

Indiana Family and Social Services Administration

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

June 24, 2019

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Overview

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

Indiana's Behavioral Health System of Care

System Overview

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

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

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

Provider Network

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

Community Mental Health Centers

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

- Individualized treatment planning
- Access to twenty-four (24) hour a day crisis intervention
- Case management
- Outpatient services, including intensive outpatient services, substance abuse services, and treatment
- Acute stabilization services including detoxification services
- Residential services
- Day treatment, partial hospitalization, or psychosocial rehabilitation
- Family support
- Medication evaluation and monitoring
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

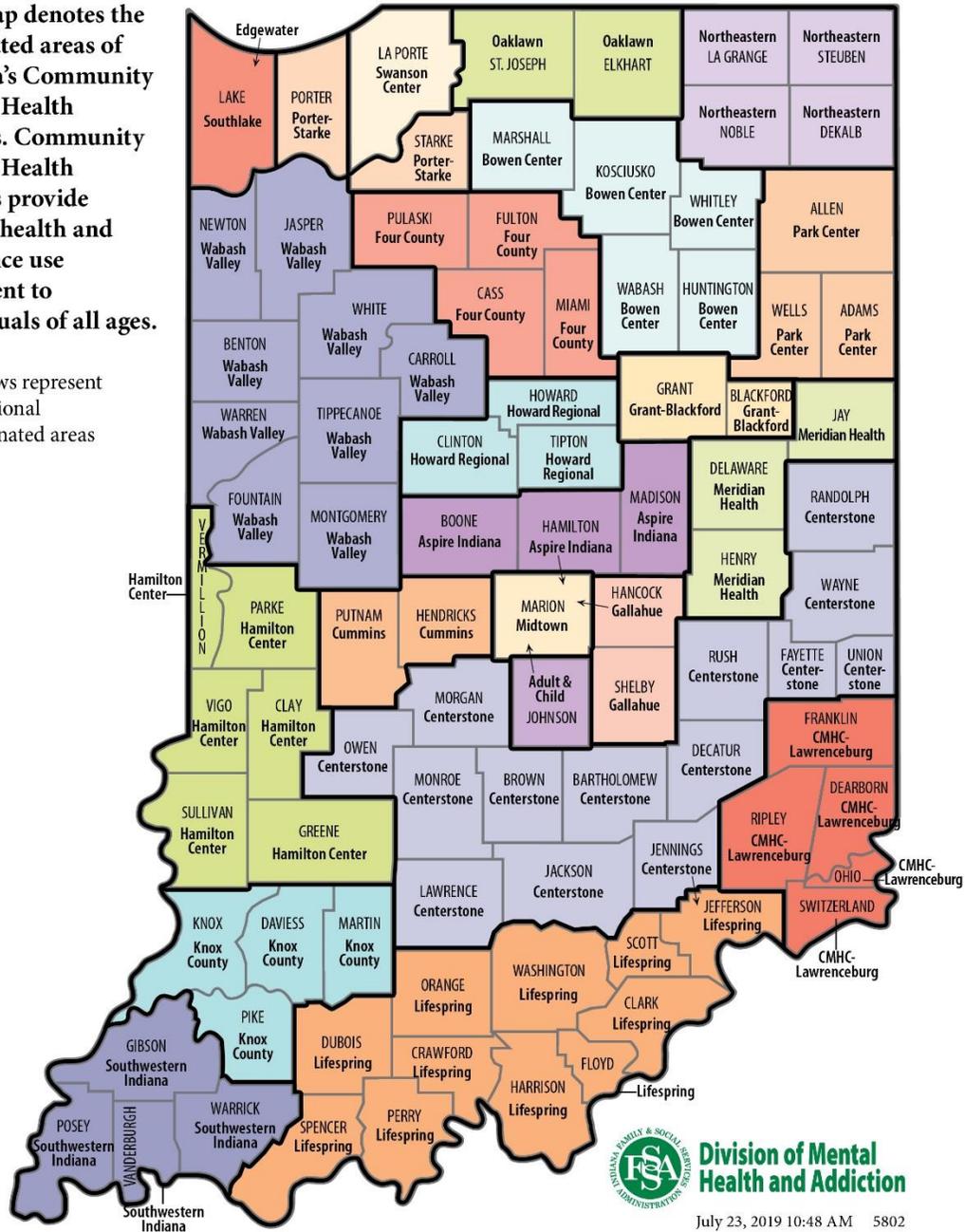
Many of these services are part of the state plan Medicaid Rehabilitation Option (MRO) services under which service need is identified through an assessment that confirms need for services

with an eligible diagnosis and level of care determination using the Child and Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA).

Community Mental Health Centers

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

→ Arrows represent additional designated areas



Current Service Continuum

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

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

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

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

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

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

- Adult day services

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

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

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

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

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

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

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

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

Amendment Goals

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

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

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

State Strategies for Addressing Waiver Milestones

Current Oversight of Institutions for Mental Disease (IMDs)

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

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

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

Indiana's Primary Care and Behavioral Health Integration

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

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

- Health Homes/Care Coordination
- Policy Development

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

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

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

Behavioral and Primary Healthcare Coordination Service Program

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

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

Child Mental Health Wraparound (CMHW) Services

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

Increasing Access to Continuum of Care Including Crisis Stabilization Services

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

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

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

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

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

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

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

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

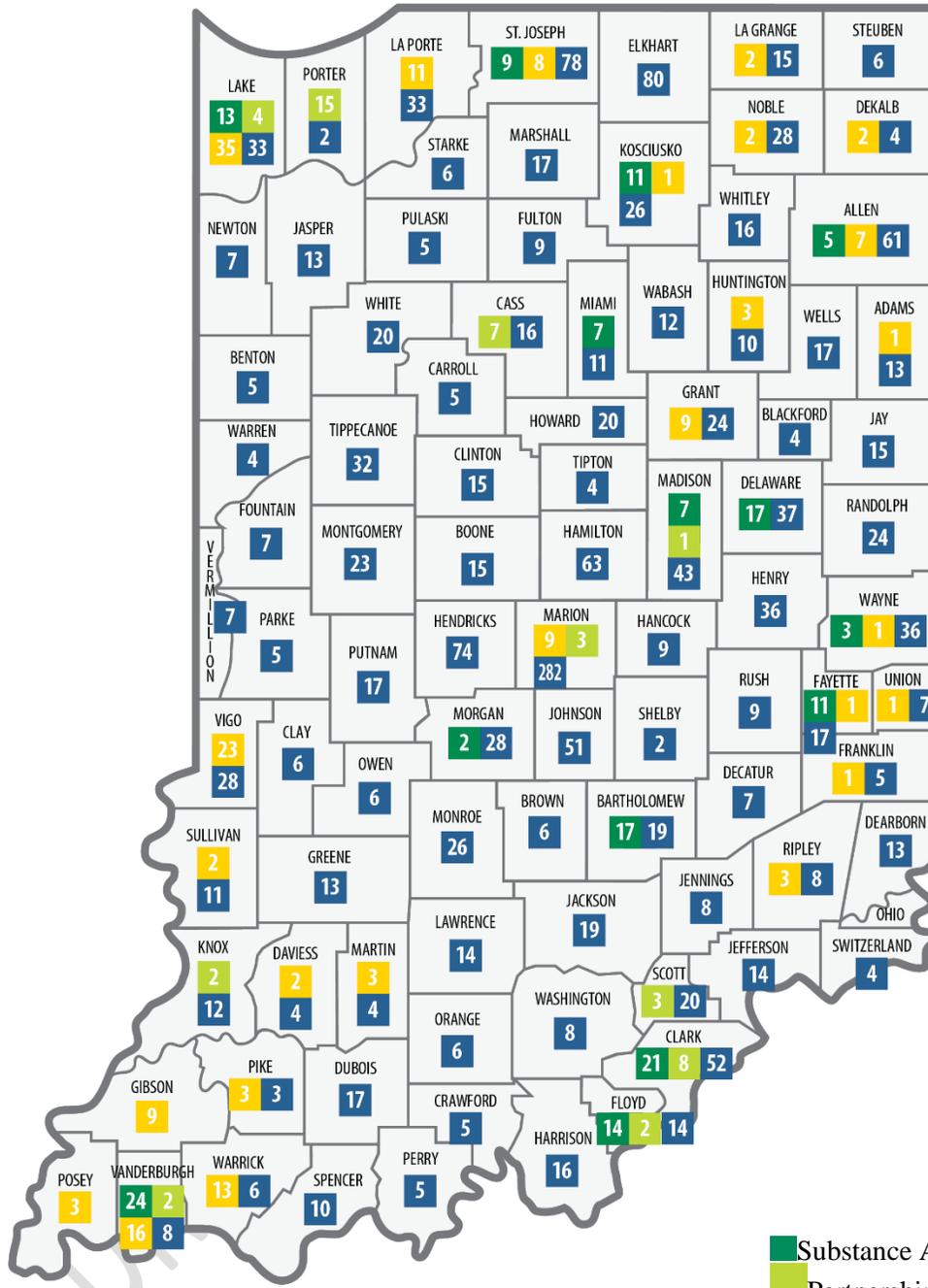
Additionally, Hoosier Care Connect MCOs, who serve the State's aged, blind and disabled Medicaid population are contractually required to ensure the availability of behavioral health crisis intervention services 24/7.

Earlier Identification and Engagement in Treatment

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

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

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



- Substance Abuse Prevention Block Grant
- Partnership for Success Grant School-Based
- Child Psychiatric Services Fund
- Certified Community Mental Health Center: School-Based Services

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

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

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

Program Description

Demonstration Eligibility

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

Table 1: Eligibility Groups Excluded from the Demonstration

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

Demonstration Cost Sharing

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

Delivery System and Payment Rates for Services

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

Program Evaluation

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

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

Table 2: Draft Evaluation Parameters

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

Demonstration Financing and Budget Neutrality

Budget Neutrality Impact

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

CHIP Allotment

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

Maintenance of Effort

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

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

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

Table 3: Outpatient Community-Based Mental Health Expenditures (\$ in Millions)¹

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

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

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

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

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

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

Requested Waivers & Expenditure Authorities

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

Public and Tribal Notice

FSSA is conducting public and tribal notice in accordance with the State's 1115 waiver special terms and conditions (STCs) and 42 CFR §§431.408 and 431.420. A summary of comments received and the State's consideration of these comments will be completed pending completion of the public and tribal notice periods.

MILLIMAN CLIENT REPORT

1115 Waiver – Healthy Indiana Plan

Budget Neutrality

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

Draft

State of Indiana

Family and Social Services Administration

July 23, 2019

[Andrew Dilworth](#), FSA, MAAA

[Renata Ringo](#), FSA, MAAA

[Christine Mytelka](#), FSA, MAAA

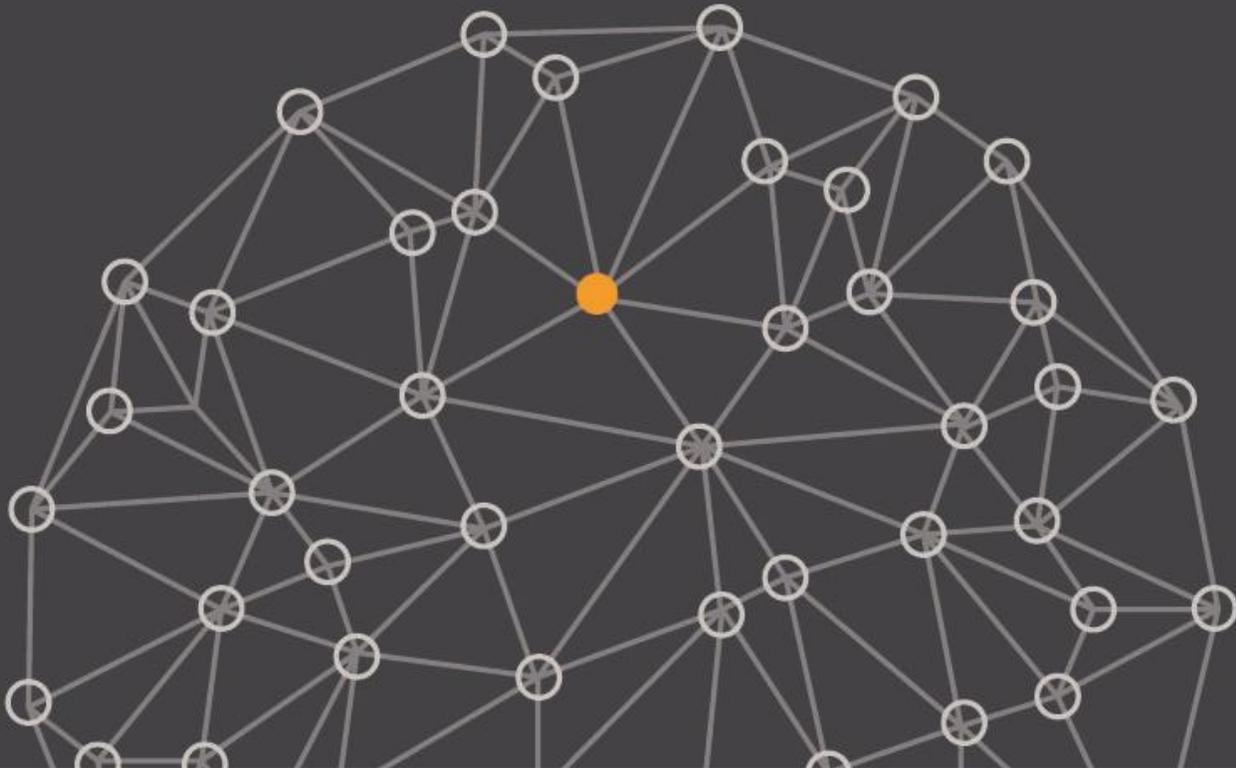




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BACKGROUND

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

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

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

Based on the CMS letter² to State Medicaid Directors dated November 13, 2018, the state wishes to revise the waiver to include Serious Mental Illness (SMI) services as well. The remainder of this report details the budget neutrality projections for this proposed waiver amendment.

EXECUTIVE SUMMARY

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

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

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

The proposed MEGs are:

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

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

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

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

² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

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

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DATA, ASSUMPTIONS, AND METHODOLOGY

DATA

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

METHODOLOGY AND ASSUMPTIONS

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

Fee-for-service methodology

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

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

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

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

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

Managed care methodology

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

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

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

Capitation payments

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

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

Services administered under FFS

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

Hospital presumptive eligibility

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

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Limitations

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

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

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

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

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

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

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

milliman.com

CONTACT

Andrew Dilworth
andrew.dilworth@milliman.com

Renata Ringo
renata.ringo@milliman.com

Christine Mytelka
christine.mytelka@milliman.com

DATA

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

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

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

METHODOLOGY AND ASSUMPTIONS

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

Fee-for-service population

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

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

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

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

Managed care populations

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

Capitation payments

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

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

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

Services administered under FFS

In addition to capitation payments, there are some services carved out of managed care that are administered via the FFS delivery system that also must be included for the managed care populations. Similar to the FFS population described above, the managed care populations include expenditures for the following two categories of service:

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

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

County-level funding allocation

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