Indiana Family and Social Services Administration

Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver – Substance Use Disorder & Serious Mental Illness IMD Waiver (Project Number 11-W-00296/5)

November 6, 2019
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Section 1: Summary of IMD Waiver Renewal Request

The State of Indiana is requesting from the Centers for Medicare & Medicaid Services (CMS) approval of a five-year extension of its substance use disorder (SUD) and serious mental illness (SMI) components of the Medicaid demonstration entitled, "Healthy Indiana Plan (HIP)" (Project Number l l-W-00296/5) in accordance with sections 1115(a) and 1915(h)(2) of the Social Security Act (the Act). On September 1, 2015, then-Governor Mike Pence issued Executive Order 15-09, establishing the Governor’s Task Force on Drug Enforcement, Treatment, and Prevention to identify best practices and make informed recommendations for policy makers. The task force included membership from the Indiana General Assembly, the Governor’s Office, the Indiana State Department of Health, the Indiana Department of Correction, the Indiana Department of Child Services, the Indiana Family and Social Services Administration, and other organizations and associations throughout Indiana. Implementation of this 1115 SUD demonstration was one of several recommendations issued in the final report of the Task Force, and realized under Indiana’s current Governor, Eric Holcomb.

On January 17, 2017, Governor Eric Holcomb introduced his “Next Level Legislative Agenda” representing five pillars designed to address key challenges facing the state, including the fourth pillar: “Attack the Drug Epidemic.” During his speech he shared that deaths from drug overdoses had increased by 500 percent since 2000, and that Indiana was ranked 15th in the country in overdose fatalities. To provide impetus, direction and oversight to combat the crisis, he appointed Jim McClelland as the Executive Director for Drug Prevention, Treatment and Enforcement, and supported legislation to create the Indiana Commission to Combat Drug Abuse, comprising key community members, leadership from State agencies, and legislators. The Commission created a strategic approach to addressing substance abuse in Indiana that focused on the reduction of the incidence of individuals with substance use disorders (SUD); additional harms that can result from substance abuse; improved treatment for individuals with SUD; and supported community-based collaborations aimed on prevention, treatment and recovery.

The Indiana Family and Social Services Administration (FSSA) has leveraged this demonstration as part of an intense and integrated effort to mitigate the adverse impact of the opioid epidemic while continuing to monitor prevalence and access to treatment for other substances of abuse impacting the State of Indiana. FSSA is responsible for the administration and oversight of Indiana’s Medicaid program and consists of six divisions including the Office of Medicaid Policy and Planning (OMPP), Division of Mental Health and Addiction (DMHA), Office of Healthy Opportunities (OHO), Division of Aging, Division of Family Resources, and Division of Disability and Rehabilitative Services. In addition to maintaining SUD services and supports that have been integrated into Medicaid’s Indiana Health Coverage Program (IHCP) network for decades, the FSSA’s OMPP has worked closely with the DMHA to add reimbursement for inpatient and residential services provided in Institutions for Mental Diseases (IMDs) under this demonstration; obtained a State Plan Amendment to offer intensive outpatient treatment (IOT) and peer recovery services for members; and removed barriers to Medication Assisted Treatment (MAT) for members. More recent efforts have introduced new providers into the IHCP network.
by adding SUD services to long-standing practices in other specialties and making SUD services newly available to IHCP members.

Further, the provision of services in an IMD for individuals with SMI 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. This component of the waiver seeks to address the historical reliance on general hospital emergency rooms to handle individuals in acute psychiatric crisis.

Section 2: Historical Narrative Summary

On February 1, 2018, CMS approved an extension to Indiana’s existing Section 1115 Medicaid demonstration waiver. The added goals of the waiver extension were aligned with the milestones outlined by CMS, as follows:

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

This waiver contributes to a comprehensive statewide strategy to combat SUD, including prescription drug abuse and opioid use disorders (OUD). The strategies within the waiver included the expansion of coverage for a full-range of SUD treatment services to Indiana Health Coverage Programs (IHCP) for members enrolled in Traditional Medicaid (full, fee-for-service coverage) or in any managed care program, including Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise. Changes under the new SUD waiver included the following:

- Expanding coverage of inpatient SUD treatment provided in IMDs;
- Adding coverage for short-term residential SUD treatment; and
- Establishing a new provider type and specialty for residential treatment.

The waiver, currently approved through December 31, 2020, allows for Indiana Medicaid beneficiaries to continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries, ages 21 through 64, gained access to expanded covered services provided while residing in an IMD for SUD short-term residential stays. The SUD program specifically allowed beneficiaries with SUD to access benefits that include SUD residential treatment, crisis stabilization and withdrawal management services provided in IMDs, which would otherwise be excluded from federal reimbursement. Under this demonstration, beneficiaries have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in
cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

Indiana, as part of its evaluation plan, established six milestones for the SUD demonstration:

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

In addition to the achievement of the metrics reported in the interim evaluation (attached to this extension application), the state took the following steps to support realization of these milestones.

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

Under the waiver, reimbursement for SUD inpatient stays for medically monitored detox in IMDs became available for all IHCP members in February 2018. Effective March 1, 2018, the IHCP began providing coverage for short-term low-intensity (American Society of Addiction Medicine [ASAM] Level 3.1) and high-intensity residential treatment (ASAM Level 3.5) for SUD in settings of all sizes, including facilities that qualify as IMDs.

FSSA requested this SUD waiver demonstration program as an outgrowth of recommendations made by the State’s Taskforce on Drug Enforcement, Treatment, and Prevention. As such, the demonstration is one component of a broader strategy to address substance use disorders, including OUD within the State. Through a state plan amendment effective July 1, 2019, the IHCP modified the coverage of crisis intervention, intensive outpatient treatment (IOT), and peer recovery services to better serve IHCP members. For dates of service (DOS) on or after July 1, 2019, crisis intervention, IOT and peer recovery services will no longer be restricted to members eligible for the Medicaid Rehabilitation Option (MRO) benefit plan. In addition, all three services will no longer be carved out of managed care to support improved care coordination.

The State has also increased access to services, funded through other state and federal dollars, to compliment the new waiver services added to the SUD continuum of care for Hoosiers. Planning for use of State Targeted Response (STR) and State Opioid Response (SOR) federal funds considered the existing Medicaid service array and filling service gaps that remained. Indiana’s DMHA is expanding access to four levels of recovery housing based on standards from the National Alliance for Recovery Residences’ Oxford Model, including in rural areas of the state. In addition, SOR funding is being leveraged to expand the number of DATA-Waived Providers Across Indiana. DMHA is also committed to funding the addition of three additional training
tracks to the existing Indiana Opioid Addiction Treatment ECHO (I-ECHO) project that utilizes both didactic and case-learning approaches. The latter two initiatives will support existing Medicaid enrolled SUD providers as well as potentially expand the Medicaid SUD provider network.

2. Use of Evidenced-Based SUD-Specific Patient Placement Criteria

Prior authorization is required for all SUD residential stays, with medical necessity/admission criteria based on the ASAM Patient Placement Criteria Level 3.1 (Clinically Managed Low-Intensity Residential Services) and Level 3.5 (Clinically Managed High-Intensity Residential Services). In addition, DMHA is working to modify the Adults Needs and Strengths Assessment (ANSA) utilized by all contracted providers to incorporate ASAM criteria and develop the algorithms to recommend the level of treatment and services that incorporate the use of evidence-based practices.

In the fourth quarter of 2018, the SUD Work Group was created to engage stakeholders in a review of the strengths and challenges specific to the elements of 1115 Waiver implementation. The charge of this cross-collaborative group included examining concerns shared by stakeholders regarding access to the newly developed SUD residential treatment services. To date, the Work Group has examined issues pertaining to the prior authorization (PA) process, SUD treatment criteria interpretation and application, and transitions of care. Recommendations from this ongoing workgroup are being implemented through an FSSA project team. This core team meets biweekly. Quarterly SUD Work Group meetings continue as well as combined quarterly meetings with the Medicaid managed care plans and SUD providers. One outcome of this collaboration was the consensus that as of February 11, 2019, all plans will authorize a minimum length of stay of at least 14 days before re-evaluation/concurrent review, unless less than 14 days is requested by the provider.

Effective March 15, 2019, the IHCP began encouraging providers to use three new forms when requesting PA for inpatient and residential treatment for SUD. These forms provide prompts for information specific to residential and inpatient treatment and apply to these services rendered under both the fee-for-service (FFS) and the managed care delivery systems.

- Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form – This form is recommended for use to request PA for inpatient and residential SUD treatment services, rather than using the standard universal PA request form.
- Initial Assessment Form for Substance Use Disorder Treatment Admission – This assessment form can be completed and submitted as an attachment to the SUD residential and inpatient treatment PA request form for initial admissions.
- Reassessment Form for Continued Substance Use Disorder Treatment – This assessment form can be completed and submitted for requests to extend authorization for residential and inpatient SUD treatment.

These forms incorporate ASAM criteria associated with the specific member and requested service. Effective June 25, 2019, each of these substance use disorder PA request forms and any attachments can be submitted on the IHCP Provider Portal.
3. **Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.**

In an effort to raise the standards of care for addictions providers in Indiana, FSSA’s OMPP partnered with the DMHA on an ASAM level of care designation process, beginning with ASAM Level 3.1 and 3.5 residential addiction treatment facilities. By July 1, 2018, all facilities seeking Medicaid reimbursement for residential SUD treatment were required to be enrolled as a new provider specialty, SUD Residential Addiction Treatment Facility (provider specialty 836, within provider type 35 [addiction services]). The first step in the enrollment process is to be certified as an *addiction treatment services provider, regular certification and residential sub-acute facility* by DMHA. To be certified and to maintain regular certification as an addiction treatment services provider, an entity must maintain accreditation from an approved accrediting agency. After obtaining the required certifications from DMHA, each facility is required to obtain ASAM designation from DMHA. Once a provider has received certification as an *addiction treatment services provider, regular certification and residential sub-acute facility* with the applicable ASAM designation, the final step is enrollment as an IHCP provider. The State plans to expand the designation process to all ASAM levels of care. 116 individuals from the State, including SUD providers, managed care entities (MCEs) staff, and other stakeholder organizations attended ASAM training in early April 2019. DMHA is planning to provide additional training opportunities later in the calendar year.

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

On February 19, 2019, the IHCP clarified billing guidelines for the SUD initial assessments; crisis intervention; and first dose induction of buprenorphine Observation. The guidance applied to enrolled IHCP providers, including affirmation that midlevel practitioners, such as licensed clinical addiction counselors, can provide these services within their scope of practice under the supervision of an enrolled IHCP provider.

In August 2019, the State applied for the Notice of Funding Opportunity under the Section 1003 Demonstration Project to Increase Substance Use Provider Capacity. The State received a notice of funding award in September 2019. Efforts under the planning phase of this opportunity align and will strengthen, as opposed to duplicate, waiver activities and goal achievement by providing a review of the existing Medicaid SUD full continuum provider network, including providers of new services under this waiver. Post-Planning Phase goals include: (1) increased access to SUD services through expanded provider participation; (2) increased access to services at each point in the prevention and treatment continuum (per ASAM levels of treatment and assessment criteria); (3) increased quality and positive outcomes through adoption of evidenced-based

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1 Current approved accreditation bodies include the Rehabilitation Accreditation Commission (CARF); Joint Commission on Accreditation of Healthcare Organizations; Council on Accreditation of Services for Families and Children (COA); and the National Committee for Quality Assurance (NCQA).
practices; and (4) increased quality and positive outcomes through provider technical assistance, monitoring, and reimbursement strategies.

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

Consider options for emergency responder reimbursement of naloxone-end of 2018

FSSA requested this SUD waiver demonstration program as an outgrowth of recommendations made by the State’s Taskforce on Drug Enforcement, Treatment, and Prevention. As such the demonstration is one component of a broader strategy to address substance use disorders, including OUD within the State. Through a state plan amendment effective July 1, 2019, the IHCP modified the coverage of crisis intervention, intensive outpatient treatment (IOT), and peer recovery services to better serve IHCP members. For dates of service (DOS) on or after July 1, 2019, IOT and peer recovery services will no longer be restricted to members eligible for the Medicaid Rehabilitation Option (MRO) benefit plan. In addition, these two services will no longer be carved out of managed care in order to support improved care coordination. Further, a multiagency group with representation from behavioral health, Medicaid and public health has convened to pursue emergency responder reimbursement of naloxone.

DMHA is currently leveraging SOR funding to expand treatment service capacity by: (1) implementing an Addiction Provider Development and Sustainability (APDS) Program that provides funding for SUD-focused MA/MSW internships within community mental health center (CMHC) settings; (2) expanding SUD-specific Project ECHO curriculum and participation; and (3) partnering with academia to implement a Leadership and Organizational Change for Implementation (LOCI) intervention to develop and create an organizational change strategy to improve organizational leadership and create or enhance organizational climate for evidence-based practice (EBP) implementation. As part of the LOCI project, DMHA intends to pilot implementation of Motivational Enhancement Therapy-Cognitive Behavioral Therapy (MET/CBT). Creation of this framework could support a future DMHA/OMPP partnership to pilot other SUD-related EBPs and, if hypothesized outcomes are achieved, consider state plan amendments to add services or create incentives though reimbursement strategies for statewide adoption.

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

In 2017, 77.1% of all Indiana Medicaid members were enrolled with a managed care entity (MCE). The OMPP requires all four contracted MCEs to provide care coordination across primary, behavioral and other specialty care. OMPP amended contracts to require that MCEs employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services. At a minimum, the MCE must offer to provide case management services to any member at risk for inpatient psychiatric or substance abuse hospitalization, and to members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. Case managers must also contact members during an inpatient hospitalization, or immediately upon receiving notification of a member’s inpatient behavioral
health hospitalization, and schedule an outpatient follow-up appointment for within seven days of discharge.

As previously noted, access to peer recovery services was expanded through a state plan amendment to eliminate a restriction of these services to an individual ineligible for the MRO benefit plan. Peer recovery services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, including support through transitions in care. In support of the expansion and utilization by provider agencies, guidance was provided regarding peer recovery services, including the requirement that they must be delivered by individuals certified in peer recovery services per the DMHA standards and must be performed under the supervision of a licensed professional or a qualified behavioral health professional (QBHP).  

Section 2.1: SMI Waiver Amendment

On August 30, 2019, FSSA submitted an amendment to the SUD demonstration to request authority to reimburse for acute inpatient stays in IMDs for individuals diagnosed with SMI. This request was part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and to improve access to acute care for Medicaid enrollees with SMI and serious emotional disturbance (SED). The State requested an amendment effective date of January 1, 2020.

The State’s goals, through this waiver amendment included:

- 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.

As the waiver amendment has not been implemented as of the submission date of this extension request, evidence regarding the progress toward meeting these goals is not yet available.

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2 BR201925 - IHCP bulletin clarified qualifications and supervision requirements for peer recovery specialist providers (June 18, 2019).
Section 3: Program Changes
In spring 2016, the Indiana General Assembly passed Senate Enrolled Act 297, which required Medicaid coverage for inpatient detoxification services for the treatment of opioid or alcohol dependence in accordance with the most current edition of ASAM or other comparable clinical criteria. Signed by Governor Holcomb on May 1, 2019, House Enrolled Act 1543 updated the requirement of providers to provide inpatient detoxification exclusively in accordance with the most current edition of ASAM criteria.

Section 4: Eligibility, Benefits and Cost Sharing
4.1: Demonstration Eligibility
The State requests no modifications to demonstration eligibility. Under this extension request, all enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and between the ages of 21 – 64, will be eligible for the SUD and SMI/SED benefits authorized through the waiver, as further described in Section 4.2. Only the eligibility groups outlined in Table 1 below will not be eligible for services under the waiver as they receive limited Medicaid benefits only.

Table 1: Eligibility Groups Excluded from the Demonstration

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

4.2: Benefits
Indiana Medicaid provides comprehensive SUD and SMI/SED treatment services to enrollees. Throughout the development of the 2017 SUD waiver application process, the State conducted an assessment of available services compared with the standards outlined through the American Society of Addiction Medicine (ASAM). Many services that align with an ASAM level of care were previously covered. However, through the waiver, in conjunction with State Plan authority, Indiana has been able to provide coverage for a more complete continuum of services. This includes services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under Section 1903 of the Social Security Act.

Additionally, in development of the waiver amendment to provide coverage for acute inpatient stays in an IMD for SMI/SED, the State undertook a comprehensive review of its community-based mental health service array. As a result of this process and in accordance with the State’s
SMI/SED Demonstration Implementation Plan, FSSA is in the process of piloting programs to increase access to crisis stabilization services.

The State requests no modification to covered benefits through this extension application. Services authorized through the waiver will continue to be available for all Medicaid enrollees, unless otherwise excluded as described in Section 4.1.

Table 2: SUD and SMI Benefits Coverage with Expenditure Authority

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medicaid Authority</th>
<th>Expenditure Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Residential Treatment</td>
<td>§1115 Waiver</td>
<td>Services provided to individuals in IMDs</td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td>State Plan</td>
<td>Services provided to individuals in IMDs</td>
</tr>
<tr>
<td>Opioid Treatment Program Services</td>
<td>State Plan</td>
<td>Services provided to individuals in IMDs</td>
</tr>
<tr>
<td>Addiction Recovery Management Services</td>
<td>State Plan</td>
<td>Services provided to individuals in IMDs</td>
</tr>
<tr>
<td>Acute inpatient stays for SMI</td>
<td>State Plan</td>
<td>Services provided to individuals in IMDs</td>
</tr>
</tbody>
</table>

4.3 Cost Sharing
All cost-sharing for SMI/SED and SUD 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 renewal request.

4.4 Delivery System and Payment Rates for Services
No modifications to the current Indiana Medicaid fee-for-service or managed care arrangements are proposed through this renewal. 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.

Section 5: Waivers & Expenditure Authority
The State requests continuation of the current expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for: (1) short term stays for acute care in a psychiatric hospital that qualifies as an IMD; and (2) treatment and withdrawal management services for SUD in facilities that meet the definition of an IMD. No additional waivers of Title XIX or Title XXI are requested in relation to the SUD/SMI initiatives through this extension application.

Section 6: Reporting
FSSA has a robust quality oversight plan for continually monitoring the services and outcomes delivered under the waiver. Oversight is conducted through a variety of strategies, including but not limited to:
- MCE monthly and quarterly reporting on compliance with contractual requirements related to behavioral health
- Annual external quality reviews (EQR) of MCEs
- Quality strategy plan which includes an overall framework for continuous quality improvement
- MCE-led quality improvement projects
- Quarterly and annual reporting in accordance with the CMS required “Medicaid Section 1115 SUD Demonstration Monitoring Protocol” and associated quantitative monitoring metrics

A summary of key findings gleaned from these oversight strategies is provided in the subsections below.

6.1: External Quality Review Organization Reports
FSSA contracts with Burns and Associates to conduct an annual EQR in accordance with the requirements at 42 CFR §438.350. The most recent EQR revealed positive findings on MCE performance related to the provision of behavioral health services. Specifically, all MCEs received the maximum score on the following contract provisions and federal regulations:

- The MCE shall employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services.
- At minimum, the MCE shall provide case management services for members discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 days following hospitalization.
- With the appropriate consents, MCE case managers shall notify both primary medical providers (PMP) and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within five calendar days of the inpatient admission or emergency treatment.
- The MCE shall, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The profile lists the physical and behavioral health treatment received by the member during the previous reporting period.
- The MCE will contractually mandate that its behavioral health care network providers notify a member’s MCE within five calendar days of the member’s visit, and submit information about the treatment plan, the member’s diagnosis, medications, and other pertinent information.
- The MCE shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted community mental health centers (CMHCs), and shall provide physical health and other medical information to the appropriate CMHC for every member.
- MCE case managers shall regularly and routinely consult with both the member’s physical and behavioral health providers to facilitate the sharing of clinical information,
and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member.

- In urban areas, the MCE must provide at least one behavioral health provider within 30 miles or 30 minutes; in rural areas, one within 45 minutes or 45 miles.
- For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven calendar days from the date of the member’s discharge.

6.2: Quality Assurance Monitoring

FSSA’s 2019 Indiana Medicaid Managed Care Quality Strategy Plan, developed in accordance with 42 CFR §438.340, also includes a series of behavioral health initiatives, with goals aligned to those of the IMD waivers.

Table 3: 2019 Behavioral Health Quality Strategy Initiatives

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>METHODOLOGY</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hoosier Healthwise and Healthy Indiana Plan Initiatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders</td>
<td>HEDIS measures for tracking the percentage of members receiving follow-up.</td>
<td>Achieve at or above the 90th percentile for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders (HEDIS).</td>
</tr>
</tbody>
</table>

| **Traditional Medicaid Initiatives** | | |
| Improvement in Behavioral Health (HEDIS-like) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders | Administrative reporting through the FSSA enterprise data warehouse (EDW) using HEDIS specifications. | Maintain with de minimis reduction in performance. |

| **Hoosier Care Connect Initiatives** | | |
| Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders – with Medicaid rehabilitation option (MRO) | HEDIS-like measure based on specifications developed by OMPP, including MRO HCPCS codes. | Achieve at or above 75th percentile for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders – with Medicaid MRO services. |

In alignment with the Quality Strategy Plan, FSSA’s managed care contracts have a financial incentive for improvements in performance on the follow up after hospitalization for mental
health disorders HEDIS measure. A portion of the capitation is withheld with the ability for the MCE to receive the funding based on performance.

In addition to the ongoing activities associated with the Quality Strategy Plan, FSSA conducts targeted studies and oversight of services rendered under the waiver. For example, Burns and Associates has been engaged to conduct two separate studies of service authorizations granted under the waiver. The first study was conducted in Spring 2019 pertaining to authorizations in CY 2018. Findings revealed MCEs are processing authorization requests for SUD services within contractually required timelines. One MCE was slightly above the target, which FSSA continues to monitor. Additionally, a sample of service denials and approvals were reviewed by an independent physician; the physician concurred with the majority of clinical decisions (96%) rendered by the MCE’s. Ongoing monitoring in this area is planned with a second study to be conducted in Spring 2020 pertaining to 2019 authorizations.

6.3: Additional Documentation on Quality and Access
FSSA monitors access to behavioral health services through a variety of strategies. For example, through regular review of MCE data on compliance with contractual requirements for network adequacy, which were developed in accordance with 42 CFR §438.68. All MCEs are currently demonstrating compliance with the access requirements for behavioral health providers for Hoosier Healthwise, HIP and Hoosier Care Connect.

The State also conducts ongoing waiver monitoring in accordance with CMS requirements for the “Medicaid Section 1115 SUD Demonstration Monitoring Protocol” and through submission of quarterly and annual reports following CMS required quantitative monitoring metrics. As the SMI portion of the IMD waiver has not been implemented as of the date of submission of this extension request, outcomes are not yet available regarding the State’s progress in meeting the milestones of this portion of the waiver. Following implementation, FSSA will implement ongoing monitoring in accordance with CMS requirements for the SMI waiver.

High level findings from the most recently completed annual report are provided below. FSSA will continue to submit quarterly and annual monitoring reports in accordance with CMS requirements through the extension period.

<table>
<thead>
<tr>
<th>Metric Name</th>
<th>Metric Description</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay in an IMD</td>
<td>The average length of stay for beneficiaries discharged from IMD residential treatment for SUD</td>
<td>7 days</td>
</tr>
<tr>
<td>SUD Provider Availability – MAT</td>
<td>The number of providers enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT</td>
<td>725</td>
</tr>
<tr>
<td>Initiation and Engagement of Alcohol and Other</td>
<td>Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit,</td>
<td>55.34%</td>
</tr>
<tr>
<td>Metric Name</td>
<td>Metric Description</td>
<td>Outcomes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Drug (AOD) Dependence Treatment (IET) [NCQA; NQF #0004; Medicaid Adult Core Set]</td>
<td>intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis</td>
<td></td>
</tr>
<tr>
<td>Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA; NQF #2951]</td>
<td>Rate per 1,000 beneficiaries age 18 and older included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer. Patients in hospice are also excluded.</td>
<td>40.9</td>
</tr>
<tr>
<td>Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]</td>
<td>Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids from four or more prescribers and four or more pharmacies.</td>
<td>27.34</td>
</tr>
<tr>
<td>Use of Opioids at High Dosage from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]</td>
<td>Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, and from four or more prescribers and four or more pharmacies.</td>
<td>1.12</td>
</tr>
<tr>
<td>Concurrent Use of Opioids and Benzodiazepines [PQA]</td>
<td>Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.</td>
<td>17.08%</td>
</tr>
<tr>
<td>Continuity of Pharmacotherapy for Opioid Use Disorder [RAND; NQF #3175]</td>
<td>Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment</td>
<td>17.44%</td>
</tr>
<tr>
<td>Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependences [NCQA; NQF #2605; Medicaid Adult Core Set]</td>
<td>Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).</td>
<td>40.33%</td>
</tr>
<tr>
<td></td>
<td>Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).</td>
<td>54.37%</td>
</tr>
</tbody>
</table>
Section 7: Financing
Please refer to the attached documentation prepared by the State’s actuary for a detailed analysis of the budget neutrality impact.

Section 8: Interim Evaluation Report
An Interim Evaluation of the SUD portion of the waiver was completed by Burns and Associates. As the IMD waiver for acute psychiatric stays is scheduled for implementation on January 1, 2020, evaluation findings are not yet available. The evaluation plan, and subsequent Summative Evaluation Report, will be updated to incorporate the SMI IMD components of the waiver and submitted for CMS review and approval in accordance with the State’s special terms and conditions (STCs).

The SUD Interim Evaluation explored the hypotheses and research questions outlined in Table 5, in accordance with the CMS-approved evaluation plan.

Table 5: SUD Waiver Hypotheses and Research Questions

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Research Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aims and Primary Drivers</strong></td>
<td></td>
</tr>
<tr>
<td>Key health outcomes improve in the SUD population in the post-waiver period.</td>
<td>Does the level and trend of initiation and engagement in treatment increase in the SUD population in the post waiver period?</td>
</tr>
<tr>
<td></td>
<td>Does the level and trend of follow-up after discharge from the Emergency Department (ED) for SUD increase among the SUD population in the post waiver period?</td>
</tr>
<tr>
<td></td>
<td>Does the level and trend in continuity of pharmacotherapy for opioid use disorder increase among the OUD population in the post waiver period?</td>
</tr>
<tr>
<td></td>
<td>Does the level and trend in concurrent use of opioids and benzodiazepines decrease in the OUD population in the post waiver period?</td>
</tr>
<tr>
<td></td>
<td>Does the level and trend in the rate of use of opioids at high dosage in persons without cancer decrease in the post waiver period?</td>
</tr>
<tr>
<td>Costs of care decreases in the SUD population in the post waiver period.</td>
<td>Does the level and trend in overall spending for the SUD population decrease in the post waiver period?</td>
</tr>
<tr>
<td></td>
<td>Does the level and trend in SUD service spending for the SUD population increase in the post waiver period?</td>
</tr>
<tr>
<td></td>
<td>Does the level and trend in acute utilization for SUD, potentially preventable emergency department or potentially preventable hospital readmissions decrease in the SUD population in the post waiver period?</td>
</tr>
<tr>
<td><strong>Secondary Drivers</strong></td>
<td></td>
</tr>
<tr>
<td>Access to care improved in the SUD population in</td>
<td>Does the level and trend in the number of SUD and primary care providers and the number of providers per capita in the SUD population increase in the post waiver period for each ASAM level of care?</td>
</tr>
<tr>
<td>Hypothesis</td>
<td>Research Questions</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>the post-waiver period</td>
<td>Does the utilization per 1,000 of SUD services and primary care in the SUD population increase in the post waiver period for each ASAM level of care?</td>
</tr>
<tr>
<td>Prior authorization (PA) requirements do not negatively impact access to residential or inpatient services (ASAM 3.1, 3.5 and 4.0).</td>
<td>Are the rates of prior authorizations (PAs) submitted and PA requests that are denied in the SUD population, controlling for volume, relatively consistent by MCE and over time? Are prior authorization (PA) denials predominately for reasons directly related to not meeting clinical criteria as opposed to administrative reasons such as lack of information submitted?</td>
</tr>
</tbody>
</table>

The full report is provided as a separate attachment to this extension application.

8.1 Evaluation Plan for Extension Period
The State requests no modifications to the evaluation plan during the extension period. Given no waiver modifications are proposed through this extension request, and the IMD waivers have been in effect for a relatively short time, FSSA will continue to study the previously approved hypotheses and research questions. All evaluation activities will be conducted in accordance with the STCs, including continued use of an independent evaluator.

Section 9: Public and Tribal Comment
FSSA is conducting public and tribal notice in accordance with 42 CFR §431.408. 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.