Section 1115 SMI/SED Demonstration Implementation Plan

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

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

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

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

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This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on eligibility and coverage demonstrations. When this template is OMB approved, then the state will be required to use it.

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

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

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

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2. Required implementation information, by SMI/SED milestone

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

This template only includes SMI/SED policies.

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

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

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

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

Prompts	Summary
types of care and to provide oversight on lengths of stay	Guidelines and OMPP reviews the MCO's UM practices; effective 7/1/19 all entities will utilize Milliman Care Guidelines.

As described in the Indiana Medicaid Medical Policy Manual, acute psychiatric inpatient admissions are available for enrollees with a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- Danger to the individual
- Danger to others
- Death of the individual

Reimbursement is available for inpatient care only when the need for admission has been certified. Emergency and nonemergency admissions require telephonic precertification review. The precertification review must be followed by a written certification of need through completion of State Form 44697 – Certification of the Need for Inpatient Psychiatric Hospital Services (1216A form) along with a written plan of care. This form documents the enrollee's:

- Psychiatric and medical evaluation
- Functional capacity
- Prognoses
- Recommendations
- Certification by an interdisciplinary team that based upon physical, mental and social evaluations the individual requires inpatient psychiatric treatment and available alternative community resources do not meet the patient's mental health care needs

All requests for PA are reviewed on a case-by-case basis. The MCO or PA entity reviews each State Form 44697 to determine whether the requested acute inpatient services meet medical necessity. Reimbursement is denied for any days the facility cannot justify a need for inpatient care. If the provider fails to complete a telephone PA precertification, reimbursement will be denied from the admission to the actual date of notification.

Additionally, in accordance with 440 IAC 1.5-3-9, all PMHIs must have policies and procedures that govern the intake and assessment process to determine eligibility for services. Each admitted Medicaid enrollee must

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

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

2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status:* Indiana Administrative Code (440 IAC 1.5-3-10) outlines minimum requirements for discharge planning. Hospitals are required to initiate discharge planning at admission that includes the following:
	
	• Facilitates the provision of follow-up care.
	• Transfers or refers consumers, along with necessary medical information and records, to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care. Required minimum information to be transferred includes:
	   o Medical history
	   o Current medications
	   o Available social, psychological and educational services

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Prompts	Summary

	o Nutritional needs
	    o Outpatient service needs
	    o Follow-up care needs
	
	Additionally, in accordance with the Indiana Medicaid Medical Policy Manual, all plans of care must document a post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the member's community to ensure continuity of care when the patient returns to his or her family and community upon discharge.
	
	Community mental health centers (CMHCs) are required, as codified in Indiana Administrative Code (440 IAC 9-2-4), to be involved in the planning of treatment for and the discharge of consumers during the time a consumer is in inpatient care, to maintain continuity of care.
	
	Additionally, MCOs are contractually required to provide case management services for any member discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 calendar days following discharge. MCO contracts also require case managers to contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization and must schedule an outpatient follow-up appointment to occur no later than seven calendar days following the inpatient behavioral health hospitalization discharge. If a member misses an outpatient follow-up or continuing treatment, the MCO is contractually required to ensure that a behavioral health care provider or the MCO's behavioral health case manager contacts that member within three business days of notification of the missed appointment.

	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A –milestone requirements already met.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* MCOs are contractually required to provide case management services for any member at risk for or discharged from an inpatient psychiatric or substance abuse hospitalization. Case managers must contact members during an inpatient hospitalization and as a component of case management, must make every effort to assist members in navigating community resources and linking members with community based services such as Connect2Help211, food pantries, housing and housing supports, legal, employment and disaster services.

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

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

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

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

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

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

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Prompts	Summary
	Summary of Actions Needed: N/A
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* Please refer to previous sections.
	Future Status: N/A
	Summary of Actions Needed: N/A

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

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

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

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

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

Prompts	Summary
settings such as the Certified Community Behavioral Health Clinic model.	*Summary of Actions Needed:* OMPP will annually identify geographic shortage areas and Provider Enrollment will conduct targeted outreach to non-Medicaid enrolled providers in those areas.

SMI/SED. Topic_6. Health IT Plan

As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[2] The HIT Plan should also describe, among other items, the:

- *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and*
- *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.*

Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.

Statements of Assurance

Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	As outlined in Indiana's State Medicaid Health Information Technology Plan (SMHP), Indiana's HIT environment is active with multi-faceted efforts to support provider HIT capacity and foster the sharing of clinical and administrative data to improve health care and support system improvements. The State has taken an active role through its state health agencies and Medicaid program to promote HIT adoption and HIE development, building upon its private health care marketplace.
	As outlined in the table below, the State is home to four well-established health information exchange networks operated by Health Information Organizations (HIOs), each functioning in different capacities for community partners.
	<table><tr><td>Regional HIO</td><td>June 2019 Status</td></tr><tr><td>HealthBridge (includes greater Cincinnati tristate area)</td><td>Utilization of the Health Collaborative's HealthBridge Suite (hb/suite): • 58 hospitals</td></tr></table>

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

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on eligibility and coverage demonstrations. When this template is OMB approved, then the state will be required to use it.

Prompts	Summary	
		• 8,901 providers • 160 million clinical results processed • 15 million monthly messages
	HealthLINC	• Delivers more than 175,000 medical results per month among hospitals, office and clinic practices and under-served clinics • Health service directory that includes more than 350 physicians and other providers
	Indiana Health Information Exchange (IHIE)	• Connection to 117 hospitals representing 38 health systems • Over 17,055 practices • Over 47,452 providers • Over 14,847,271 patients • Over 12,510,420,163 clinical data elements
	Michiana Health Information Network (MHIN)	• Over 576 data sources • 3.9 million transactions inbound per month • 20,304 providers connected
	However, a March 2019 assessment of Indiana's health information sharing (HIS), conducted based on capability maturity guidance from CMS and the Office of the National Coordination for Health Information Technology (ONC), revealed opportunities for increased electronic documentation and standardization among settings and providers not previously addressed through Meaningful Use, including behavioral health providers. Through this HIT Plan, the State intends to drive improvements in this area.	
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	This HIT Plan is aligned with the State's broader State Medicaid Health IT Plan (SMHP). The State is in the process of completing an updated SMHP with targeted completion by the end of calendar year 2019. Through this update process, areas of prioritization will take into consideration the milestones of this waiver.	

Prompts	Summary

Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[3] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Indiana will review the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B for potential inclusion into our MCO contracts. The following standards are currently utilized by our MCOs:
	
	• Documenting and Sharing Care Plans – The MCOs are contractually obligated to share care plans with primary medical providers (PMPs) and behavioral health providers with appropriate consent.
	• The MCOs have agreements with health information exchanges, such as the Indiana Health Information Exchange (IHIE) and the Michiana Health Information Network (MHIN).
	• Clinical Quality Measurement and Reporting – The MCEs report on the following HEDIS quality measures related to behavioral health:
	   o Follow-up care for children prescribed ADHD medication, initiation phase
	   o Follow-up care for children prescribed ADHD medication, maintenance phase
	   o 30-day follow-up after hospitalization for mental illness
	   o 7-day follow-up after hospitalization for mental illness
	   o Use of multiple concurrent antipsychotics in children and adolescents up to age 17
	   o Use of first-line psychosocial care for children/adolescents on antipsychotics up to age 17
	   o Antidepressant medication management, acute phase
	   o Antidepressant medication management, continuation phase
	   o 30-day follow-up after emergency department (ED) visit for mental illness
	   o 7-day follow-up after ED visit for mental illness

To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [4]

Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States

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[3] Available at https://www.healthit.gov/isa/.

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

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on eligibility and coverage demonstrations. When this template is OMB approved, then the state will be required to use it.

Prompts	Summary
	may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."[5]
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* The State does not have readily accessible data on the exact number of Medicaid-enrolled behavioral health providers who have adopted certified EHRs and are utilizing them for e-referrals and/or closed loop referrals. With multiple HIEs and large health systems that have been able to exchange effectively via EHR and prescription software vendors, it is difficult to accurately assess participation. Each HIE is able to easily report on its participants but the extent to which non-participating organizations are identified and assessed individually is meticulous work. It is known that certain hospital, facility, and provider types that were not eligible for Meaningful Use (Promoting Interoperability) are not participating due to lagging technology and/or regulatory barriers, such as with CFR 42 Part 2.

The aforementioned March 2019 HIS Assessment did reveal provider tracking of referrals may be facilitated by tools within the EHR but most still struggle with closing the referral loop. |
	Future State: The State will conduct a survey to identify the volume of providers utilizing closed loop referrals and e-referrals to identify the baseline of current activity and identify options for increasing provider uptake.
	Summary of Actions Needed: The provider survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* The State does not have readily accessible data on the exact number of Medicaid-enrolled behavioral health providers who have adopted certified EHRs and are utilizing them for e-referrals and/or closed loop referrals. The aforementioned March 2019 HIS Assessment did reveal provider tracking of referrals may be facilitated by tools within the EHR but most still struggle with closing the referral loop.
	Future State: The State will conduct a survey to identify the volume of providers utilizing closed loop referrals and e-referrals to identify the baseline of current activity and identify options for increasing provider uptake.
	Summary of Actions Needed: The provider survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.

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

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

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

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

Prompts	Summary

	capturing interdisciplinary Plans of Care and reporting, automated work lists, clinical decision support, and patient education tracking. The system must support multiple modes of data entry including, but not limited to, template notes, third-party dictation, and voice recognition. This also includes fully integrating this data across the other core functions.
	• Interfaces, data sharing and interoperability:
	   o Using common standards and implementation specifications for electronic exchange of information in accordance with MU Stage 2 guidance.
	   o Actual electronic exchange of clinical information with acute care hospitals, CMHCs, Public Health registries, LTC facilities, private practitioners, pharmacies, correctional facilities, judicial bodies, laboratories, and healthcare payers (e.g., Medicaid, Medicare, commercial insurance, Social Security Administration [SSA], private pay, etc.)
	• Case management: Functionality includes, but is not limited to, the ability for designated staff to track, manage, document, and receive alerts for case management activities.
	
	Having the State Psychiatric Hospitals interface with an HIE will give the Medicaid providers operating within the SPHs the capability to exchange health information with adjacent acute care facilities/hospitals, CMHCs, and other healthcare partners along the continuum of care. This specifically will allow Medicaid providers the capability to meet MU stage 3. More specifically the SPHs will be capable of bi-directionally exchanging summary of care records and CCDs when referring or receiving a Medicaid patient to or from another care setting. In addition, SPHs interfacing with the HIE will be capable of sending and receiving ADT notifications. These activities allow Medicaid providers within the SPHs to fulfill the objectives and enables them to report measures in accordance with MU stage 3 for HIE.

	Future State: FSSA will survey IMDs to identify the baseline of current activities to identify options for increasing IMD activity in this area.
	Summary of Actions Needed: The IMD survey will be conducted by FSSA. The dates for completion will be based on prioritization of this activity as determined during completion of the updated SMHP.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless	*Current State:* Consent/privacy is managed in a multitude of mechanisms across the Medicaid Health Information Sharing Enterprise, many still very manual, non-standardized and not electronically transmitted. HIEs rely on the participants to manage what information is delivered to them. Substance abuse disorder laws (42 CFR Part 2) require explicit patient consent and therefore typically are only shared in a one-off manual manner. Consent, segregation of highly sensitive records, and secure transport are difficult to implement and

Prompts	Summary
sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	manage and therefore infrequently done electronically. Indiana is an opt-out state for HIE. Responsibility is on provider to communicate with patients. Patient data can be shared with HIE unless the patient explicitly requests it not to be.
	Future State: To be determined based on prioritization of initiatives during the aforementioned SMHP update process.
	Summary of Actions Needed: To be determined based on prioritization of initiatives during the aforementioned SMHP update process.

Interoperability in Assessment Data (Section 4)

Prompts	Summary
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* Within the integrated care entities (ICE), core assessments and adjudicated Medicaid claims data are aggregated and available via the Relias ProAct Tool. This tool exclusively houses Medicaid patients and an external facing interface is provided for each ICE and applies 400+ measures to Medicaid claims and non-claims data. It provides individual patient history, as well as population demographics and associated costs of diagnoses, medications and utilization.
	Future State: The State will work toward compliance with the forthcoming CMS Interoperability and Patient Access final rule.
	Summary of Actions Needed: FSSA will monitor for CMS release of the final rule and determine required steps and timeline for compliance accordingly.

Electronic Office Visits – Telehealth (Section 5)

Prompts	Summary
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* Indiana received $16 million from the Federal Communications Commission's (FCC's) Rural Health Care Pilot Program, and as a result, created the Indiana Telehealth Network (ITN). ITN formed an FCC Rural Health Care Steering Committee, which was made up of representatives from healthcare providers, telecommunication companies, representatives from the Indiana Office of Community & Rural Affairs, and representatives from the Indiana Rural Health Association, the lead entity for the ITN. The five year project was divided into three phases and the work successfully concluded in 2015. The table below presents a summary of the project phases.

Phase 1	Phase 2	Phase 3
• Reduced bandwidth costs • Reduced Primary Rate Interface (PRI) costs • Doubled the speed of existing broadband connections	• Expanded ability to conduct Telehealth encounters over a dedicated health care network • Disaster Recovery • E-Learning • Internet Access	• Seamless interfaces with the Indiana Health Information Organizations (HIOs)

Prompts	Summary		
	• 85% funding for construction of fiber to their hospitals • Completed ability to transmit images • Improved economic opportunities	• Videoconferencing	

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

Additionally, as part of the 21st Century Cures Act, a portion of Indiana's awarded funding is being utilized to implement Project-ECHO-Extension for Community Healthcare Outcomes. The primary goal of ECHO is to enable rural and traditionally underserved populations to receive high-quality care, when they need it, close to home. This low-cost, high-impact intervention is achieved by leveraging technology to connect expert mentors and multiple local primary care providers in online video-conferencing TeleECHO clinics.

Future State: Continued operation of current programing.

Summary of Actions Needed: N/A

Alerting/Analytics (Section 6)

6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of	*Current State:* Some providers may have this capability, but the current volume is unknown.
	Future State: As previously described, OMPP plans to submit a health homes state plan amendment. A key component of this initiative will include leveraging HIT for enhanced integration and coordination. OMPP is currently in the process of developing HIT standards and requirements for participating providers.
	Summary of Actions Needed: OMPP plans to submit a health homes state plan amendment by the end of 2019.

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

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

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on eligibility and coverage demonstrations. When this template is OMB approved, then the state will be required to use it.

Section 3: Relevant documents

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