these questions be addressed during the interview, but the providers were encouraged to provide feedback on any other topic related to the SUD waiver as well.

The providers were given discretion as to who from their organization attended the interview. Typically, two to four representatives attended. The B&A Review Team consisted of four members, but most interviews had two B&A team members in attendance. Interviews were set for 90 minutes in duration and most interviews went this entire time, if not longer.

The list of questions sent to providers in advance of each interview appear in ***Appendix B***.
The list of providers interviewed appear in ***Appendix C***.

When the initial appointments were made with providers, B&A also requested the providers' assistance, where possible, to coordinate short interviews with some of their Medicaid clients. Many providers were able to assist in this manner. The interviews with clients who received SUD treatment were held separate from the provider interview. Interviews were conducted one-on-one with the B&A representatives and typically lasted ten minutes. Clients were told upfront that our questions pertained mostly to access to services. Individuals were told that they were not obligated to reveal personal information or their full name, although many did. Nonetheless, client names were not recorded. A total of 21 clients were interviewed.

The list of questions covered in client feedback interviews appear in ***Appendix D***.

B&A conducted one interview session with all four managed care entities (MCEs) contracted with FSSA on October 17. The MCEs were asked to ensure that representatives that regularly communicate with SUD providers participate in this meeting. Each MCE complied with this request. Each MCE Compliance Officer also attended the meeting.

Similar to the provider interviews, the MCEs were given questions in advance of the meeting so that they could be prepared for a meaningful discussion. The actual session was 120 minutes in length. Two of the B&A Review Team members who also conducted the provider and client interviews attended the MCE meeting. There was equal participation and feedback from the representatives from all four MCEs.

The list of questions sent to the MCEs in advance of their interview appear in ***Appendix E***.

Summary of Feedback by Stakeholder Group

Provider and MCE Feedback

Although all of the providers expressed appreciation for the expanded services available to Medicaid beneficiaries, their feedback about the initial rollout of the waiver and more current day-to-day operations was mixed. B&A asked for specific examples of what was working well (or had improved since the initial rollout) and where there were items that continue to be of concern.

Much of the concerns expressed by providers were related to their interactions with the MCEs. Many of the providers interviewed are contracted with all four of the MCEs. The positive and negative feedback about MCEs was not lopsided; that is, some providers had positive feedback about one of the MCEs while others had the opposite feedback. The providers were also able to isolate their positive or negative feedback about a particular MCE to specific functional areas. For example, a provider may have a very positive experience with the MCE's care coordination team but a negative experience with the same MCE's utilization management or billing team.

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

The specific areas that B&A is reporting on related to provider and MCE feedback appear below. A notation is given if the feedback reported is from both providers and MCE, from providers only, or from MCEs only.

1. Guidance from the FSSA on the initial rollout of the waiver (both)
2. Specific items that have improved or continue to be a problem in CY 2019 (both)
3. Perception of provider knowledge base on the SUD benefit or Medicaid processes (MCEs only)
4. The prior authorization process, overall and with specific MCEs (providers only)
5. Provider compliance with the prior authorization process (MCEs only)
6. The claims billing process with specific MCEs (providers only)
7. MCE care coordination activities with providers (providers only)
8. Written communication from the FSSA to providers (providers only)
9. MCE care coordination activities with providers and provider receptivity to this process (MCEs only)
10. In-person communications/meetings/training between the FSSA and providers (providers only)
11. Client perceptions of benefits and knowledge base to access services (both)
12. Unintended positive consequences of the SUD waiver (both)
13. Unintended negative consequences of the SUD waiver (both)

Beneficiary Feedback

The feedback from beneficiaries (Medicaid members) was obtained more informally. The B&A interviewer allowed the interviewee to discuss items important to him/her. The specific items that were covered in all interviews are discussed in the section below and include:

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

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

Client perceptions

- *Clients do not understand benefits (providers).* All of the providers stated that clients do not understand the services available to them as part of their benefit package until they enter treatment. Overall, there is not a good understanding of medical necessity. Individual clients who are longer-term recovery patients have a much better understanding of the SUD services available to them. Access to sober living and, in particular, facilities that would take someone on medication assisted treatment (MAT) were expressed as concerns.

- *Clients do not have a good understanding of their benefits or knowledge base to access services (MCEs).* The MCEs felt that, in part, this is connected with the disease of substance abuse and difficulties with daily functions.

- *Clients are afraid insurance will not cover inpatient or residential care that they need (providers).* The residential treatment providers interviewed indicated that prior authorization denials, and the process to appeal them, cause significant anxiety with their Medicaid patients and their family members, mostly because it takes a lot to get someone to commit to treatment.

- *(beneficiaries)* Many of the members interviewed said that they found out about treatment primarily from a friend, family member, sponsor, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings, receiving other care from the provider, or as a result of going through the criminal justice system.

Access to services

- *(beneficiaries)* Most members stated that they did not know they had access to care and what Medicaid covered. They thought that getting treatment for addictions was only for rich people.

Improvements in access with the waiver

- *Ability to get treatment in settings not previously covered by Medicaid (MCEs).* The MCEs overwhelmingly were supportive of the ability to cover care in treatment settings not previously covered, specifically residential treatment centers. They all expressed that this was a huge gap in care and felt that the waiver was providing access to a much-needed service. The MCEs felt that there still needed to be clearer understandings of who needs to get this type of care and the appropriate level of care.

- *Better able to deal with relapses that are part of SUD treatment (providers).* Providers were appreciative that the waiver has allowed access to treatment settings not previously covered by Medicaid. One positive outcome is that Medicaid members can get care as many times as needed through residential treatment programs, where they were limited to one time with prior DMHA grant funding. This is particularly beneficial for SUD treatment where relapses are a fact of recovery.

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

The prior authorization process, overall and specific situations

- *Differing interpretations/results of authorizations (providers).* All of the providers have had issues with prior authorization in terms of getting different interpretations or results of SUD authorization approvals and denials across the MCEs and the FFS vendor. Each provider interviewed stated that they have gotten different decisions for patients with the same clinical conditions from each of the MCEs and the FFS vendor.

- *Rationale for denials is insufficient (providers).* All of the providers interviewed stated that the rationale for denials is insufficient and that it is difficult to understand why the authorization was denied, most specifically from a clinical perspective. The majority of the providers stated that they just want to know upfront what the MCEs want so that they can get approvals and avoid denials and appeals.

- *Concurrent review process and documentation requirements differ across MCEs and FFS (providers).* Providers overwhelming expressed concerns with the lack of a consistent concurrent review process and documentation requirements across the MCEs and FFS. While there were significant issues with initial approvals at the outset of the waiver of only 7 to 14 days, providers said that this has gotten better with the FSSA policy clarification requiring MCEs to approve a minimum of 14 days for residential treatment upfront. The remaining issues relate to differing documentation requirements that must accompany the authorization request for the remaining requested length of stay. The MCEs in general only approve seven days at a time. Many of the providers stated that the approval process causes angst for members receiving treatment as they most often don't have someplace to go after discharge and they lack the skillsets and supports to remain sober without a structured environment, at least on an initial basis.

- *Peer-to-peer process is difficult (providers).* All of the providers expressed that the clinical peer-to-peer process for review of authorization decisions is difficult. It was reported that most MCEs require that the provider offers three date/time blocks for the MCE to contact a clinician at the provider's office to obtain additional clinical information. It was expressed that this was burdensome from a scheduling perspective. Further, all of the providers expressed frustration over missed calls with the MCEs due to lack of specific scheduling and that their clinicians are actively seeing and treating patients on a fulltime basis. Many of the providers thought that the use of specific appointment times (as opposed to offering up dates/times and hope for a call) may help to improve the success rate of provider and MCE clinician' discussions.

- *Improvements in the authorization process since the FSSA-sponsored ASAM training and B&A presentation on its independent review of prior authorization (MCEs).* MCEs have noticed a huge shift in how providers and the State interact with the MCEs – it has become much more collaborative. The single prior authorization form has helped to set expectations on what is needed for prior authorization and criteria used to make determinations. One noted area that they cited could be improved is that the form currently lacks other levels of care for SUD treatment outside of inpatient or residential. The FSSA should plan to add these.

- *Additional clarification on prior authorization criteria needed (MCEs).* The MCEs felt that FSSA should provide further clarification on the criteria that is to be used for prior authorization as the ASAM criteria are not responsive for continued stays. Specifically, the ASAM goals are not laid out in enough detail.

Perception of provider knowledge base on the SUD benefit or Medicaid processes

- *Lack of understanding of the ASAM treatment model (MCEs).* There are no rules on residential treatment centers and what services they should provide in conjunction with the ASAM treatment model. This has led to frustration on the part of providers and has created issues with provider enrollment and prior authorization for the MCEs.

Unintended negative consequences of the SUD waiver

- *Denials for alcohol only detoxification admissions (providers).* The majority of residential and inpatient providers have had issues with obtaining MCE approvals for alcohol-only detoxification which they largely believe is the result of statements made by the ASAM trainer.

- *Denials for inpatient or residential treatment for those coming out of the criminal justice system (providers).* The majority of inpatient and residential treatment providers stated that the MCEs are initially denying treatment in these care settings because the member is coming from a "clean period or environment". All of the providers who mentioned this stated that prisons and jails are not clean environments. Patients coming from the criminal justice system are using substances while incarcerated. The providers have asked the FSSA to review the current criteria for admission to a residential or inpatient setting and to provide clarification that would allow coverage in these settings for those coming out of the criminal justice system.

- *Conflicts between court-ordered treatment setting and medical necessity (providers).* Many providers felt that it would be helpful to provide training to the courts regarding SUD treatment settings and the role of medical necessity for Medicaid payment to occur. In particular, they felt this may alleviate court-ordered treatment settings that are eventually not approved by the MCEs due to lack of medical necessity.

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

Unintended negative consequences of the SUD waiver

- *ASAM 3.1 and 3.5 requirements resulting in limited 3.1 provider availability (providers).* Many of the residential treatment providers expressed that the physical barrier requirement established by DMHA to separate ASAM 3.1 and 3.5 programs is inherently limiting to the usual way these services are delivered (e.g., program specific to pregnant women, program specific to men, etc.). That, in conjunction with reimbursement rate differences, has led providers to choose to enroll as an ASAM level 3.5 provider which leaves the availability of ASAM 3.1 sites more limited. As of the date of this report, there are 15 ASAM 3.1 providers and 26 ASAM 3.5 providers.

- *Differing licensure requirements by ASAM level (providers).* Providers could not understand why there is not a licensure requirement for ASAM 3.7 and that development of licensure for this level may help alleviate some of the authorization denials at ASAM 4.0. In other words, if providers could request authorization for ASAM level 3.7, they would not always be as likely to request ASAM level 4.0 (and getting denied). Currently, there is no other option between ASAM level 4.0 and 3.5 or IOP.

Onboarding providers

- *Issues with credentialing and onboarding with MCEs (providers).* Some of the providers, but not all, expressed that they had issues with credentialing and onboarding with the MCEs at the outset of the SUD waiver. Providers did acknowledge that this has improved over the past year. The primary issue expressed that remains is the need to start over in the credentialing process with

seasoned clinicians who are credentialed as part of another provider organization. This is impacting their ability to effectively serve patients due to scarce clinical resources for SUD treatment.

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

Ease of finding treatment options

- *(beneficiaries)* Almost all members stated that they had trouble finding access to care near their home county. Many had to travel at least 1 to 2 hours to get care. The exception appeared to be in the Southwest Region (Evansville). Providers also thought the SUD network there was adequate.

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

Identification of services not available (actual or perceived) in the client's region of the state

- *(beneficiaries)* Services most often mentioned include: supportive housing, specifically one that will accept member who is receiving MAT; therapists, transportation; and dental care.

- *(beneficiaries)* Other services mentioned include: help with paying for medications when insurance won't cover it; IOP classes not covered by insurance; treatment places where you can bring your children or assistance with getting daycare; place for single fathers to go to get help so they won't lose their children.

- *(MCEs)* Concern with the low counts of lower ASAM level providers. In particular, the MCEs noted counts of OTP, PHP, and ASAM level 3.1 residential treatment provider settings are low and present issues with access on the continuum of care. Overall, the MCEs cited concern that they are not seeing providers diversify to cover the continuum of care.

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

Guidance from the FSSA on the initial rollout of the waiver

- *Initial guidance at rollout unclear (providers).* The majority of the providers interviewed expressed concerns with the initial rollout of the waiver, primarily that the guidance around the waiver was not clear. Some of the providers commented that they felt that the waiver may have been rolled out too quickly. While they have seen improvements in the second year of the waiver, the feedback received was that there continue to be "growing pains" associated with implementation. The most recent example is the transition of what were MRO services provided on a FFS basis to state plan services that are now available through managed care.

- *30-day length of stay assumptions (providers).* Residential treatment providers overwhelmingly commented that FSSA originally communicated to providers that the anticipated average length of stay for residential settings would be 30 days, but this did not happen.

- *Lack of clarity on FSSA policies and what rules the MCEs needed to follow (MCEs).* At issue was the original length of stay guidance of 30 days as issued by FSSA and what this meant. The FSSA provided subsequent clarification that, at minimum, the MCEs must authorize 14 days in a residential treatment setting. A more recent example is how to treat leave of absence or community outings from residential treatment centers.

- *Lack of clarity on roles of the MCEs versus FSSA and DMHA with respect to network compliance (MCEs).* The MCEs stated that roles with respect to network compliance were unclear, specifically whether it was DMHA or the MCE's responsibility to ensure that providers enrolled as ASAM level 3.1 or 3.5. Also, who had responsibility to ensure that certification requirements were met on an ongoing basis.

Systems-related readiness

- *FSSA and MCEs processes and systems were incomplete on day one of waiver go live (providers).* FSSA and the MCEs were not completely ready for the waiver on day one. There were process issues with prior authorization and credentialing. Billing/payment systems were also not ready. Both of these issues caused operational and cash flow issues for providers. Many providers cited progress on the authorization process in particular and credentialing has mostly been cleared up. But there have been lingering billing issues that have been compounded each time FSSA issues new guidance or policy around the waiver. The majority of the providers commented that they felt that there was insufficient time allowed for both FFS and MCE systems to be modified to process claims in accordance with the stated policy effective dates.

- *MCEs do not have sufficient time to update their systems before new policies are implemented (providers).* Many providers expressed concern that FSSA is issuing guidance or policy changes associated with the waiver without allowing sufficient time for the MCEs to implement the necessary system changes to process claims accurately. Providers suggested delaying implementation deadlines, using grace periods, or working more closely with both the MCEs and providers to come up with an implementation plan that would avoid denials and adjustments.

- *MCEs were asked to enroll providers and prior authorize services before FSSA systems were ready (MCEs).* This resulted in providers having to enroll more than once. Complicating the issue was re-enrollment after July 1, 2018 if a provider did not meet the new DMHA provider certification criteria for residential treatment. There were instances where MCEs had to transition members out of residential treatment centers after July 1 because the provider could no longer provide the service after July 1, 2018. The MCEs stated that this seemed to be backwards and required a lot of provider education to get through the initial and reenrollment periods.

Written communications from the FSSA to providers

- *Hard to track changes in provider bulletins (providers).* The majority of providers indicated that it was hard for them to track policy changes using the provider bulletins as they presented information on an isolated basis. Often, there are correction bulletins sent out by FSSA at later dates.

- *Provider bulletins not clear and lack examples (providers).* Although the providers did appreciate the bulletins as a mode of communication, most providers felt that the bulletins could be improved with the provision of topic-specific examples. Also, the lack of clarity of specific terminology has led to differing interpretations on the part of the MCEs, the FFS vendor, and providers.

- *Lack of clarity on SUD benefit, provider requirements and billing (MCEs).* The MCEs felt that while well intended, provider bulletins have contributed to confusion in the provider community. Recent examples noted include: confusion surrounding movement of crisis stabilization, peer recovery, and IOT services out of the MRO package of services and into the state plan benefit - BT201929, "IHCP to modify coverage of certain mental health services"; and provider

assumptions regarding 30 calendar days coverage for residential treatment as referenced in BT201821 SUD FAQ, reinforced by an FSSA presentation.

- *Provider manual useful, but online modules not as helpful (providers).* Several providers suggested that a cohesive provider manual would be helpful in seeing the larger picture with respect to coverage policies. They did not feel that the current online training modules were that helpful, as they just consolidate the information in the bulletins. There is no new information provided.

- *Want a dedicated contact person to call for clarifications (providers).* The majority of providers would like a dedicated contact person to call with clarifying questions. This is lacking in the current bulletins issued by FSSA.

Other communications

- *Advertise provider services and locations (beneficiaries).* Make it real by showing before and after pictures that illustrate the impact addictions has on you and your family. Members mentioned online, social media, radio, television, print media, and billboards as examples of advertising medium.

- *Have more readily available pamphlets (beneficiaries)* with information about what Medicaid covers, provider services, and locations on where to get treatment. Suggested locations to place the pamphlets included: in any local government office (e.g., WIC, welfare, IMPACT job training sites); jails and parole offices; homeless shelters; self-help meeting sites like AA or NA; provider waiting rooms; and hospitals.

- *Targeted outreach to teens and young adults (beneficiaries)* via social media on the dangers of addiction and where to get help.

Improvements in CY 2019 compared to CY 2018

- *Single prior authorization form has been helpful (providers).* Residential treatment and inpatient providers expressed that the FSSA single prior authorization form for residential and inpatient settings has been an improvement. However, they all felt that there are still some issues with the prior authorization process itself with the MCEs, specifically with inconsistent decisions across MCEs and lack of clarity on medical necessity criteria used to deny services.

- *Provider and MCE quarterly meetings with FSSA are beneficial (providers).* Providers did state that they appreciate the open-door policy of the FSSA, the Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health and Addiction (DMHA). Specifically, providers cited each division's willingness to work collaboratively with both providers and MCEs on resolving issues. Providers have found the quarterly meetings between providers, MCEs and the State team to be very beneficial.

- *In person meetings appreciated (providers).* The providers were complimentary of FSSA, OMPP and DMHA for their willingness to meet in person with them on a one-on-one basis.

Challenges that continue in CY 2019

- *Transition of IOP from MRO services has been difficult (providers).* Providers of outpatient services, in particular those who formerly offered MRO benefits, expressed concern with having to get prior authorization at all (something new for them). Further, the process, form,

documentation and criteria used to make decisions has been inconsistent among the MCEs and between the MCEs and traditional Medicaid.

- *Ongoing billing issues (providers).* Billing system issues and the need for adjustments due to policy changes have continued to be a problem throughout CY 2019. Several providers suggested that it may have been better to allow grace periods for billing. Others went so far as to suggest that FSSA should have implemented the waiver in the FFS environment first and then transition the delivery to the MCEs later in order to minimize process and systems issues that have resulted from rapid implementation.

- *Billing requirements vary across MCEs (providers).* The majority of providers expressed that billing processes were not uniform. The includes the required documentation to get the claim paid. One example is different guidance on the NPI to insert in the rendering provider field. For providers contracting with multiple MCEs, they have to track which MCE wants the entity's NPI and which want the practitioner's NPI. Another issue cited by all providers is issues with presumptive eligibility in terms of members being approved, assigned to an MCE, and then resolving prior authorization and payment responsibility issues between FFS and the MCE (because the member had initially been enrolled in FFS at the start of the presumptive period). Many of the providers commented about having to keep paper copies of eligibility verification on a daily basis to be used in billing for services once the member became Medicaid eligible.

Unintended positive consequences of the SUD waiver

- *Relationship building (MCEs).* Trainings facilitated by the FSSA on prior authorization and ASAM training have been very helpful and resulted in a huge shift in the MCEs' working relationship with state staff and providers to the positive. The prior authorization training held by FSSA emphasized the no wrong door policy when working with providers and how to help members get to where they need to be.

Unintended negative consequences of the SUD waiver

- *Focus of waiver not broad enough – addiction problem is more than opioids (providers).* All of the providers interviewed were grateful to have the waiver and the access to more SUD treatment settings and services for Hoosiers. However, many of them expressed concern that the focus on opioids was marginalizing other substances that are far more dangerous, such as fentanyl. Many of the providers felt that more attention should be directed to alcohol and methamphetamines which are a bigger issue than opioids in some parts of the state.

- *Lack of coordination with Recovery Works (providers).* Recovery Works is an FSSA program that is designed to provide support services to those without insurance and who are involved in the criminal justice systems. Specific focus is on access to mental health and addition services with the goal of decreasing recidivism[9]. The majority of providers stated that Recovery Works appears to be following Medicaid in decision making – that is, if Medicaid denies an authorization request, then Recovery Works follows suit. The apparent unintended impact of this is that Recovery Works is being eliminated as another funding source for those coming out of the criminal justice system when Medicaid will not cover the service.

- *Policy changes affecting service delivery (MCEs).* A recent example of an unintended negative consequence is the recent policy bulletin BT 201943, Who Can Supervise Treatment Plan, that has created barriers by requiring licensed clinical addiction counselors (LCACs) to be part of IOP

[9] https://secure.in.gov/fssa/dmha/2929.htm

provider services. This was a change from recognizing other licensed clinicians with SUD experience. They stated that LCACs are hard to find. The MCEs were concerned that this may have the unintended consequence of limiting or delaying access to care as providers struggle to comply with the policy.

- *Increased administrative burden (providers).* Many of the providers stated that the waiver has had the unintended consequence of increasing their administrative burden and staffing levels. They most often stated that this is associated with prior authorization, presumptive eligibility, and resolution of claims/billing issues.

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

MCE care coordination activities with providers

- *Care coordination activities with providers varies (providers).* Provider experiences were highly variable and ranged from direct interaction with MCE care coordinators to no interaction at all. A few providers indicated that care coordination activities had decreased since waiver inception, but these appeared to be isolated instances. Yet other providers had nothing but positive feedback about specific MCEs, and in particular specific individuals at the MCE, who assist them with care coordination.

- *Providers would like help with discharge and after care planning (providers).* In particular, residential treatment providers expressed that it would be helpful to partner with the MCEs' care coordinators in locating available services close to the member's home and to know what will be covered on an outpatient basis as part of developing the discharge and after care plan.

- *Finding housing post discharge (MCEs).* The MCEs have found issues with some providers, in particular with some residential treatment centers, that expect the member to find their own housing. In addition, the MCEs felt that this process was not being initiated early enough (it was beginning closer to discharge). The MCEs felt that one possibility is that providers who lack the next level of care may struggle to find appropriate placement.

- *Communication challenges regarding early discharge (MCEs).* The MCEs expressed that they, at times, have a hard time getting notified of a discharge if the member leaves early. This has created challenges in helping to get the member to the next appropriate level for follow-up.

- *Communication challenges regarding appropriate level of care (MCEs).* The MCEs described communication challenges regarding the appropriate level of care for members, even with those providers that have a broad continuum of care within their network.

Ease of finding treatment options or access to services

- *(beneficiaries)* Members who received either inpatient or residential treatment stated concerns that the length of stay was not long enough. This is due to the fact that they have been using for many years, have had multiple relapses, and that they need sufficient time to develop the skillsets to go to the next treatment level to have a good chance of successful sobriety.

Identification of services not available (actual or perceived) in the client's region of the state

- *(beneficiaries)* Many members expressed concerns that they have difficulties finding care to transition to after an inpatient or residential treatment center admission that is close to or within their county of residence. Many stated that they traveled long distances to come to get care.

Unintended negative consequences of the SUD waiver

- *Mixed feedback on the ASAM trainings (providers).* The majority of providers attended the most recent ASAM trainings but the feedback was mixed on how useful it was. Several providers had concerns with ASAM trainer comments that 80% of alcohol detoxifications could be done on an outpatient basis, since they stated it was one of the more dangerous detoxifications from a medical perspective. On the whole, providers were in favor of the in-person trainings and requested that they be made available by video to accommodate staff coverage issues (i.e., not all staff who could benefit could attend), and to assist with onboarding new staff. One observation from the B&A team was that providers that are newer to Medicaid found the training most helpful, whereas those providers that have been contracted with Medicaid (albeit, perhaps for mental health and not substance abuse) found the training less helpful.

SECTION V: SUMMARY OF PROGRESS, POTENTIAL RISKS TO FUTURE SUCCESS AND RECOMMENDATIONS

Introduction

In this final section, B&A offers a summary of progress-to-date, potential risks to future success, and recommendations for the FSSA as it continues to improve the access and quality of SUD-related services and its SUD delivery system while also maintaining its waiver cost budget. B&A has organized its assessments around the FSSA's Milestones. Our assessment incorporates the findings from the information we gathered related to progress on the FSSA's SUD Implementation Protocol (Section II), our own computation of metrics (Section III), and our primary data collection of stakeholder feedback (Section IV). B&A offers 26 specific recommendations to the FSSA to provide continuous improvement toward meeting its milestones. The recommendations that B&A deems would be most impactful toward meeting the milestones are in bold.

Summary of Progress, Potential Risks and Recommendations for each FSSA Milestone in its SUD Monitoring Framework

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

Summary of Progress:

- The number of SUD beneficiaries receiving outpatient services is increasing.
- The number of SUD beneficiaries receiving residential treatment is increasing.
- The number of SUD beneficiaries receiving medication assisted treatment is increasing.
- As of January 1, 2019, the FSSA is requiring its MCEs to report quarterly on the number of its members with SUD that have been identified and have enrolled in (or refused) complex case or care management.

Potential Risks:

- Since the State has abandoned its initiative to align the CANS and ANSA tools with ASAM criteria, there is little knowledge of the consistency of placement criteria being conducted by providers other than through the authorization request process.
- The SUD Implementation Plan calls for developing a supportive housing solution, but there has been no meaningful activity on this item in the first two years of the waiver.
- Providers cited the lack of an ASAM 3.7 licensure level as potentially a barrier to treatment when ASAM level 4.0 is denied due to lack of medical necessity by the MCEs but ASAM 3.5 is insufficient. As a result, there are no ASAM level 3.7 programs available for Medicaid beneficiaries.
- There has been very little reported utilization of early intervention services in the waiver period.
- There has been very little reported utilization of withdrawal management in the waiver period.
- The utilization of intensive outpatient services has been relatively unchanged since the start of the waiver.
- The total days covered in ASAM level 4.0 has been reduced in the waiver period, particularly among the model population. It is unknown what the root cause is for this reduction.

Recommendations to FSSA:

1. **The FSSA is encouraged to develop a mechanism for periodic review (e.g. annual or every two years) of the method used by high-volume SUD providers to determine how they assess patient need for SUD services. This may be a shared responsibility between the State**

agencies, OMPP and DHMA, and/or a shared responsibility between the FSSA and its contracted MCEs.

2. If not already completed as part of the prior CANS and ANSA project stated above, the FSSA should develop a compendium of tools used by providers with more experience in the field that can be shared to educate newer-contracted providers.

3. **Given the positive feedback of the FSSA-sponsored sessions on authorizations and ASAM levels of care, the FSSA clinical team is encouraged to facilitate an educational session with the providers and the MCEs on the application of the tools commonly used to assess patient need for substance use treatment and how these tools align with ASAM.**

4. **The FSSA should outreach to the existing provider base about its capacity and interest to be licensed as ASAM 3.7 providers.**

5. **The FSSA should also outreach to existing providers and potential other entities about options to build a supportive housing network of providers statewide. In particular, both providers and members mentioned the need for supportive housing options for those receiving medication assisted treatment.**

6. The FSSA, in coordination with its MCEs, should conduct a root cause analysis of why early intervention services and withdrawal management are not being reported. For example, determine if the cause is lack of knowledge by providers that the services are covered, the services are being rendered but coded differently from the CMS specification, or providers are not delivering the services for other reasons.

7. **The FSSA should convene its MCEs and FFS counterparts to determine if it is possible to allow some standardization of the amount and duration of intensive outpatient service sessions. One of the concerns expressed by providers is that the amount and duration has been curtailed since this service has been managed by the MCEs.**

8. The FSSA, in coordination with its MCEs, should conduct a root cause analysis to determine if the total days in ASAM level 4.0 that has been reduced in the waiver period, particularly among the model population, is due to overly-restrictive criteria applied by the MCEs or because there are additional services across ASAM levels that are now more appropriate for the beneficiary.

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

Summary of Progress:

- FSSA has held multiple sessions with providers and the MCEs to mitigate issues that surfaced in the service authorization process.
- FSSA worked with the MCEs to develop the uniform SUD authorization form that is required to be used by all MCEs in an effort to reduce provider administrative burden but also to articulate the requirements for authorization approval.
- FSSA facilitated ASAM training for MCEs and providers that was led by ASAM staff to educate stakeholders on the application of ASAM criteria for patient placement.
- As of January 1, 2019, the FSSA is requiring its MCEs to report quarterly on the number of pre-service, concurrent review and retrospective SUD-related authorization requests. This includes approval and denial rates as well as timeliness of decision-making.

Potential Risks:

- The variation seen in the rate of denials for inpatient and residential treatment services in particular for the same provider across MCEs is indicative that interpretation of guidelines may vary among the staff at each MCE.
- The variation in the approval and denial rates seen across providers may also be indicative of the knowledge base of the staff at the provider who is seeking authorization approval from the MCEs.

Recommendations to FSSA:

9. **The FSSA should require reporting by each of its MCEs of inter-rater reliability testing conducted on its clinical staff to review SUD-related authorization requests.**

10. **Separately, the FSSA should conduct its own inter-rater reliability test of clinicians across the MCEs. Specific examples used in the test should come from providers that have specifically cited this as a concern in the feedback meetings conducted by B&A.**

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

Summary of Progress:

- The FSSA created licensing requirements and standards for residential ASAM levels 3.1 and 3.5.

Potential Risks:

- The requirement that the FSSA has imposed of a physical barrier to separate ASAM residential 3.1 and 3.5 programs is inherently limiting to the way that some of these programs have traditionally been delivered by providers (e.g., program specific to pregnant women).

Recommendations to FSSA:

11. **The FSSA should consider either a removal of the physical location requirement between ASAM 3.1 and 3.5 programs or allow for waivers of this requirement, particularly for programs that were in place prior to the waiver.**

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

Summary of Progress:

- The FSSA developed internal systems to more easily track and trend data for SUD providers discretely from other provider categories in its data warehouse.
- Residential treatment beds at ASAM level 3.1 have grown 142 percent in CY 2019. Beds at ASAM level 3.5 have grown 15 percent during CY 2019.

Potential Risks:

- There remain some geographic portions of the state with very limited or no residential treatment providers.
- There are very limited residential treatment options for adolescents.

Recommendations to FSSA:

12. The FSSA should track diagnoses for authorization requests by region of the state to better understand trends and potentially develop provider outreach or other policies specific to the needs of different communities in the state.

13. The FSSA should consider financial and/or non-financial incentives (e.g., reduced administrative requirements) to incentivize providers to develop residential treatment programs specifically for adolescents.

14. **The FSSA may want to consider piloting a bundled payment model for selected residential programs to encourage participation. A bundled payment could reduce administrative burden and allow for more predictable cash flow for smaller-size providers.**

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

Summary of Progress:

- As of January 1, 2019, the FSSA is requiring its MCEs to report quarterly on the CMS Metric #15 (Initiation and Engagement of Alcohol and Other Drug Dependence Treatment).
- Other measures that are being tracked have remained steady or changed very little during the waiver period, but it may be too soon to make a definitive assessment. Examples include the rate of use of opioids at high dosage and the rate of continuity of pharmacotherapy for opioid use disorder.
- There are perceptions that there is a lack of access to MAT treatment, for both opioid treatment programs (OTP) and office-based opioid treatment (OBOT).
- Requests made by prescribers to the State's patient drug monitoring program software (INSPECT) tripled during the first 15 months of the waiver.
- The number of registered users in INSPECT increased 75 percent during the first 15 months of the waiver.
- There are 21 integrated hospital networks (109 hospital locations) that are integrated with INSPECT.
- The rate of the use of opioids in persons without cancer from multiple providers has decreased during the waiver period, particularly for the model population.
- The rate of concurrent use of opioids and benzodiazepines had decreased during the waiver period.

Potential Risks:

- Although efforts have been put in place to enable emergency responders to bill and reimburse Medicaid for naloxone, none have done so yet.
- The rate of initiation of SUD treatment decreased in the first year of the waiver compared to the year immediately prior to the start of the waiver. The rate of engagement did improve modestly.
- The growth in both OTP and OBOT providers is not sufficient to meet growing demand.
- The State, through its Indiana Professional Licensing Agency, has been able to report on only one of the three measures it stated it would be reporting on in its SUD Health IT Plan.
- There does not appear to be a specific plan to get the remaining hospitals in the State integrated with INSPECT by December 31, 2020. This is the State's self-imposed deadline to integrate all of Indiana's hospitals with INSPECT within the first three years of the waiver.

Recommendations to FSSA:

15. The FSSA should consider making either Initiation and Engagement of AOD Treatment or Follow-up After Discharge from an Emergency Department for AOD as one of its pay-for-outcomes measures in its contracts with the MCEs.

16. The FSSA should encourage or require a SUD-specific quality improvement program from each of its MCEs that focuses on one or more of the SUD-related measures. Examples could include a study of the root cause analysis of barriers for follow-up after ED visits.

17. The FSSA should determine the barriers for emergency responders to bill Medicaid for naloxone.

18. The FSSA should track access to both OTP and OBOT and identify strategies to support the increased use of OBOT and buprenorphine waivered clinicians.

19. The State's IPLA needs to develop a plan to either report on the measures that have been specified in the SUD Health IT Plan or develop replacement measures.

20. The plan to get 100% compliance among in-state hospitals to integrate with INSPECT by the end of CY 2020 needs to be developed, shared and enforced.

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

Summary of Progress:

- As of January 1, 2019, the FSSA is requiring its MCEs to report quarterly on the CMS Metric #17 (Follow-up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence).
- As of January 1, 2019, the FSSA is requiring its MCEs to report quarterly on the number of hospital discharges related to SUD.
- As of January 1, 2019, the FSSA is requiring its MCEs to report quarterly on SUD-related grievances and appeals.
- Total ED visits and ED visits per 1,000 SUD-identified members in the model population are significantly lower in the waiver period, particularly starting in September 2018, than in the pre-waiver period.

Potential Risks:

- Although the 7-day and 30-day rate of follow-up after an ED visit for alcohol or other drug dependence did increase modestly during the first year of the waiver, there is still room for considerable improvement.
- With the exception of one MCE (MHS), in CY 2018, very few Medicaid members enrolled with a managed care plan identified with SUD were enrolled in case or care management.
- In CY 2018, there was little transition of Medicaid members from an inpatient ASAM 4.0 facility to a residential treatment facility (ASAM 3.5 or 3.1).
- Transitions from residential treatment to medication assisted treatment are sporadic across regions of the state.
- The grievance and appeals reporting by the MCEs is self-reported and needs to be validated.

Recommendations to FSSA:

21. **The FSSA should consider both incentives and penalties for providers who do not participate with the MCEs in transitions of members across ASAM levels of care.**

22. The FSSA should add accountability standards in its MCE contracts to ensure a higher level of documented transitions of its members across ASAM levels of care.

23. The FSSA should implement common billing guidelines for SUD services across FFS and managed care.

24. The FSSA should provide either a summary of changes at the start of provider bulletins that are updates or replacements of other bulletins.

25. The FSSA should provide more specific language and terminology to avoid different interpretations of the same policy statement. More specific examples to illustrate the policy are also encouraged. A workgroup comprised of provider and MCE representatives could serve as a peer review committee.

Budget Neutrality

Summary of Progress:

- The FSSA has been able to maintain aggregate budget neutrality with a projected 3.0 percent "room" in the last two years of the waiver.

Potential Risks:

- Because most of the SUD population is enrolled in managed care, the budget neutrality projections rely heavily on timely, accurate and complete encounter submissions. Incomplete encounters could skew the budget neutrality projection.

Recommendations to FSSA:

26. In order to assess the accuracy and completeness of data for use in budget neutrality calculations, the FSSA is encouraged to build and run encounter lag tables on key SUD-related services. These lag tables would be used when considering the assessment of the results shown for ongoing checks against budget neutrality.

State Response to the Mid-Point Assessment

The FSSA has reviewed the Mid-Point Assessment prepared by B&A. In its review, FSSA focused on prioritizing recommendations that B&A deemed would be most impactful toward meeting its Milestones. We focused on those that were ranked as medium risk of not being achieved (note that no milestones ranked as high). In addition to level of risk, the FSSA considered feasibility and impact when assigning a priority level in one of two tiers—either top or second level priority. A listing of each of the priority tiers and related recommendations is found on page V-7 and is organized by FSSA Milestone and recommendation number.

The FSSA also carefully reviewed each of these recommendations against the Monitoring Protocol and approved Implementation Plan to determine if modifications were needed to either document. Based upon this review, it was determined that no Implementation Plan updates are required for the top priority recommendations. There is potentially a need to make a change related to recommendation #14 (see page V-7). Any change would be dependent upon the design of any proposed bundled payment pilot.

There is one required amendment to the Monitoring Protocol for recommendation #19 (see page V-7). In response to the Mid-Point Assessment, Indiana revised the SUD HIT metric (S.3) that lacked sufficient data sources. This metric has been submitted as part of the revised SUD Monitoring Protocol on May 8, 2020.

Lastly, the impact of the Coronavirus (COVID-19) pandemic on current and future SUD utilization patterns and delivery system needs is uncertain. While the FSSA response has been prepared using the best information as of the date of this document, the assigned priority level and related activities could change to be responsive to the needs of Indiana Medicaid beneficiaries with an SUD.

FSSA Mid-Point Assessment Response and Proposed Prioritization of B&A Assessed Impactful Recommendations

Milestone		B&A Recommendations Assessed as Most Impactful on Milestones	FSSA Assessed Modifications		Risk Level
			Monitoring Protocol	Implementation Plan	
Top Priority Recommendations					
#1 Access to Critical Levels of Care for SUD Treatment	3	The FSSA clinical team is encouraged to facilitate an educational session with the providers and the MCEs on the application of the tools commonly used to assess patient need for substance use treatment and how these tools align with ASAM.	**No**	**No**	**Medium**
	4	The FSSA should outreach to the existing provider base about its capacity and interest to be licensed as ASAM 3.7 providers.	**No**	**No**	
	7	The FSSA should convene its MCEs and FFS counterparts to determine if it is possible to allow some standardization of the amount/duration of intensive outpatient service	**No**	**No**	
#3 Use of Nationally-Recognized SUD-specific Program Standards for Residential Treatment	11	The FSSA should consider either a removal of the physical location requirement between ASAM 3.1 and 3.5 programs or allow for waivers of this requirement, particularly for programs that were in place prior to the waiver.	**No**	**No**	**Low**
#5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse	19	The State's IPLA needs to develop a plan to either report on the measures that have been specified in the SUD Health IT Plan or develop replacement measures.	**Yes**	**No**	**Medium**
Second Priority Recommendations					
#1 Access to Critical Levels of Care for SUD Treatment	1	The FSSA is encouraged to develop a mechanism for periodic review (e.g. annual or every two years) of the method used by high-volume SUD providers to determine how they assess patient need for SUD services.	**No**	**No**	**Medium**
	5	The FSSA should also outreach to existing providers and potential other entities about options to build a supportive housing network of providers statewide.	**No**	**No**	
#2 Use of Evidence-Based SUD-specific Patient Placement Criteria	9	The FSSA should require reporting by each of its MCEs of inter-rater reliability testing conducted on its clinical staff to review SUD-related authorization requests.	**No**	**No**	**Low**
	10	The FSSA should conduct its own inter-rater reliability test of clinicians across the MCEs.	**No**	**No**	
#4 Sufficient Provider Capacity at Critical Levels of Care	14	The FSSA may want to consider piloting a bundled payment model for selected residential programs to encourage participation.	**No**	**Potential**	**Medium**
#6 Improved Care Coordination and Transition Between Levels of Care	21	The FSSA should consider both incentives and penalties for providers who do not participate with the MCEs in transitions of members across ASAM levels.	**No**	**No**	**Medium**