Independent Assessment of 1915(b)(4) Waiver and 1915(i) SPAs

May 24, 2024

PURDUE UNIVERSITY

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Introduction and Background of 1915(i) SPAs and 1915(b)(4) Waivers

Federal Policy Background

1915(b) Waivers

Waivers pertaining to section 1915(b) of the Social Security Act, were introduced under the Omnibus Budget Reconciliation Act in 1981 ("1915(b) Waivers," n.d.). First introduced to the House of Representatives on June 6th, 1981, the bill was signed by the President and enacted on August 13th of the same year. Under the Reagan Administration, the bill was designed to suppress the growth of the Federal Budget, and projected savings of $459 million for the fiscal year of 1982 (Domenici et al., n.d.). The Omnibus Reconciliation Act (Public Law 97-35) amended the Social Security Act, authorizing the use of waivers to bypass certain Medicaid requirements in the interest of preferentially guiding individuals to more cost-effective health care during implementation of managed care delivery systems ("1915(b) Waivers," n.d.). The bill granted the Centers for Medicare and Medicaid Services the ability to issue four 1915(b) waiver types, all of which may be referred to by the blanket term "freedom-of-choice waivers," although that term is technically specific to 1915(b)(1) waivers ("1915(b) Waivers," n.d.). 1915(b)(4) waivers are uniquely termed Selective Contracting waivers and allow the state to select specific providers for which Medicaid users may seek certain services (medicaid.gov, n.d.). Aligned with the intent of the Omnibus Reconciliation Act, waiver application requires the state to demonstrate that exercising use of the waiver will not result in an increased cost incurred for services. Although waiver approvals were initially approved and renewed in 2-year increments, the Patient Protection and Affordable Care Act allowed for 5-year approvals when enrollees were both Medicare and Medicaid eligible ("1915(b) Waivers," n.d.).

1915(i) State Plan Amendments (SPAs)

In more recent developments, the Patient Protection and Affordable Care Act (PPACCA) amended the Deficit Reduction Act of 2005 and updated the 1915(i)-establishment legislation. The amendment introduced Section 1915(i) of the Social Security Act. Under 1915(i), states can bypass the federal waiver requirement to implement programs that cover home and community-based services (HCBS) as a part of state Medicaid plans. Directed by 1915(i), the state is not burdened to provide proof that HCBS programs reduce institutional care costs (Dorn et al., 2016). Currently, 4 states only utilize Section 1915(i) mental health State Plan Amendments (SPAs) and there are seven states jointly using Section 1915(c) HCBS waivers and Section 1915(i) mental health SPAs.

Indiana Policy Background

Following the 1915(i) Social Security Act amendment, Indiana implemented 3 qualifying programs, including Adult Mental Health Habilitation (AMHH) and Behavioral Primary Healthcare Coordination (BPHC). The Indiana Office of Medicaid Policy and Planning (OMPP) is the operating Medicaid agency and Indiana's Division of Mental Health and Addiction (DMHA) is the agency administering the service programs. The programs currently share some similar eligibility requirements, such that enrollees must be 19 years of age, Medicaid eligible, and recipients of a qualifying mental health diagnosis. AMHH and

BPHC have different sets of eligible diagnosis codes and are shown in Appendix A. Before April 1, 2020, the age requirement for AMHH was at least 35 years of age and became 19 on this date. Additionally, applicants must meet certain requirements for home and community-based services as specified at the federal level (DMHA, 2022; DMHA, 2015). However, there are accompanying requirements unique to each program, and the services rendered are quite distinct from one another. Eligibility requirements for both AMHH and BPHC are listed in Appendix A.

The state of Indiana uses the 1915(b)(4) waiver in conjunction with the 1915(i) SPAs AMHH and BPHC to target individuals with serious mental illness (SMI) and substance use disorders (SUDs). This waiver allows Indiana to selectively contract Community Mental Health Centers (CMHCs) to be the sole providers for AMHH and BPHC services. There are currently 24 different CMHCs operating across the state, each serving multiple counties, ensuring all 92 counties in Indiana are being served by at least one CMHC. As of November 2022, BPHC recognized over 200 diagnosis codes, ranging across alcohol abuse, post-traumatic stress disorder, and postpartum depression. AMHH currently serves beneficiaries with 47 eligible diagnosis codes to help focus care on a specific population (Indiana FSSA, 2022). Services for AMHH include 1) adult day services, 2) home and community-based habilitation and support, 3) therapy and behavioral support services, 4) addiction counseling, 5) supported community engagement services, 6) care coordination, 7) medication training and support, and 8) respite care. There is only one main service of BPHC, which is behavioral and primary health coordination, which includes 1) logistical support, advocacy, and education to assist individuals in navigating the healthcare system, 2) assessment of the eligible recipient to determine service needs, 3) development of an individualized integrated care plan (IICP), 4) referral and related activities to help the recipient obtain needed services, 5) monitoring and follow-up, and 6) evaluation.

In Indiana, AMHH had an original effective date of November 1, 2014, and BPHC had an effective date of June 1, 2014. AMHH and BPHC had projected numbers of 968 and 4,562 unique enrollees for the first year, respectively. However, the most recent data for 2023 shows approximately 15 AMHH participants and 2,389 BPHC participants.

Mental Health Background in Indiana

There is a significant need for improved mental healthcare across Indiana. The prevalence of SMI in the state is 5.9%, of which 52.5% report not receiving any mental health treatment within the past year. The number of people in Indiana who experience an SMI or an SUD is expected to increase, creating a higher demand for mental health and behavioral healthcare services (Taylor et al., 2023). These programs serve as an important strategy to address these concerns and establish why a program evaluation of the 1915(i) and 1915(b)(4) waiver is essential to continuing to provide high-quality, accessible, and cost-effective care to this population.

Table 1: Indiana Rates of Mental Health Risk for Adults in 2023

Measure	Rate per 100,000	Rank out of 50 States
# of People at Risk of Depression	40.2	47th
# of People at Risk of Suicidal Ideation	37.7	47th
# of People at Risk of PTSD	24.8	46th
# of People Identifying as Trauma Survivors	90.9	45th
# of People at Risk for Psychotic-Like Experiences	27.2	43rd

Source: Mental Health America, 2023

Methods

Table 2: Data Sources Used

Data Source	Years	Description	Triple Aim Area(s)
Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS) Survey	2022-2023	Focused on recipients' experience of care and provider perspectives on the 1915(i) programs	Quality, Access
Indiana Medicaid Claims	2017-2023	Full claims dataset for Indiana Medicaid	Quality, Access, Cost
1915(i) Approval Packages	AMHH – 2022 BPHC – 2020	Outlines the plans for administration, operation, and implementation of the programs	Quality, Access
1915(b)(4) Waiver Application	1915(b)(4) - 2013 and 2023	Applications for the waivers that include program over, standards, quality,	Quality, Access, Cost

		program operations, and waiver cost-effectiveness and efficiency	
DMHA Quality Assurance (QA) and Corrective Action Plan (CAP) Reports	2019-2023	Annual state-level quality assurance monitoring for non-compliance in the application process and service provisions	Quality
Critical Incidents Report Log	2019-2023	Quarterly data on residential and outpatient critical incidents per CMHC	Quality
OMPP Quarterly Reviews for AMHH and BPHC	2019-2022	Quarterly data on CMS performance measures	Quality
Final Report of CMS Quality Review	2018-2021	CMS quality review of performance measure requirements	Quality
Grievance and Appeals Process	N/A	Detailed documents about the process program recipients must use for program eligibility denials	Quality, Access
National Accreditation Standards	N/A	Details the standards regarding timely access and quality of care specific to CMHC certification and behavioral health accreditation	Quality, Access
1915(i) SPA Evaluation Interviews	2024	Structured interviews with CMHC administrators about the quality and access of AMHH and BPHC	Quality, Access
1915(i) Marketing Flyers	AMHH – 2020 BPHC - 2018	Marketing flyers on FSSA's website for detailed information about AMHH and BPHC	Access

1915(i) Provider Directory	2019	Approved provider directory for AMHH and BPHC services on FSSA's website	Access
1915(i) Trainings	AMHH – 2017 and 2020 BPHC – 2021	Presentations about updates to AMHH and BPHC SPAs on FSSA's website	Access
Availability of DMHA Hotline	N/A	Hotline specific for questions about DMHA programs	Access
Disenrollment Log	N/A	Numbers for each state fiscal year for AMHH and BPHC about disenrollment (voluntary or involuntary) with provider specific information	Access
Referral System Tracking	N/A	Data about provider and specialist availability to see beneficiaries	Access
Outreach Plan	N/A	Data about how frequently marketing materials and educational webinars take place	Access

Analysis Plan

Quality

Many data sources used for measuring access to care were also utilized for measuring quality of care. For detailed information on these data sources, please refer to the Quality section of the report.

Quality Assurance (QA) and Corrective Action Plans (CAPs)

Each fiscal year, the CMHCs undergo a quality assurance process that identifies compliance with the application process and services provided for both AMHH and BPHC programs. This process is to monitor and enforce CMHC adherence to the 1915(i) program standards and responds to complaints or incidents. Not only is quality indicator data collected, but there is also member feedback. The State Evaluation Team (SET) is responsible for conducting the site visits to each CMHC. Key areas that are evaluated for both AMHH and BPHC are:

Application Process

1. Staff meets evaluation standards for BPHC

2. Residential Setting Screening Tool (RSST) is completed properly for IICP
3. Recipients provided choice of eligible services
4. Recipients provided choice of providers
5. Clients and/or legal guardians provided or offered a copy of IICP
6. Face-to-face evaluation for BPHC eligibility
7. Adult Needs and Strengths Assessment (ANSA) completed according to policy
8. Super user review of ANSA prior to submission

Service Provision

1. Indicate date of service within the IICP dates
2. Name of staff that complete the service
3. Staff qualified to provide BPHC services
4. Service beneficial to member
5. Symptoms, needs, goals, or issues addressed
6. Member strengths identified in documentation
7. Progress toward meeting goals
8. Eligible reimbursable service activity related to the program

Upon initial submission of QA and CAP documentation, the team read through each document for each CMHC between 2019 and 2023. Documents included for each CMHC were a Microsoft Excel sheet detailing non-compliance data, the QA Review Summary document, and if needed, the CAP approval document and follow-up evaluation. The non-compliance Microsoft Excel sheet included compliance codes, area of compliance, discovery source, comments about each observation, overall compliance, overall compliance for application process and service provision, and date of review. The QA Review Summary was sent to each CMHC as a follow-up to the site visit and included overall 1915(i) compliance, overall application process compliance, overall service provision compliance, and determination on whether a CAP was necessary. If a CAP was necessary (less than 86% compliance), then CMHCs had to submit a CAP for approval to DMHA and a follow-up evaluation was later conducted to determine whether the issue(s) had been rectified. The Annual Programs Review CAP had data about whether the CMHC was now compliant in the previously noncompliant area(s) and whether there will be a need for additional training.

To analyze the effectiveness of this process, our team used SPSS 29.0 software to evaluate whether the percentage of compliance improved across each fiscal year for individual CMHCs, the accuracy and consistency between the QA non-compliance and the QA review summary that gets sent to the CMHC, and whether the CAPs prevent similar issues in the following years. A master dataset was compiled from each CMHC's non-compliance percentages and the number of noncompliance codes for each state fiscal year site visit to conduct the analysis. Additionally, the structured interviews conducted by the Purdue team addressed areas of strengths and weaknesses of the QA and CAP processes from the perspective of CMHC administrators.

1915(i) SPA Programs Evaluation Interviews

An inductive approach to conventional content analysis was used to analyze qualitative data collected from program administrators affiliated with FSSA[1] to garner insight into quality, access, and cost related to the 1915(b)(4)-waiver adoption. We conducted 15 individual interviews and eight focus groups, speaking with a total of 42 participants. The inductive approach was chosen given the limited research and lack of previous evaluation of the 1915(b)(4)-waiver impact of the triple aim (access, quality, and cost) outcomes for the programs in the 1915(i)-SPA for Indiana. Conventional content analysis allowed for the categories and themes to develop directly from the transcription data rather than being pre-established priori prior to code application.

Qualitative Data Collection

The Purdue team worked with members of the WISE Indiana group to develop structured interviews for data collection. The Principal Investigator (Purdue) emailed FSSA Community Mental Health Centers (CMHCs) invitations along with consent forms to schedule individual and focus group interviews to gain insight into adoption and application of the 1915(i) SPAs for beneficiaries receiving the services. Once scheduled, a Zoom™ link was sent out to the participants. In addition to written consent, verbal consent was also collected prior to data collection (IRB-2024-55). Three members of the Purdue team completed interviews via Zoom™ over the course of three weeks where they administered structured interviews and recorded the sessions. Once completed, audio files were uploaded into Temi™, an online transcription service, and then Purdue team members worked to ensure the transcriptions matched the audio recordings verbatim. Completed transcripts were then uploaded into Dedoose™, a cloud sharing qualitative analysis software, for analysis.

Qualitative Data Analysis

Initially, two coders worked independently to review three of the 23 transcripts and annotated respondents' noteworthy statements. Once reviewed independently, the two Purdue team members met and identified similarities and differences in annotation and met with a 3rd Purdue team member to reach consensus and code definitions. After initial code application, a second round of coding took place to ensure consistency of code application. The comparative process was then repeated to define newly identified codes. Structural coding and pattern coding were used to allow for codes to emerge rather than having pre-established codes. Pattern coding allowed for the development of coding patterns and establishment of themes. Upon consensus and definition refinement, the remaining transcripts were divided among four Purdue team members working in pairs (each pair given 10 transcripts) to apply codes and note significant statements from respondents. Following code application completion, the Purdue team convened to review coding application and resolve any inconsistencies. As a result of completed coding and consensus through member checking, themes emerged through grouping individual codes further described in the results section of this report. Identifiable information, such as demographic information, was not used for qualitative analysis.

[1] Research team report uses FSSA interchangeably with DMHA/DFR and other components of FSSA throughout reporting from respondents.

Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In 2022, the HCBS CAHPS survey began and was implemented by the Indiana University Center for Survey Research (CSR), FSSA, and Wellbeing Informed by Science and Evidence in Indiana (WISE Indiana). This standardized survey was developed by CMS specifically for state Medicaid programs to voluntarily use for monitoring recipient experience with HCBS programs. The specific questions used are included in Appendix B. In addition to the core HCBS CAHPS questions, it also included cognitive screening questions, questions to identify from whom recipients received services and demographic questions. The target population of this survey was recipients who received BPHC or AMHH services and were continuously enrolled for 3 months before the survey delivery.

Indiana Medicaid Claims Data

Indiana Medicaid collects data for every claim issued to Medicaid and is stored by year in the secure Indiana University Research Desktop. SAS 9.4 was used within this secure environment to conduct the analysis. The claims datasets have 313 variables and each year had multiple datasets. The Purdue team had access to the years 2017 to 2023 for this evaluation to conduct a clinical review of utilization patterns to analyze the quality of healthcare services between those in the 1915(i) programs and those not enrolled in the program with similar eligibility criteria. Cases (referred to as adult 1915(i) program beneficiaries) were defined as individuals who had any observation where the Public Health Program variable had 'AMHH' or 'BPHC' listed. Controls were defined as individuals in the dataset that ever had an eligible 1915(i) diagnosis code but never had 'AMHH' or 'BPHC' in the public health program variable. After the final subset, only paid claims were included in the final datasets and voided claims were removed to complete analyses.

To perform this analysis, the full dataset was subset by following this coding procedure:

1. Identify variable that identified AMHH- or BPHC-related claim.
    a. Character variable named 'claim_public_health_pg', which identified which Medicaid public health program the claim was associated with.
2. Create table of distinct recipient identification numbers from the full claims' datasets.
3. Sort the tables by recipient identification number and deduplicate.
4. Merge the identification tables so all recipients for the year can be identified in the full dataset.
5. Create a new dataset for each dataset in a single year that merges the full claims dataset and the recipient identification number table so that only the claims that appear in the identification table and the full dataset are pulled.
6. Merge the multiple new datasets from each year into a final annual dataset specifically containing AMHH and BPHC SPA participants' claims.

A frequency check on three random identification numbers was performed to ensure that all observations for 1915(i) SPA participants were included in the final dataset. The next part of the analysis was identifying a similar population to compare utilization patterns, health outcomes, and (in)appropriate usage of primary or emergency services against those in the programs. The steps for creating these datasets included the following:

1. Determine the eligibility requirements across the years (eligibility requirements for each year in Appendix C).
2. Select recipient identification numbers with an eligible age and ICD-10 diagnosis code for the appropriate year and program (AMHH and BPHC were pulled separately).
3. Sort the data by recipient identification number.
4. Merge the AMHH and BPHC recipient identification number tables.
5. Remove all SPA program recipient identification numbers in the merged AMHH and BPHC tables.
6. Sort the new tables by recipient identification number and deduplicate.
7. Create a new dataset for each dataset in a single year that merges the full claims dataset and the recipient identification number table so that only the claims that appear in the identification table and the full dataset are pulled.
8. Merge the multiple new datasets from each year into a final annual dataset to create the control group.

Variables used to analyze the claims dataset included the Primary Diagnosis Code, Primary Procedure Code, Amount Paid Total, Paid Denied Code, NDC Code, Admission Type, Admission Source, Major Diagnosis Category, Recipient ID, Public Health Program Indicator, Recipient Age, Recipient Race, and Recipient Gender. Definitions for each variable can be found in Appendix D. Variables based on the primary diagnosis code were created to flag recipients if they ever had an ICD10-CM diagnosis code that fell into one of six categories: substance abuse, substance dependence, psychotic disorders, mood disorders, anxiety disorders, and other SMI. Because recipients could have more than SMI/SUD, multiple recipients have been flagged with more than one of these categories. Analysis was stratified based on these six categories to identify areas of need and areas of strength for each SMI/SUD because of their unique and diverse healthcare needs. The total amount billed, the total amount paid, admission types, admission sources, age, gender, and major diagnosis category were also stratified by year and whether it was a drug claim to determine time trends and changes in utilization across the waiver period. Code that was written to create the cases and control groups, descriptive statistics, time trends, and new variables are available upon request.

1915(i) Approval Packages and 1915(b)(4) Application

There are currently two active approval packages for AMHH and BPHC programs in the state of Indiana. The most current AMHH SPA approval became effective on October 1, 2022, and the most current BPHC SPA approval became effective on October 1, 2020. The BPHC benefit was approved for a five-year period that expires May 31, 2024. These waivers have been approved for the next waiver time period and the new approval date is effective June 1, 2024. These approval packages helped the Purdue team identify standards for each program, quality improvement strategy, system improvement, and methods for evaluating the effectiveness of system change. The Purdue team used these standards and strategies to identify whether they were being met and if the state was conducting improvement and effectiveness analysis in the timeframe stated in the SPA approval packages.

The 1915(b)(4) waiver application also included quality standards, contract monitoring, coordination, and continuity of care standards. Standards set in the waiver application included DMHA certification and approval as CMHCs, Medicaid certifications, and state monitoring of quality, performance, and

outcomes. The Purdue team used these standards and reports of monitoring to determine whether CMHCs were improving or worsening in compliance with quality standards.

Critical Incidents Log

CMHCs are required to submit critical incidents to DMHA with details such as the date of the incident, whether the reporting time frame was met, type of setting, type of incident, and whether a CAP was submitted due to the incident. This log helped measure adherence to practice guidelines, evaluation of quality of life, state efforts to evaluate beneficiary quality of life, and state efforts to collect and analyze encounter data. All data was uploaded and analyzed using SPSS 29.0 software. A master dataset was created so all state fiscal year data could be analyzed at once. New variables were created that were a count of each incident type in each setting type by CMHC. The number of incidents was evaluated across each submitted fiscal year (2019 to 2023) by individual CMHCs to determine whether the rate of critical incidents overall was decreasing or increasing, whether there are specific problem areas that need to be addressed through additional trainings or sanctions, and general overall quality of life for beneficiaries. Additionally, the Purdue team analyzed the frequency of reporting timeframes being met and what was done by the state when a CMHC did not adhere to the timeframe.

Office for Medicaid Policy and Planning (OMPP) Quarterly Reviews and CMS Final Quality Report

The OMPP is responsible for quality and program oversight for utilization management, qualified provider enrollment, execution of Medicaid provider agreement, and establishment of a consistent rate methodology for each State plan HCBS. OMPP analyzes performance measure data trends quarterly and works with DMHA to develop and evaluate quality improvement strategies. Performance measures data is sent to CMS for a final quality review to determine if the state is meeting compliance with the design and implementation of an accountability system for complying with the seven requirements:

1. Service plans
2. Eligibility requirements
3. Qualified providers
4. Home and community-based settings
5. Administrative authority
6. Financial accountability
7. Incidents of abuse, neglect, and exploitation.

To measure these seven requirements, there are a total of 20 performance measures, which are listed in Appendix E. This final quality report by CMS is according to 1915(f)(1) of the Social Security Act and 42 CFR 441.304(g)(2). These performance measures and reports provided an overview of the state quality improvement strategy, adherence to guidelines, and quality monitoring. The Purdue team reviewed the OMPP quarterly review data, annual data, and what was reported in the CMS quality report to ensure the data matched across all documents. A master dataset was created for each quarter, with the percentage of compliance for each requirement, and the percentage of compliance for each 20 sub-requirements for 2019 to 2022. SPSS 29.0 software was used to analyze basic trends of the requirements and sub-requirements to identify effective quality improvement strategies and identify potential areas of concern.

Grievance and Appeals Process

The grievance and appeals process allows consumers to appeal a denial of BPHC or AMHH coverage by the SET. This process was evaluated during the structured evaluation interviews by the Purdue team. The process was reviewed to determine whether the process would be effective for the behavioral health population and the level of burden it would place on CMHC administrators and providers. Grievance patterns for the 1915(i) waiver could not be analyzed because the state does not track grievance data which is considered a limitation of this evaluation.

Access

HCBS CAHPS Survey

The CAHPS survey included measures that allowed the team to analyze beneficiary and provider perception of access to providers for preventive and specialty care. Additionally, the qualitative data from providers was analyzed to identify problematic areas to improve access to healthcare that need to be changed to maximize the benefit of the 1915(i) programs. This survey also covers provider and beneficiary perception of the state's efforts to ensure all covered benefits are available and accessible.

Indiana Medicaid Claims Data

To evaluate increased or decreased emergency room utilization rates over the time of the program, the claims data was used to look at trends through comparison to the control group, described above. The steps for creating the control group are listed in the previous Quality section. Additionally, a comparative analysis of number of claims associated between program recipients and the control group identified level of access to healthcare.

1915(i) Approval Packages and 1915(b)(4) Application

Like the quality standards discussed in the previous section, the approval packages and application outlined baseline timely access standards that are required of CMHCs to provide to program recipients. These documents also provided general referral procedures and standardized enrollment processes that ensure program access to potential recipients.

Grievance and Appeals Process

This process is associated with the ability of potential recipients to enroll in the program and the steps needed when the individuals, or their care team, believe they should not have been denied access. Currently, DMHA has a customer service hotline that caters to all their programs but is not tracked at the waiver level. An outside vendor supports the hotline, but it is not tracked or logged to avoid a conflict of interest and the HCBS team will become involved if further customer service is required.

Because data is not available, it is considered a limitation of this evaluation. However, the procedural process for responding to grievances was provided and could be analyzed for ease and appropriateness for the population and CMHCs. Additionally, the Purdue team included this question in the CMHC interviews to identify how accessible this process is for administrators and recipients.

1915(i) SPA Programs Evaluation Interviews

In these interviews, 17 questions were asked of CMHC administrators about the programs. Key areas were the ability to receive care, the enrollment process, and the grievance and appeals process. The coding techniques used to analyze access are identical to the methods described in the Quality section.

Provider Reference Modules

The reference modules were analyzed for thoroughness and accessibility for providers to reference procedures and CMHC programming. Additionally, these were used to determine provider awareness and comprehension of the programs and care systems and whether agencies had access to effective education about requirements.

Marketing Flyers and Provider Directory

In total, there were six different marketing flyers created by FSSA identified in this evaluation process for the 1915(i) programs. From each respective program's website, there was one program flyer publicly available and there were four other general information flyers from the HCBS website. All were analyzed for accuracy, clarity, appropriate comprehension level, language, and cultural appropriateness for the targeted population of the flyer, such as providers, CMHC employees, the general population, and the population using the programs. Readability was assessed using the Flesch-Kincaid calculator and it is acknowledged that the limitations associated with it are that the grade level score is based on the average length of the words and sentences and that the formulas do not measure comprehension or reading ease. However, it is a good tool for alerting when text is too difficult for a target audience. Two flyers sent directly to the Purdue team by FSSA included the flyers discussing consumer rights for adults in HCBS programs, which were also available on the HCBS website. All flyers are attached in Appendix F. The Purdue team also identified the most recent update made to the flyers as well as the provider directory. The provider directory is publicly available on the FSSA website, it identifies approved providers of AMHH and BPHC services, along with their respective phone numbers and counties served (Appendix G). The provider directory was analyzed by double-checking whether the CMHC provides the services listed, the accuracy of the counties served list and the accuracy of the phone number. DMHA does not track when and how often the provider directories and marketing flyers are distributed, which is considered a limitation of this evaluation.

1915(i) SPA Trainings

These publicly available trainings are listed on FSSA's website for AMHH, BPHC, and HCBS. BPHC has five listed training courses, AMHH has eight training courses, and FSSA has seven listed training courses. These cover service comparisons, provider training, program information/updates, policy information/updates, and service qualifications. At the time of this evaluation, DMHA does not track attendance or completion by CMHCs of required training and therefore has been added as a limitation of this evaluation. However, after results and feedback from the CAHPS survey, DMHA is developing additional verification steps that should be used in the next evaluation.

Availability of DMHA Consumer Service Line (CSL), Disenrollment Log, Referral System, Outreach Plan

These are four components of access evaluation that are not tracked by FSSA and are considered a limitation of this evaluation. The DMHA CSL would have provided information about the numbers of calls for the 1915(i) SPA programs and the types of compliments or concerns being reported. It is important to note that DMHA tracks this information, but not specific to any program. Examples of measures that would have fallen under these categories include the availability of primary care providers to see participants, ease of beneficiaries to get necessary referrals, ability to address problematic areas, review of the process for provider feedback, and rate of disenrollment (voluntary and involuntary) by providers.

Cost

Indiana Medicaid Claims

The claims data was used to analyze the annual cost of AMHH and BPHC-related claims and further stratified by age, sex, and primary diagnosis group. Additionally, the Purdue team compared the cost of these waiver programs to the costs of the same services to a similar population without the waiver as defined above. A similar population is the control group, which was defined in the Quality section. Further analysis included sources of cost savings in the program such as changes in utilization and evidence of a decrease in recipients or services being provided.

1915(b)(4) Application

Project waiver expenditures for each year of the program were included in both the 2013 and 2023 waiver applications. Based on FSSA-wide procedures, this cost analysis was outsourced to Myers and Stauffer for the financial predictions and the methods used for these calculations and rate settings were not available for validation and is considered a limitation of this evaluation. However, this allowed the Purdue team to compare the projected waiver expenditures for 2019 to 2023 and compare the costs identified in the Medicaid claims data.

Provider Reference Modules

In both the AMHH and BPHC modules, there is a service codes and rates table that allowed the Purdue team to validate the state's rate-setting and reimbursement strategies. The service codes and rates table for both programs are attached in Appendix H. The methods used to set the rates, however, were not available and are also considered a limitation of this evaluation.

Results

Quality Assurance (QA) and Corrective Action Plan (CAP)

Adult Mental Health Habilitation (AMHH)

Across State Fiscal Year (SFY) 2019 and 2023, only seven centers had AMHH compliance data, and the centers that provided AMHH services to recipients changed across the years. This resulted in only one- or two-years' worth of data for most centers. This is due to the small number of clients being eligible for and utilizing AMHH services. In 2019 and 2020, only five centers had AMHH clients and there were only two centers in the remaining years.

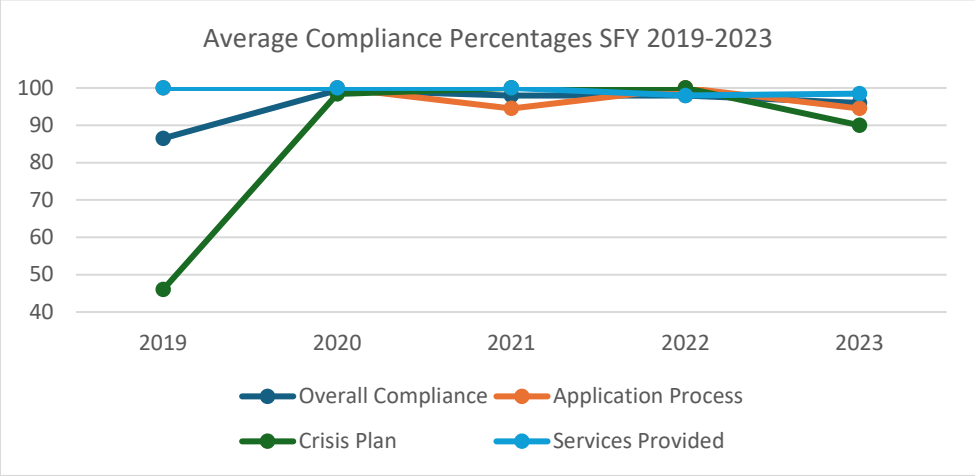
Compliance Percentages

Figure 1 shows the average compliance percentages for overall compliance, crisis plan, services provided, and application process of all centers from SFY 2019 to SFY 2023. ANSA compliance percentage is not included in this graph because it was 100% for the first year and was missing data for the others. The average overall compliance percentage for all CMHCs combined increased significantly from SFY 2019 to SFY 2020 with values of 86.5% and 100%, respectively. After SFY 2020, the overall compliance percentage decreased and in 2023, the compliance percentage was 96%. The average services provided compliance percentage remained at or above 98% across all SFYs. The lowest value for services provided was 98% in SFY 2022. In 2019, the crisis plan percentage was 46%, but rose to 90% by the end of 2023.

The crisis plan compliance percentage increased significantly from 2019 to 2023 with a percent change of 95.65%. Application process compliance percentages also remained high across all SFYs at or above 94.5%.

After 2019, the AMHH program was consistently meeting compliance percentage requirements as outlined in the State Plan Amendment (SPA) and did not have a percentage less than 86% that would have required a CAP.

Figure 1: AMHH Average Compliance Percentages



Behavioral and Primary Healthcare Coordination (BPHC)

Unlike AMHH, all 24 centers had BPHC compliance data for every SFY. However, in 2019, there were multiple CMHCs that DMHA did not have QA and CAP documentation available for this review. FSSA has reported that there were issues internal to their agency, which is the reason for the missing documentation. The issue resolved itself in the following years, but it is considered a limitation of this study. Additional concerns for the BPHC QA and CAP documentation review were the number of minor discrepancies between documentation. For example, one CMHC in 2020 had an overall compliance percentage of 98% listed in the QA Excel sheet, but 95% in the QA Review Summary.

Overall, all average compliance percentages for BPHC declined beginning in 2020. The most significant drop in overall compliance occurred between SFY 2021 and 2022, with an 11.7% decrease. Across each SFY, the application process compliance percentage was higher than the services provided compliance percentage. Interestingly, as the application process compliance percentage dropped so did services provided in every SFY, implying that there are similar causes to what makes a CMHC compliant in both areas. Specific compliance percentages for each area are included in Figure 2. As of 2023, the overall compliance percentage was 76.4%, the application process percentage was 78.7%, and the services provided percentage was 73.6%. As the average compliance percentage decreased, the number of CAPs needed increased.

The explanation from DMHA for this drop in compliance is partly due to the contracted providers failure to complete documentation activities and/or services as required by the SPA due to the COVID-19 public health emergency (PHE) in 2020. Throughout the PHE, recipients continued to receive 1915(i) program and Medicaid benefits regardless of the fulfillment of administrative requirements. The DMHA SET

provided information annually, beginning in 2020 with training and up-to-date webinars and one-on-one to each provider at the end of the QA process that administrative requirements must be maintained to continue to demonstrate person-centered driven care. Unfortunately, as recently as 2024, CMHCs are still reporting that they did not know this to be true. For services provided, DMHA has observed that the PHE allowed beneficiaries to remain as 1915(i) recipients to continue receiving Medicaid coverage but were not utilizing the services of the program. When DMHA was able to verify that discontinuing BPHC was a clinical decision made with the client, they were removed from the QA process. However, those individuals would have been in the original selection of the 10 randomized consumers reviewed for the QA process, not knowing that they were no longer receiving the services. During the QA review completion, DMHA would then adjust the compliance outcomes to be based on the number of charts completed, rather than 10. When this occurs for any area with a finding, there is a greater impact on the compliance rate. The DMHA SET has returned to standard, non-PHE practices as of April 1, 2023, and it is expected that the QA results for SFY 2024 will show marked compliance improvements.

Decisions on whether a CMHC needs a CAP are based on the compliance percentage for each area. For example, if the application process compliance percentage is less than 86%, then a CAP is needed that addresses the issues within the application process. If a CMHC has less than 86% for both the application process and services provided, then only one CAP is needed. For this analysis, however, if a CMHC has less than 86% in both areas, then two CAPs will be counted. Specific numbers of CAPs needed for both application processes and services provided are listed in Table 3. As expected, the number of CAPs needed followed the compliance percentage trends. Between 2019 and 2023, the number increased from 3 to 27. Across all SFYs, services provided required more CAPs than the application process. This suggests that CMHCs struggle to understand and meet the compliance requirements for services provided and may need additional training, especially when there are changes to the requirements.

Figure 2: BPHC Average Compliance Percentages

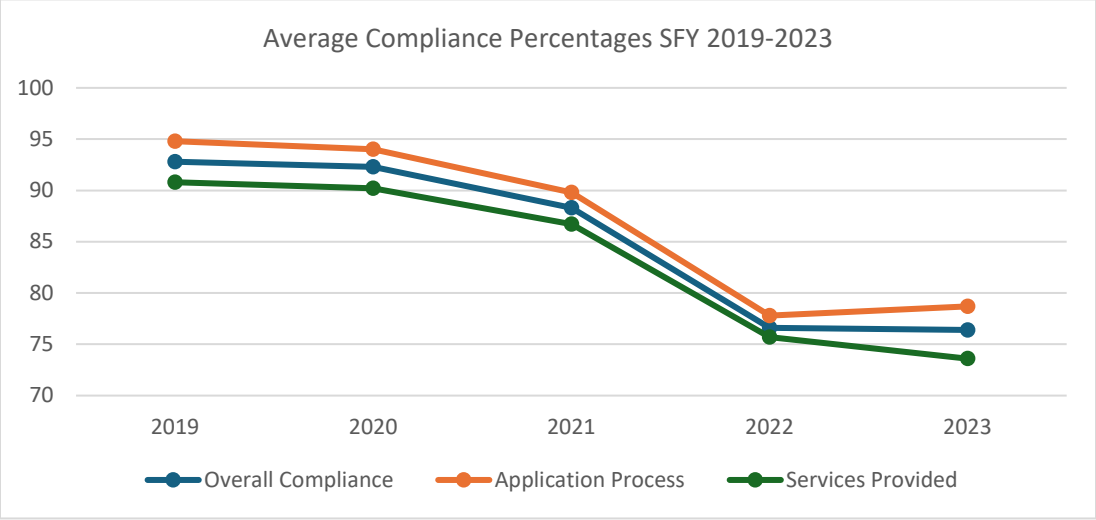


Table 3: Number of CAPs Needed for Application Process and Services Provided by SFY

	2019	2020	2021	2022	2023

Number for Application Process	1	2	3	12	11
Number for Services Provided	2	6	4	13	16
Total Needed	3	8	7	25	27

Recommendations

It is recommended that FSSA leadership ensure that their reviewers understand the documentation and enact a quality assurance system that makes sure CMHCs are receiving accurate information about their center's level of compliance for BPHC. Furthermore, CMHCs require further training on the requirements for BPHC services provided and the BPHC application process. If changes are made to these requirements, there needs to be clear documentation sent to providers and administrators of CMHCs to help them navigate the changes. Complications associated with training on requirements are that it is difficult to protect CMHC staff and provider time when trainings with DMHA are not billable hours. Allowing DMHA and CMHC staff to work directly together is a recommended strategy to improve overall communication between parties.

Critical Incidents Log

General Overview

CMHCs are required to submit a record of critical incidents to the DMHA that includes information such as the event setting, incident type, and if the event resulted in the submission of a corrective action plan (CAP). Incident reporting allows a way of reporting and responding to critical or sentinel incidents occurring in connection with the 1915(i) programs. The 1915(i) State Evaluation Team is required to send critical incident reporting (CIR) data to CMS every quarter and there is now an online reporting portal for more convenient submitting of incidents. The Critical Incidents Log that was evaluated for this waiver period contained data spanning from 2019 to 2023 with a total of 906 events. The data from 2023 contained information from all three quarters and partial data from the fourth quarter. Event types were broken down into two broad categories: outpatient (305 events) and residential (601 events). The specific types of incidents in each setting are detailed in Table 4. The trainings on the FSSA website for critical incidents log only lists the incidents identified in Table 4, but different names are utilized in the internal quarterly documents and these differences will be reflected in other results sections and figures. The data was condensed to total incidents and events regardless of CMHC to maintain anonymity. The incidents and events were organized by SFY and analyzed to observe periodic trends, identify problematic areas, and assess the strengths of how CMHCs and DMHA handle critical incidents. In 2020, two incidents were not assigned to a setting type and were not assigned an incident type even though one was an ER visit, and one was a medication error. Additionally, in 2020, one incident had both a residential and an outpatient setting type assigned. For 2021, there was one incident reported where its information was filled in for both residential and outpatient data, however, it only appeared to be a residential incident.

Table 4: Incident Reporting Setting Type Variations

Residential Setting Types	Outpatient Setting Types
Fire requiring a local fire department response	Injury
Any emergency rendering the residence temporarily or permanently uninhabitable	A suicide/suicide attempt by a resident
Any serious injury of a resident requiring professional medical attention	Death
Suspected or alleged exploitation, neglect, or abuse	Homicide
A suicide/suicide attempt by a resident	Medication error
Incident involving the resident requiring a police response – Assault on staff/client	Suspected or alleged exploitation, neglect, or abuse
Medication Error	
Elopement	
Seclusion and restraint	
Death	

For each year, the number of residential incidents was much higher than the number of outpatient events. Additionally, residential incidents had a lower percentage of incidents being reported on time than outpatient incidents, except for 2021 (Table 5).

Table 5: Yearly Number of Incidents, Number of Incidents Reported Timely, and Percentage Reported Timely by Setting Type

	Outpatient			**Residential**			**Total**		
	Number of Incidents	Number Reported Timely	% Time Compliance	Number of Incidents	Number Reported Timely	% Time Compliance	Number of Incidents	Number Reported Timely	% Time Compliance
2019	67	48	72%	100	69	69%	167	117	70%
2020	70	61	87%	148	126	85%	218	187	86%
2021	80	68	85%	166	145	87%	246	213	87%
2022	87	81	93%	141	127	90%	228	208	91%
2023	86	73	85%	107	92	86%	193	165	85%

Between 2019 and 2021, there was a general increase in the total number of incidents, and it dipped in 2022. This trend indicates that CMHCs showed some difficulty controlling the number of incidents in 2021 but have made progress in the most recent year (2022) and this trend can be seen in Figure 3. For 2023, there has been an overall decrease in the number of incidents as of Q2 compared to previous years. This suggests that the CMHCs are making effective progress in controlling the number of incidents following the difficulties in the 2019-2021 time period. Even though only 70% of critical incidents were reported on time in 2019, that percentage has jumped to 91% in 2022. Figure 4 shows the percentage of critical incidents reported on time.

Figure 3: Total Number of Events for 2019 through 2022

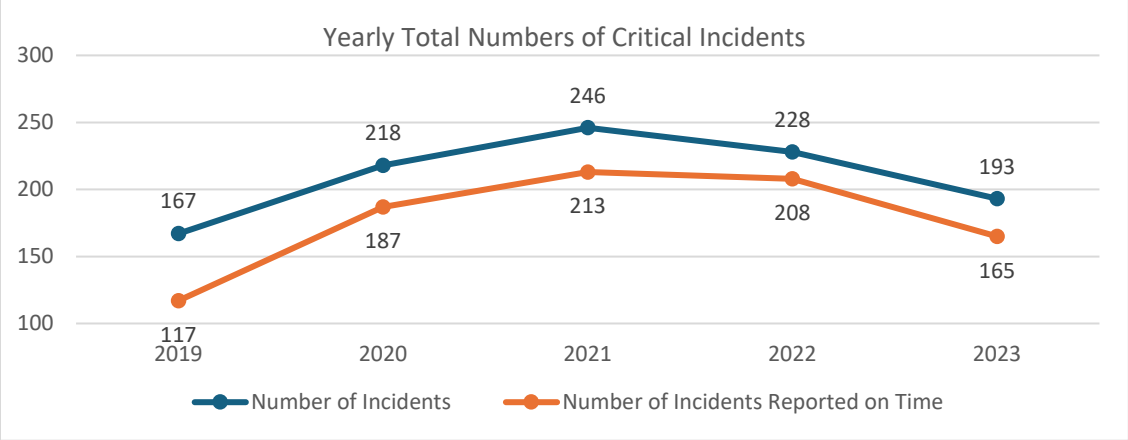
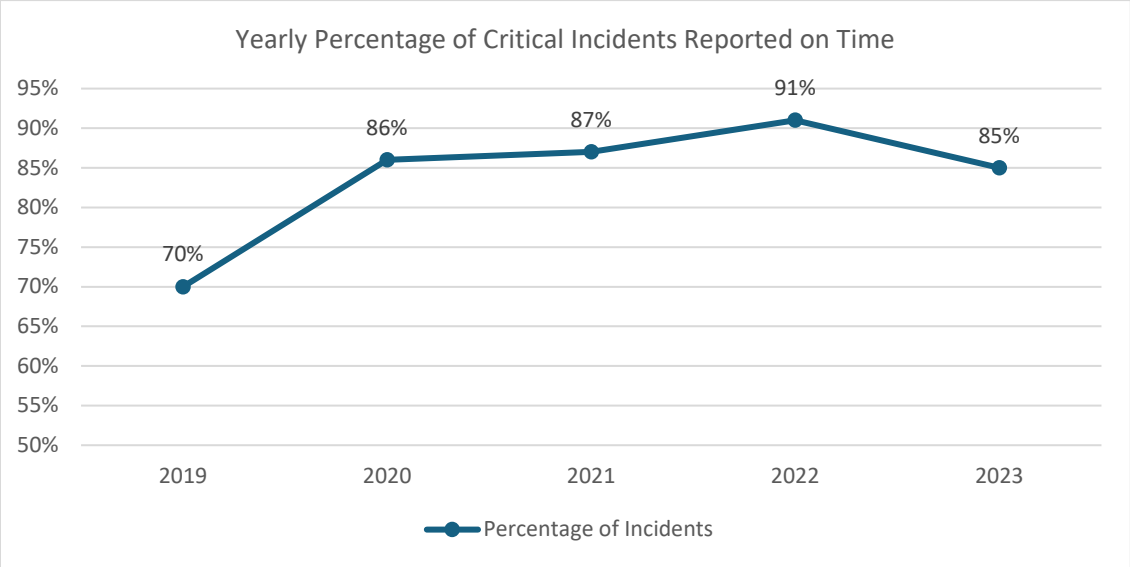


Figure 4: Time Trend for Percentage of Critical Incidents Reported Timely



Residential Incidents

The number of residential events by year can be seen in Table 6. There were eleven possible incident types for residential events. For the 2019–2022 span, there was an increase in eight incident types and a decrease in two incident types. The incidents that saw a rise in numbers alleged abuse, neglect, or exploitation, assault, elopement, emergency room (ER) visits, fires, medication errors, other, and police response. Based on percent change, the incident type that increased the most between 2019 and 2022 was elopement. However, the incident type that increased the most based on count was ER visits. The incident types that decreased between 2019 and 2022 were death and injury. Deaths saw a drastic decrease of 60% and injuries decreased by 75%. The percent change between years for each incident type can be seen in Table 7. Overall, ER visits consistently made up the largest percentage of incidents, followed by medication errors. The yearly numbers and percentages for each incident type can be seen in Table 6.

Table 6: Number of Each Residential Incident Type 2019-2023

	2019	2020	2021	2022	2023*	Incident Total	Percentage of Total Incidents
Abuse, neglect, or exploitation	0	1	0	1	0	2	0%
Assault	1	2	3	2	1	9	1%
Death	5	3	5	2	4	19	3%
Elopement	2	8	9	5	3	27	4%
ER Visit	39	92	106	72	61	370	56%
Fire	0	0	1	1	0	2	0%
Injury	8	1	1	2	1	13	2%
Medication Error	28	17	8	31	17	101	15%
Other	6	10	21	12	7	56	8%
Police Response	9	13	12	13	13	60	9%
Suicide Attempt	1	1	1	1	0	4	1%
Yearly Total	99	148	167	142	107	663	

*Data for 2023 is not complete.

Table 7: Percent Change for Each Residential Type for 2019-2022

	2019-2020	2020-2021	2021-2022	2019-2022
Abuse, neglect, or exploitation	-100%	100%	-100%	-100%
Assault	-100%	-50%	33%	-100%
Death	40%	-67%	60%	60%
Elopement	-300%	-13%	44%	-150%
ER Visit	-136%	-15%	32%	-85%
Fire	0%	-100%	0%	-100%
Injury	88%	0%	-100%	75%
Medication Error	39%	53%	-288%	-11%
Other	-67%	-110%	43%	-100%
Police Response	-44%	8%	-8%	-44%
Suicide Attempt	0%	0%	0%	0%
Yearly Total	-49%	-13%	15%	-43%

*Cells are highlighted green if the percentage change was positive and a reduction in incidents was seen.

*Cells are highlighted red if the percentage change was negative and an increase in events was seen.

Outpatient Incidents

The total number of outpatient events increased each year, with a total percent increase of 31% between 2019 and 2022. The most common incident type in the outpatient setting for 2019 through 2023 was the death of a beneficiary, making up 48% of all incidents. The only CAP issued for all incidents

was for an outpatient beneficiary death. Four outpatient incident types decreased between 2019 and 2022 and four had 0 incidents in 2022. The incident type that saw the largest decrease in percent change was suicide attempt. Between 2019 and 2022, two incident types had concerning percent changes in the outpatient setting. Alleged abuse, neglect, or exploitation incidents had a -100% percent change and injury had -117%. Based on the current data in 2023, the 'other' incident type has seen a significant increase and has almost doubled from the 2022 numbers. Specific numbers of each incident type across years are shown in Table 8 and the percentage change across years is shown in Table 9.

Table 8: Number of Each Outpatient Incident Type for 2019 through 2023

	2019	2020	2021	2022	2023*	Incident Total	Percentage of Total Incidents
Abuse, neglect, or exploitation	1	0	2	2	0	5	1%
Death	28	36	44	44	32	184	48%
Homicide	0	2	1	0	0	3	1%
Injury	6	1	6	13	5	31	8%
Medication Error	4	8	2	2	0	16	4%
Other	18	21	25	24	45	133	34%
Serious Bodily Injury	3	0	0	0	0	3	1%
Suicide	1	1	1	0	0	3	1%
Suicide Attempt	4	1	0	0	3	8	2%
Yearly Total	65	70	81	85	86	386	

*Data for 2023 is not complete.

Table 9: Percent Change for Each Outpatient Type for 2019-2022

	2019-2020	2020-2021	2021-2022	2019-2022
Abuse, neglect, or exploitation	100%	-200%	0%	-100%
Death	-29%	-22%	0%	-57%
Homicide	-200%	50%	100%	0%
Injury	83%	-500%	-117%	-117%
Medication Error	-100%	75%	0%	50%
Other	-17%	-19%	4%	-33%
Serious Bodily Injury	300%	0%	0%	300%
Suicide	0%	0%	100%	100%
Suicide Attempt	75%	100%	0%	400%
TOTAL	-8%	-16%	-5%	-31%

*Cells are highlighted green if the percent change was positive and a reduction in incidents was seen.
*Cells are highlighted red if the percent change was negative and an increase in events was seen.

State Standards

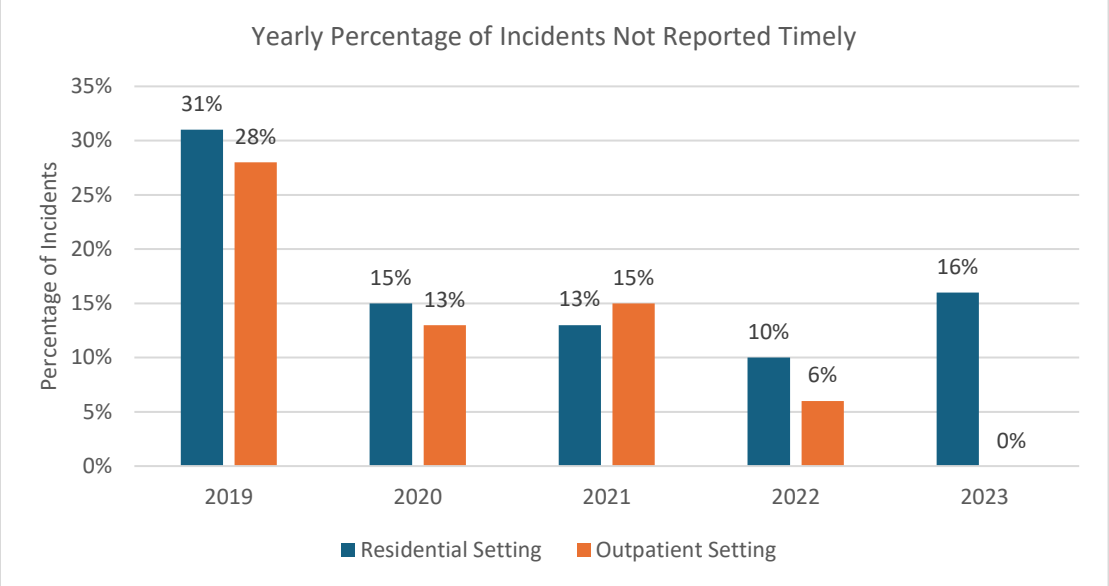
DMHA requires the CMHCs to submit incident reports within a certain window following the event to ensure timely notification. Reporting time frames for residential settings is 24 hours and the timeframe for a home or community-based setting is 72 hours unless a death occurs, which is also 24 hours. For the critical incident reporting of deaths, reporting should be completed in 24 hours, regardless of the environment in which the individual resides. CMHCs should conduct an internal review of all deaths that occur. An incident report is not needed for medication errors when an individual is not home at the time of typical medication or if the individual declines to take the medication. When that time frame is not met, potential safety concerns arise. A summary of this data can be seen in Table 10. Between 2019 and the first two quarters of 2023, 137 reports missed the time frame, with the majority occurring in the residential setting. Six late reports did not have a designated setting type in 2019 and were left off for analysis. Figure 5 shows that the number of incidents reported outside the time frame has consistently decreased from 2019 to 2022, except for a small increase in outpatient reports in 2021. Generally, CMHCs are showing marked improvement in submitting critical incidents in a timely fashion.

Table 10: Number of Incidents Reported Late by Setting Type for 2019 to 2023

	2019	**2020**	**2021**	**2022**	**2023***	**Total**
Residential Incident Time Frame Not Being Met	31	22	21	14	15	103
Outpatient Incident Time Frame Not Being Met	19	9	12	6	13	59
Total	**50**	**31**	**33**	**20**	**28**	**162**

*Data for 2023 was incomplete and only included quarters one and two.

Figure 5: Percentage of Incidents Reported Outside Time Frame by Event Type 2019-2022



Recommendations

Based on the critical incident reports, it is recommended that continuous improvement is encouraged for incident reduction and timely reporting. It is also suggested that more training programs and resources could be aimed at improving incident management skills among CMHC staff. This could include training on error reduction techniques, crisis intervention, and reporting protocols. However, it is known that CMHCs currently struggle with having enough providers and staff for current obligations and making time to participate in training that is not considered billable hours can be difficult. It could also be helpful if more advanced data analysis techniques were implemented to identify trends and patterns in incident data as they occur to proactively address emerging issues and allocate resources more effectively. By implementing recommendations, Indiana Medicaid can help ensure that CMHCs are better equipped to manage critical incidents effectively, leading to improved patient safety and quality of care. Finally, the last recommendation for FSSA is to make the residential and outpatient settings mutually exclusive on their online reporting tool, so it is easier to identify trends by setting type and determine whether actions are needed. In the reporting tool, it is also recommended that users are forced to choose an incident type so they can be properly counted.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Respondent Demographics

The CAHPS survey achieved a response rate of 36%, with 608 respondents fully or partially completing it. Most respondents were aged 55 or older (71.3%), female (56.9%), had at least a high school diploma or GED (86.2%), spoke only English at home (94.1%), and had a primary diagnosis of depression (32.1%). Urban residents comprised 57.1% of respondents, 62.4% were the only adults in their household and 94.8% lived in a private or independent home. Among those living with others, 69.8% lived with family members. Only 29.8% of respondents lived with people who were not related to them. On average, 42% of respondents rated their physical health as fair and 39.6% rated their mental health as fair. The scale used for this measure was 1=poor, 2=fair, 3=good, 4=very good, and 5=excellent. For more complete demographic information, refer to Table 11. Demographic categories with an n-value of 608 drew from the sample, but those with an n-value lower than 608 drew from consumer responses (Table 11).

Table 11: Survey Respondents' Demographics (n=608)

Category	Measure	% of Respondents
Age (n=597)	18-34	1.7
	35-44	6.9
	45-54	20.3
	55-64	39.4
	65-74	27.0
	75 or older	4.9
Sex (n=598)	Female	56.9
	Male	43.1
Race (n=608)	White	83.7
	Black or African American	10.7
	Other Race	8.4
Ethnicity (n=592)	Not Hispanic	98.8

Education level (n=595)	8th grade or less	4.2
	Some high school but did not graduate	9.6
	High school graduate or GED	37.3
	Some college or 2-year degree	32.8
	4-year college graduate	10.9
	More than a 4-year college degree	5.2
Rurality (n=608)	Urban	57.1
	Mixed	31.7
	Rural	11.2
Diagnosis (n=608)	Schizophrenia	15.0
	Schizoaffective	16.9
	Bipolar	19.4
	Depression	32.1
	All else	16.6
Adults living in home (n=608)	1 (just respondent)	62.4
	2 to 3	32.4
	4 or more	5.2

Beneficiary Perception

National Quality Forum (NQF)-Endorsed Measures Description

There were seven scale measures and six independent questions from the NQF measures. The paragraphs below provide a summary of the overall scores for each measure, representing the proportion of respondents who provided the most "positive" response. Higher scores indicate more positive outcomes, and these scores provide insights into the perceptions and experiences of respondents regarding various aspects of behavioral health programs, including staff reliability, communication, case management, transportation, safety, and overall satisfaction. General results of disparities existing among scales measures and individual questions by group are listed in Table 12 at the end of this section.

Scale Measures

Scale measures were scored based on multiple questions specific to a similar construct. The seven categories measured were 1) Staff are reliable and helpful, 2) Staff listen and communicate well, 3) Case manager is helpful, 4) Choosing the services that matter for you, 5) Transportation to medical appointments, 6) Personal safety and respect, and 7) Planning your time and activities. SM1 measured how reliable and helpful staff are to participants and scored 87.38%, indicating a high level of reliability and helpfulness among staff (n=532). Staff listening and communication were measured by SM2 with the second lowest score of 77.78%, suggesting satisfactory communication skills among staff with respondents (n=532). The SM3 evaluated case manager assistance, which achieved a high score of 91.80%, indicating that case managers are very helpful to participants (n=514). Choosing services was measured by SM4, scoring 87.98%, which shows that respondents can choose services that are important to them (n=570). SM5 measured overall ease of accessing transportation to medical

appointments, which scored 90.75%, suggesting high accessibility of transportation services to medical appointments (n=595). The SM6 evaluated personal safety and respect, which achieved the highest score of 95.99%, indicating a very high level of perceived safety and respect (n=604). Finally, SM7 assessed planning time and activities, with the lowest score of 74.37%, suggesting there needs to be an improvement in planning services (n=601).

Individual Questions

The remaining NQF measures are individual questions that focus on ratings of staff, recommendations, unmet needs, and physical safety. The global rating measures were ratings from 0 (worse help possible) to 10 (best help possible), which was used to rate behavioral health staff, homemakers, and case managers. Finally, the recommendations measures were used for respondents to indicate whether they would recommend their behavioral health staff, homemaker, or case manager to family and friends.

Q35 measured the global rating of behavioral health staff, which scored 90.99%, indicating a high level of satisfaction with behavioral health staff (n=517). The second question was Q54, which was the global rating of case managers, and it achieved a score of 89.80%, also indicating a high level of overall satisfaction with case managers (n=510). Q36 (n=516) and Q55 (n=507) measured whether respondents would recommend behavioral health staff and case manager (respectively), to family and friends. Q36 scored 88.44% and Q55 scored 88.89%, indicating a high likelihood of recommendation to family and friends. Q25 measured the percentage of respondents who had no unmet needs for medication administration due to lack of help, which scored 75.68% (n=37). Key takeaways from Q25 about unmet needs demonstrate that a high proportion of respondents have unmet needs in medication administration due to factors other than a lack of help. Q27 was the last question and it evaluated not being hit or hurt by staff. It achieved a very high score of 99.5%, indicating a low incidence of respondents reporting being hit or hurt by staff (n=600).

NQF Stratification

Rurality

Further analysis of the scale measures and the individual questions was through the stratification by rurality, race, and diagnosis. Two major concerns for the rurality-adjusted scores included the SM3 (case manager is helpful) and Q54 (rating of case manager). Respondents in rural areas had a significantly lower average overall adjusted score for whether the case manager is helpful and for the case manager's global rating. This suggests there needs to be strategies that improve the relationship between case managers and respondents specifically in a rural area and that further investigation is needed to determine the causes of this difference. However, there were two measures with a statistically higher score for the rural adjusted score compared to the average overall adjusted score, SM5 (transportation) and SM6 (safety and respect). This suggests that respondents in rural areas had a higher level of ease to access transportation for medical services than those in mixed (88.96) or urban areas (90.96). This difference could be due to rural respondents utilizing CMHC-specific transport to get to appointments, creating a perception that transportation to appointments is easy. Additionally, because SM6 scored highest in rural areas (99.00), it indicates that people in rural areas had a higher level of perceived safety and respect compared to mixed (96.64) and urban areas (95.04).

Race

The race-adjusted scores for the NQF measures were broken down into three categories, White, Black, and Other Race. Overall, Other Race respondents tended to give lower scores across most measures compared to White and Black respondents. Four measures were significantly lower: SM2, SM6, Q35, and Q36. Other Race respondents had a lower adjusted score of staff listening and communicating (74.08) as well as a lower score for a perceived level of safety and respect (90.84) compared to Black and White respondents, suggesting that there needs to be further investigation into the causes of these perceptions and strategies to improve relationships between participants and staff. Additionally, Q35 and Q36 were concerned with the satisfaction of care received from behavioral health staff. Other Race respondents also had much lower for the global rating of behavioral health staff (85.58) and the percentage that would recommend behavioral health staff (77.45) scores compared to Black and White respondents. Like SM2 and SM6, strategies need to be developed for improving the relationships between Other Race waiver participants and behavioral health staff.

Diagnosis

Diagnosis adjusted scores were created for the following groups: psychotic disorder, severe mood disorder, SUD, and all other SMIs. Disparity concerns for overall program and staff satisfaction were highest for those diagnosed with a psychotic disorder. Measures that were significantly lower compared to the overall adjusted score were SM1, SM2, SM6, Q35, Q36, and Q55. SM1 (staff reliable/helpful) and SM2 (staff listen/communicate) scored 81.81 and 74.72 respectively, for those with a psychotic disorder. This indicates another group that needs strategies to improve relationships and perceived problems with staff helpfulness and ability to effectively communicate. Similar issues arose when evaluating Q35 and Q36 for the general satisfaction of relationships with the behavioral health staff. Those with a psychotic disorder had significantly lower ratings of the behavioral health staff rating (87.57) and whether they would recommend that staff (81.99). Finally, those with a psychotic disorder also had significantly lower scores for the perceived feelings of safety and respect (93.44) and whether they would their case manager (85.41). It is recommended that the state follow up with those diagnosed with a psychotic disorder to determine changes needed to improve feelings of safety and satisfaction with the staff. While not significantly lower to the overall adjusted score, there were significant variations in the scores of (no) medication needs (Q25) across diagnosis groups. For example, those with a psychotic disorder had an adjusted score of 62.50, severe mood disorder respondents had a score of 85.71, those with an SUD had a score of 90.96, and all other SMI had a score of 91.42. This suggests a need for a more comprehensive approach to addressing the needs of individuals with these diagnoses.

However, those diagnosed with an SUD had significantly higher scores associated with SM7, Q54 and Q36. The ability of staff to plan activities had a score of 78.32 among those with an SUD compared to those with a psychotic disorder (72.63), severe mood disorder (74.74) and all other SMI (73.17). Finally, those with an SUD had higher scores for the ratings of their case manager (92.54) and whether they would recommend the behavioral health staff (94.54) compared to the overall adjusted score. The last group with significantly higher scores included all other SMI diagnoses group. The two measures that differed included Q35 and Q36. For the rating of behavioral health staff, their score was 93.63 and the recommendation of behavioral health staff score was 92.54.

General Themes from the NQF Measures

General themes that emerged from the diagnosis stratification was that those with a psychotic disorder consistently had lower scores for satisfaction and feelings of safety with staff compared to other diagnostic groups. This indicates a need for targeted strategies to improve the experiences of this group, possibly focusing on enhancing relationships with staff and addressing perceived problems with staff helpfulness and communication. It should be acknowledged that those with a psychosis disorder have multiple factors contributing to these results. For example, those with a psychosis disorder can create higher levels of needs, staff may be less responsive, staff may not treat them as well, but a symptom of their disorder is lower levels of trust and higher levels of paranoia. However, individuals with an SUD or other unspecified SMI reported higher satisfaction scores in certain areas such as ratings of case managers and willingness to recommend behavioral health staff. This suggests that certain diagnostic groups may have more positive experiences within the behavioral health program. Groups with significantly higher and/or lower values for each scale measure, global rating measure, and recommendation measures are shown in Table 12.

Table 12: Statistically Significant Scale Measures, Global Rating Measures, and Recommendation Measures

Measure	Significantly Higher	Significantly Lower
SM1: Staff reliable/helpful		Psychotic disorder
SM2: Staff listen/communicate		Other race Psychotic disorder
SM3: Case manager helpful		Rural Other race
SM5: Transportation to medical appointments	Rural	
SM6: Personal safety and respect	Rural	Other race Psychotic disorder
SM7: Planning time and activities	Substance use disorder	
Q35: Rating of behavioral health staff	All other diagnoses*	Other race Psychotic disorder
Q54: Rating of case manager	Substance use disorder	Rural
Q36: Recommend behavioral health staff	Substance use disorder All other diagnoses*	Other race Psychotic disorder
Q55: Recommend case manager		Psychotic disorder

All other diagnoses are diagnoses that did not fall under psychotic disorder, severe mood disorder, or SUD.

Provider Feedback

To elicit service provider feedback on the facilitators and barriers of working with the Adult 1915(i) programs, four focus groups were conducted. 38 providers signed up to participate and 28 attended sessions that represented 14 of the 24 CMHCs. Four major themes arose from the provider feedback: 1) providers experiences providing care, 2) client experiences with receiving care, 3) provider experiences with DMHA, and 4) provider experiences with DFR.

Provider Experiences with Providing Care

Frequent themes that arose about challenges in providing services included program restrictions in the 1915(i) program itself. Specific issues included finding acceptable housing and accommodating clients with serious mental illness can impact the care that they offer. Affordable housing for those with an SMI or SUD is increasingly difficult to find, especially for those with a disability. Furthermore, some clients have had to choose between housing and receiving BPHC benefits due to the HCBS Final Rule. For example, this quote was pulled from the focus groups into the CAHPS Final Report about the housing issue, "For some (sic) it's either BPHC or move…it's kind of like you either find housing that meets the criteria or you're possibly out of luck." Providers face additional challenges such as clients missing appointments or relying solely on their providers for transportation, making it difficult to fulfill administrative requirements and assess progress. Despite the challenges presented to them, providers highlighted success stories of clients who have benefitted from the program, showcasing its effectiveness and the gratitude both providers and clients have for the opportunities that it can offer for care and success. Overall, the focus groups had an emphasis on the complex interactions between program limitations, provider efforts, and client needs within the 1915(i)-program framework.

Client Experiences with Receiving Care

This section of the CAHPS report delved into client experiences with accessing care and highlighted several key points of needs, unmet needs, transportation challenges, and client challenges. Providers shared the varied needs of their clients, including mental health support, primary care, case management, medication assistance, and transportation. They emphasized the importance of establishing trusted relationships with clients to ensure their health needs are met effectively. Additional provider concerns included clients' unmet needs, such as access to dental, psychiatric, and specialist care. Many clients, especially those in rural areas, face challenges accessing specialists due to distance and frequent missed appointments. Almost all providers identified transportation as a major ongoing issue for their clients. Transportation emerged as a significant barrier, with providers consistently noting its sporadic availability and unreliability. This lack of consistent transportation can hamper clients' abilities to attend appointments, exacerbating their health concerns. The contrast between the consumers' positive ratings of transportation services could possibly be due to receiving transportation directly from their providers. Finally, providers shared that clients face difficulties in making and keeping appointments, often due to anxiety or difficulty understanding physician instructions, particularly among those with severe mental illness. Providers acknowledged the additional challenges posed by mental health conditions, including reduced functioning and trust issues with new providers. This theme underscores the multifaceted challenges clients encounter in accessing and navigating healthcare services, particularly related to transportation and mental health barriers.

Provider experiences with DMHA and DFR

These final sections outline provider experiences working with the Division of Mental Health and Addiction (DMHA) to address the needs of their 1915(i) clients, focusing on program strengths, areas for growth, provider wants, and experiences with the Department of Family Resources (DFR). Providers expressed gratitude for the BPHC program and generally find DMHA responsive to their needs, particularly for high-level program staff. They appreciated the quick communication regarding

application issues and corrections, highlighting DMHA's overall helpfulness and responsiveness. However, providers noted inconsistency in feedback received on applications, which frequently led to confusion and frustration. They suggested having a standardized template or syntax for applications to reduce their initial rejections. Consistent feedback is seen as crucial for smoother processes. Additional provider desires included improvements in the application process, such as better integration with Electronic Health Records (EHR) systems to reduce manual input. They also requested more frequent and accessible trainings on BPHC from DMHA to keep up with program updates and requirements. Finally, providers shared challenges in communicating with local DFR offices to get clients approved for BPHC. They reported instances of miscommunication and delays, with some DFR staff lacking understanding of the 1915(i) programs. Providers highlighted the impact on client care, including missed appointments due to ineffective communication methods. This section underscores the importance of effective communication, consistency in processes, and improved integration of systems to streamline the provision of care for clients.

Recommendations

Based on the analysis of the CAHPS Survey and Final Report, there are seven general areas of recommendations.

1. Consistency and standardization
2. Prioritization of communication between DMHA and providers
3. Improved integration between DMHA and EHR systems
4. Addressing transportation challenges
5. Specific group strategies
6. Improving FSSA interagency communication

For consistency and standardization, there needs to be efforts to standardize procedures and provide consistent feedback, especially in the application process. Developing standardized templates or application syntax can help reduce initial rejections and streamline the process for both providers and clients. Prioritization of enhanced communication from DMHA with providers and offer more frequent and accessible trainings will help providers stay updated on program requirements and improve their ability to serve clients effectively. The third recommendation is better integration between DMHA systems and EHR systems used by providers. This can reduce manual input and administrative burden, allowing providers to focus more on delivering care to clients. To address transportation challenges, efforts should be made to address the transportation challenges faced by clients, especially those in rural areas. Providing reliable and accessible transportation services can help ensure that clients can attend appointments and access necessary care without barriers. Focusing on client needs is the fifth recommendation. Providers should continue to prioritize understanding and addressing the diverse needs of their clients, including mental health support, primary care, case management, medication assistance, and transportation. Specific groups need targeted strategies to address disparities identified among different demographic groups, such as those based on rurality, race, and diagnosis. Targeted strategies may be needed to improve experiences and outcomes for groups facing lower satisfaction scores or unmet needs. Finally, the last recommendation is improving interagency communication. There needs to be improved communication between providers, DMHA, and DFR offices to ensure timely approvals and coordination of care for clients. Clear communication channels and protocols can help

prevent delays and misunderstandings that impact client care. By implementing these recommendations, stakeholders can work towards improving the overall effectiveness and efficiency of 1915(i) programs, ultimately enhancing the quality and accessibility of care provided to beneficiaries.

1915(i) SPA Evaluation Interviews

An inductive approach to content analysis was used to evaluate feedback from transcripts regarding the 1915(i)-waiver in Indiana. Findings are presented according to the following four overarching themes: 1) generalized identified barriers and facilitators to care from administrator perspective, 2) beneficiary experience with processes and educational resources from an administrator perspective, 3) administrator experience with processes and available support, and 4) services provided and client impact. Frequency of code application is displayed in Table 13. Code application and code definitions will be reported by theme.

Theme 1. Generalized identified barriers and facilitators to care utilization from administrator perspective

The first theme, “generalized identified barriers and facilitators to care utilization from administrator perspective,” is defined through responses from program administrators on barriers and facilitators to care, as well as care utilization, for beneficiaries of the 1915(i) waiver. Table 13 identifies codes and code definitions used to develop theme 1. The following exemplary quotes highlight responses to identified barriers and facilitators to accessing care for beneficiaries of the 1915(i) waiver noting specific barriers like transportation and training associated with new staff. Respondents identified concerns with staff and provider shortages, communication between facilities, along with barriers to transportation for beneficiaries of the 1915(i) waiver.

Table 13: Generalized Identified Barriers to Care Utilization from Administrator Perspective

Code	Code Definition	Code Frequency
Administrative barriers to meeting criteria	Ability of administrator to meet external criteria to provide services to clients (e.g., need 3 appointments where they receive BPHC services in 6'-'months and it's difficult to meet criteria)	16
Beneficiary eligibility '-' access services	eligibility to access services through the waiver	1
Beneficiary eligibility '-' enrollment	eligibility of beneficiary to enroll into the waiver	15
Capacity	Ability of administrator to provide services due to lack of available staff	43
Care coordination	Ability to coordinate care across providers	13

Improvement Recommendations	Administrator recommendations to improve beneficiaries access/utilization of services (i.e. hire more staff, enrollment process)	47
Provider eligibility	Eligibility of provider to provide services. Provider meeting certain criteria	2
Transportation barriers	Barriers identified by administrator to accessing reliable transportation (e.g., client not being able to access a bus due to living in a rural area)	53
Travel time	Time it takes for clients to travel to and from clinics	35
Barrier to continued care	Beneficiary loss to follow up (e.g., decompensation	96

Staff and provider shortages remained a primary concern for respondents across interviewed facilities,

"everyone's short-staffed in a lot of our communities… Medicaid CAHPS… Medicaid CAHPS have been short staffed."

Other respondents noted turnover with FSSA disrupting patient care,

"oftentimes when we're following up, you know, FSSA, they have frequent turnover as well. So, we'll be calling in to follow up on a BPHC application and we'll have someone ask us like, what is that? I've never heard of that. So, then we're trying to not only educate FSSA on what our application we're applying for, but also trying to make sure they have everything they need. And then it just delays the process."

Delay in care for patients receiving the 1915(i)-waiver can lead to more complicated and severe health concerns. Additionally, respondents expressed frustration with the inability of facilities and systems to effectively communicate,

"everybody's speaking a different language. It's a terminology right? And so, um, you know, the way that FSSA looks as, you know, DFR pending and conditional and all of those things, like as a mental health provider or administrator, you're having to learn, um, you know, way of terminology and, and looking at those things that we don't have any training on."

Given the rurality of Indiana paired with unreliable or non-existent public transportation, many respondents noted this as a primary barrier to receiving care for clients ultimately costing time and money,

"their one-hour appointment could be a six-hour ordeal." One respondent noted, "Medicaid pays for people's transportation. You could get, um, some services from them and they contract with private companies to provide that. And that's very unreliable."

Inconsistencies and unavailability of transportation paired with inconsistencies and complexity of accessing the 1915(i)-waiver services further exacerbates the negative impact of clients,

"they're renewed, but again, they're confused why they have to do it every six months. But yet, Medicaid isn't every six months. Medicaid is every year or two years, or whatever it is. So, there's that discrepancy as well. I mean, we could renew, we could fail to renew their BP application and they could continue to have Medicaid for an additional, you know, amount of time. So, it doesn't really line up and make sense with the eligibility period."

Given the complexity and factors outside BPHC (e.g., disability, financial, household size, etc.) the determine DRF determination for Medicaid eligibility, further refinement of processes for eligibility of both the facility and client, along with support and training of staff across facilities is recommended.

Theme 2. Beneficiary experiences with processes and education resources from administrator perspective

The second theme, "beneficiary experiences with processes and education resources from administrator perspective," has been defined as the administrator experience with enrollment and training processes for both staff and beneficiaries of the 1915(i)-waiver. Table 14 identifies codes and code definitions used to develop theme 2. Exemplary quotes have been used to highlight primary findings which included identification of initial training, a call for more advanced training opportunities, and improved efficacy of enrollment communication with clients.

Table 14: Beneficiary experiences with processes and education resources from administrative perspective

Code	Code Definition	Code Frequency
Admin experience with grievance / appeals '-' favorable	indicate a score x>3	5
Admin experience with grievance / appeals '-' unfavorable	indicate a score x<3	3
Communication of enrollment status	Ways enrollment status is communicated with beneficiary (e.g., receiving a notice in the mail they have lost coverage)	3
Administrator Training / Education	education and training staff receives on the waiver program	36
Understanding	Beneficiary ability to understand (i.e., processes, enrollment status, etc.)	12

Beneficiary eligibility '-' enrollment	eligibility of beneficiary to enroll into the waiver	15
Client / Beneficiary education	Educational resources provided by facility regarding the 1915(i) waiver (i.e., waiting room materials, brochures, etc.)	31
Enrollment process for beneficiaries. '-' favorable	indicates a score x>3	9
Enrollment process for beneficiary. '-' unfavorable	indicate a score x<3	5
Enrollment barriers	Barriers associated with getting beneficiaries enrolled in the waiver program (from beneficiary perspective)	35

Many respondents reported initial training during the new employee onboarding process, as well as self-identifying as individuals who were present during the rollout of the 1915(i)-waiver program:

"my agency does training, like every new employee has to go through a separate training specifically for BPHC. They learn about the program, they learn about the requirements. Um, we give them like a, a list of examples of services that they can do. Um, on that, my spec, I'm the coordinator for the program, for my agency. My contact information is there. Um, when they start doing their notes, we review the notes to make sure that they know what they're doing. Um, and, you know, we do re-training whenever we need to make sure that they're doing what the clients need"

However, others reported fewer substantive resources,

"all we really have access to is the, like PowerPoints and documents that are on your website, which is very few,"

with another stating,

"it's not like FSSA comes in and says, let's give you this training so that you can better understand our system. And we don't have that. So, we have to figure it out ourselves."

Worth noted, these statements refer to a barrier with CMHC leadership, which limits DMHA engagement with CMHC staff. Given the intricacies of the 1915(i)-waiver and unique healthcare needs associated with beneficiaries, it remains imperative that ongoing training is available for administrators to provide equitable resources to 1915(i)-waiver beneficiaries.

Similarly, beneficiary population specific training should be provided. One respondent explained, “the complexities of the process, um, that our staff experience as administrators looking at it and trying to translate that information into easily understandable information for our clients who struggle with many different things.” Furthermore, it remains imperative to provide resources for staff and administrators to effectively communicate service need, requirements, and utilization with clients:

“it's very difficult to explain to them. So sometimes we have gotten resistant because they don't really understand why they have to meet with us again. Yeah. You know, they have a hard time connecting the roles between their direct care provider and then the person doing their application. And then, you know, all how it all connects together, the reapplication of Medicaid. Um, it's a, it's hard. It's a hard concept for them to grasp.”

Also,

“FSSA, um, that a lot of their frontline, um, employees that are registered and accepting these applications don’t just seem to be as familiar with the waiver or understand that when we talk about BPHC or AMHH.”

Further illustrating the necessity for clarity, training, and effective communication between systems working within the 1915(i)-waiver program.

Ultimately several respondents discussed the need for creating more efficient and effective ways to communicate with clients and get them enrolled into the appropriate services,

“if they can make that application process a little shorter so it’s not so cumbersome for client and staff and maybe they could streamline the ISP that, you know, uh, providers have. Well, it can be maybe loaded up in the system so we’re not duplicating.”

Additionally, providing plain language guides and resources for clients to better understand the enrollment process is recommended,

“our clients are the ones receiving full printouts on, um, required paperwork from FSSA and, you know, determinations on their AMHH, BPHC, or traditional Medicaid status, which they struggle to understand what most of that means.”

Additional training for administrators and staff on eligibility criteria and enrollment processes is recommended.

Theme 3. Administrator experiences with processes and available support

The third theme, “administrator experiences with processes and available support,” aimed to explain the relationship between support provided to administrators and processes related to enrollment of beneficiaries. Table 15 identifies codes and code definitions used to develop theme 3. The following statements from respondents indicate a lack of structural and financial support for administrators.

Table 15: Administrator experiences with processes and available support

Code	Code Definition	Code Frequency
Admin Support '-' Favorable	Lack resources available to support administrators in providing care to clients (scale x>3)	4
Admin Support '-' Unfavorable	Lack resources available to support administrators in providing care to clients (scale <3)	2
Administrator burden	Over utilization of administrator resources (i.e., duplication of work)	104
Enrollment process for admin. '-' favorable	indicated a high score of x>3	5
Enrollment process for admin. '-' unfavorable	indicated a score x<3	7
Recommendations '-' QA / Corrective Action Plans	Recommendations made to improve QA/CAPs from admin perspective	40
Communication	Process facilitators / barriers that relates specifically to communication between (e.g., BPHC / AMHH and FSSA)	13

A primary frustration for administrators includes the auditing process and excessive documentation requirements,

“that's just frustrating when, you know, you're trying to manage all of these challenges of documentation as a community mental health center and then to have the additional audits, um, where you're constantly having then to do, you know, corrective action or, you know, it's just, it's a lot.”

One respondent mentioned the feeling that the requirements for documentation and auditing procedures are detached from the initial purpose of the program itself,

“some of those requirements, those administrative requirements feel slightly detached from what the intent of the program was.”

This indicates a lack of communication with administrators who complete the processes and FSSA.

Furthermore,

"at each DMHA audit, it seems like they change some of the rules or what they're looking at. So you're constantly trying to pivot and, um, and fine tune a system that you thought you were doing everything correctly. But then, you know, you go through an audit and there's, there's always something. And, um, so that's just kind of frustrating."

Additional burden on administrators further reduces access and quality of services able to be provided to clients. Another respondent noted,

"we're underfunded and, um, you know, that's hard to then, for staffing and, um, and that impacts care."

Billing issues emerged during discussions as well,

"making some things billable that aren't? So the evaluation for AMHH isn't billable and I, I told the other gentleman that I had met with from the state, um, there is a lot of administrative burden to signing people up for these programs. Um, you know, lots of questions that if you're an evaluator that has never met the person before, you need to gather a lot of information either in person in that evaluation that's non-billable or from other providers that's taking their time. And that also is non-billable. Um, so I think that is a, um, a big barrier, especially with a workforce shortage."

The inability of providers and facilities to bill for services provided remains a primary concern. Ultimately the goal of the 1915(i)-waiver is to increase access and improve quality care, without the necessary funding this goal cannot be met. At present, initial applications for both programs are not billable, it is recommended that this be amended to allow for retroactive payment for services.

Theme 4: Services provided and client impact

The fourth and final theme, "services provided and client impact," discusses the overall impact on client's ability to access care. Table 16 identifies codes and code definitions used to develop theme 4. Given that the purpose of this waiver is to increase access, it remains crucial to mitigate restrictions and reduce barriers to beneficiaries of the 1915(i)-waiver. Respondents identified specific burdens for clients, as well as specific services provided.

Table 16: Services provided and client impact

Code	Code Definition	Code Frequency
Beneficiary burden	Physical or emotional stressors of waiver beneficiaries from processes (i.e., the effects of enrollment eligibility, appeals process, accessing services)	6
Facilitators to receiving services	Support or support services provided to clients from CMHCs (administrator or provider support, patient navigator)	10
Process recommendations	Recommendations from administrators on how to improve enrollment processes	27

Recommendation '-' Process barriers	Systematic processes that prevent or delay enrollment into the waiver program	1
Recommendation '-' waiver services	Administrator recommendations on additional services that could / should be provided (e.g., ADLs)	7
Process strength	Processes currently in place to support either administrator or client	88
Services Provided	services provided by facility to beneficiaries	23
Transportation	Identification of types of transportation available and/or utilized by clients	9
Transportation utilization	Description of client transportation utilization to commute to and from clinics	53

The complexity of the 1915(i)-waiver impedes client ability to effectively navigate services provided by facilities throughout the state of Indiana,

"some of the requirements just make it a lot of hoops that both the organization, the program, and then individual have to walk through in order to achieve that access."

One respondent noted the direct impact the 1915(i)-waiver has on clients,

"we're able to capture a population of people that are really in need of this, um, and would not be otherwise able to access the, you know, the level of life skills and case management and, um, kind of care coordination that they need to, to stay alive and well."

The care provided by these facilities produces life-long results through skill development and care-coordination when available. Ensuring services continue and include comprehensive and equitable access remains imperative.

Office of Medicaid Policy and Planning (OMPP) Reports

Both AMHH and BPHC are evaluated according to the following Office of Medicaid Policy & Planning (OMPP) Requirements, Sub-Requirements, and Performance Measures (PM):

- **Requirement 1: Service Plans - a) address assessed needs of 1915(i) participants; b) are updated annually; c) document choice of services and providers.**
    - Sub-requirement 1a: The state must demonstrate that service plans address assessed needs of 1915(i) participants.
    - Sub-requirement 1b: Service plans are updated annually.

    - Sub-requirement 1c: Service plans document the 1915(i) participant's choice of services and providers.
- **Requirement 2: Eligibility Requirements - a) an evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately, and; c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**
    - Sub-requirement 2a: An evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
    - Sub-requirement 2b: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.
    - Sub-requirement 2c: The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.
- **Requirement 3: Qualified Providers - Providers meet required qualifications.**
- **Requirement 4: Home and Community Based Settings Requirements - Settings meet the home and community-based settings requirements as specified in this State Plan Amendment (SPA) and in accordance with 42 CFR 441.710(a)(1) and (2).**
- **Requirement 5: Administrative Authority - The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight.**
- **Requirement 6: Financial Accountability - The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
- **Requirement 7: Incidents of Abuse, Neglect, and Exploitation - The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

Each requirement has at least one sub-requirement and these sub-requirements are evaluated via performance measures (PMs). The compliance percentages for these PMs need to remain at or above the 86% threshold to remain compliant. These percentages indicate whether the state has successfully demonstrated the requirement. BPHC and AMHH have different performance measures associated with each requirement.

Adult Mental Health Habilitation (AMHH)

This section outlines the areas in which the state successfully and unsuccessfully demonstrated the OMPP requirements for the AMHH benefit. According to a CMS Final Report, the state successfully demonstrated Requirements 2 through 6 but failed to demonstrate compliance of Requirements 1 and 7, between benefit years (BYs) 1 and 3. The final documentation for Year 4 and Year 5 is not comprehensive. They are both missing data for Requirements 5 and 6 and at the time of data collection, Year 5 only contained the first two quarters of data. After comparing each individual OMPP quarterly report, the annual report, and the CMS Final Report, only a couple concerns arose. While the data

matched across documentation, the quarterly and annual reports provided were consistently missing data for different requirements that were reported in the CMS Final Quality Report.

Requirement 1: Service Plans

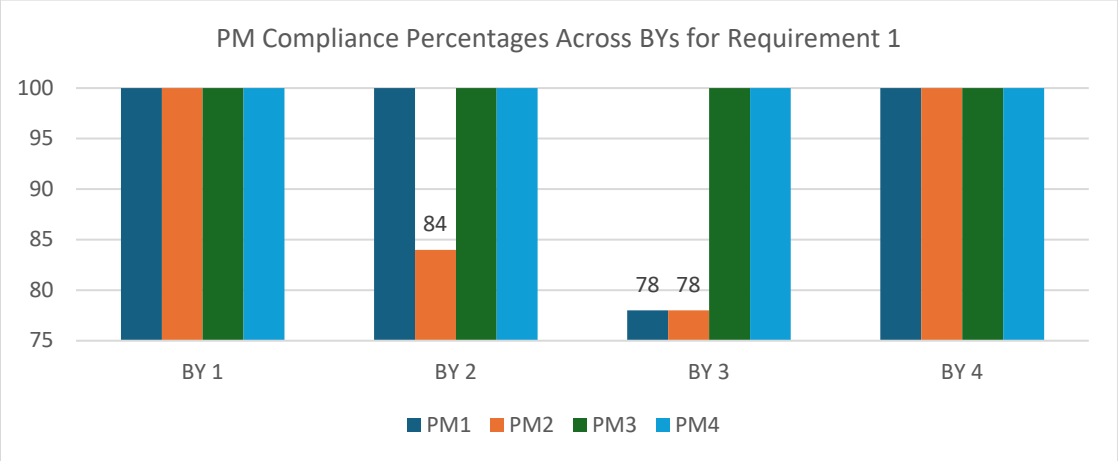
Service plan compliance was assessed utilizing three sub-requirements and their corresponding PMs. PMs were not numbered in the original final Centers for Medicare and Medicaid Services (CMS) report, so the Purdue team numbered them (and changed some existing numbering) for the purposes of this report (Table 17).

Table 17: PMs of each Sub-Requirement for Service Plans

Sub-Requirement	Performance Measure
1a: The state must demonstrate that service plans address assessed needs of 1915(i) participants	PM1: Number and percent of IICPs that address recipient's needs
1b: Service plans are updated annually	PM2: Number and percent of IICPs reviewed and revised as warranted on or before annual review date
1c: Service plans document the 1915(i) participant's choice of services and providers	PM3: Number and percent of recipients with documentation of choice of eligible services
	PM4: Number and percent of recipients with documentation of choice of providers

The state did not successfully demonstrate this requirement, primarily because it did not demonstrate sub-requirement 1b (Figure 6). In PM2, the state's compliance began at 100% in BY1, but dropped to 78% in BY3. The explanation for the drop in BY2 from Indiana Medicaid is that the performance measure in the SPA was not accurately reflected on their reporting tool, so incorrect data was captured. Indiana Medicaid is unsure when the change in PM occurred and of the duration of the incorrect reporting tool and data collection occurred. However, Indiana Medicaid has since resolved the issue, which can be reflected in BY4. Additionally, in BY3, four applications were automatically renewed that were not up to standard to ensure those people did not lose coverage or experience a lapse in coverage during the public health emergency. After these two incidents, PM2 increased to 100% compliance in BY4 and remained at 100% for the first two quarters in BY5.

Figure 6: Requirement 1 Compliance Trends - AMHH



Sub-requirements 1a and 1c were both successfully demonstrated, but it is worth noting that PM1 experienced a drop in compliance in BY3, from 100% to 78%. This decline was due to auto-renewals of benefits and the public health emergency. Additionally, because BYs 1 and 2 had 100% compliance, the state was found to adequately demonstrate Sub-requirement 1a. PM1 experienced an increase in compliance to 100% in BY4 and remained at 100% compliance in the first half of BY5. For sub requirement 1c, PMs 3 and 4 both maintained compliance percentages of 100% across BYs 1 through 4, and through Q1 and 2 of BY5.

Requirement 2: Eligibility Requirements

This requirement was assessed utilizing three sub-requirements and their corresponding PMs (Table 18).

Table 18: PMs of each Sub-Requirement for Eligibility Requirements

Sub-Requirement	**Performance Measure**
2a: An evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future	PM5: Number and percent of IICPs reviewed and revised as warranted on or before annual review date
2b: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately	PM6: Number and percent of Adult Needs and Strengths Assessment (ANSA)s that were completed according to policy
2c: The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequently, as specified in the approved state plan for 1915(i) HCBS	PM7: Number and percent of AMHH re-evaluations conducted

The state successfully demonstrated Requirement 2. For all Sub-requirements, there was no data reported for BY1, because the reporting template being used at that point was missing PMs. However, for the remainder of the data, percentages remained at 100% compliance for all PMs across the BYs 2, 3, and 4, and in Q1 and 2 of BY5.

Requirement 3: Qualified Providers

This requirement was assessed utilizing the following requirement and its corresponding PMs (Table 19).

Table 19: PMs of each Sub-Requirement for Qualified Providers

Performance Measure
PM8: Number and percent of provider agencies that meet qualifications at time of enrollment
PM9: Number and percent of provider agencies recertified timely

The state successfully demonstrated Requirement 3 and maintained a compliance percentage of 100% for both PMs across all four BYs. Compliance remained at 100% for Q1 and 2 of BY5.

Requirement 4: Home and Community Based Settings Requirements

The fourth requirement was assessed utilizing the following requirement and its corresponding PM (Table 20).

Table 20: PMs of each Sub-Requirement for HCBS Settings

Performance Measure
PM10: Number and percent of settings in compliance with criteria that meet standards for community living

The state successfully demonstrated Requirement 4. The state did not report any data for BY1 due to the reporting template missing PMs but maintained a compliance percentage of 100% for PM10 across BYs 2 through 4. Compliance for PM10 remained at 100% for Q1 and 2 of BY5.

Requirement 5: Administrative Authority

Administrative Authority was assessed utilizing the following requirement and its corresponding PM (Table 21).

Table 21: PMs of each Sub-Requirement for Administrative Authority

Performance Measure
PM11: Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight

The state successfully demonstrated Requirement 5 and maintained a compliance percentage of 100% for PM11 across all three BYs. Requirement 5 compliance data for BY4 and 5 is missing from the final reports, which is why these values cannot be included in this report.

Requirement 6: Financial Accountability

This requirement was assessed utilizing the following requirement and its corresponding PMs (Table 22).

Table 22: PMs of each Sub-Requirement for Financial Accountability

Performance Measure
PM12: Number and percent of 1915(i) claims paid during the review period according to the published rate
PM13: Number and percent of 1915(i) claims paid during the review period for recipients enrolled in the 1915(i) program on the date the service was delivered

The state successfully demonstrated Requirement 6. For PM12, the state reported compliance percentages of 96%, 98%, and 98% for BYs 1, 2, and 3, respectively. For PM13, the state maintained a compliance percentage of 100% across BYs 1-3. Requirement 6 compliance data for BY4 and 5 is missing from the final reports, which is why these values cannot be included in this report.

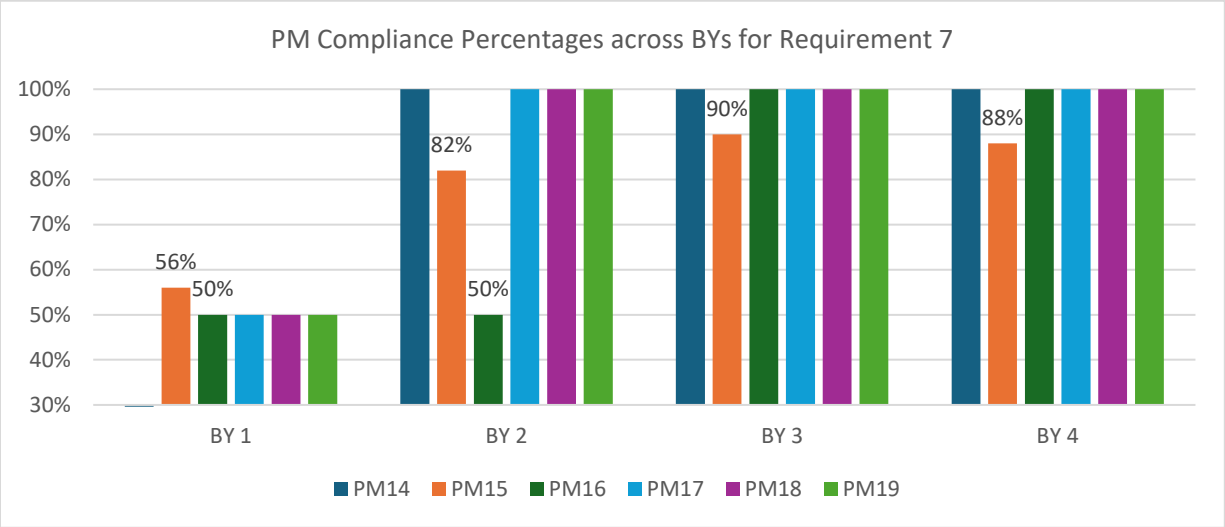
Requirement 7: Incidents of Abuse, Neglect, and Exploitation

This Requirement was assessed utilizing the following Requirement and its corresponding PMs (Table 23). For PMs 15, 16, 17, 18, and 19, the state did not meet the 86% compliance threshold at some point within the three BYs.

Table 23: PMs of each Sub-Requirement for Incidents of Abuse, Neglect, and Exploitation

Performance Measure
PM14: Number and percent of IICPs that address health and welfare needs of the recipient
PM15: Number and percent of incidents reported within required timeframe
PM16: Number and percent of reports for medication errors resolved according to policy
PM17: Number and percent of reports of seclusions and restraints resolved according to policy
PM18: Number and percent of reports for abuse, neglect, and exploitation resolved according to policy
PM19: Number and percent of incidents for abuse, neglect, and exploitation that required a corrective action plan

Figure 7: Requirement 7 Compliance Trends – AMHH



The state did not successfully demonstrate Requirement 7. For PM 14, data was not reported for BY1 which is why there is no data shown for this year in Figure 7. However, through BYs 2, 3, and 4, the state maintained 100% compliance. For PMs 15, 16, 17, 18, and 19, the state did not meet the 86% compliance threshold at some point within the three BYs. For PM15, the state reported 56% compliance for BY1, which then increased to 82% in BY2, to 90% in BY3, and then decreased to 88% in BY4. For PM16, the state reported 50% compliance in BYs 1 and 2, followed by an increase to 100% in BYs 3 and 4. For PMs 17, 18, and 19, the state reported 50% compliance for BY1, followed by an increase to 100% for all three PMs, across BYs 2, 3, and 4. PMs 17 and 18 are not visible in Figure 7 because they follow the same trend as PM19. All PMs for Requirement 7 are at 100% compliance for Q1 and 2 of BY5.

Recommendations

Drops in compliance for Requirement 7 are primarily due to medication errors and service plans, which need to include health and safety risks. It is recommended that the state continue to monitor any incidents and ensure they meet standards that address the health and safety of clients and that medication errors have been mitigated. Additionally, it is recommended that Indiana Medicaid keeps a more comprehensive documentation in their quarterly and annual OMPP excel sheets to allow for independent and internal quality evaluations.

Behavioral and Primary Healthcare Coordination (BPHC)

This section outlines whether the state demonstrated the OMPP Requirements for the BPHC benefit for each Benefit Year (BY). According to the CMS Final Report, the state successfully demonstrated all Requirements for BYs 1 through 3. After comparing each individual OMPP quarterly report for BY1, BY2, and BY3 and the CMS Final Report, the quarterly reports provided were consistently missing data for Requirements 5 and 6, which were reported in the CMS Final Quality Report. Some discrepancies in the percentage of compliances were found between the CMS Final Report and the quarterly reports with about a 1% difference between data sources. For the purposes of this section, all graphs include measurements from the CMS Final report and discrepancies are noted. Furthermore, due to BY4 not being complete at the time of this evaluation, only Q1, Q2, and Q3 of BY4 will be reported.

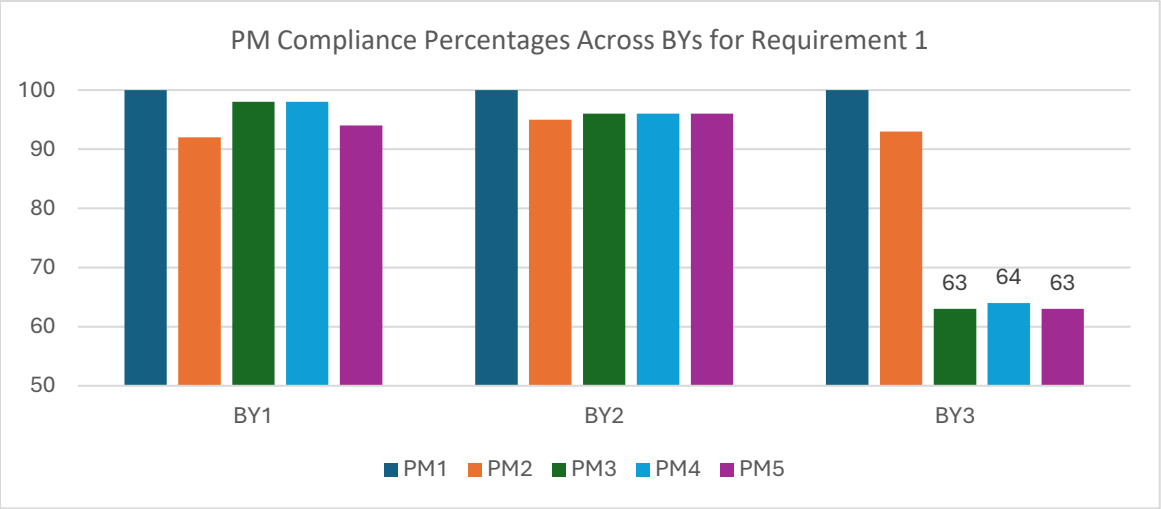
Requirement 1: Service Plans

Service plan compliance was assessed utilizing three sub-requirements and five performance measures (Table 24).

Table 24: PMs of each Sub-Requirement for Service Plans

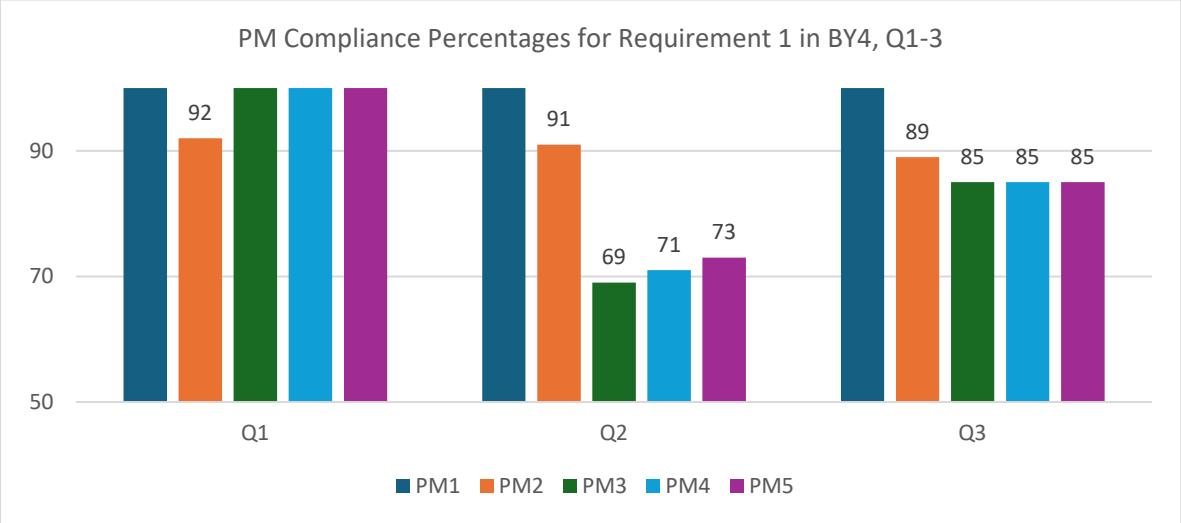
Sub-Requirement	**Performance Measure**
1a: The state must demonstrate that service plans address assessed needs of 1915(i) participants.	PM1: Number and percent of IICPs that address recipient needs.
1b: Service plans are updated annually.	PM2: Number and percent of IICPs reviewed and revised on or before the IICP review date.
1c: Service plans document the 1915(i) participant's choice of services and providers.	PM3: Number and percent of recipients with documentation of choice of eligible services.
	PM4: Number and percent of recipients with documentation of choice of providers.
	PM5: Number and percent of clients or legal guardians that were offered a copy of the completed IICP.

Figure 8: Requirement 1 Compliance Trends – BPHC



The state successfully demonstrated Requirement 1. As shown in Figure 8, PM1 maintained 100% compliance BY1-BY3. However, PMs 3 through 5, dropped to less than 70% in BY3. The state implemented a Corrective Action Plan (CAP) to help remediate these issues. The current data for BY4 shows the average for PM3 is 84.7%, the average for PM4 is 85.3%, and the average for PM5 is 86%. Specific changes in the compliance percentages per quarter in BY4 are shown in Figure 9. Despite the improvements in Q3 of BY4, the current averages for PMs 3 and 4all remain below the 86% compliance threshold. It is recommended that the state continue to monitor compliance percentages and ensure standards are appropriately met.

Figure 9: Requirement 1 Compliance Trends in BY4, Q1-3 – BPHC



Furthermore, some discrepancies were found between the CMS Final Report and the BY1 quarterly report. Specifically, for PM4, the CMS final report indicated 98% compliance, but the 4th quarter report for BY1 indicated an annual summary of 99%. Full record-keeping of each PM and detailed quality assurance is recommended to help prevent this issue.

Requirement 2: Eligibility Requirements

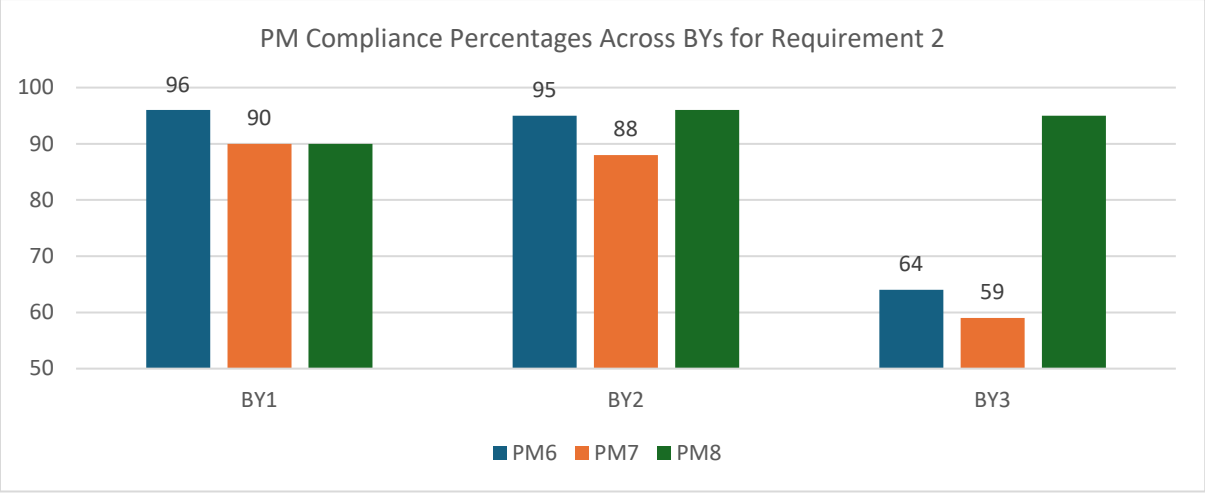
This requirement was assessed utilizing three sub-requirements and three PMs (Table 25).

Table 25: PMs of each Sub-Requirement for Eligibility Requirements

Sub-Requirement	Performance Measure
2a: An evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.	PM6: Number and percent of new applicants who had a face-to-face evaluation for BPHC eligibility prior to enrollment.
2b: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.	PM7: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.
2c: The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.	PM8: Number and percent of enrolled individuals re-evaluated at least bi-annually or more frequently, as specified in the approved 1915(i) benefit.

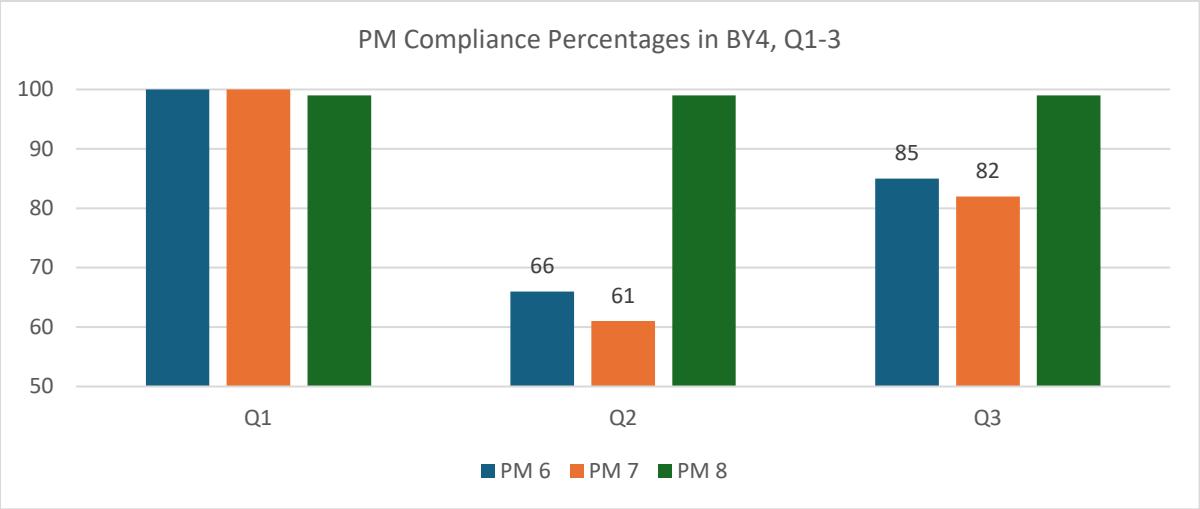
The state successfully demonstrated Requirement 2. PM8 remained above 86% across all years, however, PMs 6 and 7 dropped to 64% and 59% in BY3, respectively. These percentage changes can be seen in Figure 10. It appears there was a sudden change in how the processes and instruments in the SPA determining eligibility were either measured or applied, which could have had an influence on PM8. The state implemented CAPs to bring the compliance percentages back to an acceptable level.

Figure 10: Requirement 2 Compliance Trends – BPHC



Despite the CAPs, PMs 6 and 7 remain below the 86% threshold in the third quarter of BY4. The current average for PM6 in BY4 is 83.7% and the average for PM7 is 81%. PMs 6 and 7 experienced increases in compliance to 100% in Q1. They both dropped in Q2 and then experienced an increase again in Q3. Because these percentages still fall below the 86% threshold, it is recommended that the state continue to monitor compliance percentages and implement a new CAP strategy to address the issues. Specific changes for each PM are shown in Figure 11.

Figure 11: Requirement 2 Compliance Trends in BY4, Q1-3 - BPHC



For PM8, the BY1 quarterly report did not match the CMS Final Report. More specifically, the 4th quarter report indicated 91% compliance, while the CMS final report indicated 90% compliance. Like previous recommendations, it is suggested that complete documentation is kept for all time periods.

Requirement 3: Qualified Providers

This requirement was assessed utilizing the two PMs, as shown in Table 26.

Table 26: PMs of each Sub-Requirement for Qualified Providers

Performance Measure
PM8: Number and percent of provider agencies who meet qualifications
PM9: Number and percent of provider agencies recertified timely

The state successfully demonstrated Requirement 3 and maintained a compliance percentage of 100% for both PMs across all BY1-3. Compliance remained at 100% for Q1, 2, and 3 of BY4.

Requirement 4: Home and Community Based Settings Requirements

The fourth requirement was assessed utilizing the following requirements and its corresponding PM (Table 27).

Table 27: PMs of each Requirement for HCBS Settings

Performance Measure
PM11: Number and percent of provider owned, controlled, and operated residential settings in compliance with criteria that meets standards for community living.

The state successfully demonstrated Requirement 4 and maintained a compliance percentage of 99% for the PM across all years. Current data for BY4 shows compliance increased to an average of 100%.

Requirement 5: Administrative Authority

Administrative authority was assessed utilizing the following requirement and its corresponding PM.

Table 28: PMs of each Sub-Requirement for Administrative Authority

Performance Measure
PM12: Number and percent of performance measure data reports from DMHA and contracted entities that were provided timely.
PM13: Number and percent of performance measure data reports from DMHA and contracted entities that were provided in correct format.

According to the CMS Final Report, the state successfully demonstrated Requirement 5 and maintained a compliance percentage of 100% for both PMs across BY1-3. Requirement 5 compliance data is missing from most quarterly reports for BY1-3, which is why BY1-3 values cannot be confirmed, and BY4 values cannot be included in this report.

Requirement 6: Financial Accountability

This requirement was assessed utilizing the following requirement and its corresponding PMs (Table 29).

Table 29: PMs of Requirement for Financial Accountability

Performance Measure
PM14: Number and percent of claims paid according to the published rate during the review period.
PM15: Number and percent of claims paid during the review period for recipients enrolled in the program on the date the service was delivered.

The state successfully demonstrated Requirement 6. For both PMs, the state maintained a compliance percentage of 100% across BY1-3. Requirement 6 compliance data is missing from the internal quarterly reports for BY1-3, which is why BY1-3 values cannot be confirmed, and BY4 values cannot be included in this report.

Requirement 7: Incidents of Abuse, Neglect, and Exploitation

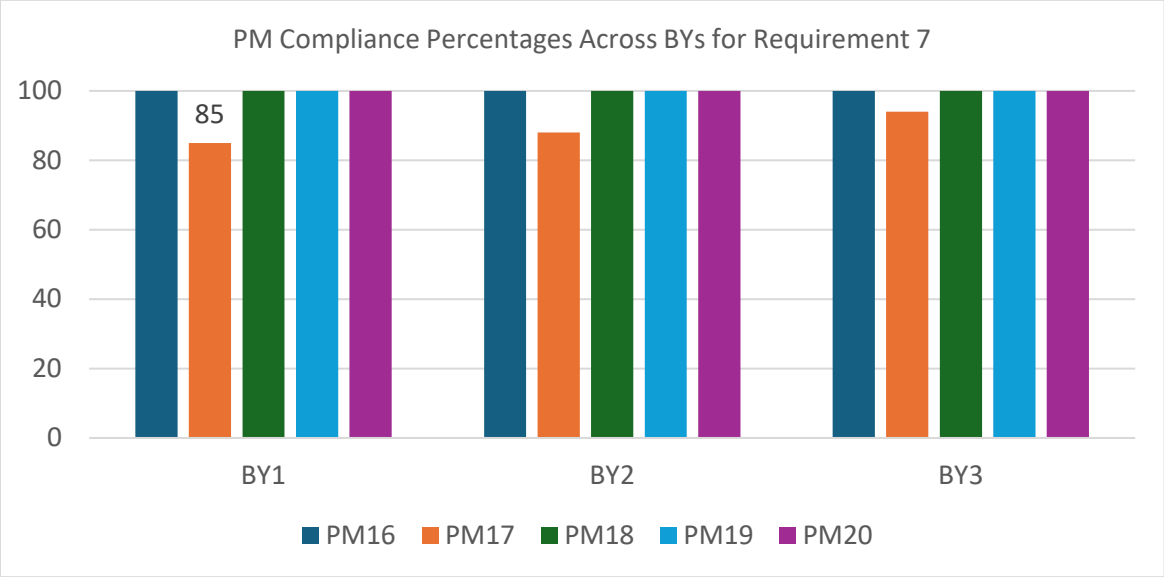
This requirement was assessed utilizing corresponding PMs, as shown in Table 30.

Table 30: PMs of each Sub-Requirement for Critical Incidents

Performance Measure
PM16: Number and percent of provider agencies who have policies and procedures to prevent incidents of abuse, neglect, exploitation.
PM17: Number and percent of incidents reported within required timeframe.
PM18: Number and percent of incident reports involving medication errors resolved according to policy.
PM19: Number and percent of incident reports involving seclusions and restraints resolved according to policy.
PM20: Number and percent of incident reports involving death resolved according to policy.

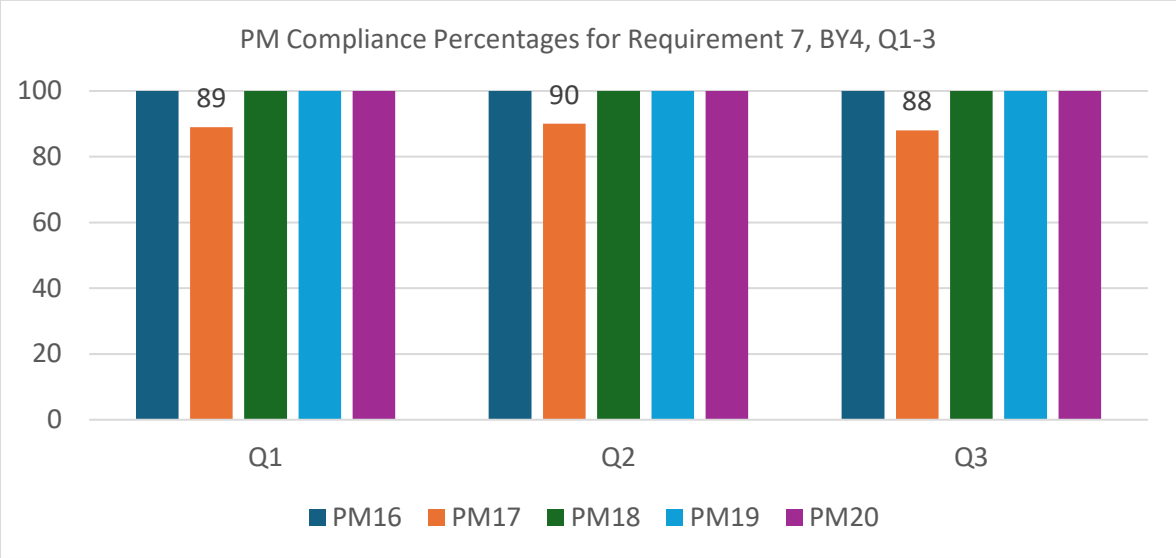
The state successfully demonstrated Requirement 7. As shown in Figure 12, PMs 16, 18, 19, and 20 maintained a compliance percentage of 100% across BY1-3. PM17 started at 85% in BY1, followed by increases to 88% and 94% in BY2 and BY3, respectively. Based on these percentages, it is indicated that CMHCs can struggle with reporting incidents within the current required timeframe.

Figure 12: Requirement 7 Compliance Trends – BPHC



In BY4, PMs 16, 18, 19, and 20 remained at 100% compliance throughout Q1, 2, and 3, as shown in Figure 13. PM17 experienced a decrease to 89% in Q1, followed by an increase to 90% in Q2, and a decrease to 88% in Q3. Although compliance percentages fluctuate for PM17, they remain above the 86% threshold.

Figure 13: Requirement 7 Compliance Trends for BY4, Q1-3 – BPHC



Recommendations

Like AMHH recommendations, it is suggested that Indiana Medicaid keeps a complete, comprehensive documentation in their quarterly and annual OMPP Excel sheets to allow for independent and internal quality evaluations.

Provider Directory

This section focuses on the analysis of the publicly available provider directory, which informs users of approved providers for the 1915(i) services. The provider directory was last updated on the FSSA websites for both AMHH and BPHC on December 18, 2019. Overall, the provider directory contains mostly accurate information. However, there have been updates made to specific CMHC names as well as which services they are approved to provide. For example, Grant Blackford Mental Health Inc. merged with Family Service Society, Inc. in late 2022 and it now operates under the name, 'Radiant Health'. This is not reflected in the provider directory and should be updated to accurately reflect the current operating names of each CMHC. Additionally, Gallahue Mental Health Center, Community Howard Regional Health, and Regional Mental Health Center show that they are only approved to provide BPHC services. When asked to FSSA, it was determined that these three CMHCs can provide both AMHH and BPHC services. This can confuse potential SPA program recipients, providers, and other stakeholders and needs to be updated. Another issue discovered is that when the phone number for Gallahue Mental Health Center is searched, Community Howard Regional Health is the CMHC shown to be associated with that phone number. However, when the phone number listed for Community Howard Behavioral Health Services is searched, the user is brought to a completely different website than the one previously found. The final issue discovered during this review was that only 91 counties are listed as being served in the provider directory when all 92 Indiana counties are supposed to be served by the contracted CMHCs. The missing county in the list is Randolph County.

Recommendations

It is recommended that FSSA go through all 24 approved CMHCs to update names, counties served, approved service designations, and phone numbers as well as add addresses for each location and the best URL link for each CMHC. Another high-priority recommendation is to investigate which CMHC is supposed to be serving Randolph County and where beneficiaries are receiving care. Currently, the provider directory is not considered accessible to the public. These issues can make enrollment into the 1915(i) programs more difficult and confusing for potential beneficiaries and their family members. It is also encouraged by this team that CMHCs list AMHH and BPHC as services provided on their respective websites.

Claims

Demographics

The Indiana Medicaid claims dataset that was analyzed contained years 2017 through 2023 and was subset into two groups: adult 1915(i) program beneficiaries (on AMHH or BPHC programs) and control participants (meet clinical definition of adult 1915(i) programs and age requirement but not on AMHH or BPHC during the calendar year). The final master dataset had 4,864 unique beneficiaries for the adult 1915(i) programs and 527,997 unique beneficiaries for the control group in all seven years. On average,

there were 2,388 individuals in the adult 1915(i) programs group program in any given year and 177,131 in the control group. The specific number of people in each group by year is listed in Table 31.

Table 31: Number of Beneficiaries in Group by Year

	2017	2018	2019	2020	2021	2022	2023
Adult 1915(i) Program Beneficiaries	2,678	2,835	2,851	2,900	2,790	2,665	2,404
Control Group Beneficiaries	159,810	168,583	170,929	190,322	220,144	251,237	222,725

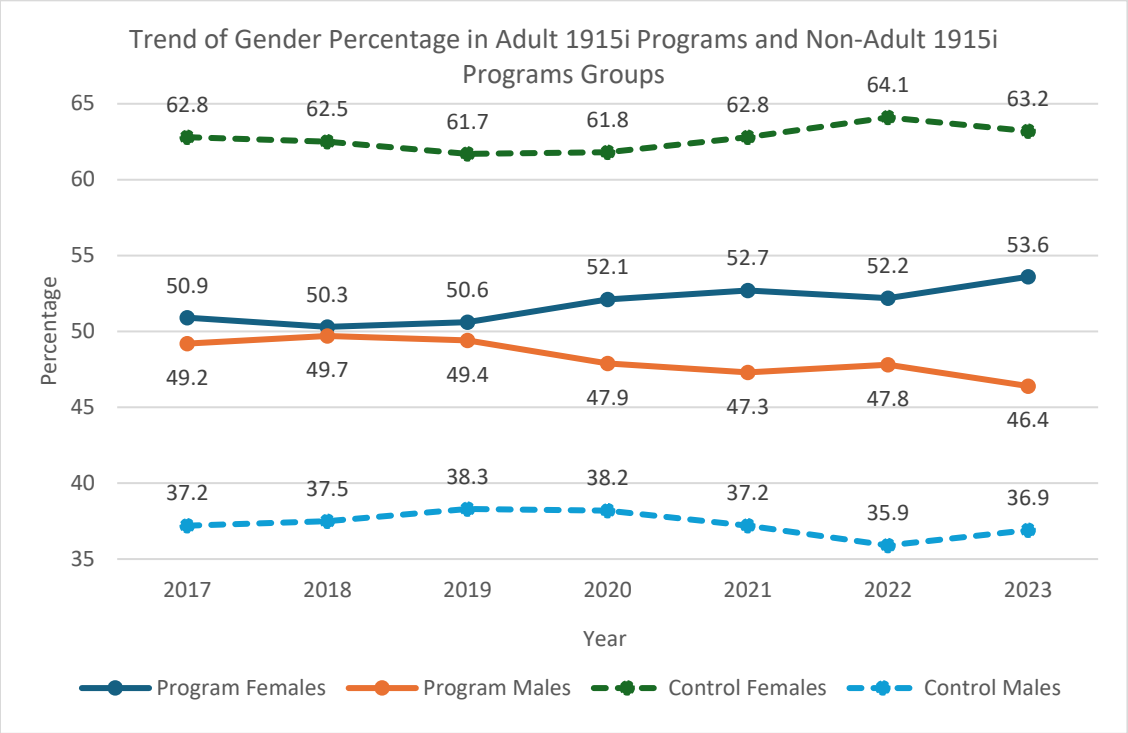
In the adult 1915(i) programs group, the average age for all combined years was 56, while the control group had a statistically younger average of 42.44 years (*p-value* < 0.05). From 2017 to 2023, there was an increased gender gap in the number of females being diagnosed with an SMI/SUD. In 2023, the females comprised 53.60% of the adult 1915(i) programs group and 63.15% of the control group. Figure 14 provides a visual representation of the gap between females and males. For both groups, the most common race/ethnicity was White, Non-Hispanic, followed by Black, Non-Hispanic. More complete details about the demographic makeup of the adult 1915(i) programs and control beneficiaries are listed in Table 32.

Table 32: Demographics of Programs Group and Control Group Beneficiaries

	2017	2018	2019	2020	2021	2022	2023
Adult 1915(i) Program Beneficiaries							
Age (mean)	54.88	55.21	55.65	56.41	57.16	57.73	58.48
Sex (%)							
Female	50.85	50.30	50.64	52.07	52.74	52.18	53.60
Male	49.15	49.70	49.36	47.93	47.26	47.82	46.40
Race (%)							
White NH	83.75	83.56	83.28	82.61	81.46	82.21	80.98
Black NH	13.05	13.30	13.47	13.95	14.23	13.2	13.52
Asian or Pacific Islander	0.34	0.25	0.32	0.31	0.32	0.44	0.60
American Indian or Alaskan Native	0.08	0.07	0.04	0.10	0.07	0.24	0.26
Hispanic	1.13	1.28	1.20	0.97	0.57	0.28	0
Other Race	0.04	0	0	0	0	0	0
Control Group Beneficiaries							
Age (mean)	42.79	42.99	43.54	42.42	41.65	42.00	41.67
Sex (%)							
Female	62.84	62.46	61.66	61.81	62.80	64.13	63.15
Male	37.16	37.54	38.34	38.19	39.20	35.87	36.85
Race (%)							

White NH	81.85	81.32	81.28	79.06	73.38	71.54	70.12
Black NH	13.36	13.12	13.04	12.57	10.66	9.69	9.72
Asian or Pacific Islander	0.36	0.41	0.42	0.44	0.49	0.49	0.50
American Indian or Alaskan Native	0.13	0.12	0.13	0.14	0.22	0.23	0.24
Hispanic	2.56	2.66	2.73	2.42	0.68	0.28	0.13
Other Race	0.02	0.02	0.03	0.02	0.01	0.01	0.01

Figure 14: Trend of Sex Percentage within Groups for 2017-2023



Hospital Claims

General Utilization Trends

Overall, the adult 1915(i) program beneficiaries had a higher average amount billed for yearly hospital claims compared to those in the control group but had a significantly lower average amount paid per claim. The average amount paid per hospital claim was $195 in the program group and $619 in the non-program group. The yearly average amount paid per beneficiary in the adult 1915(i) programs group was $1,847 and the control group yearly cost per beneficiary was 1.9 times greater at $3,563. Yearly trends for the average number of hospital claims per beneficiary and the average amount paid per beneficiary in a year are shown in Figure 15 and Figure 16, respectively. Across all years, the adult 1915(i) programs group had a higher number of hospital claims per beneficiary, however they also had a lower average cost per claim compared to the control group.

Figure 15: Average Number of Hospital Claims per Beneficiary for 2017 through 2023

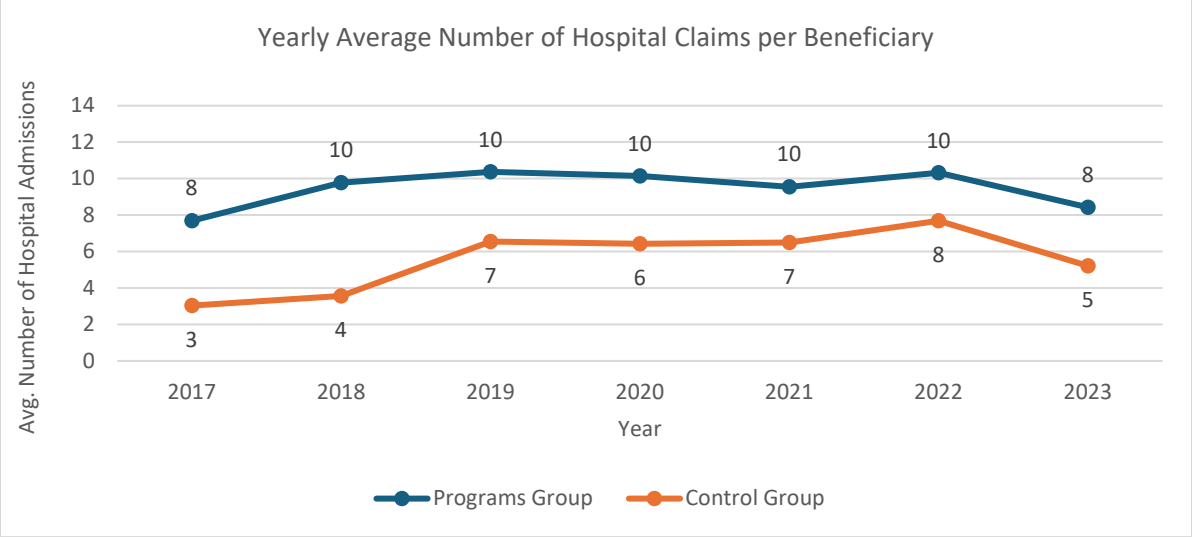
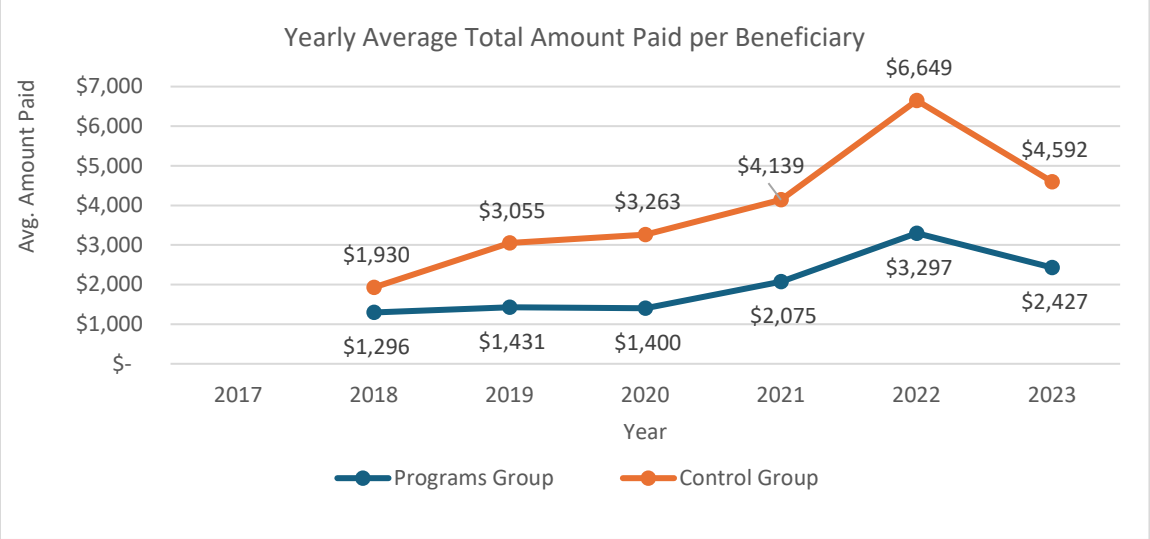
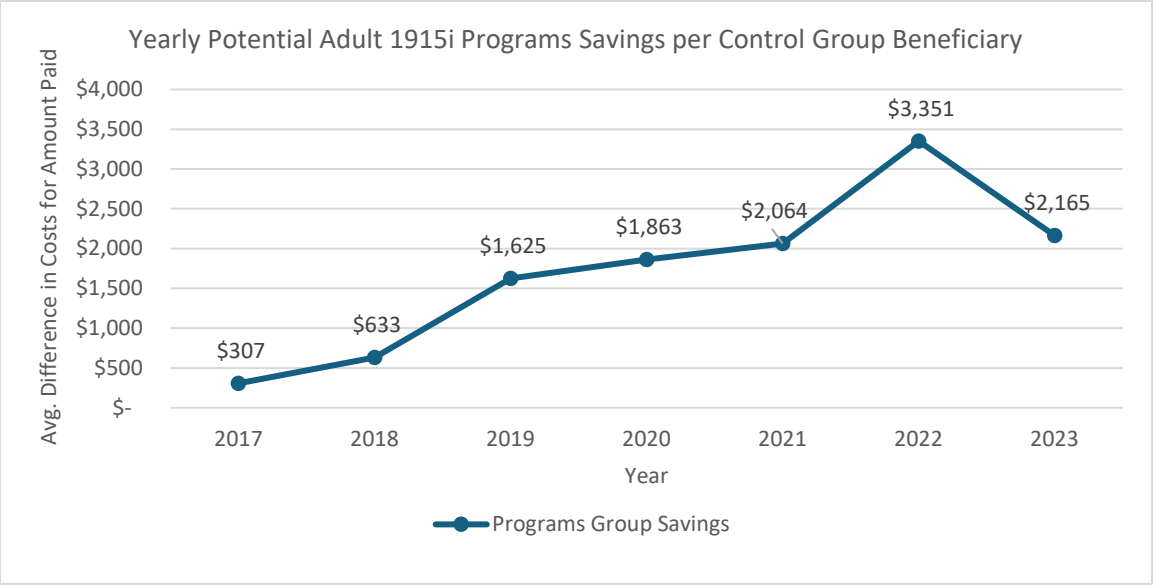


Figure 16: Yearly Total Average Amount Paid per Beneficiary



Between 2017 and 2023, there is a wide range of potential yearly savings if a control group beneficiary had been a part of the 1915(i) program which is detailed in Figure 17. As the years progressed, the gap between the average amount paid per beneficiary for hospital claims continued to increase between the groups. In each year, the adult 1915(i) programs group was more cost-effective for hospital claims than the control group.

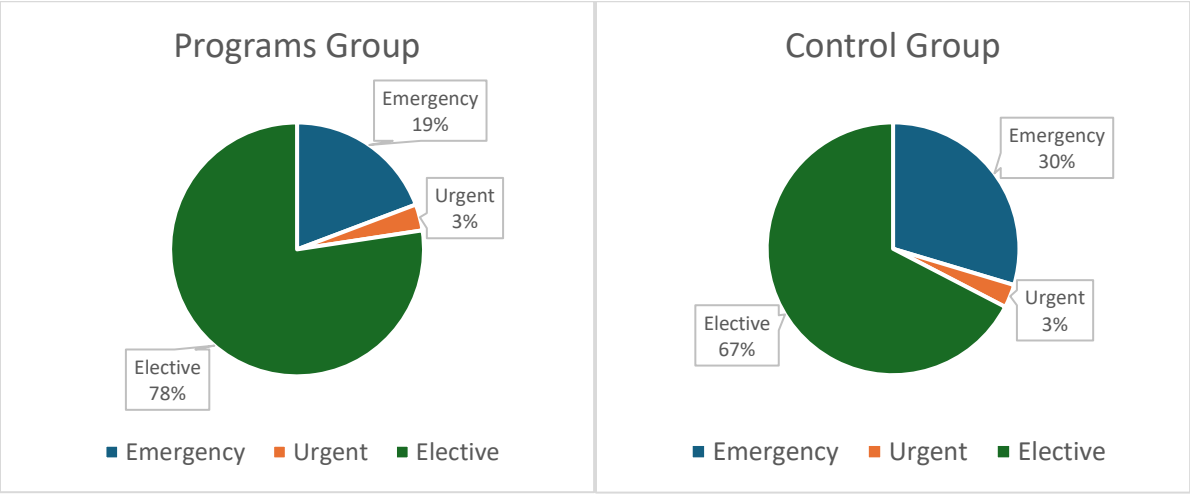
Figure 17: Yearly Potential Adult 1915(i) Programs Group Savings in Amount Paid per Control Group Beneficiary



Admission Types

For hospital visits, there are five main admission types: emergency, urgent, elective, newborn, and trauma. Definitions for each admission type are listed in Appendix I. The most common admission type among both groups was elective. In the adult 1915(i) programs group, elective admissions made up 78% of hospital claims and emergencies comprised only 19%. However, elective admissions made up 68% of the hospital claims and emergency made up 30%. Specific percentages for each admission type are shown in Figure 18 for both groups.

Figure 18: Percentages of each admission type for 2017-2023



On average, an adult 1915(i) programs group beneficiary had 1.59 emergency admission hospital claims per year and a control group beneficiary had 1.55. Additionally, the yearly average number of elective hospital admissions per adult 1915(i) programs group participant was 6.38, and per control group beneficiaries was 3.52. Adult 1915(i) programs group participants had a higher yearly average of urgent admissions (0.28) compared to control group beneficiaries (0.16). Another major difference between

groups was the number of newborn admissions. The adult 1915(i) programs group only had 1 newborn admission hospital claim for all years combined and the control group beneficiaries had 138. However, both groups had an average newborn admission rate per year of 0. The most expensive type of admission for both groups was trauma, but it was the second least frequent type among all five. Figure 19 represents the average total amount paid by admission type, which highlights the significant difference in the amount paid between the two groups. The adult 1915(i) programs group participants consistently have lower average amounts paid across all admission types.

Figure 19: Average Total Amount Paid per Hospital Claim by Admission Type

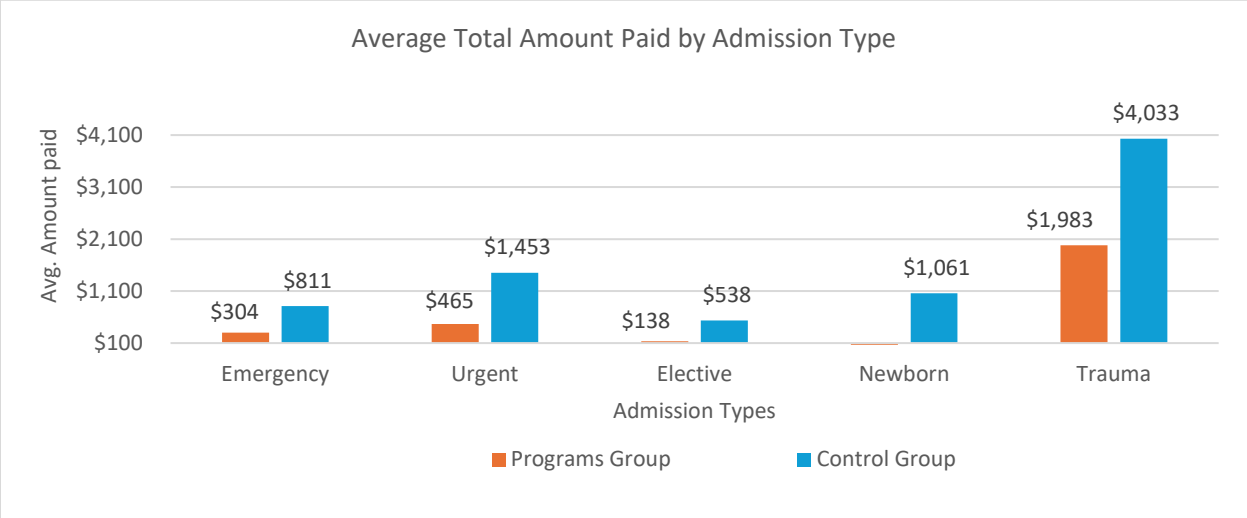
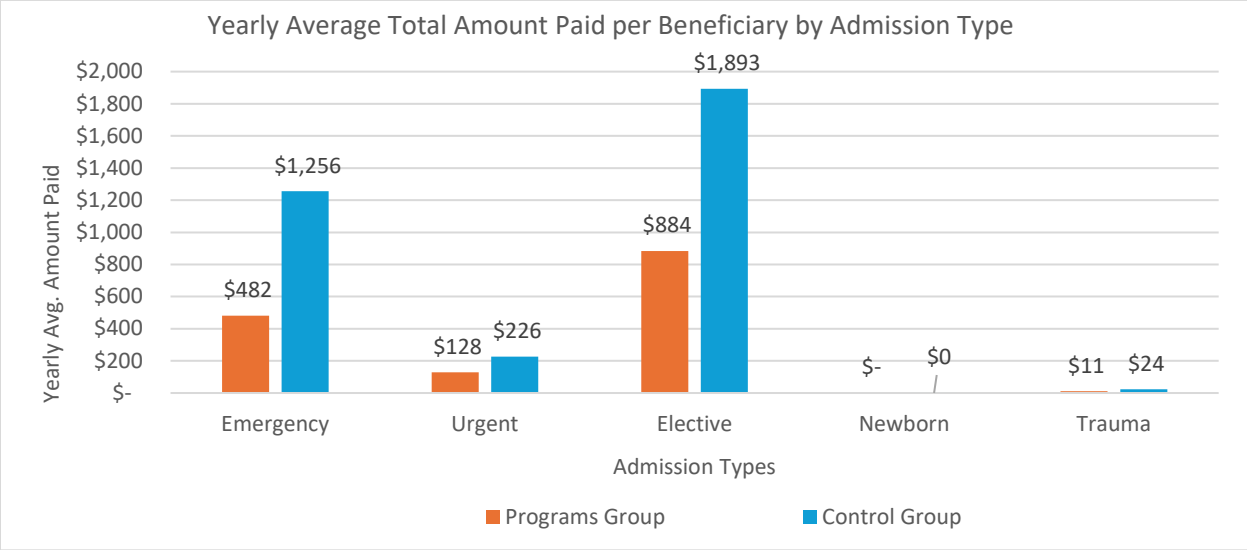


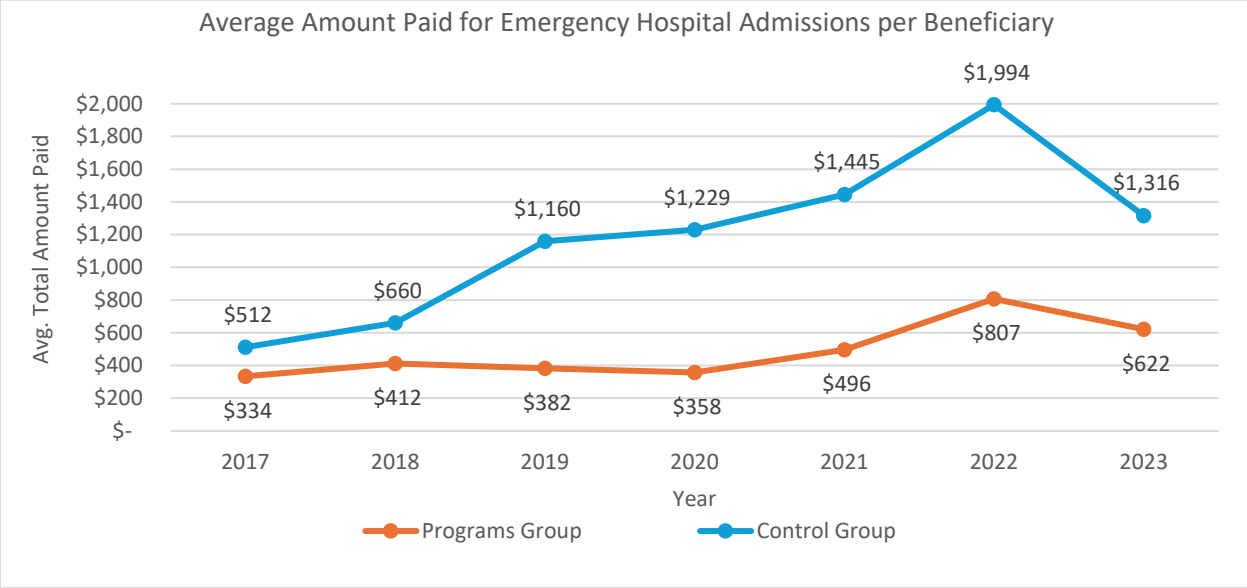
Figure 20: Yearly Average Total Amount Paid per Beneficiary by Admission Type



The largest price difference for yearly total amount paid per beneficiary by admission type was for elective admissions (Figure 20). The average amount paid per beneficiary for each admission type are shown in Figure 20. Adult 1915(i) programs group beneficiaries only had an average yearly cost of $884 for an elective admission claim, while the group control beneficiaries had an average yearly cost of $1,893. This created a total yearly cost difference of $1,009 per beneficiary. Like the previously discussed

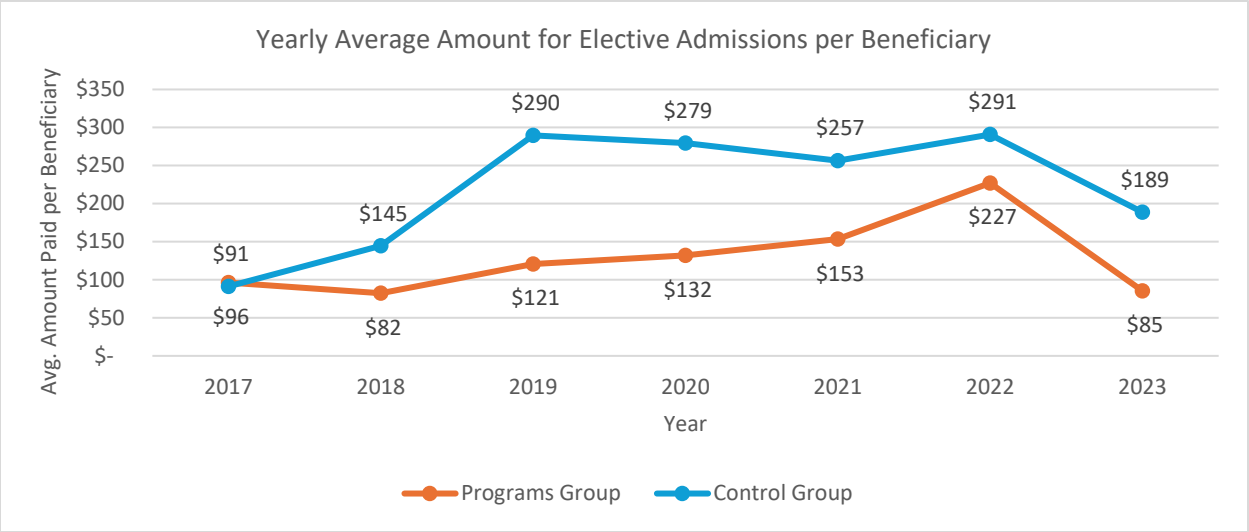
trend of a slow increase in the average yearly total amount paid for hospital claims per control group beneficiary, the emergency admissions had the same result. Between 2017 and 2022, the control group experienced a yearly cost increase of 289% per beneficiary. Even though the adult 1915(i) programs group only experienced a $473 increase between 2017 and 2022, they still had a 141% increase in the yearly average amount paid for emergency admission hospital claims per beneficiary. Yearly trends in the amount paid for emergency admissions between the groups are highlighted in Figure 21. Additionally, the control group had an increase in the number of emergency admission hospital claims per person of 0.91 to 2.06 between 2017 and 2022, respectively. However, the adult 1915(i) programs group did not experience this type of increase for emergency admission claims and remained stable throughout the time period.

Figure 21: Yearly Trends in Emergency Hospital Admission Costs



The second most frequent admission type for the adult 1915(i) programs group was elective admissions. Per hospital claim, the average total amount paid for elective admissions in the adult 1915(i) programs group was only $138 and the amount for the control group was $538. The control group experienced a sudden increase in the average amount paid per claim for elective admissions in 2019. Between 2017 and 2019, the control group experienced a cost increase of 219% for the average amount paid for an elective admission claim per beneficiary. However, the adult 1915(i) programs group remained relatively stable throughout the same time period. This group only experienced a 26% increase in the average amount paid per beneficiary for elective hospital admission claims. Yearly trends in the average amount paid per beneficiary for elective admissions between the groups are highlighted in Figure 22.

Figure 22: Yearly Trends in Elective Hospital Admission Costs per Beneficiary

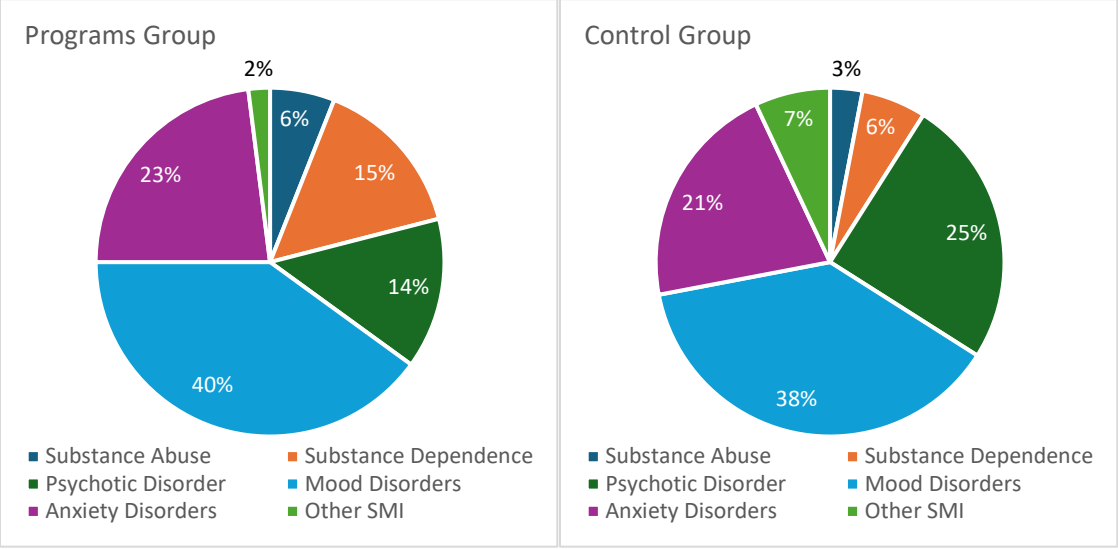


SMI/SUD Stratification

History of SMI/SUD Diagnosis

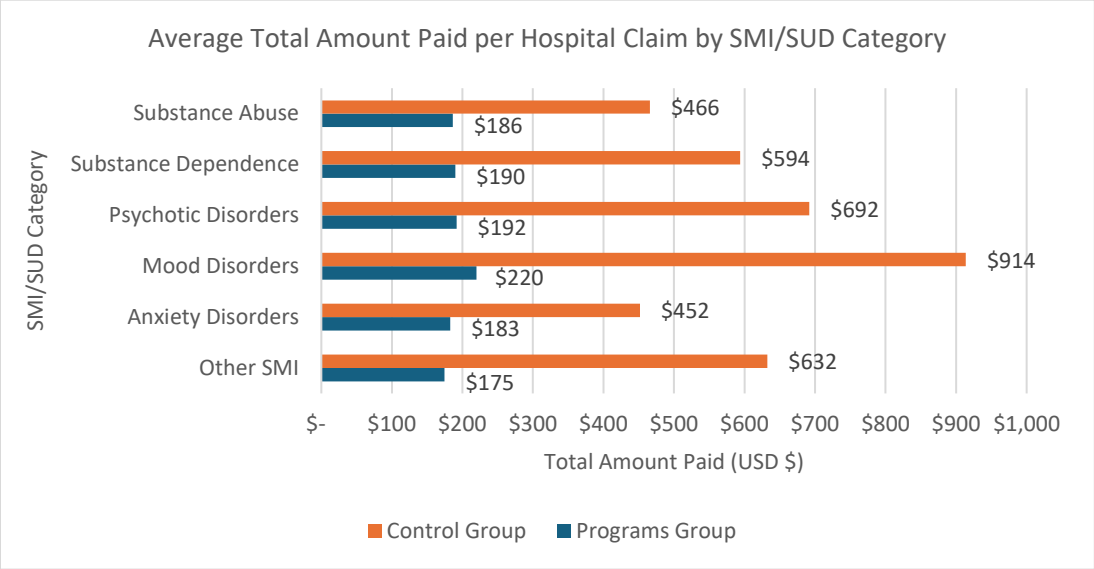
Among recipients with a history of an SMI/SUD as a primary diagnosis, those with mood disorders made up the highest percentage of hospital claims for both adult 1915(i) programs group (38%) and control group (40%). Percentages for each SMI/SUD category for the groups are shown in Figure 23. In both the Adult 1915(i) programs group and control groups, the category with the highest average amount paid per hospital claim was Mood Disorders. For each category, the average amount paid per hospital claim for those not on the adult 1915(i) programs group is significantly higher than the amount paid for those on the adult 1915(i) programs group. Details for each category are listed in Figure 24.

Figure 23: Percent Makeup of Hospital Claims by SMI/SUD Category



One major finding is that in both the adult 1915(i) programs group and the control group, those with substance abuse comprised a higher percentage of emergency admissions and trauma admissions compared to their overall percentage in hospital claims. Additionally, in the control group, those with substance dependence represented 23% of trauma claims while only making up 15% of all hospital claims. This disparity did not exist in the adult 1915(i) programs group. This is crucial from the cost perspective because trauma admission claims had the highest average amount paid per claim. The average amount paid for a trauma admission type is $2,050 higher for the control group than the adult 1915(i) programs group. Within the adult 1915(i) programs group, the only occurrence of this type of disparity was for those with mood disorders. Even though they only made up 38% of hospital claims, they represented 43% of urgent admissions.

Figure 24: Total Amount Paid per Hospital Claim by SMI/SUD

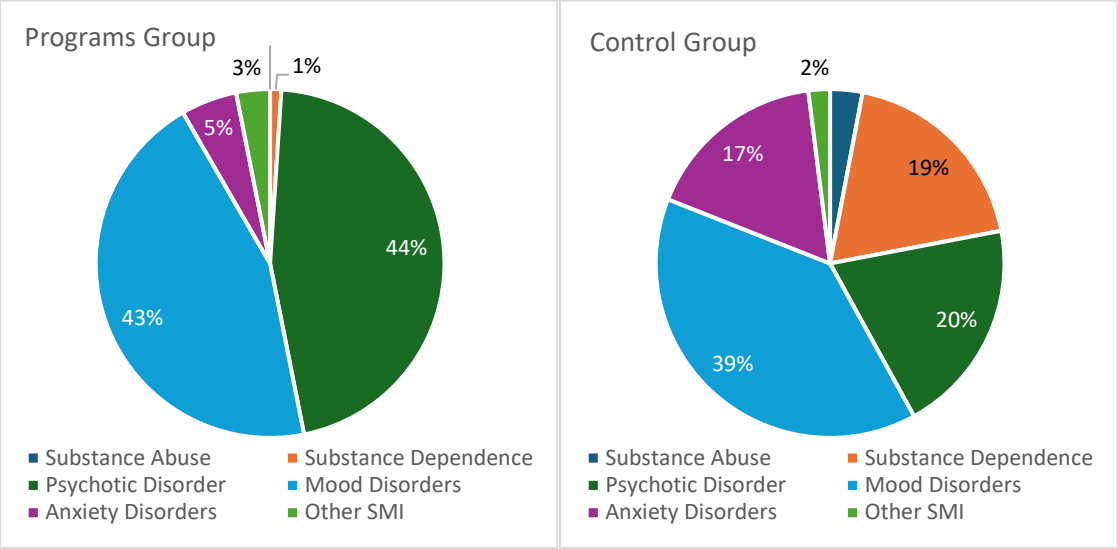


SMI/SUD Primary Diagnosis

Additionally, among hospital claims where the SMI/SUD was listed as the primary diagnosis code, the categories that made up more than 80% of the adult 1915(i) programs group's claims were substance abuse and substance dependence. However, the control group had a more even distribution among SMI/SUD categories. An important trend that emerged was that those with a mood disorder comprised a disproportionate percentage of urgent admission hospital claims specifically for their SMI compared to other SMI/SUD categories. For example, within the control group, for claims with an urgent admission where a mood disorder is listed as the primary diagnosis made up only 38% of hospital claims where the primary diagnosis is an SMI/SUD. However, they made up 52% of hospital claims with an urgent admission. Another important example for the control group is that even though those with substance abuse only made up 3% of claims where the primary diagnosis was an SMI/SUD, they made up 42% of trauma admission claims. Additionally, they also comprised 10% of emergency admission claims. These inequities are one of the major differences between the adult 1915(i) programs group and control group. While claims with a primary diagnosis of a psychotic disorder or mood disorder made up the majority of claims where an SMI/SUD was the primary diagnosis, the adult 1915(i) programs group did not experience a significant disproportion among emergency-, urgent-, elective-, or trauma-related

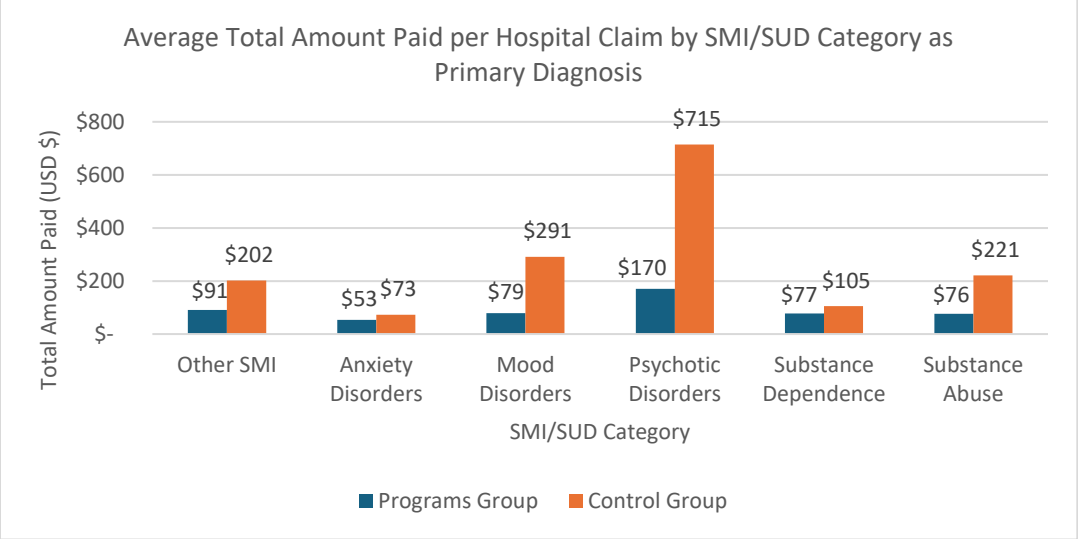
admissions. Figure 25 demonstrates the percentage makeup of hospital claims for each SMI/SUD category when one is listed as the primary diagnosis.

Figure 25: Percentage of Hospital Claims for each SMI/SUD Category where SMI/SUD is Primary Diagnosis



Similar to the cost findings in the previous section, those not on the adult 1915(i) programs group had a much higher cost for the amount paid per claim for all SMI/SUD categories that were listed as a primary diagnosis. The category with the largest price difference between the groups was psychotic disorders, with the average amount paid per claim was $545 higher for the control group. The group with the second largest price difference was for mood disorders, where the average amount paid per claim was $212 higher for the control group. These findings are important for cost-effectiveness, because among hospital claims where an SMI/SUD was the primary diagnosis, those with a psychotic disorder or mood disorder made up the majority of claims in both the adult 1915(i) programs group and the control group.

Figure 26: Total Amount Paid per Hospital Claim by SMI/SUD as Primary Diagnosis



ICD-10-CM Diagnoses

For each group, the ten most common primary ICD10-CM diagnoses were pulled to identify common conditions and to compare the frequency of primary diagnoses between the groups. For the adult 1915(i) programs group, the top diagnoses were schizophrenia, major depressive disorder, and schizoaffective disorder. For the control group, the top diagnoses were major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder, opioid dependence, and chronic obstructive pulmonary disease. A major difference between the groups is that substance dependence codes did not make an appearance within the top ten diagnoses for the adult 1915(i) programs group, while the control group had two (opioid and alcohol). Within the adult 1915(i) programs group, schizophrenia (6.31%) and various schizoaffective disorders (8%) are more prevalent than the control group. This is important for the SMI/SUD composition of hospital claims because those with a history of a psychotic disorder and mood disorder will show up in both groups. Dual diagnoses will cause percentages to be greater than 100% later in the results. Additionally, almost 16% of all hospital claims for the control group are specifically for an SMI/SUD and almost 25% of these claims for the adult 1915(i) programs group are also specifically for an SMI/SUD. Within both groups, one of the most common codes was for chronic obstructive pulmonary disease, unspecified. Specific percentages for each diagnosis code are shown for the adult 1915(i) programs group in Table 33 and in Table 34 for the control group.

Table 33: Top 10 ICD10-CM Diagnoses in the Adult 1915(i) Programs Group

ICD Code	Code Description	Percentage (%)
F20.9	Schizophrenia, unspecified	6.31%
F33.1	Major depressive disorder (MDD), recurrent, moderate	4.04%
F25.0	Schizoaffective disorder, bipolar type	3.99%
F33.2	Major depressive disorder, recurrent severe without psychotic features	2.56%
F25.1	Schizoaffective disorder, depressive type	2.18%
F31.9	Bipolar affective disorder, unspecified	2.05%
J44.9	Chronic obstructive pulmonary disease, unspecified	1.84%
F25.9	Schizoaffective disorder, unspecified	1.83%
F43.10	Post-traumatic stress disorder, unspecified	1.66%
I10	Essential (primary) hypertension	1.54%

Table 34: Top 10 ICD10-CM Diagnoses in the Control Group

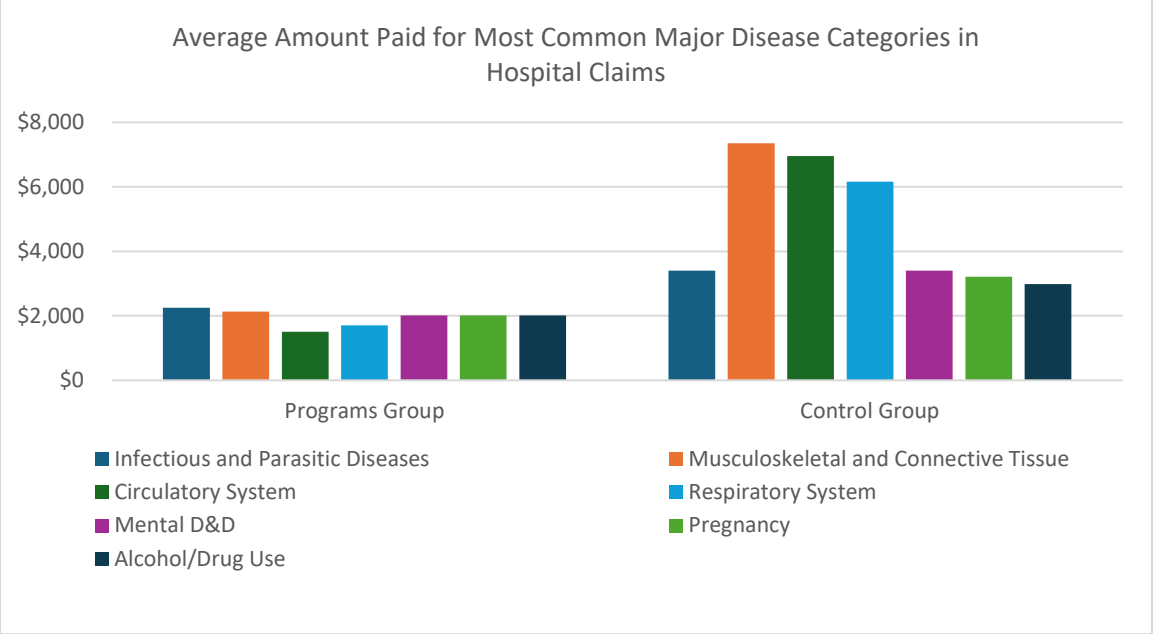
Procedural Code	Code Description	Percentage (%)
F33.1	Major depressive disorder (MDD), recurrent, moderate	2.65%
F41.1	Generalized anxiety disorder	2.17%
F43.10	Post-traumatic stress disorder, unspecified	1.82%
F11.20	Opioid dependence, uncomplicated	1.80%
J44.9	Chronic obstructive pulmonary disease, unspecified	1.77%
F33.2	Major depressive disorder, recurrent severe without psychotic features	1.73%
F20.9	Schizophrenia, unspecified	1.65%
F25.0	Schizoaffective disorder, bipolar type	1.30%
F31.9	Bipolar affective disorder, unspecified	1.26%

F10.20	Alcohol dependence, uncomplicated	1.24%

Major Diagnostic Categories (MDCs)

The second stratification analysis was by major diagnostic category. A list of all 25 major diagnostic categories possible are listed in Appendix D. The top five most common categories in hospital claims for the adult 1915(i) programs group were infectious and parasitic diseases, diseases and disorders of the musculoskeletal system and connective tissue, diseases and disorders of the circulatory system, diseases and disorders of the respiratory system, and mental diseases and disorders. For the control group, the top five MDCs were infectious and parasitic diseases, pregnancy, childbirth, and the puerperium, diseases and disorders of the respiratory system, alcohol/drug use and induced mental disorders, and mental diseases and disorders. Overlapping categories between the groups were infectious and parasitic diseases, circulatory and respiratory diseases and disorders, and mental diseases and disorders. One considerable difference between the frequencies of the groups was that the alcohol/drug use and induced mental disorders category was the second most frequent category for the control group and did not reach any of the top five most frequent categories for the adult 1915(i) programs group. Following previous trends, the average amount paid for the adult 1915(i) programs group is significantly lower than the control group. Figure 27 highlights these cost differences.

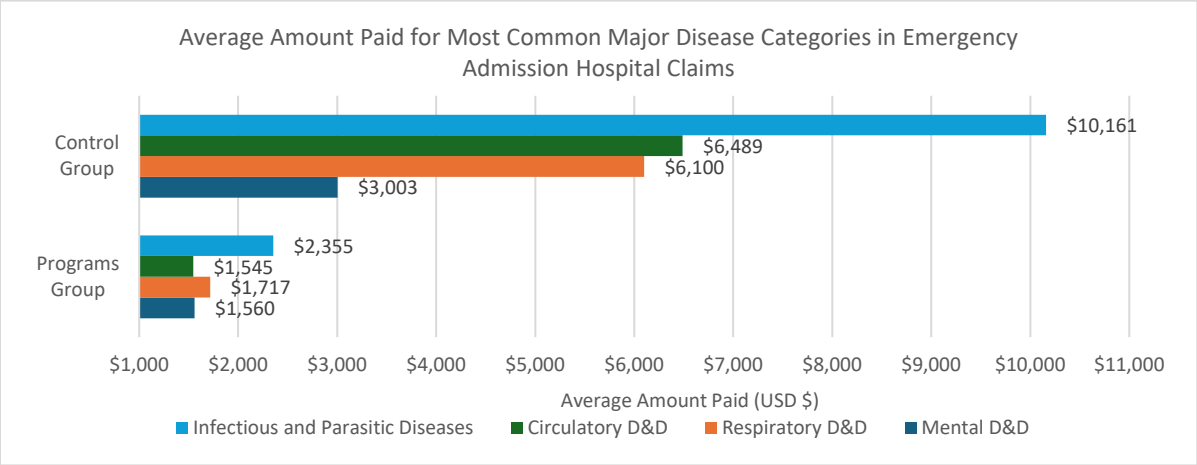
Figure 27: Average Amount Paid for the Most Common MDCs in Hospital Claims



Among emergency admission, the top three major diagnostic categories present for the adult 1915(i) programs group are mental diseases and disorders, respiratory system diseases and disorders, and circulatory system diseases and disorders, respectively. For the control group, the most frequent categories are mental diseases and disorders, respiratory system diseases and disorders, and infectious and parasitic diseases, respectively. An important difference between the groups is the frequency of infectious and parasitic diseases in the emergency admission hospital claims because it had the most significant cost difference in the average amount paid per claim. The average amount paid for these claims in the control group was $7,806 higher than in the adult 1915(i) programs group. The cost

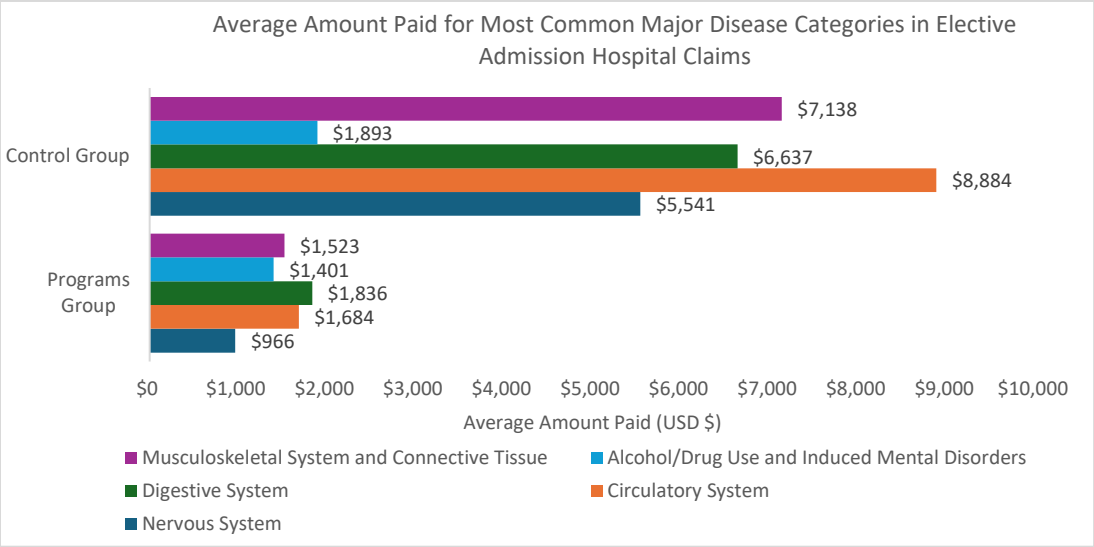
differences in the average amount paid per claim for each diagnostic category for emergency admission are shown in Figure 28.

Figure 28: Average Amount Paid per Claim for Most Common MDCs in Emergency Admissions



In elective admissions, the three most common major diagnostic categories for the adult 1915(i) programs group were diseases and disorders of the nervous system, diseases and disorders of the circulatory system, and diseases and disorders of the digestive system, respectively. For the control group, the respective categories were diseases and disorders of the nervous system, alcohol/drug use and induced mental disorders, and diseases and disorders of the musculoskeletal system and connective tissue. The diagnostic category with the most significant difference in amount paid per claim for elective admissions was for diseases and disorders of the circulatory system. Elective admission claims for diseases and disorders of the circulatory system were $7,200 higher in the control group compared to the adult 1915(i) programs group. This is important when considering the overall costs to Medicaid because circulatory diseases and disorders are one of the most common MDCs across all admission types and those on the adult 1915(i) programs group produce significantly lower costs for this category. Specific cost differences for amount paid are shown in Figure 29.

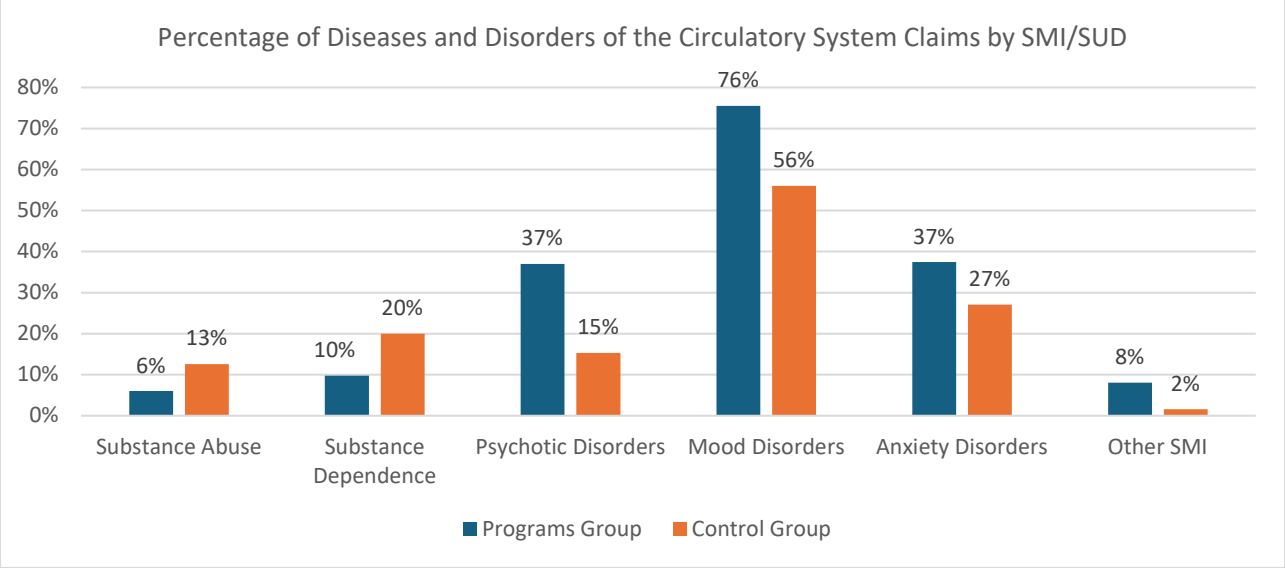
Figure 29: Average Amount Paid per Claim for Most Common Diagnostic Categories in Elective Admissions



SMI/SUD Stratification

The major diagnostic categories were further broken down by SMI/SUD categories of recipients. Among the adult 1915(i) programs group, people with a history of being diagnosed with a mood disorder represented at least 70% of all hospital claims associated with each of the most common major diagnostic categories. Those with a mood disorder were disproportionately compared to their overall percentage of hospital claims, shown in Figure 23. The percentages in the control group were more spread out between SMI/SUD categories compared to the adult 1915(i) programs group. However, even in the control group, participants diagnosed with a mood disorder consistently represented 50% or more of all hospital claims associated with the most common major diagnostic categories except for alcohol/drug use and induced mental disorders. Another concerning trend was that for claims with injuries, poisonings, or toxic effects of drugs, those with a mood disorder made up at least 60%. The adult 1915(i) programs group beneficiaries who had a history of a psychotic disorder made up 75% of these claims. Additionally, for hospital claims related to circulatory diseases and disorders, those with a history of a mood disorder again made up 76% of these for the adult 1915(i) programs group. This is important for overall costs because those with a mood disorder had the highest average amount paid for hospital claims compared to all other SMI/SUD categories, shown in Figure 24. Figure 30 below provides an example from the circulatory system diseases and disorders category percentages by SMI/SUD category. Because individuals may have had more than one SMI/SUD primary diagnosis in the past, they can appear in multiple groups, causing percentages to add up to more than 100%. The other four graphs for the common diagnostic categories are listed in Appendix J.

Figure 30: Percentage of Diseases and Disorders of the Circulatory System Claims by SMI/SUD



Procedures

Procedures that occurred in both groups were home visit services, hospital outpatient clinic visits, unlisted dialysis services and procedures, group psychotherapy, collection of venous blood, psychotherapy, and emergency department visits with detailed components. Specific percentages for each procedure in the adult 1915(i) program and control groups in Tables 35 and 36, respectively. An intriguing similarity between the groups is that both had dialysis procedures in their top ten due to insufficient renal functioning. Major differences between the groups are the those on the adult 1915(i) programs group had a much higher percentage of home visit services (17%) compared to those not on the adult 1915(i) programs group (9%). Additionally, one of the top ten procedures in hospital claims for the adult 1915(i) programs group included a Federally Qualified Health Center (FQHC) visit and this did not appear in the top ten procedures for the control group. Another finding was that those on the SPA had a higher exposure to psychotherapy than those not on the adult 1915(i) programs group. Finally, 4.86% of procedures in the control group were attributed to an emergency department visit where the adult 1915(i) programs group only had 1.92%. This is important because emergency admission claims had an average amount paid $507 higher in the control group than the adult 1915(i) programs group. Additionally, those on the SPA had a significantly higher exposure to therapy than those not on the adult 1915(i) programs group.

Table 35: Adult 1915(i) Programs Group Top 10 Hospital Procedural Codes, Descriptions, and Percentages

Procedural Code	Code Description	Percentage (%)
99600	Home visit services	17.09%
G0463	Hospital outpatient clinic visits for the assessment and management of patients	8.30%
90834	Psychotherapy, 45 minutes	5.81%
G0467	Federally qualified health center (FQHC) visit, established patient	3.86%
90999	Dialysis services or procedures that do not have a specific code	3.31%

97110	Therapy procedure using exercise to develop strength, endurance, range of motion and flexibility, each 15 minutes	3.23%
90853	Group psychotherapy	3.25%
36415	Collection of venous blood by venipuncture	2.20%
99284	Emergency department visit for the evaluation and management of a patient with detailed history, detailed examination, and medical decision making of moderate complexity	1.92%
96372	Injection of drug or substance under skin or into muscle	1.89%

Table 36: Control Group Top 10 Hospital Procedural Codes, Descriptions, and Percentages

Procedural Code	Code Description	Percentage (%)
99600	Home visit services	8.95%
36415	Collection of venous blood by venipuncture	4.90%
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	4.30%
80053	Comprehensive metabolic panel	2.95%
90834	Psychotherapy, 45 minutes	2.72%
99284	Emergency department visit for the evaluation and management of a patient with detailed history, detailed examination, and medical decision making of moderate complexity	2.47%
99283	Emergency department visit for the evaluation and management of a patient with an expanded problem-focused history, expanded problem-focused examination, and medical decision making of moderate complexity	2.39%
G0463	Hospital outpatient clinic visits for the assessment and management of patients	2.00%
90853	Group psychotherapy	3.25%
90999	Dialysis services or procedures that do not have a specific code	1.91%

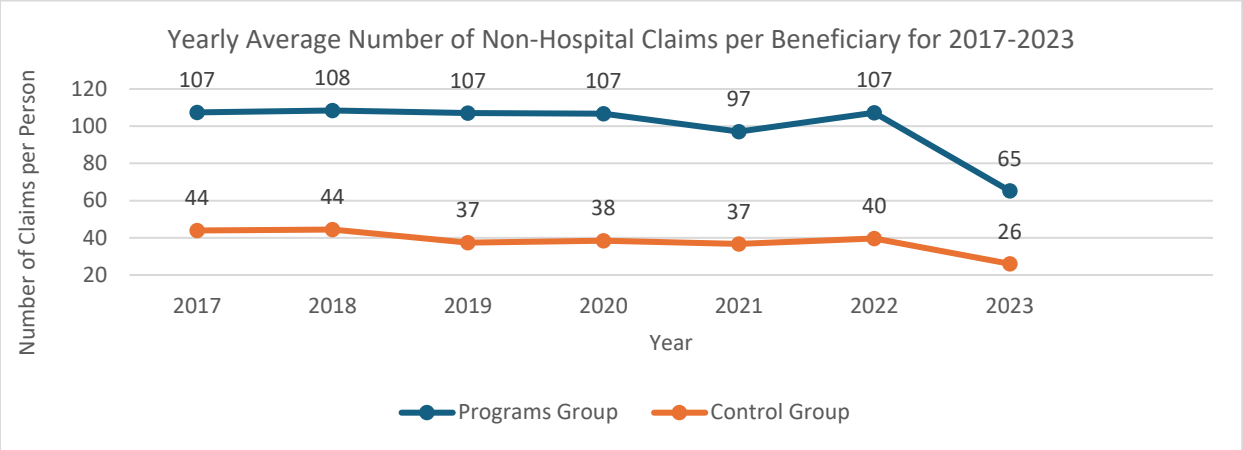
Non-Hospital Claims

General Utilization Trends

Overall, the Adult 1915(i) programs group participants had both a higher yearly amount billed, and a lower amount paid per claim for non-hospital settings. Both Adult 1915(i) programs group and control group beneficiaries saw a decline in the average number of claims per year. In general, the adult 1915(i) programs group had a gradual increase in the cost per claim while the control group saw a steep decline followed by stabilization and a slight increase. Adult 1915(i) programs group beneficiaries consistently incur higher yearly costs per beneficiary compared to the control group beneficiaries, although this gap has narrowed over time. Yearly trends for the average number of hospital claims per beneficiary, the average amount paid per claim, and the average amount paid per beneficiary in a year are shown in Figure 31, Figure 32, and Figure 33, respectively. Across all years, the adult 1915(i) programs group had a

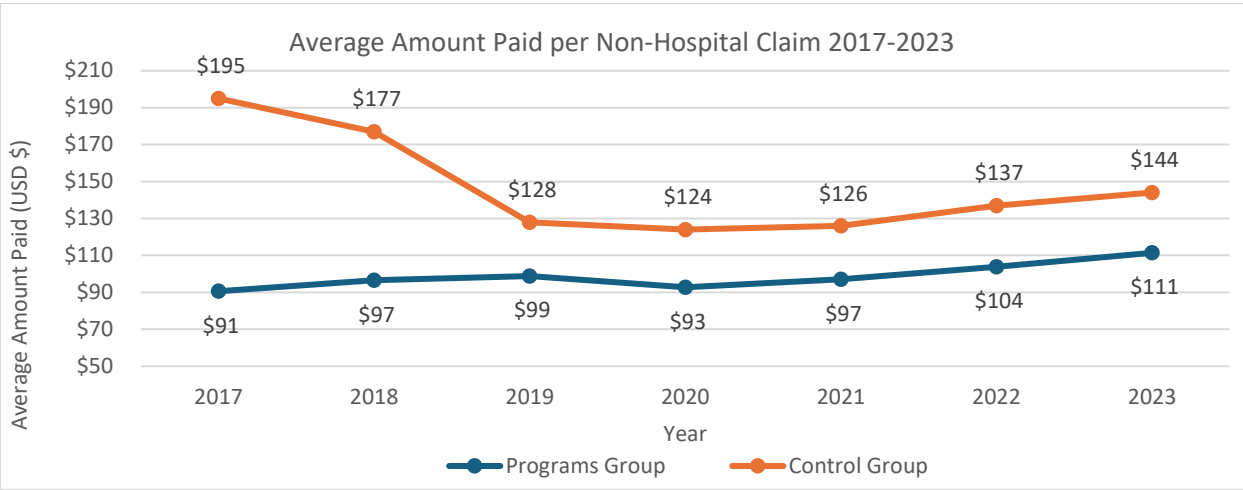
higher average number of claims per beneficiary than the control group. However, the average number of claims per beneficiary remained relatively stable around 107 claims per year in the adult 1915(i) programs group compared to the control group (excluding the year 2021). Between 2017 and 2021, the control group had a 16% decline in the average number of claims for non-hospital settings. The adult 1915(i) programs group only experienced a 9% decline.

Figure 31: Yearly Average Number of Non-Hospital Setting Claims per Beneficiary 2017-2023



On average, the amount paid per non-hospital claim for the Adult 1915(i) programs group was $99 while it was $147 in the control group. At the beginning of the time period, there was a significant gap in the average amount paid per non-hospital claim ($76 difference) between the groups. In 2019, the control group's average amount paid per claim dropped to $128 and has been slightly increasing each year. For the adult 1915(i) programs group, the cost per claim has been gradually increasing from $91 in 2017 to $111 in 2023. Overall, the average amount paid per claim is consistently lower for the adult 1915(i) programs group compared to the control group. The amount paid per claim is shown by year in Figure 32.

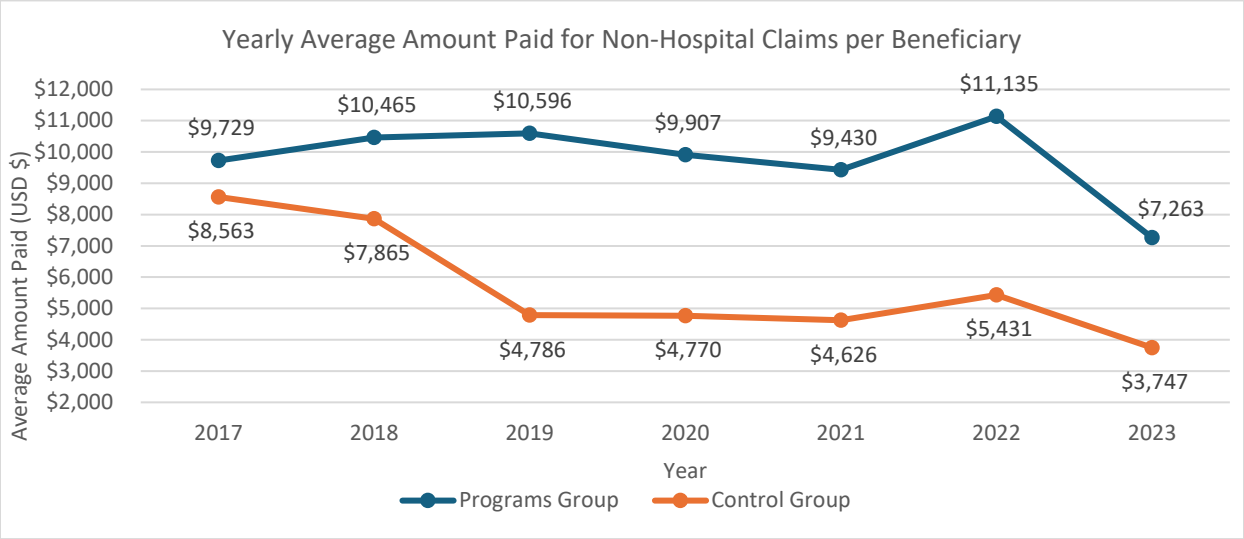
Figure 32: Average Amount Paid per Non-Hospital Claim 2017-2023



The yearly average amount paid per beneficiary in the Adult 1915(i) programs group was $9,789 and the control group yearly cost per beneficiary cost was $5,273. Another trend that emerged in the adult

1915(i) programs group was that the yearly amount paid per beneficiary increased from $9,729 in 2017 to a peak of $11,135 in 2022. Interestingly, the yearly average amount paid per beneficiary dropped significantly for the control group between 2018 and 2019, from $7,865 to $4,786. For the control group, the yearly amount paid per beneficiary sharply decreased from $8,563 in 2017 to $4,770 in 2019. Beginning in 2019 there has been a significant gap in the costs between the two groups, with the adult 1915(i) programs group costing $5,810 more per person than the control group. The partial 2023 data shows that this gap has shrunk for this moment in time. The yearly trends for the average amount paid per beneficiary for both groups are shown in Figure 33.

Figure 33: Yearly Total Average Amount Paid for Non-Hospital Claims per Beneficiary 2017-2023

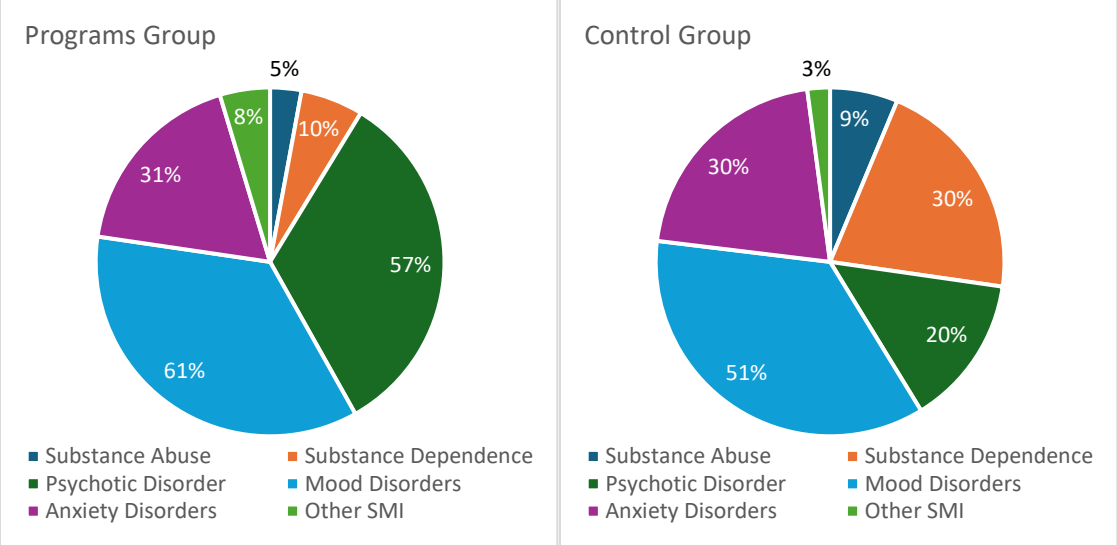


SMI/SUD Stratification

SMI/SUD History

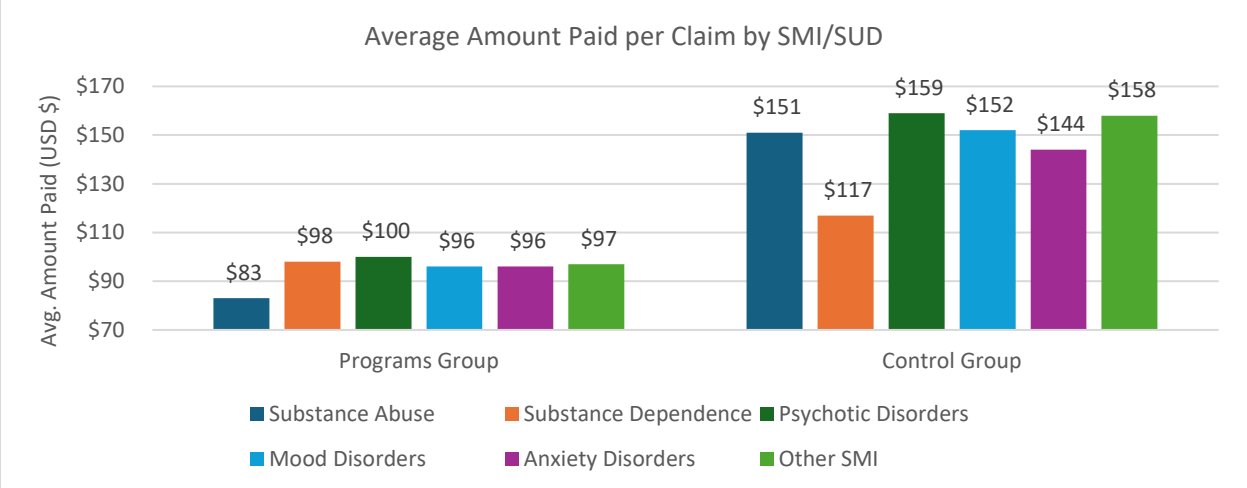
Among recipients with a history of an SMI/SUD as a primary diagnosis, psychotic disorders are the most prevalent, comprising 57% of the claims for the adult 1915(i) programs group. Anxiety disorders are also significant at 31%. The distribution is more balanced in the control group, with psychotic disorders at 20% and substance dependence and anxiety disorders at 30%. Control group beneficiaries have a significantly higher proportion of substance dependence (30%) compared to SPA program beneficiaries (10%). Both groups have a relatively small proportion of substance abuse claims, but control beneficiaries have a slightly higher percentage (9% vs 5%). Percentages for each SMI/SUD category for the groups are shown in Figure 34.

Figure 34: Percentage of Non-Hospital Claims for each SMI/SUD Category



Among both groups, the SMI/SUD category with the highest average amount paid per claim was psychotic disorders. Across all SMI/SUD categories, the average amount paid per claim is higher in the control group compared to the adult 1915(i) programs group. The largest cost difference in the amount paid per claim between the SPA program and control group exists for substance abuse. Claims for beneficiaries with substance abuse are $68 higher in the control group. Additionally, the costs per claim are more similar between SMI/SUD categories in the adult 1915(i) programs group compared to the control group.

Figure 35: Average Amount Paid per Non-Hospital Claim by SMI/SUD



SMI/SUD Primary Diagnosis

Among non-hospital claims for the adult 1915(i) programs group, 68% had an SMI/SUD listed as the primary diagnosis. However, in the control group, only 38% of non-hospital claims had an SMI/SUD listed as the primary diagnosis. In the adult 1915(i) programs group, 38% of all non-hospital claims were specifically for a psychotic disorder and in the adult 1915(i) programs group, only 8% of claims were for

this disorder category. Mood disorders were the second highest for the adult 1915(i) programs group, comprising 24% of these claims. However, the control group again had a significantly lower percentage of claims for this category (11%). The only category in the control group that exceeded the adult 1915(i) programs group was for substance dependence. Substance dependence-specific claims made up 12% of the claims in the control group. Specific percentages for these are shown in Figure 36. This is important for costs to Indiana Medicaid because the average amount paid for a non-hospital claim specifically for substance dependence is $19 higher in the control group compared to the adult 1915(i) programs group. Additionally, claims for anxiety disorders were $87 higher in the control group compared to the adult 1915(i) programs group. Overall, the average amount paid for claims with an SMI/SUD as the primary diagnosis is slightly less expensive for beneficiaries on the SPA ($4) than those not on the SPA. Specific average amounts paid per claim by SMI/SUD are shown in Figure 37.

Figure 36: Percentage of Non-Hospital Claims by SMI/SUD where the SMI/SUD is the Primary Diagnosis

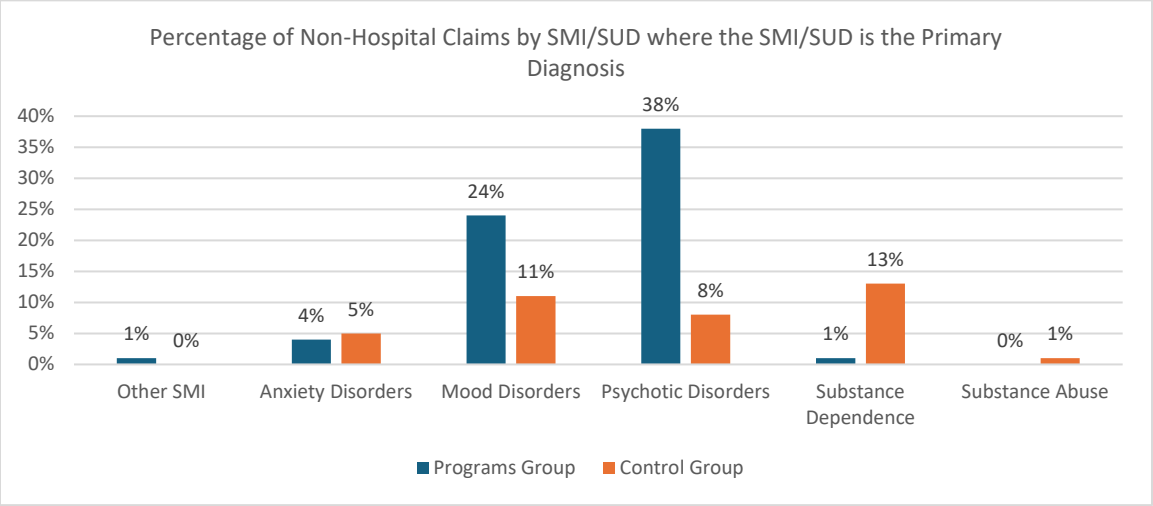
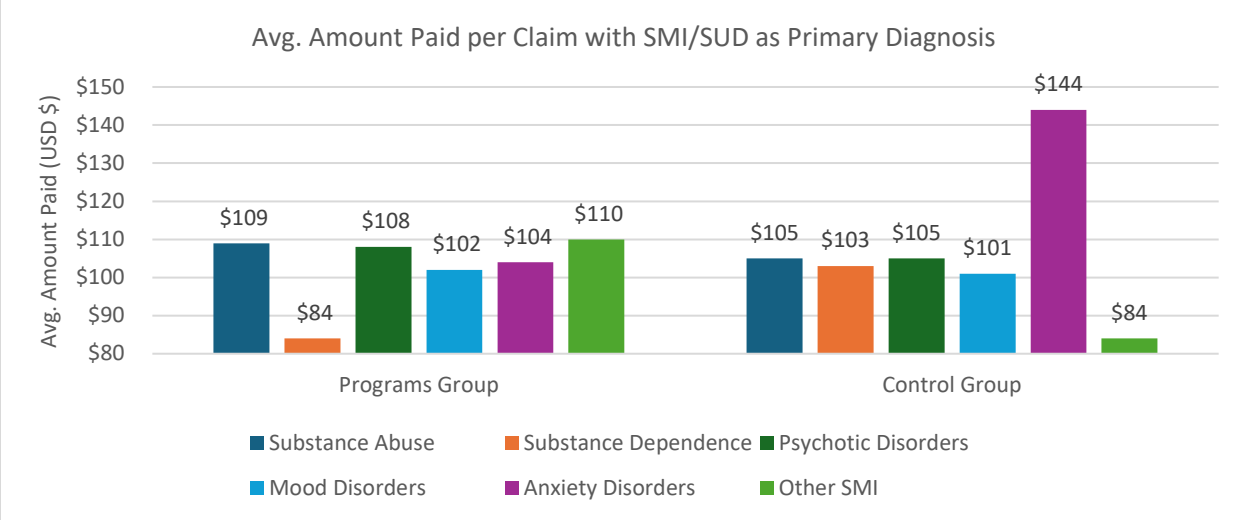


Figure 37: Average Total Amount Paid per Non-Hospital Claim where SMI/SUD is Primary Diagnosis



ICD-10-CM Diagnoses

The only major commonalities between the two groups for the most common ICD10-CM codes were that almost all diagnoses were for an SMI/SUD and that mood disorders were prevalent in both groups but were more diversified and frequent among SPA program beneficiaries. Key insights from the most common ICD10 codes were that the adult 1915(i) programs group had a significantly higher prevalence of claims specifically for schizophrenia (14%) compared to the control group (2.5%). Additionally, the adult 1915(i) programs group also had various types of schizoaffective disorders (totaling over 17%), while the control group just contained the bipolar type (2.2%). SPA program beneficiaries with psychotic disorders make up a significantly higher amount of non-hospital claims than control beneficiaries. Further differences between the groups are that control beneficiaries report a higher percentage of unspecified general illness, typically used when there is an unclear diagnosis or there is insufficient information to assign a more specific one. For substance dependence codes, these did not reach the top ten for the adult 1915(i) programs group, but opioid dependence comprised 10% of all non-hospital claims for the control group. This is important for costs because for claims of beneficiaries with a history of substance dependence diagnosis, the average amount paid per claim is $19 higher in the control group. Additionally, codes for anxiety disorders and post-traumatic stress disorders (PTSD) were more prevalent among control beneficiaries. This is again important for costs because claims for a beneficiary with a history of anxiety disorder were $48 more expensive for the control group. Finally, a concerning insight was that the code for ill-defined and unspecified causes of mortality comprised 2.4% of non-hospital claims for the control group while it did not appear in the top ten for the adult 1915(i) programs group. Specific codes, their descriptions, and percentages are shown for the adult 1915(i) programs and control group in Tables 37 and 38, respectively.

Table 37: Top 10 ICD10-CM Diagnoses in the Adult 1915(i) Programs Group for Non-Hospital Claims

ICD Code	Code Description	Percentage (%)
F20.9	Schizophrenia, unspecified	14.20%
F25.0	Schizoaffective disorder, bipolar type	9.22%
R69	Illness, unspecified	6.80%
F33.1	Major depressive disorder (MDD), recurrent, moderate	5.47%
F25.1	Schizoaffective disorder, depressive type	4.41%
F20.0	Paranoid schizophrenia	
F25.9	Schizoaffective disorder, unspecified	3.78%
F33.2	Major depressive disorder, recurrent severe without psychotic features	3.32%
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	2.11%
F41.1	Generalized anxiety disorder	2.02%

Table 38: Top 10 ICD10-CM Diagnoses in the Control Group for Non-Hospital Claims

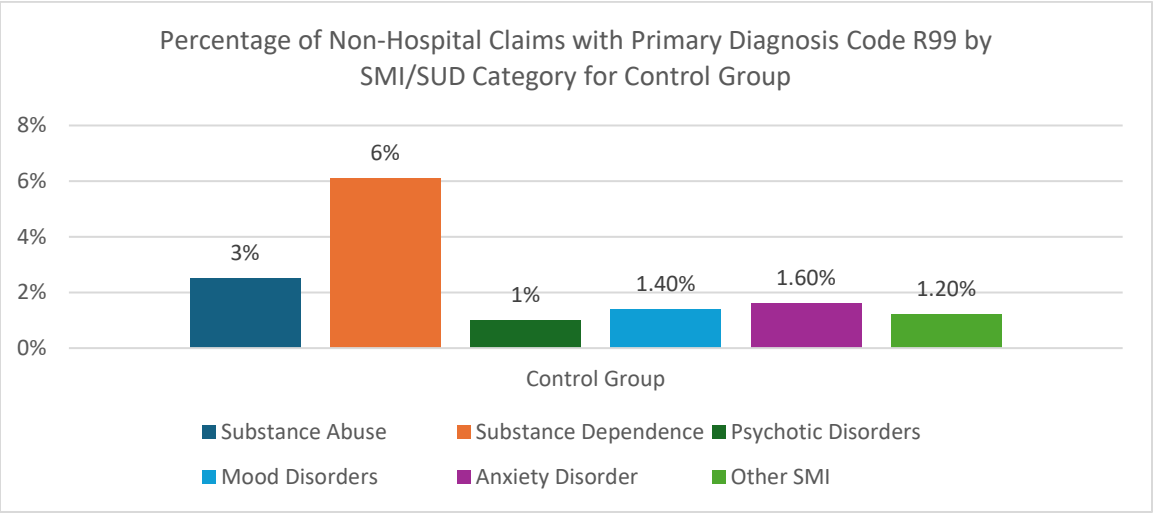
ICD Code	Code Description	Percentage (%)
R69	Illness, unspecified	10.93%
F11.20	Opioid dependence, uncomplicated	10.04%
F33.1	Major depressive disorder (MDD), recurrent, moderate	3.10%
F41.1	Generalized anxiety disorder	2.50%

F20.9	Schizophrenia, unspecified	2.50%
R99	Other ill-defined and unspecified causes of mortality	2.35%
F25.0	Schizoaffective disorder, bipolar type	2.21%
F33.2	Major depressive disorder, recurrent severe without psychotic features	1.68%
F43.10	Post-traumatic stress disorder, unspecified	1.58%
F10.20	Alcohol dependence, uncomplicated	1.31%

These tables show a clear difference in the prevalence of various diagnoses between SPA program and control beneficiaries. SPA program beneficiaries have higher incidence of non-hospital claims specifically for severe mental health conditions, particularly schizophrenia and schizoaffective disorders. Control beneficiaries face significant challenges with substance dependence, particularly opioid dependence, and general illness. Because ill-defined or unspecified mortality (R99) was listed as one of the top ten codes in the control group, further analysis was completed to investigate whether a specific SMI/SUD suffered mortality disparities and if these patterns also occurred in the adult 1915(i) programs group.

Upon further analysis, when the ten most common codes were pulled for both groups, R99 did not appear in any of the SMI/SUD categories for the adult 1915(i) programs group. However, for control beneficiaries with a history of substance dependence as a primary diagnosis, ill-defined and unspecified causes of mortality made up 6% of the claims. While each SMI/SUD category had at least 1% of non-hospital claims attributed to ill-defined or unspecified causes of mortality, substance abuse and substance dependence had the highest percentages. Specific percentages are shown in Figure 38. Interestingly, substance dependence and substance abuse made up a significantly higher percentage of individuals in the control for all claim types compared to the adult 1915(i) programs group. Based on this finding, it is strongly encouraged that the state of Indiana creates and implements targeted strategies to recruit and retain individuals struggling with substance abuse and dependence into the 1915(i) adult 1915(i) programs to improve health outcomes and prevent mortality. It is also suggested that further analysis be completed to determine the causes of these substantial differences between groups.

Figure 38: Percentage of Non-Hospital Claims with Primary Diagnosis Code R99 by SMI/SUD Category



Procedures

Procedures that appeared in both groups included case management, evaluation and management services, psychotherapy sessions, non-emergency transportation, office or other outpatient visits, skills training and development, and subsequent hospital care. However, the percentages of these differed greatly between groups. In the adult 1915(i) programs group, the top three procedural codes in the claims were focused on skills training or case management, making up almost 50% of procedures and aligning with the 1915(i) SPA services. One important note from this list was that skills training and development comprised 33% of procedures in the non-hospital claims for the SPA program beneficiaries but only 6% for the control group beneficiaries. Evaluation and management made up 4% of all procedural codes for the adult 1915(i) programs group and 6% for the control group. Another major difference between them is that alcohol and/or drug services for methadone administration or provision was the most common procedure in the control group and it did not appear in the top ten procedures for the adult 1915(i) programs group. However, an explanation for this is that the control group had a higher percentage of beneficiaries with substance abuse and substance dependence. Finally, psychotherapy comprised a higher percentage of procedures in the control group (4%) and only 2% in the adult 1915(i) programs group. Specific procedural codes and their respective percentages for both groups are shown in Tables 39 and 40.

Table 39: Adult 1915(i) Programs Group Top 10 Non-Hospital Setting Procedural Codes, Descriptions, and Percentages

Procedural Code	Code Description	Percentage (%)
H2014	Skills training and development for the context of mental health and substance abuse treatment services, each 15-minutes	32.62%
T1016	Case management, each 15 minutes	13.47%
H0034	Medication training and support, each 15 minutes	3.53%
99214	Office or outpatient visit for the evaluation and management of an established patient with at least two of these three components: a detailed history, detailed examination, and medical decision making of moderate complexity	3.09%
99600	Home visit services	2.92%
99213	Established patient office or other outpatient visit, 20-29 minutes	2.74%
S5125	Attendant care services, each 15 minutes	2.31%
T2003	Non-emergency transportation; encounter/trip	2.02%
90834	Psychotherapy, 45 minutes	1.79%
99232	Subsequent hospital inpatient or observation care visit involving evaluation and management with at least two of three components: expanded problem focused history, medical decision making of moderate complexity, and level 2 problem severity	1.19%

Table 40: Control Group Top 10 Non-Hospital Setting Procedural Codes, Descriptions, and Percentages

Procedural Code	Code Description	Percentage (%)

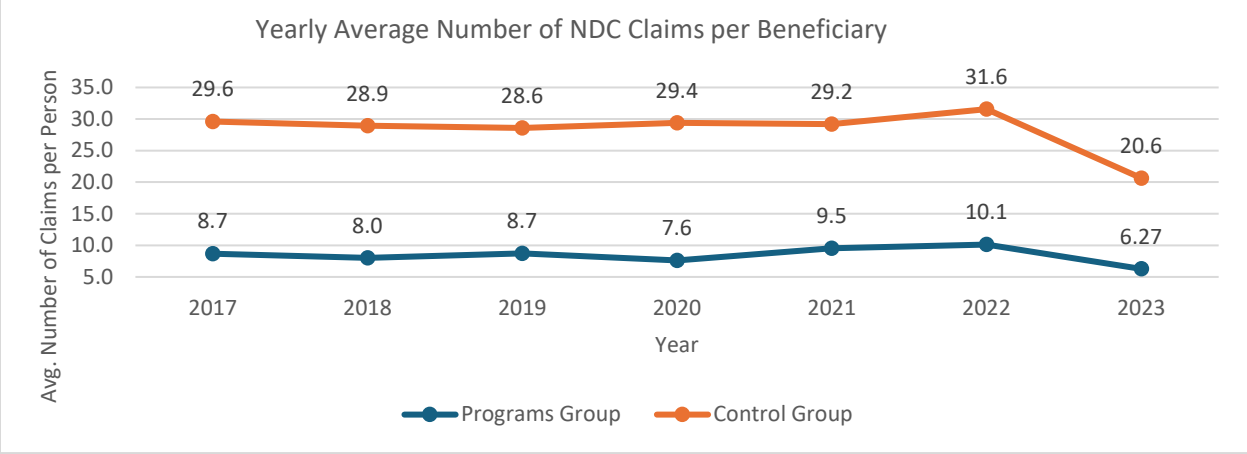
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	8.63%
H2014	Skills training and development for the context of mental health and substance abuse treatment services, each 15-minutes	5.89%
99214	Office or outpatient visit for the evaluation and management of an established patient with at least two of these three components: a detailed history, detailed examination, and medical decision making of moderate complexity	4.20%
99213	Established patient office or other outpatient visit, 20-29 minutes	4.06%
T2003	Non-emergency transportation; encounter/trip	2.89%
T2016	Habilitation, residential, Adult 1915(i) programs group, per diem	2.49%
90834	Psychotherapy, 45 minutes	2.18%
T1016	Case management, each 15 minutes	2.08%
99232	Subsequent hospital inpatient or observation care visit involving evaluation and management with at least two of three components: expanded problem focused history, medical decision making of moderate complexity, and level 2 problem severity	1.98%
90853	Group psychotherapy	1.80%

Prescription Drugs

General Utilization

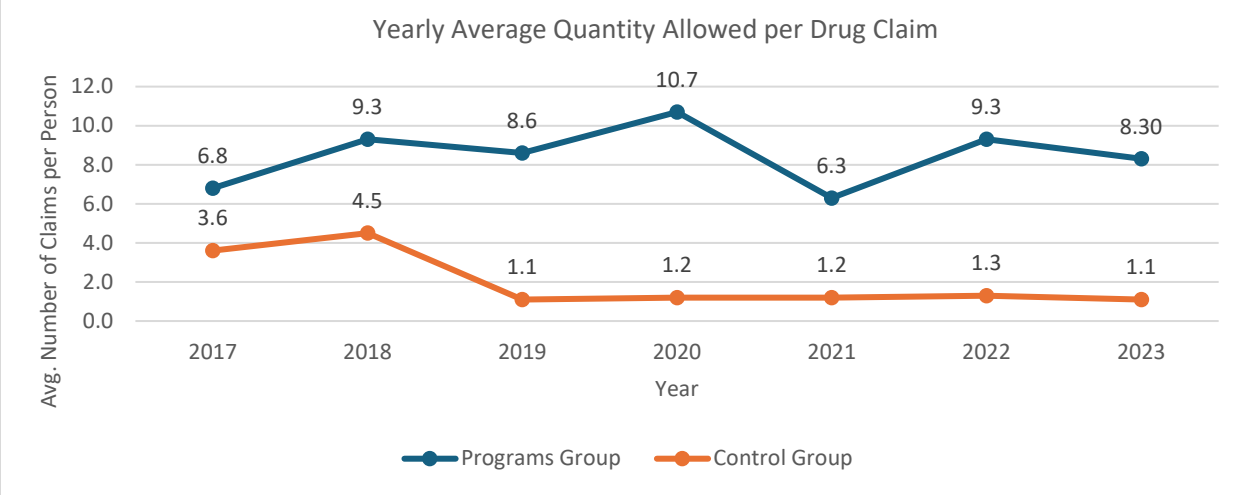
Between 2017 and 2023, the yearly average number of prescription drug claims per person in the adult 1915(i) programs group was 8.4 and 28.3 for the control group. The control group had approximately 3.4 times more prescription-related claims than the adult 1915(i) programs group. The average amount paid per drug claim in the adult 1915(i) programs group was $76 and the average amount paid for the control group was $116. The yearly changes in the average amount paid per drug claim are shown in Figure 42. The yearly average number of NDC claims per beneficiary remained similar across all years, with only a slight increase between 2021 and 2022 for both groups. Figure 40 shows the changes over time in the average number of NDC claims per person.

Figure 39: Yearly Trends in Average Number of NDC Claims Per Beneficiary



It is important to note that the average quantity allowed to be dispensed per drug claim was significantly lower in the control group than the adult 1915(i) programs group, resulting in cost differences. Quantity allowed refers to the maximum amount of a specific medication that is permitted for reimbursement or dispensation within a defined period, typically per prescription or per day. Because the control group had an average of only 1.9 quantity allowed per drug claim, they required a higher frequency of drug claims to receive the same amount of medication. Yearly changes in quantity allowed per drug claim are shown in Figure 40. Additionally, 42% of prescription drug claims for the control group had 0 refills, 12% had 1 refill, and 22% had at least 3 refills. The adult 1915(i) programs group had a different quantity refilled makeup. For this group, 35% of their prescription drug claims had 0 refills, 8% had 1 refill, 25% had at least 3 refills and 7.37% had 99 refills. Additionally, both groups have a significant percentage of claims with zero refills, but this is higher for the control group (42%) compared to the adult 1915(i) programs group (35%).

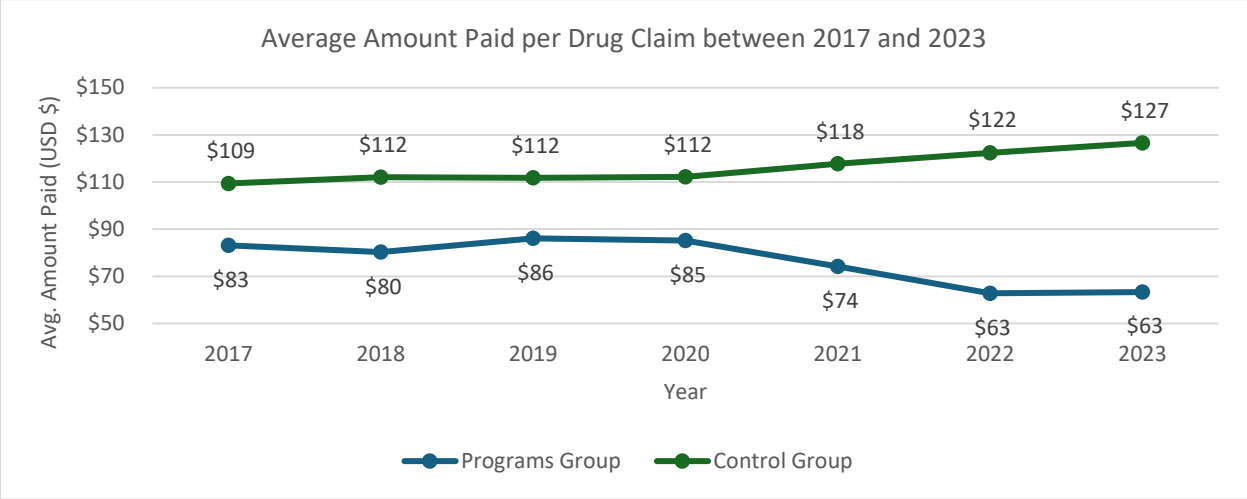
Figure 40: Yearly Average Quantity Allowed per Drug Claim



By 2023, the average amount paid per drug claim in the control group was approximately twice the amount of the adult 1915(i) programs group. For the control group, the average amount paid per claim shows a gradual increase from $109 in 2017 to $127 in 2023. The average amount paid per claim for the

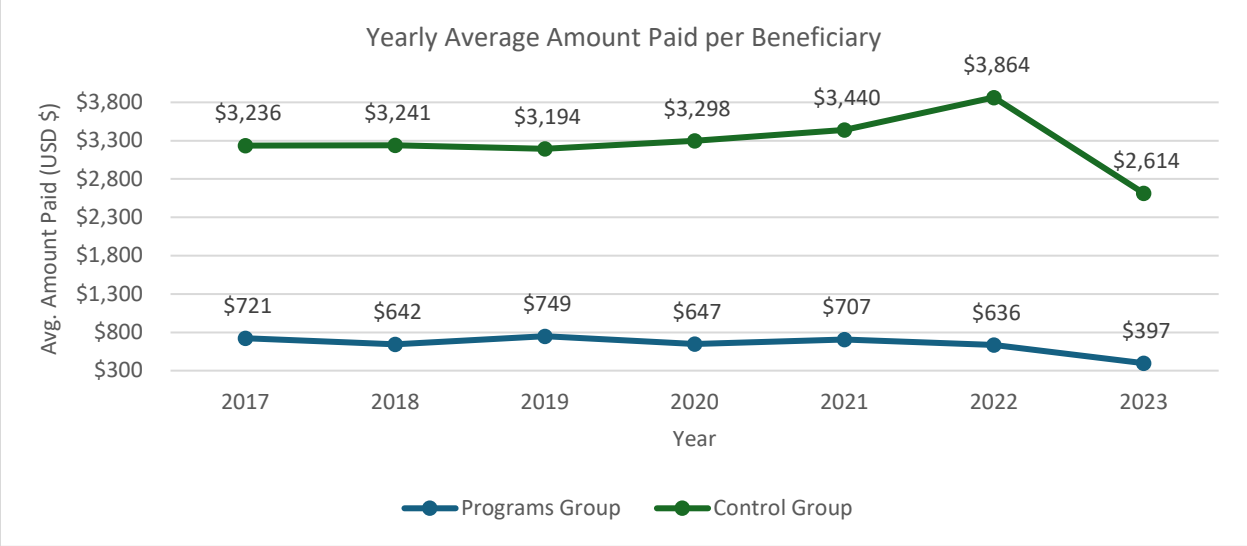
adult 1915(i) programs began decreasing from $86 in 2019 to $63 in 2022 and experienced more variability in the amount paid per claim. On average, the amount paid per drug claim was $40 higher for the control group than the adult 1915(i) programs group.

Figure 41: Time Trend in Average Amount Paid per Drug Claim



However, the yearly average amount paid per person for drug claims still had a significant difference between the adult 1915(i) programs group and control group. Similarly to the average amount paid, the year with the highest cost difference per beneficiary was 2022. Per person, the total cost to Indiana Medicaid for drug claims among the control group was significantly higher across all years. Specific numbers are shown in Figure 42. On average, there is a potential yearly savings of $2,627 for drug claims if a control beneficiary had been enrolled into one of the adult 1915(i) programs.

Figure 42: Time Trend in Average Amount Paid per Beneficiary for Drug Claims



The top ten most common NDC codes were pulled for each group and only two appeared in both. Vitamin D analogs and antihistamines were the only two drugs that appeared in both groups. However, antihistamines made up 2.36% of the drug claims in the adult 1915(i) programs group and only 0.65% in

the control group. Table 43 shows the drug classes in their respective rankings for both adult 1915(i) programs group participants and control group participants. Between the two groups, those not on one of the adult 1915(i) programs group have a significant focus on medications for opioid dependence treatment, indicating a higher prevalence or prioritization of this condition. Additionally, those on one of the adult 1915(i) programs group appear to be managing conditions related to deficiencies (vitamin D, iron) and chronic diseases (CKD-related anemia). Both groups use medications for pain relief, but the control group relies more on opioid analgesics, whereas the adult 1915(i) programs group uses aspirin. Finally, both groups utilize antihistamines for allergy symptoms, but the adult 1915(i) programs group has a slightly higher percentage usage. Further investigation into the underlying conditions and healthcare strategies of each group might provide additional insights.

Figure 43: Most Prescribed Drugs Among Adult 1915(i) Programs Group and Control Group

	Prescription Drug	**Percentage**
Programs Group	Docusate sodium, capsule	2.66%
	Vitamin D - ergocalciferol capsule	2.08%
	Ferrous sulfate	1.63%
	Hectorol - doxicalciferol injection, solution	1.35%
	Loratadine antihistamine, tablet	1.24%
	Cetrizine hydrochloride, tablet	1.13%
	Loratadine antihistamine, tablet	1.12%
	Epogen - epoetin alfa solution	0.98%
	Aspirin low dose, tablet, delayed release	
Control Group	Buprenorphine hydrochloride and naloxone hydrochloride dihydrate tablet	2.96%
	Buprenorphine hydrochloride and naloxone hydrochloride - tablet	0.70%
	Loratadine antihistamine, loratadine tablet	0.65%
	Albuterol sulfate HFA - albuterol sulfate aerosol, metered	0.54%
	Gabapentin capsule	0.41%
	Hydrocodone bitartrate and acetaminophen tablet	0.34%
	Ergocalciferol capsule, liquid filled	0.33%
	Buprenorphine and naloxone, tablet	0.31%

Adult 1915(i) Programs Group

For stool softeners, the most commonly cited one was docusate sodium and it is a laxative that assists with constipation, hemorrhoids, and anal fissures (*Docusate*, 2018). Doxicalciferol and ergocalciferol fall into the vitamin D analogs drug class and are used to treat disorders caused by a vitamin D deficiency.

They work by increasing vitamin D levels in the body and help the body absorb more calcium. Additionally, vitamin D analogs are useful in treating psoriasis by slowing the production of skin cells and by having an anti-inflammatory effect (*Psoriasis - Treatment*, 2017). Specifically, the iron supplement that appeared was ferrous sulfate, used to treat iron-deficiency anemia when a person does not get enough iron from the diet. Other than diet, some health conditions and medications can decrease the body's ability to absorb iron which can include digestive conditions like ulcerative colitis and Crohn's disease, intestine and stomach surgeries, and conditions that destroy too many red blood cells like autoimmune diseases and certain infections. People most likely to develop iron-deficiency anemia are those menstruating, pregnant people, frequent blood donors, those with kidney failure (especially if on dialysis), premature babies, or those with certain cancers, or those with heart failure (*About Ferrous Sulfate*, 2023). Loratadine antihistamine and cetirizine hydrochloride are both prescription antihistamines used to relieve more symptoms due to hay fever or other upper respiratory allergies (*Antihistamines*, 2017). Epogen is considered an erythropoiesis-stimulating agent (ESA), which work by stimulating red blood cell production and are used to help treat anemia caused by chronic kidney failure, some anticancer drugs, and certain HIV treatments, and to lower the number of blood transfusions needed for certain major surgeries (*DailyMed - EPOGEN- Epoetin Alfa Solution*, n.d.). Finally, the last drug is aspirin, which can be used to relive pain for minor aches and pains (*DailyMed - ASPIRIN LOW DOSE- Aspirin Tablet, Delayed Release*, n.d.).

Control Group

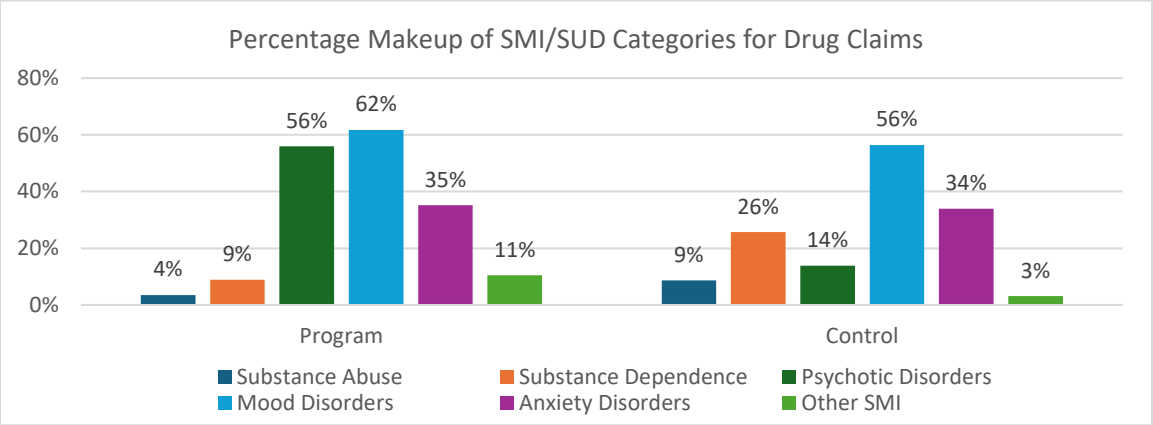
The most common drug class in this group was opioid partial agonist-antagonists are a group of drugs that are a powerful analgesic which can treat moderate to severe acute pain and block withdrawal (Rosow, 1987). Specific drugs that fall under this category are buprenorphine hydrochloride and naloxone hydrochloride and its respective dihydrate tablet, as well as buprenorphine and naloxone tablets. They are utilized to support recovery from an opioid use disorder and have been shown to be effective in decreasing opioid use and harmful related behaviors, especially as a part of a comprehensive treatment program (*Pharmacological Treatment | Medication Assisted Recovery*, n.d.). Albuterol belongs to a drug class known as bronchodilators. These are medications that help with breathing by relaxing lung muscles and widening airways. These drugs are typically used to help treat long-term lung conditions such as asthma and chronic obstructive pulmonary disease (COPD) (*Bronchodilators*, 2017). Gabapentin is in a class of drugs called anticonvulsants and these aid in the prevention and treatment of seizures or convulsions by regulating abnormal electrical activity in the brain. Primarily prescribed for epilepsy and other seizure-related conditions, they also find application in managing bipolar disorder, nerve pain, migraine headaches, fibromyalgia, and restless leg syndrome (*Definition of Anticonvulsant - NCI Dictionary of Cancer Terms - NCI*, 2011). Hydrocodone belongs to narcotic analgesics, which act on the central nervous system to relive pain and can stop or prevent cough. The combination of hydrocodone and acetaminophen are used when there is severe enough pain that requires opioid treatment and when other pain medicines did not work or cannot be tolerated by the patient (*Hydrocodone And Acetaminophen (Oral Route) Description and Brand Names - Mayo Clinic*, n.d.).

SMI/SUD Stratification

In both the Adult 1915(i) programs group and control groups, the SMI/SUD category with the highest percentage of drug claims was those with mood disorders. However, in the adult 1915(i) programs group, psychotic disorders had the second highest number while the second highest in the control group was anxiety disorders. The most drastic difference between the groups was that those with psychotic

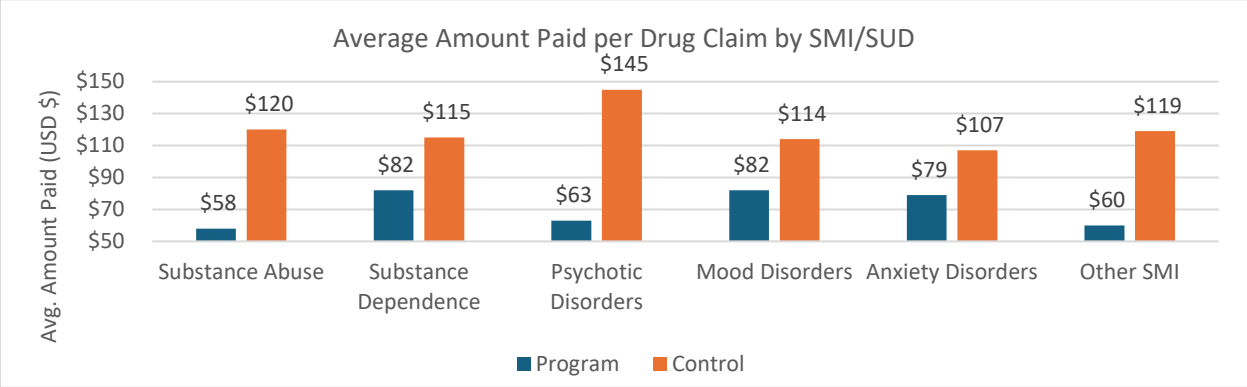
disorders made up 56% of drug claims in the adult 1915(i) programs group and only 14% in the control group. Those with substance abuse had the lowest number of drug claims across all years in the adult 1915(i) programs group. In the control group, the category with the lowest number of claims was for other SMI. Figure 44 shows the specific percentage makeup of each SMI/SUD category for drug claims among both groups.

Figure 44: Percentage Makeup of SMI/SUD Categories for Drug Claims



Across all SMI/SUD categories, the control group had significantly higher average drug claim costs compared to the adult 1915(i) programs group. The largest cost difference between the adult 1915(i) programs group and control was for those with psychotic disorders ($82). For substance abuse and substance dependence, there are significant cost differences between the adult 1915(i) programs group and control groups, especially for substance abuse. Costs varied more for those not on the adult 1915(i) programs group with the largest cost difference occurring between psychotic disorders and anxiety disorders. On average, the amount paid per drug claim for individuals with a psychotic disorder was $38 higher than for those with an anxiety disorder. The average amount paid per claim had very little difference between SMI/SUD groups for those on the 1915(i) SPAs. Comparisons between the amount paid for each SMI/SUD category are shown in Figure 45.

Figure 45: Average Amount Paid per Drug Claim by SMI/SUD for Adult 1915(i) Programs Group and Control Group



Recommendations

Based on the claims data and results, the following recommendations are made to improve the cost-effectiveness and health outcomes for adult 1915(i) program participants as well as the control group (those not on either program).

1. Expand waiver enrollment. Encourage and enable CMHCs to reach more eligible individuals to enroll in the 1915(i) SPA programs. The analysis showed significant cost savings and better health outcomes for those in the waiver program compared to non-waiver participants, especially in hospital claims and drug costs.
2. Targeted recruitment for substance dependence. Implement targeted strategies to recruit and retain individuals struggling with substance abuse and dependence into the 1915(i) SPA programs. This could help in reducing high-cost trauma and emergency admissions prevalent among non-waiver participants with substance dependence as well as reduce the number of mortalities present.
3. Enhanced mental health services. Increase the provision of mental health services, particularly for those with mood and psychotic disorders. 1915(i) program participants have shown better cost management and health outcomes with these conditions, but those with psychotic and mood disorders still need more healthcare services specific for their SMI.
4. Cost management strategies. Implement strategies to manage costs for high-expense categories, such as emergency and elective admissions, especially for non-waiver participants. This includes better pre-admission screening and enhanced outpatient care to reduce hospitalizations.
5. Focus on preventative care. Strengthen preventative care measures for common high-cost diagnoses such as circulatory and respiratory diseases. This could include regular health screenings and early intervention programs to manage chronic conditions before they require costly hospital admissions.
6. Medication management programs. Develop medication management programs to ensure appropriate use and reduce the number of prescription drug claims, particularly for non-waiver participants. This can help in managing the cost difference observed in prescription drug claims.
7. Address gender disparities. Addressing the increasing gender gap in SMI/SUD diagnoses, particularly among females. Tailored outreach and support programs could help in reducing this disparity and improving outcomes.
8. Enhanced support for home visits and psychotherapy. Increase support for home visit services and psychotherapy sessions, especially for waiver participants. These services have been shown to be beneficial for managing mental health conditions.
9. Data-driven policy making. Continue using detailed claims data to inform policy decisions. Regular analysis of claims data can help in identifying trends and making evidence-based decisions to improve the waiver program and overall healthcare costs.

Limitations

Analyzing the Triple Aim components using state Medicaid data for specific waiver programs presents several limitations. One key issue is waiver eligibility and potential selection bias, where individuals qualifying for the waiver might differ significantly from those who do not, leading to possible confounding by indication. This can affect the generalizability and accuracy of the findings. Additionally, Medicaid claims data often do not account for enrollment strategies, making it difficult to determine if observed differences, such as gender gaps, are meaningful or merely artifacts of the enrollment process.

This limitation complicates efforts to draw conclusions about the effectiveness of outreach and other interventions. Moreover, the absence of claims for certain services does not necessarily indicate a lack of need or coverage; other access barriers, such as stigma or logistical challenges, could prevent individuals from utilizing available mental health services. Consequently, interpreting the data without considering these external factors may lead to incomplete or misleading conclusions about the program's impact on health outcomes, costs, and patient experience.

Conclusions

The analysis of the Indiana Medicaid claims dataset from 2017 to 2023 reveals significant cost and health outcome differences between waiver and non-waiver participants. 1915(i) program participants consistently show lower costs per claim and better management of chronic conditions and mental health disorders. Expanding the waiver program and implementing targeted strategies for high-cost categories and substance dependence can lead to substantial cost savings and improved health outcomes. By focusing on preventative care, medication management, and enhanced mental health services, Indiana Medicaid can ensure better care for its beneficiaries while managing healthcare costs effectively. Regular data analysis and evidence-based policy making will be crucial in achieving these goals.

Based on the claims analysis and the most recent 1915(b)(4) waiver application, the projected waiver cost for 2022 was $62,228,844 and the actual total amount paid for all beneficiaries in 2022 was $40,156,475.32. The 1915(i) SPAs have an efficient and economic provision of covered care and services.

Final Recommendations and Conclusions

Recommendations

Based on the results and analyses presented, the following recommendations are made to enhance the effectiveness and accessibility of the 1915(i) SPA programs for the providers specified in the 1915(b)(4) waiver in Indiana.

1. Increase Provider and Staff Capacity: Address the shortage of providers and staff across CMHCs. Implement targeted recruitment and retention strategies to ensure sufficient personnel to meet the demands of waiver participants, especially when it is recommended to increase the number of people on the waiver.
2. Enhance Communication and Training: Improve communication between CMHCs and DMHA. Provide consistent feedback, standardized templates, and more frequent training sessions on program requirements and updates. It is understood that training typically relies on CMHCs themselves, and not DMHA, however, incentives should be created for these trainings to occur.
3. Streamline Application Processes: Simplify the application process for both beneficiaries and providers. Ensure clear documentation and reduce the administrative burden by integrating the waiver application system with Electronic Health Records (EHRs).
4. Improve Transportation Services: Develop reliable and accessible transportation services, particularly in rural areas. Address the transportation challenges faced by waiver participants to ensure they can attend appointments and access necessary care.
5. Targeted Interventions for Specific Groups: Implement targeted strategies to address disparities among different demographic groups, such as those based on rurality, race, and diagnosis. Focus

on improving experiences and outcomes for groups facing lower satisfaction scores or unmet needs.

6. Standardize Incident Reporting and Improve Response: Ensure critical incidents are reported timely and accurately. Provide additional training on error reduction techniques, crisis intervention, and reporting protocols. Implement advanced data analysis techniques to proactively address emerging issues.
7. Improve Interagency Communication: Enhance communication between DMHA, providers, and DFR. Establish clear communication channels and protocols to prevent delays and misunderstandings that impact client care.
8. Focus on Beneficiary Needs and Unmet Needs. Prioritize understanding and addressing the diverse needs of beneficiaries, including mental health support, primary care, case management, medication assistance, and transportation. Implement strategies to reduce unmet needs in medication administration and other areas.
9. Monitor and Evaluate Program Effectiveness: Continuously monitor and evaluate the effectiveness of the 1915(i) SPA programs. Use detailed claims data, performance measures, and beneficiary feedback to inform policy decisions and improve program implementation.

Conclusions

The evaluation of the 1915(i) SPAs and 1915(b)(4) waivers in Indiana highlighted significant areas for improvement, particularly in provider capacity, communication, application processes, and transportation services. Addressing these issues is crucial for enhancing the effectiveness and accessibility of the program. By implementing targeted interventions and improving interagency communication, Indiana can better meet the needs of waiver participants. Continuous monitoring and evaluation, coupled with consistent training and standardized procedures, will ensure the program provides high-quality, cost-effective care to its beneficiaries. These recommendations aim to foster a more efficient, responsive, and equitable system for delivering mental health and substance use disorder services across the state. These programs are crucial for improving the overall health and wellbeing of individuals with serious mental illness and/or substance use disorders within Indiana, and it is strongly encouraged that the state provide CMHCs with the necessary resources to increase the number of waiver participants and reach more eligible individuals.

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Appendix

Appendix A: Current Eligibility Requirements for BPHC and AMHH

Table 41: Requirements for 1915(i) Programs

Requirement	BPHC	AMHH
Clinically eligible	19 years or older	19 years or older
	Has been diagnosed with a BPHC-eligible primary mental health diagnosis (Appendix B)	Has been diagnosed with an AMHH-eligible primary mental health diagnosis (Appendix B)
Needs-based criteria	Demonstrated needs related to the management of his/her behavioral and physical health	Reached maximum benefit from rehabilitative treatment
	Demonstrated impairment in self-management of physical and behavioral health services	Clinically benefit from and who want a habilitation approach and services to help them maintain the gains made in rehabilitation and/or acquiring, retaining, and improving the skills necessary to reside successfully in community settings
	A health need that requires assistance and support in coordinating behavioral and physical health treatment	At risk of institutionalization without long-term supports and/or intense home and community-based services
	A recommendation for intensive community-based care based on the uniform FSSA/DMHA-approved behavioral health assessment tool (Adult Needs and Strengths Assessment – ANSA) as indicated by a rating of three or higher	A recommendation for intensive community-based care based on the uniform FSSA/DMHA-approved behavioral health assessment tool (Adult Needs and Strengths Assessment – ANSA) as indicated by a rating of four or higher
Housing criteria	Must reside in a setting that meets federal setting requirements for home and community-based services	Must reside in a setting that meets federal setting requirements for home and community-based services
	Each setting must be assessed independently to determine if an applicant resides in a community-based setting	Each setting must be assessed independently to determine if an applicant resides in a community-based setting
Financially eligible	An individual countable income up to 300% above FPL. Income limits are updated annually when the federal government releases the new FPL standards	An individual countable income up to 300% above FPL. Income limits are updated annually when the federal government releases the new FPL standards

Other criteria	Not enrolled in 1915(c) services	Medicaid enrolled in an approved Indiana Health Coverage Program (IHCP) aide category

Table 42: BPHC Eligible Primary ICD10-CM Codes

Diagnosis Code	Description	SMI/SUD Category
F10.10	Alcohol abuse, uncomplicated	Substance Abuse
F10.120	Alcohol abuse with intoxication, uncomplicated	Substance Abuse
F10.130	Alcohol abuse with withdrawal, uncomplicated	Substance Abuse
F10.131	Alcohol abuse with withdrawal delirium	Substance Abuse
F10.132	Alcohol abuse with withdrawal with perceptual disturbance	Substance Abuse
F10.139	Alcohol abuse with withdrawal, unspecified	Substance Abuse
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions	Substance Abuse
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations	Substance Abuse
F10.188	Alcohol abuse with other alcohol-induced disorder	Substance Abuse
F10.19	Alcohol abuse with unspecified alcohol-induced disorder	Substance Abuse
F10.20	Alcohol dependence, uncomplicated	Substance dependence
F10.21	Alcohol dependence, in remission	Substance dependence
F10.220	Alcohol dependence with intoxication, uncomplicated	Substance dependence
F10.230	Alcohol dependence with withdrawal, uncomplicated	Substance dependence
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions	Substance dependence
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations	Substance dependence
F10.29	Alcohol dependence with unspecified alcohol-induced disorder	Substance dependence
F11.10	Opioid abuse, uncomplicated	Substance Abuse
F11.120	Opioid abuse with intoxication, uncomplicated	Substance Abuse
F11.13	Opioid abuse with withdrawal	Substance Abuse
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions	Substance Abuse
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations	Substance Abuse
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified	Substance Abuse
F11.19	Opioid abuse with unspecified opioid-induced disorder	Substance Abuse
F11.20	Opioid dependence, uncomplicated	Substance dependence
F11.21	Opioid dependence, in remission	Substance dependence
F11.220	Opioid dependence with intoxication, uncomplicated	Substance dependence

F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions	Substance dependence
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations	Substance dependence
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified	Substance dependence
F11.29	Opioid dependence with unspecified opioid-induced disorder	Substance dependence
F12.10	Cannabis abuse, uncomplicated	Substance Abuse
F12.120	Cannabis abuse with intoxication, uncomplicated	Substance Abuse
F12.13	Cannabis abuse with withdrawal	Substance Abuse
F12.150	Cannabis abuse with psychotic disorder with delusions	Substance Abuse
F12.151	Cannabis abuse with psychotic disorder with hallucinations	Substance Abuse
F12.19	Cannabis abuse with unspecified cannabis-induced disorder	Substance Abuse
F12.20	Cannabis dependence, uncomplicated	Substance dependence
F12.21	Cannabis dependence, in remission	Substance dependence
F12.220	Cannabis dependence with intoxication, uncomplicated	Substance dependence
F12.250	Cannabis dependence with psychotic disorder with delusions	Substance dependence
F12.251	Cannabis dependence with psychotic disorder with hallucinations	Substance dependence
F12.29	Cannabis dependence with unspecified cannabis-induced disorder	Substance dependence
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	Substance Abuse
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated	Substance Abuse
F13.130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated	Substance Abuse
F13.131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium	Substance Abuse
F13.132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance	Substance Abuse
F13.139	Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified	Substance Abuse
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	Substance Abuse
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	Substance Abuse
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder	Substance Abuse

F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder	Substance Abuse
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	Substance dependence
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission	Substance dependence
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated	Substance dependence
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated	Substance dependence
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	Substance dependence
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	Substance dependence
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic induced persisted amnestic disorder	Substance dependence
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic induced disorder	Substance dependence
F14.10	Cocaine abuse, uncomplicated	Substance Abuse
F14.120	Cocaine abuse with intoxication, uncomplicated	Substance Abuse
F14.13	Cocaine abuse, unspecified with withdrawal	Substance Abuse
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions	Substance Abuse
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations	Substance Abuse
F14.19	Cocaine abuse with unspecified cocaine-induced disorder	Substance Abuse
F14.20	Cocaine dependence, unspecified	Substance dependence
F14.21	Cocaine dependence, in remissions	Substance dependence
F14.220	Cocaine dependence with intoxication, uncomplicated	Substance dependence
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions	Substance dependence
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations	Substance dependence
F14.29	Cocaine dependence with unspecified cocaine-induced disorder	Substance dependence
F15.10	Other stimulant abuse, unspecified	Substance Abuse
F15.120	Other stimulant abuse with intoxication, uncomplicated	Substance Abuse
F15.13	Other stimulant abuse with withdrawal	Substance Abuse

F15.19	Other stimulant abuse with unspecified stimulant-induced disorder	Substance Abuse
F15.20	Other stimulant dependence, unspecified	Substance dependence
F15.21	Other stimulant dependence, in remission	Substance dependence
F15.220	Other stimulant dependence with intoxication, uncomplicated	Substance dependence
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder	Substance dependence
F16.10	Hallucinogen abuse, uncomplicated	Substance Abuse
F16.120	Hallucinogen abuse with intoxication, uncomplicated	Substance Abuse
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)	Substance Abuse
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder	Substance Abuse
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder	Substance Abuse
F16.20	Hallucinogen dependence, uncomplicated	Substance dependence
F16.21	Hallucinogen dependence, in remission	Substance dependence
F16.220	Hallucinogen dependence with intoxication, uncomplicated	Substance dependence
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions	Substance dependence
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations	Substance dependence
F16.283	Hallucinogen dependence with hallucination persisting perception disorder (flashbacks)	Substance dependence
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder	Substance dependence
F18.10	Inhalant abuse, uncomplicated	Substance Abuse
F18.120	Inhalant abuse with intoxication, uncomplicated	Substance Abuse
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions	Substance Abuse
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations	Substance Abuse
F18.19	Inhalant abuse with unspecified inhalant-induced disorder	Substance Abuse
F18.20	Inhalant dependence, uncomplicated	Substance dependence
F18.21	Inhalant dependence, in remission	Substance dependence
F18.220	Inhalant dependence with intoxication, uncomplicated	Substance dependence
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions	Substance dependence
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations	Substance dependence
F18.29	Inhalant dependence with unspecified inhalant-induced disorder	Substance dependence
F19.10	Other psychoactive substance abuse, uncomplicated	Substance Abuse

F19.120	Other psychoactive substance abuse with intoxication, uncomplicated	Substance Abuse
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances	Substance Abuse
F19.130	Other psychoactive substance abuse with withdrawal, uncomplicated	Substance Abuse
F19.131	Other psychoactive substance abuse with withdrawal delirium	Substance Abuse
F19.132	Other psychoactive substance abuse with withdrawal with perceptual disturbance	Substance Abuse
F19.139	Other psychoactive substance abuse with withdrawal, unspecified	Substance Abuse
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions	Substance Abuse
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations	Substance Abuse
F19.16	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with amnestic disorder	Substance Abuse
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder	Substance Abuse
F19.20	Other psychoactive substance dependence, uncomplicated	Substance dependence
F19.21	Other psychoactive substance dependence, in remission	Substance dependence
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated	Substance dependence
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance	Substance dependence
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated	Substance dependence
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance	Substance dependence
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions	Substance dependence
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations	Substance dependence
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder	Substance dependence
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder	Substance dependence
F20.0	Paranoid schizophrenia	Psychotic disorder

F20.1	Disorganized schizophrenia	Psychotic disorder
F20.2	Catatonic schizophrenia	Psychotic disorder
F20.3	Undifferentiated schizophrenia	Psychotic disorder
F20.5	Residual schizophrenia	Psychotic disorder
F20.81	Schizophreniform disorder	Psychotic disorder
F20.89	Other schizophrenia	Psychotic disorder
F20.9	Schizophrenia, unspecified	Psychotic disorder
F22	Delusional disorders	Psychotic disorder
F24	Shared psychotic disorder	Psychotic disorder
F25.0	Schizoaffective disorder, bipolar type	Psychotic disorder
F25.1	Schizoaffective disorder, depressive type	Psychotic disorder
F25.8	Other schizoaffective disorders	Psychotic disorder
F25.9	Schizoaffective disorder, unspecified	Psychotic disorder
F28	Other psychotic disorder not due to a substance or known physiological condition	Psychotic disorder
F29	Unspecified psychosis not due to a substance or known physiological condition	Psychotic disorder
F30.10	Manic episode without psychotic symptoms, unspecified	Mood disorder
F30.12	Manic episode without psychotic symptoms, moderate	Mood disorder
F30.13	Manic episode, severe, without psychotic symptoms	Mood disorder
F30.2	Manic episode, severe with psychotic symptoms	Mood disorder
F30.3	Manic episode in partial remission	Mood disorder
F30.9	Manic episode, unspecified	Mood disorder
F31.0	Bipolar disorder, current episode hypomanic	Mood disorder
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified	Mood disorder
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate	Mood disorder
F31.13	Bipolar disorder, current episode manic without psychotic features, severe	Mood disorder
F31.2	Bipolar disorder, current episode manic severe with psychotic disorders	Mood disorder
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	Mood disorder
F31.32	Bipolar disorder, current episode depressed, moderate	Mood disorder
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	Mood disorder
F31.5	Bipolar disorder, current episode, severe, with psychotic features	Mood disorder
F31.60	Bipolar disorder, current episode mixed, unspecified	Mood disorder
F31.62	Bipolar disorder, current episode mixed, moderate	Mood disorder
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features	Mood disorder

F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	Mood disorder
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic	Mood disorder
F31.73	Bipolar disorder, in partial remission, most recent episode manic	Mood disorder
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	Mood disorder
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	Mood disorder
F31.81	Bipolar II disorder	Mood disorder
F31.89	Bipolar disorder, unspecified	Mood disorder
F31.9	Other bipolar disorder	Mood disorder
F32.1	Major depressive disorder, single episode, moderate	Mood disorder
F32.2	Major depressive disorder, single episode, severe without psychotic features	Mood disorder
F32.3	Major depressive disorder, single episode, severe with psychotic features	Mood disorder
F32.4	Major depressive disorder, single episode, in partial remission	Mood disorder
F33.1	Major depressive disorder, recurrent, moderate	Mood disorder
F33.2	Major depressive disorder, recurrent severe without psychotic features	Mood disorder
F33.3	Major depressive disorder, recurrent severe with psychotic symptoms	Mood disorder
F33.41	Major depressive disorder, recurrent, in partial remission	Mood disorder
F33.9	Major depressive disorder, recurrent, unspecified	Mood disorder
F34.0	Cyclothymic disorder	Mood disorder
F34.1	Dysthymic disorder	Mood disorder
F40.00	Agoraphobia, unspecified	Mood disorder
F40.01	Agoraphobia with panic disorder	Anxiety disorder
F40.02	Agoraphobia without panic disorder	Anxiety disorder
F40.10	Social phobia, unspecified	Anxiety disorder
F41.0	Panic disorder [episodic paroxysmal anxiety]	Anxiety disorder
F41.1	Generalized anxiety disorder	Anxiety disorder
F42.2	Mixed obsessional thoughts and acts	Anxiety disorder
F42.3	Hoarding disorder	Anxiety disorder
F43.10	Post-traumatic stress disorder, unspecified	Anxiety disorder
F43.11	Post-traumatic stress disorder, acute	Anxiety disorder
F43.12	Post-traumatic stress disorder, chronic	Anxiety disorder
F44.81	Dissociative identity disorder	Other SMI
F45.41	Panic disorder exclusively related to psychological factors	Other SMI
F50.00	Anorexia nervosa, unspecified	Other SMI
F50.01	Anorexia nervosa, restricting type	Other SMI

F50.02	Anorexia nervosa, binge eating/purging type	Other SMI
F50.2	Bulimia nervosa	Other SMI
F50.81	Binge eating disorder	Other SMI
F50.82	Avoidant/restrictive food intake disorder	Other SMI
F50.89	Other specified eating disorder	Other SMI
F50.9	Eating disorder, unspecified	Other SMI
F51.4	Sleep terrors [night terrors]	Other SMI
F53.0	Postpartum depression	Mood disorder
F60.0	Paranoid personality disorder	Other SMI
F60.3	Borderline personality disorder	Other SMI

Table 43: AMHH Eligible Primary ICD10-CM Codes

Diagnosis Code	Description	SMI/SUD Category
F20.0	Paranoid schizophrenia	Psychotic disorder
F20.1	Disorganized schizophrenia	Psychotic disorder
F20.2	Catatonic schizophrenia	Psychotic disorder
F20.3	Undifferentiated schizophrenia	Psychotic disorder
F20.5	Residual schizophrenia	Psychotic disorder
F20.81	Schizophreniform disorder	Psychotic disorder
F20.89	Other schizophrenia	Psychotic disorder
F20.9	Schizophrenia, unspecified	Psychotic disorder
F22	Delusional disorders	Psychotic disorder
F24	Shared psychotic disorder	Psychotic disorder
F25.0	Schizoaffective disorder, bipolar type	Psychotic disorder
F25.1	Schizoaffective disorder, depressive type	Psychotic disorder
F25.8	Other schizoaffective disorders	Psychotic disorder
F25.9	Schizoaffective disorder, unspecified	Psychotic disorder
F29	Unspecified psychosis not due to a substance or known physiological condition	Psychotic disorder
F30.10	Manic episode without psychotic symptoms, unspecified	Mood disorder
F30.12	Manic episode without psychotic symptoms, moderate	Mood disorder
F30.13	Manic episode, severe, without psychotic symptoms	Mood disorder
F30.2	Manic episode, severe with psychotic symptoms	Mood disorder
F30.3	Manic episode in partial remission	Mood disorder
F30.9	Manic episode, unspecified	Mood disorder
F31.0	Bipolar disorder, current episode hypomanic	Mood disorder
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified	Mood disorder
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate	Mood disorder
F31.13	Bipolar disorder, current episode manic without psychotic features, severe	Mood disorder
F31.2	Bipolar disorder, current episode manic severe with psychotic disorders	Mood disorder
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	Mood disorder
F31.32	Bipolar disorder, current episode depressed, moderate	Mood disorder
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	Mood disorder
F31.5	Bipolar disorder, current episode, severe, with psychotic features	Mood disorder
F31.60	Bipolar disorder, current episode mixed, unspecified	Mood disorder
F31.62	Bipolar disorder, current episode mixed, moderate	Mood disorder

F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features	Mood disorder
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	Mood disorder
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic	Mood disorder
F31.73	Bipolar disorder, in partial remission, most recent episode manic	Mood disorder
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	Mood disorder
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	Mood disorder
F31.81	Bipolar II disorder	Mood disorder
F31.9	Bipolar disorder, unspecified	Mood disorder
F31.89	Other bipolar disorder	Mood disorder
F33.1	Major depressive disorder, recurrent, moderate	Mood disorder
F33.2	Major depressive disorder, recurrent severe without psychotic features	Mood disorder
F33.3	Major depressive disorder, recurrent severe with psychotic symptoms	Mood disorder
F33.41	Major depressive disorder, recurrent, in partial remission	Mood disorder
F33.9	Major depressive disorder, recurrent, unspecified	Mood disorder
F42.2	Mixed obsessional thoughts and acts	Anxiety disorder
F42.3	Hoarding disorder	Anxiety disorder

Appendix B: CAHPS Survey Questions

Cognitive Screening Questions

1. Does someone come into your home to help you?
2. How do they help you?
3. What do you call them?

Identification Questions

4. In the last 3 months, did you get (program-specific term for personal assistance) at home?
5. What do you call the person or people who gave you (program-specific term for personal assistance)? For example, do you call them (program-specific term for personal assistance), staff, personal care attendants, PCAs, workers, or something else?
6. In the last 3 months, did you get (program-specific term for behavioral health specialist services) at home?
7. What do you call the person or people who gave you (program-specific term for behavioral health specialist services)? For example, do you call them (program-specific term for behavioral health specialists), counselors, peer supports, recovery assistants, or something else?
8. In the last 3 months, did you get (program-specific term for homemaker services) at home?
9. What do you call the person or people who gave you (program-specific term for homemaker services)? For example, do you call them (program-specific term for homemaker), aides, homemakers, chore workers, or something else?
10. [IF (Q4 or Q6) and Q8 = YES, ASK] In the last 3 months, did the same people who help you with everyday activities also help you clean your home?
11. In the last 3 months, did you get help from (program-specific term for case manager services) to help make sure that you had all the services you needed?
12. What do you call the person who gave you (program-specific term for case manager services)? For example, do you call the person a (program-specific term for case manager), case manager, care manager, service coordinator, supports coordinator, social worker, or something else?

Getting Needed Services from Personal Assistant and Behavioral Health Staff

13. First I would like to talk about the {personal assistance/behavioral health staff} who are paid to help you with everyday activities—for example, getting dressed, using the bathroom, taking a bath or shower, or going places. In the last 3 months, how often did {personal assistance/behavioral health staff} come to work on time?
    a. ALTERNATE VERSION: First I would like to talk about the {personal assistance/behavioral health staff} who are paid to help you with everyday activities—for example, getting dressed, using the bathroom, taking a bath or shower, or going places. In the last 3 months, did {personal assistance/behavioral health staff} come to work on time?
14. In the last 3 months, how often did (personal assistance/behavioral health staff) work as long as they were supposed to?

    a. ALTERNATE VERSION: In the last 3 months, did {personal assistance/behavioral health staff} work as long as they were supposed to?
15. Sometimes staff cannot come to work on a day that they are scheduled. In the last 3 months, when staff could not come to work on a day that they were scheduled, did someone let you know that (personal assistance/behavioral health staff) could not come that day?
16. In the last 3 months, did you need help from (personal assistance/behavioral health staff) to get dressed, take a shower, or bathe?
17. In the last 3 months, did you always get dressed, take a shower, or bathe when you needed to?
18. In the last 3 months, was this because there were no (personal assistance/behavioral health staff) to help you?
19. In the last 3 months, how often did {personal assistance/behavioral health staff} make sure you had enough personal privacy when you dressed, took a shower, or bathed?
    a. ALTERNATE VERSION: In the last 3 months, did {personal assistance/behavioral health staff} make sure you had enough personal privacy when you dressed, took a shower, or bathed?
20. In the last 3 months, did you need help from {personal assistance/behavioral health staff} with your meals, such as help making or cooking meals or help eating?
21. In the last 3 months, were you always able to get something to eat when you were hungry?
22. In the last 3 months, was this because there were no (personal assistance/behavioral health staff) to help you?
23. Sometimes people need help taking their medicines, such as reminders to take medicine, help pouring them, or setting up their pills. In the last 3 months, did you need help from (personal assistance/behavioral health staff) to take your medicines?
24. In the last 3 months, did you always take your medicine when you were supposed to?
25. In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?
26. Help with toileting includes helping someone get on and off the toilet or help changing disposable briefs or pads. In the last 3 months, did you need help from {personal assistance/behavioral health staff} with toileting?
27. In the last 3 months, did you get all the help you needed with toileting from {personal assistance/behavioral health staff} when you needed it?

How Well Personal Assistant and Behavioral Health Staff Communicate with and Treat You

28. In the last 3 months, how often did {personal assistance/behavioral health staff} treat you with courtesy and respect?
    a. ALTERNATE VERSION: In the last 3 months, did {personal assistance/behavioral health staff} treat you with courtesy and respect?
29. In the last 3 months, how often were the explanations {personal assistance/behavioral health staff} gave you hard to understand because of an accent or the way {personal assistance/behavioral health staff}spoke English?

    a. ALTERNATE VERSION: In the last 3 months, were the explanations {personal assistance/behavioral health staff} gave you hard to understand because of an accent or the way {personal assistance/behavioral health staff} spoke English?

30. In the last 3 months, how often did {personal assistance/behavioral health staff} treat you the way you wanted them to?
    a. ALTERNATE VERSION: In the last 3 months, did {personal assistance/behavioral health staff} treat you the way you wanted them to?
31. In the last 3 months, how often did {personal assistance/behavioral health staff} explain things in a way that was easy to understand?
    a. ALTERNATE VERSION: In the last 3 months, did {personal assistance/behavioral health staff} explain things in a way that was easy to understand?
32. In the last 3 months, how often did {personal assistance/behavioral health staff} listen carefully to you?
    a. ALTERNATE VERSION: In the last 3 months, did {personal assistance/behavioral health staff} listen carefully to you?
33. In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what kind of help you needed with everyday activities, like getting ready in the morning, getting groceries, or going places in your community?
34. In the last 3 months, did {personal assistance/behavioral health staff} encourage you to do things for yourself if you could?
35. Using any number from 0 to 10, where 0 is the worst help from {personal assistance/behavioral health staff} possible and 10 is the best help from {personal assistance/behavioral health staff} possible, what number would you use to rate the help you get from {personal assistance/behavioral health staff}?
    a. ALTERNATE VERSION: How would you rate the help you get from {personal assistance/behavioral health staff}?
36. Would you recommend the {personal assistance/behavioral health staff} who help you to your family and friends if they needed help with everyday activities? Would you say you would recommend the {personal assistance/behavioral health staff}

Your Case Manager

37. Do you know who your {case manager} is?
38. In the last 3 months, could you contact this {case manager} when you needed to?
39. Some people need to get equipment to help them, like wheelchairs or walkers, and other people need their equipment replaced or fixed. In the last 3 months, did you ask this {case manager} for help with getting or fixing equipment?
40. In the last 3 months, did this {case manager} work with you when you asked for help with getting or fixing equipment?
41. In the last 3 months, did you ask this {case manager} for help in getting any changes to your services, such as more help from {personal assistance/behavioral health staff and/or homemakers if applicable}, or for help with getting places or finding a job?

42. In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?
43. Using any number from 0 to 10, where 0 is the worst help from {case manager} possible and 10 is the best help from {case manager} possible, what number would you use to rate the help you get from {case manager}?
    a. ALTERNATE VERSION: How would you rate the help you get from the {case manager}? Would you say . . .
44. Would you recommend the {case manager} who helps you to your family and friends if they needed {program-specific term for case-management services}? Would you say you would recommend the {case manager}

Choosing Services

45. In the last 3 months, did your [program-specific term for "service plan"] include things that are important to you?
46. In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what's on your [program-specific term for "service plan"], including the things that are important to you?
47. In the last 3 months, who would you have talked to if you wanted to change your [program-specific term for "service plan"]? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]

Transportation

48. Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. In the last 3 months, how often did you have a way to get to your medical appointments?
    a. ALTERNATE VERSION: Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. In the last 3 months, did you have a way to get to your medical appointments?
49. In the last 3 months, did you use a van or some other transportation service? Do not include a van you own.
50. In the last 3 months, were you able to get in and out of this ride easily?
51. In the last 3 months, how often did this ride arrive on time to pick you up?
    a. ALTERNATE VERSION: In the last 3 months, did this ride arrive on time to pick you up?

Personal Safety

52. Who would you contact in case of an emergency? [INTERVIEWER MARKS ALL THAT APPLY]
53. In the last 3 months, was there a person you could talk to if someone hurt you or did something to you that you didn't like?

The next few questions ask if anyone paid to help you treated you badly in the last 3 months. This includes {personal assistance/behavioral health staff, homemakers, or your case manager}. We are asking everyone the next questions—not just you. [ADD STATE-SPECIFIC LANGUAGE HERE REGARDING MANDATED REPORTING, IF APPROPRIATE—"I want to remind you that, although your answers are

confidential, I have a legal responsibility to tell {STATE} if I hear something that makes me think you are being hurt or are in danger."

54. In the last 3 months, did any {personal assistance/behavioral health staff, homemakers, or your case managers} take your money or your things without asking you first?
55. In the last 3 months, did someone work with you to fix this problem?
56. In the last 3 months, who has been working with you to fix this problem? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]
57. In the last 3 months, did any {staff} yell, swear, or curse at you?
58. In the last 3 months, did someone work with you to fix this problem?
59. In the last 3 months, who has been working with you to fix this problem? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]
60. In the last 3 months, did any {staff} hit you or hurt you?
61. In the last 3 months, did someone work with you to fix this problem?
62. In the last 3 months, who has been working with you to fix this problem? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]

Community Inclusion and Empowerment

63. Do you have any family members who live nearby? Do not include family members you live with.
64. In the last 3 months, when you wanted to, how often could you get together with these family members who live nearby?
    a. ALTERNATE VERSION: In the last 3 months, when you wanted to, could you get together with these family members who live nearby?
65. Do you have any friends who live nearby?
66. In the last 3 months, when you wanted to, how often could you get together with these friends who live nearby?
    a. ALTERNATE VERSION: In the last 3 months, when you wanted to, could you get together with these friends who live nearby?
67. In the last 3 months, when you wanted to, how often could you do things in the community that you like?
    a. ALTERNATE VERSION: In the last 3 months, when you wanted to, could you do things in the community that you like?
68. In the last 3 months, did you need more help than you get from {personal assistance/behavioral health staff} to do things in your community?
69. In the last 3 months, did you take part in deciding what you do with your time each day?
70. In the last 3 months, did you take part in deciding when you do things each day—for example, deciding when you get up, eat, or go to bed?

About You

71. In general, how would you rate your overall health?
72. In general, how would you rate your overall mental or emotional health?
73. What is your age?

    a. ALTERNATE VERSION: In what year were you born?
74. [IF NECESSARY, ASK, AND VERIFY IF OVER THE PHONE] Are you male or female?
75. What is the highest grade or level of school that you have completed?
76. Are you of Hispanic, Latino, or Spanish origin?
77. Which group best describes you? [READ ALL ANSWER CHOICES. CODE ALL THAT APPLY.]
78. What is your race? You may choose one or more of the following.
79. Which group best describes you? [READ ALL ANSWER CHOICES. CODE ALL THAT APPLY.]
80. Which group best describes you? [READ ALL ANSWER CHOICES. CODE ALL THAT APPLY.]
81. Do you speak a language other than English at home?
82. What is the language you speak at home?
83. [IF NECESSARY, ASK] How many adults live at your home, including you?
84. [IF NECESSARY, ASK] Do you live with any family members?
85. [IF NECESSARY, ASK] Do you live with people who are not family or are not related to you?
86. Are you open to receiving additional contacts from DMHA staff related to these services?

Interviewer Questions

87. Was the respondent able to give valid responses?
88. Was any one else present during the interview?
89. Who was present during the interview? (mark all that apply.)
90. Did someone help the respondent complete this survey?
91. How did that person help? [mark all that apply.]
92. Who helped the respondent? (mark all that apply.)

Appendix C: AMHH and BPHC Eligibility Requirements Across the Time Period

AMHH

- October 1, 2016
    - Added ICD10-CM Codes: F42.2 (Mixed obsessional thoughts and acts), F42.3 (Hoarding disorder), and F42.8 (Other obsessive-compulsive disorder)
    - Removed ICD10-CM Code: F42 (Obsessive-compulsive disorder)
- November 10, 2016
    - Removed ICD10-CM Code: F42.8 (Other obsessive-compulsive disorder)
- April 1, 2020
    - Age requirement moved from at least 35 years old to at least 19 years old

BPHC

- March 2, 2016
    - Removed ICD10-CM Code: F32.9 (Major depressive disorder, single episode, unspecified)
- October 1, 2016
    - Added ICD10-CM Codes: F42.2 (Mixed obsessional thoughts and acts), F42.3 (Hoarding disorder), F42.8 (Other obsessive-compulsive disorder), F50.81 (Binge eating disorder), and F50.89 (Other specified eating disorder)
    - Removed ICD10-CM Codes: F42 (Obsessive-compulsive disorder) and F50.8 (Other eating disorders)
- November 10, 2016
    - Removed ICD10-CM Code: F42.8 (Other obsessive-compulsive disorder)
- October 1, 2017
    - Added ICD10-CM Code: F50.82 (Avoidant/restrictive food intake disorder)
    - Removed ICD10-CM Code: F41.0 (Panic disorder [episodic paroxysmal anxiety]
- October 1, 2018
    - Added ICD10-CM Code: F53.0 (Postpartum depression): F10.
- October 1, 2020
    - Added ICD10-CM Codes: F10.130 (Alcohol abuse with withdrawal, uncomplicated), F10.131 (Alcohol abuse with withdrawal delirium), F10.132 (Alcohol abuse with withdrawal with perceptual disturbance), F10.139 (Alcohol abuse with withdrawal, unspecified), F11.13 (Opioid abuse with withdrawal), F12.13 (Cannabis abuse with withdrawal), F13.130 (Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated), F13.131 (Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified), F13.132 (Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance), F13.139 (Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified), F14.13 (Cocaine abuse, unspecified with withdrawal), F15.13 (Other stimulant abuse with withdrawal), F19.130 (Other psychoactive substance abuse

with withdrawal, uncomplicated), F19.131 (Other psychoactive substance abuse with withdrawal delirium), F19.132 (Othe psychoactive substance abuse with withdrawal with perceptual disturbance), F19.139 (Other psychoactive substance abuse with withdrawal, unspecified)

- October 1, 2022
    - Added ICD10-CM Codes: F10.90 (Alcohol use, unspecified, uncomplicated), F10.91 (Alcohol abuse, unspecified, in remission), F11.91 (Opioid use, unspecified, in remission), F12.91 (Cannabis use, unspecified, in remission), F13.91 (Sedative, hypnotic or anxiolytic use, unspecified, in remission), F14.91 (Cocaine use, unspecified, in remission), F15.91 (Other stimulant use, unspecified, in remission), F16.91 (Hallucinogen use, unspecified, in remission), F18.91 (Inhalant use, unspecified, in remission), F19.91 (Other psychoactive substance use, unspecified, in remission), T43.652D (Poisoning by methamphetamines intentional self-harm, subsequent encounter), T43.652S (Poisoning by methamphetamines intentional self-harm, sequela)
- November 29, 2022
    - Removed ICD10-CM Codes: F10.90 (Alcohol use, unspecified, uncomplicated), F10.91 (Alcohol abuse, unspecified, in remission), F11.91 (Opioid use, unspecified, in remission), F12.91 (Cannabis use, unspecified, in remission), F13.91 (Sedative, hypnotic or anxiolytic use, unspecified, in remission), F14.91 (Cocaine use, unspecified, in remission), F15.91 (Other stimulant use, unspecified, in remission), F16.91 (Hallucinogen use, unspecified, in remission), F18.91 (Inhalant use, unspecified, in remission), F19.91 (Other psychoactive substance use, unspecified, in remission), T43.652D (Poisoning by methamphetamines intentional self-harm, subsequent encounter), T43.652S (Poisoning by methamphetamines intentional self-harm, sequela)

Appendix D: Claim Variable Definitions

Table 44: Variable Definitions for Indiana Medicaid Claims Data

Measure	Definition	Values
Recipient ID	Unique sequence of numbers assigned to each individual in Indiana Medicaid.	
Recipient Age	Age of each recipient	
Recipient Gender	Gender of each recipient	Female Male
Recipient Race	Categorical variable that denotes the recipient's race.	B or N = Black A or P or F or D = Asian or Pacific Islander O or C = White G or I = American Indian or Alaskan Native J = Native Hawaiian 8 = Not available 1 or 16 = Missing 7 = Not provided
Primary Diagnosis Code	Primary/principal ICD10-CM diagnosis code as reported on the claim.	
Primary Procedural Code	A procedure code based on ICD-10 used by the state to identify procedures performed during the hospital stay referenced by this claim. Principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes.	
Amount Billed Total	The total amount billed for this claim as submitted by the provider.	
Amount Paid Total	The total amount paid by Medicaid on the claim, the sum of the amounts paid by Medicaid at the detail level.	
NDC Code	The National Drug Code is a unique 10-digit, 3-segment number that is a universal product identifiers for human drugs in the United States.	
Admission Type	Basic types of admission for inpatient hospital stays and a	1 = Emergency 2 = Urgent 3 = Elective

	code indicating the priority of the admission.	4 = Newborn 5 = Trauma 9 = Info N/A
Admission Source	Indicates the source of the referral for an admission or visit	1 = Non-Healthcare Facility Point of Origin 2 = Clinic or Physician's Office 4 = Transfer from a hospital (different facility) 5 = Transfer from a skilled nursing facility (SNF), assisted living facility (ALF), intermediate care facility (ICF), or other nursing facility 6 = Transfer from another healthcare facility 8 = Court or law enforcement 9 = Information not available D = Transfer from one distinct unit of the hospital to another distinct unit of the same hospital E = Transfer from ambulatory surgery center F = Transfer from a hospice facility
Emergency Services Indicator	Flag that indicates whether the claim was associated with emergency services.	0 = No 1 = Yes
Substance Abuse Services Indicator	Flag that indicates whether the claim was associated with substance abuse services.	0 = No 1 = Yes
Major Diagnosis Category (MDC)	Assignment of ICD-10 codes to broader categories similar to the Clinical Classification Software Refined (CCSR) developed by the Healthcare Cost and Utilization Project (HCUP) and sponsored by the Agency for Healthcare Research and Quality's (AHRQ).	00 = Multiple/ Pre MDC/ Not assigned to MDCs 01 = D&D of the nervous system 02 = D&D of the eye 03 = D&D of the ear, nose, mouth, and threat 04 = D&D of the respiratory system 05 = D&D of the circulatory system 06 = D&D of the digestive system 07 = D&D of the hepatobiliary system and pancreas

		08 = D&D musculoskeletal system and connective tissue 09 = D&D skin, subcutaneous tissue and breast 10 = Endocrine, nutritional, & metabolic D&D 11 = D&D of the kidney and urinary tract 12 = D&D of the male reproductive system 13 = D&D of the female reproductive system 14 = Pregnancy, childbirth, and the puerperium 15 = Newborn and neos with conditions originating perinatal 16 = D&D of the blood and blood forming organs 17 = Myeloproliferative disorders 18 = Infectious and parasitic diseases 19 = Mental diseases and disorders 20 = Alcohol/drug use and induced mental disorders 21 = Injuries, poisonings, toxic effect of drugs 22 = Burns 23 = Factors influencing health status and contact with health services 24 = HIV Infection 25 = Multiple significant trauma
Public Health Program Indicator		AMHH and BPHC*

*The public health program indicator had more than 100 categories, the only two this evaluation was interested in were 'AMHH' and 'BPHC'.

Appendix E: Office for Medicaid Policy and Planning (OMPP) Requirements, Sub-requirements, and Performance Measures (PMs)

AMHH

Table 45: AMHH Requirements and PMs

Requirement	Sub-Requirement(s)	PM(s)
Requirement 1: Service Plans	The state must demonstrate that service plans address assessed needs of 1915(i) participants	Number and percent of IICPs that address recipient's needs.
	Service plans are updated annually.	Number and percent of IICPs reviewed and revised as warranted on or before annual review date.
	Service plans document the 1915(i) participant's choice of services and provider	Number and percent of recipients with documentation of choice of eligible services.
		Number and percent of recipients with documentation of choice of providers
Requirement 2: Eligibility Requirements	An evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.	Number and percent of IICPs reviewed and revised as warranted on or before annual review date.
	The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.	Number and percent of Adult Needs and Strengths Assessment (ANSA)s that were completed according to policy
	The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.	Number and percent of AMHH re-evaluations conducted.
Requirement 3: Qualified Providers	Providers meet required qualifications.	Number and percent of provider agencies that meet qualifications at time of enrollment
		Number and percent of provider agencies recertified timely.

Requirement 4: Home and Community Based Settings Requirements	Settings meet the home and community-based settings requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).	Number and percent of settings in compliance with criteria that meets standards for community living
Requirement 5: Administrative Authority	The SMA retains authority and responsibility for program operations and oversight.	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight.
Requirement 6: Financial Accountability	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	Number and percent of 1915(i) claims paid during the review period according to the published rate
		Number and percent of 1915(i) claims paid during the review period for recipients enrolled in the 1915(i) program on the date the service was delivered.
Requirement 7: Incidents of Abuse, Neglect, and Exploitation	The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	Number and percent of IICPs that address health and welfare needs of the recipient.
		Number and percent of incidents reported within required timeframe.
		Number and percent of reports for medication errors resolved according to policy
		Number and percent of reports of seclusions and restraints resolved according to policy.
		Number and percent of reports for abuse, neglect, and exploitation resolved according to policy.
		Number and percent of incident for abuse, neglect, and exploitation that required a corrective action plan.

BPHC

Table 46: BPHC Requirements and PMs

Requirement	Sub-requirement(s)	PMs
Requirement 1: Service Plans	The state must demonstrate that service plans address assessed needs of 1915(i) participants.	Number and percent of Individualized Integrated Care Plans (IICP) that address recipient needs.
	Service plans are updated annually.	Number and percent of IICPs reviewed and revised on or before the IICP review date.
	Service plans document the 1915(i) participant's choice of services and providers.	Number and percent of recipients with documentation of choice of eligible services
		Number and percent of recipients with documentation of choice of providers
		Number and percent of clients or legal guardians that were offered a copy of the completed IICP.
Requirement 2: Eligibility Requirements	An evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future	Number and percent of new applicants who had a face-to-face evaluation for BPHC eligibility prior to enrollment.
	The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.	The processes and instruments described in the approved state plan for determining 1915 (i) eligibility are applied appropriately
	The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.	Number and percent of enrolled individuals re-evaluated at least bi-annually or more frequently, as specified in the approved 1915(i) benefit.
Requirement 3: Qualified Providers	Providers meet required qualifications.	Number and percent of provider agencies who meet qualifications.
		Number and percent of provider agencies re-certified timely.
Requirement 4: Home and Community Based Settings Requirements	Settings meet the home and community-based settings requirements as specified in this	Number and percent of provider owned, controlled, and operated residential settings in compliance with criteria that

	SPA and in accordance with 42 CFR 441.710(a)(1) and (2).	meets standards for community living.
Requirement 5: Administrative Authority	The SMA retains authority and responsibility for program operations and oversight.	Number and percent of performance measure data reports from DMHA and contracted entities that were provided timely.
		Number and percent of performance measure data reports from DMHA and contracted entities that were provided in correct format.
Requirement 6: Financial Accountability	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	Number and percent of claims paid according to the published rate during the review period.
		Number and percent of claims paid during the review period for recipients enrolled in the program on the date the service was delivered.
Requirement 7: Incidents of Abuse, Neglect, and Exploitation	The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	Number and percent of provider agencies who have policies and procedures to prevent incidents of abuse, neglect, exploitation.
		Number and percent of incidents reported within required timeframe.
		Number and percent of incident reports involving medication errors resolved according to policy.
		Number and percent of incident reports involving seclusions and restraints resolved according to policy.
		Number and percent of incident reports involving death resolved according to policy.

Appendix F: Marketing Flyers

HCBS Requirements - Beneficiaries.pdf

Important information for Medicaid members enrolled in AMHH and/or BPHC

What is HCBS?

In March 2014, the U.S. Centers for Medicare and Medicaid Services passed the "HCBS Settings Final Rule." The rule is meant to ensure that individuals receiving home and community-based services, like Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination, live in settings that are fully integrated into the community and offer opportunities for full community access, in the same manner as individuals not receiving these services.

A setting which meets federal HCBS settings requirements has these qualities:

- Is integrated in and supports full access to the greater community
- Is selected by the individual from among setting options
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy and independence
- Facilitates individual choice regarding services and supports

There are additional requirements for residential settings which are owned, controlled or operated by a provider of AMHH and/or BPHC services.

Home- and Community-Based Services settings requirements and me.

Due to a new Medicaid rule in 2014, Medicaid members who receive services through the Adult Mental Health Habilitation or Behavioral and Primary Healthcare Coordination programs are required to live in a place that meets federal guidelines for home- and community-based services settings.

This pamphlet helps explain what the new rule means to you, and how it may affect where you live and the services you receive.

Does this mean I have to move?

In most cases, no.

How the "HCBS Settings Final Rule" affects you depends in large part on where you currently live.

Most people who receive services through the AMHH and/or BPHC programs live in their own home, which automatically meets federal HCBS settings requirements. Nothing will need to change for these individuals.

Some people who receive services through the AMHH and/or BPHC programs live in residential settings owned or operated by a provider of those services. These settings may need some changes in order to meet federal HCBS settings requirements.

If you are homeless or live in a homeless shelter or temporary (transitional) housing, you are eligible for AMHH and BPHC services.

What if the place where I live doesn't meet the rules?

Your provider will work with the Division of Mental Health and Addiction and other state agencies to help where you live meet all requirements.

There may be a very few instances where a person who receives services through the AMHH and/or BPHC programs lives in a residential setting which is unable to meet federal HCBS settings requirements. For these individuals, they will choose whether to move or to stay where they live but stop receiving AMHH and/or BPHC services. If this situation occurs, your provider will inform you well in advance, so you can begin to consider options and make plans.

You have the right to choose anyone you want to help you make the decision on whether to move or to stop receiving AMHH and/or BPHC services, including:

- Family or friends
- Your legal guardian
- Your case manager

In addition, you may choose to ask for assistance from advocacy organizations who can help you make an informed decision:

- Indiana Disability Rights, toll-free 800-622-4845
- Mental Health America of Indiana Mental Health and Addiction Ombudsman, toll-free 800-555-6424 ext. 239
- DMHA Consumer Service Line, toll-free 800-901-1133

What if I don't agree with the provider's decision to no longer provide HCBS services?

The following procedure identifies the timeline that an appeal needs to be submitted to your Community Mental Health Center. Complete the CMHC's appeal/grievance document and submit to the CMHC as directed.

1. Within 15 days of being notified the setting is closing/no longer an eligible HCBS setting, residents can submit an appeal/grievance to the identified CMHC grievance procedure staff.
2. In 30 days of receipt of the appeal, the grievance procedure staff will review the appeal and any new evidence submitted by resident/family in support of keeping the setting open/compliant with HCBS.
3. Within 15 days of review, the grievance procedure staff submits final decision to the resident regarding the setting in question.

Consumer Rights.pdf

CONSUMER RIGHTS FOR ADULTS IN INDIANA'S HOME- AND COMMUNITY-BASED SERVICES PROGRAMS

Clients of 1915(i) programs in Indiana, which include Adult Mental Health Habilitation and Behavioral Primary and Healthcare Coordination, have rights that are designed to help them thrive in their community. Those are:

1. **Where a person lives allows them full access to the community.**

2. **Where a person lives is their choice.**

Where a person lives ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.

Where and how a person lives is based on individual initiative, autonomy and independence in making life choices, including, but not limited to, daily activities, physical environment and with whom to interact.

3. **A person can choose what supports they use and who provides them.**

4. **A person has a right to have a legally enforceable living/rental agreement that allows them safety/ protections from eviction as any other tenant/resident.**

5. **A person has a right to privacy, which includes a lock on their door, locks on bathrooms, the right to make roommate changes and the right to make changes in their living environment as they desire.**

6. **A person has the right to schedule their activities as they desire and have access to food at any time.**

7. **A person has the right to have visitors without restrictions.**

8. **A place a person lives must meet their physical requirement needs.**

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Indianapolis, IN 46204

Community
Residential Settings.

COMMUNITY-BASED RESIDENTIAL SETTINGS

There are five setting types in which an individual receiving home- and community-based services may reside:

✔ **Private/Independent**	*No financial relationship between provider agency and property owner.*
✔ **Provider-Owned, Controlled or Operated Residential (also known as "POCO")**	*Owned, co-owned/operated or operated by a provider of HCBS.*
✔ **Non-POCO Residential**	*Owned, controlled or operated by a provider of services that does not provide HCBS.*
✔ **Non-CMHC POCO Residential**	*Settings under the oversight of an HCBS provider that is not a CMHC; typically either the Division of Aging or the Division of Disability and Rehabilitative Services.*
✔ **Potential Presumed Institutional**	*A residential setting that, by its nature (such as geography or co-location), is potentially isolating or provides inpatient care.*

There are six setting types which are considered to be institutional and may NOT be occupied by HCBS clients:

✘ **Nursing Home**	✘ **ICF/IID**
✘ **Hospital**	✘ **Jail/Correctional Facility**
✘ **Institution for Mental Disease**	✘ **Substance Use Disorder Treatment**

Pursuant with home- and community-based goals of ensuring clients access care in the least restrictive settings possible, as similar as possible to those not receiving HCB services, individuals living in POCO settings (and others in which HCB services are delivered) are guaranteed certain resident rights.

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Non-POCO
Residential Settings.

CONSUMER RIGHTS FOR ADULTS IN INDIANA'S HOME- AND COMMUNITY-BASED SERVICES PROGRAMS

NON-POCO Residential

The provider of services is an entity other than the home- and community-based services provider. "Non-POCO" means "non-provider controlled, owned and operated." NON-POCO residential settings are owned, controlled or operated by an entity that provides a service or set of services. Examples include, but are not limited to assisted living facilities, group homes, adult foster care, room and board facilities, sober living environments, etc.

The Big Five

1. The setting is integrated in and supports full access to the greater community.
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
5. Facilitates individual choice regarding services and supports, and who provides them.

The POCO Five for Residential Settings

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city or other designated entity.
2. Each individual has privacy in their sleeping or living unit:
   a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
   b. Individuals sharing units have a choice of roommates in that setting.
   c. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.
4. Individuals are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.

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AMHH Flyer.pdf

Division of Mental Health and Addiction

Adult Mental Health Habilitation Program

What is AMHH?

AMHH is an option for consumers with long-term behavioral health needs, who may benefit more from a habilitative approach to treatment rather than a traditional rehabilitative approach.

What's the difference between habilitation and rehabilitation?

Habilitation can help you gain, maintain or improve your skills so that you are successful. Rehabilitation helps you regain skills you had at one time.

How can it benefit me?

The AMHH program is a package of specialized services to help meet the habilitative goals of consumers with long-term behavioral health needs. The services are similar to other programs that offer skills training, therapy, medication support, case management and other services. However, they are specialized in their design to help individuals maintain and sustain their current level of functioning in an attempt to avoid a reduction in functioning level. AMHH services also provide training and support for family members, friends and other unpaid caregivers.

What if I already have some of these services?

You may already be enrolled in a program that offers many of these services but AMHH also offers benefits that other programs do not, such as Respite services to help your guardian or family members who support you, assistance in helping you become involved in your Community through volunteerism and community service, and Adult Day Services support. You can always switch back if AMHH is not the best fit for your needs.

Am I eligible?

If you are 19 years or older, enrolled in an eligible Medicaid program, live in a community-based setting and have a qualifying mental health diagnosis, you may be eligible! There are additional requirements, but this is a good start.

Whom do I contact?

If you are currently receiving services through a Community Mental Health Center, you can ask your provider for additional information. If you are not currently involved with a CMHC but think you may qualify, then please contact your local Community Mental Health Center or you can contact the Division of Mental Health and Addiction at 317-232-7800. You can also visit the website at https://www.in.gov/fssa/dmha/3102.htm.

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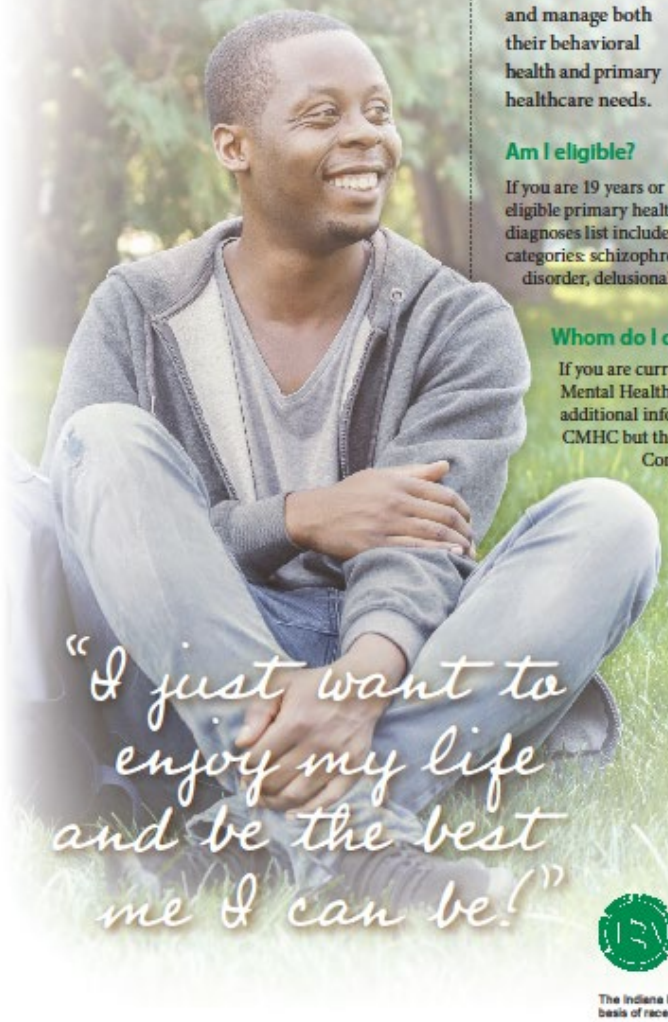
www.fssa.IN.gov

June 11, 2020 1:24 PM

BPHC Flyer.pdf

Division of Mental Health and Addiction

Behavioral and Primary Healthcare Coordination (BPHC)



What is BPHC?

The BPHC is a program to help people with serious mental illnesses. We want to help individuals who have a co-existing health issue to coordinate and manage both their behavioral health and primary healthcare needs.

How can it benefit me?

The BPHC program consists of one service that comprises a variety of reimbursable activities intended to assist in the coordination of mental health and primary health care needs of the member. These services include coordination of healthcare services (which may include direct assistance in gaining access to services), coordination of care, oversight of the entire case and linkage to services. BPHC can also assist in using the healthcare system which could include logistical support, advocacy and education. In addition, staff at the community health centers can help members by serving as a communication conduit, notification of changes in medication regimens and health status, and coaching members for more effective communication with providers.

Am I eligible?

If you are 19 years or older and have been diagnosed with a BPHC-eligible primary health diagnosis, you may be eligible! The eligible diagnoses list includes, but is not limited to, the following general categories: schizophrenic disorder, major depressive disorder, bipolar disorder, delusional disorder and psychotic disorder.

Whom do I contact?

If you are currently receiving services through a Community Mental Health Center (CMHC), you can ask your provider for additional information. If you are not currently involved with a CMHC but think you may qualify, then please contact your local Community Mental Health Center or the Division of Mental Health and Addiction at 317-232-7800.

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Appendix G: Provider Directory

Approved_BPHC and AMHH Provider_List.pdf

Appendix H: Services Codes and Rates

Table 47: AMHH Service Codes and Rates

AMHH Service	HCPCS Code	Modifiers	Unit/Rate
Adult Day Services	S5101	UB	$28.80 per half/day unit
HCB Habilitation and Support with Member (Individual Setting)	H2014	UB	$26.14 per 15-minute unit
HCB Habilitation and Support with Family and Member (Individual Setting)	H2014	UB HR	$26.14 per 15-minute unit
HCB Habilitation and Support with Family without the Member Present (Individual Setting)	H2014	UB HS	$26.14 per 15-minute unit
HCB Habilitation and Support with Family the Member (Group Setting)	H2014	UB U1 HR	$4.71 per 15-minute unit
HCB Habilitation and Support with Member (Group Setting)	H2014	UB U1	$4.71 per 15-minute unit
HCB Habilitation and Support with Family without the Member Present (Group Setting)	H2014	UB U1 HS	$4.71 per 15-minute unit
Respite Care (Hourly)	S5150	UB	$3.50 per 15-minute unit
Respite Care (Daily)	S5151	UB	$100.00 per 1-day unit
Therapy and Behavioral Support Services with Member (Individual Setting)	H0004	UB	$28.65 per 15-minute unit
Therapy and Behavioral Support Services with Family and Member (Individual Setting)	H0004	UB HR	$28.65 per 15-minute unit
Therapy and Behavioral Support Services without Member Present (Individual Setting)	H0004	UB HR	$28.65 per 15-minute unit
Therapy and Behavioral Support Services with Member (Group Setting)	H0004	UB U1	$7.16 per 15-minute unit
Therapy and Behavioral Support Services without Member Present (Group Setting)	H0004	UB U1 HS	$7.16 per 15-minute unit
Therapy and Behavioral Support Services with	H0004	UB U1 HR	$7.16 per 15-minute unit

Family and Member (Group Setting)			
Addiction Counseling with Member (Individual Setting)	H2035	UB	$58.32 per 1-hour unit
Addiction Counseling with Family and Member (Individual Setting)	H2035	UB HR	$58.32 per 1-hour unit
Addiction Counseling with Family without the Member Present (Individual Setting)	H2035	UB HS	$58.32 per 1-hour unit
Addiction Counseling with Member (Group Setting)	H2035	UB U1	$14.58 per 1-hour unit
Addiction Counseling with Family and Member (Group Setting)	H2035	UB U1 HR	$14.58 per 1-hour unit
Addiction Counseling without Member Present (Group Setting)	H2035	UB U1 HS	$14.58 per 1-hour unit
Supported Community Engagement Services	97537	UB	$26.14 per 15-minute unit
Care Coordination	T1016	UB	$14.53 per 15-minute unit
Medication Training and Support with Member (Individual Setting)	H0034	UB	$18.62 per 15-minute unit
Medication Training and Support with Family and Member (Individual Setting)	H0034	UB HR	$18.62 per 15-minute unit
Medication Training and Support without Member Present (Individual Setting)	H0034	UB HS	$18.62 per 15-minute unit
Medication Training and Support with Member (Group Setting)	H0034	UB U1	$3.35 per 15-minute unit
Medication Training and Support with Family and Member (Group Setting)	H0034	UB U1 HR	$3.35 per 15-minute unit
Medication Training and Support without Member Present (Group Setting)	H0034	UB U1 HS	$3.35 per 15-minute unit

*Table 48: BPHC Service Codes and Rates**

BPHC Service	HCPCS Code	Modifiers	Unit/Rate
Case management (Individual Setting)	T1016	UC	$14.53 per 15-minute unit
Case management (Group Setting)	T1016	UC	$8.55 per 15-minute unit

***BPHC did not have the same table of service codes and rates available as those in the AMHH Provider Reference Module**

Appendix I: Admission Type Definitions

Table 49: Admission Type Definitions from Claims Data

Admission Type	**Definition**
Emergency	The patient requires immediate medical intervention as a result of severe, life-threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
Newborn	The patient is a newborn delivered either inside the admitting hospital or outside of the hospital.
Trauma	The patient visits a trauma center (a trauma center means a facility licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation).

Appendix J: SMI/SUD Percentages of Most Common MDCs in Hospital Claims

Figure 46: Percentage of Mental Diseases and Disorders by SMI/SUD

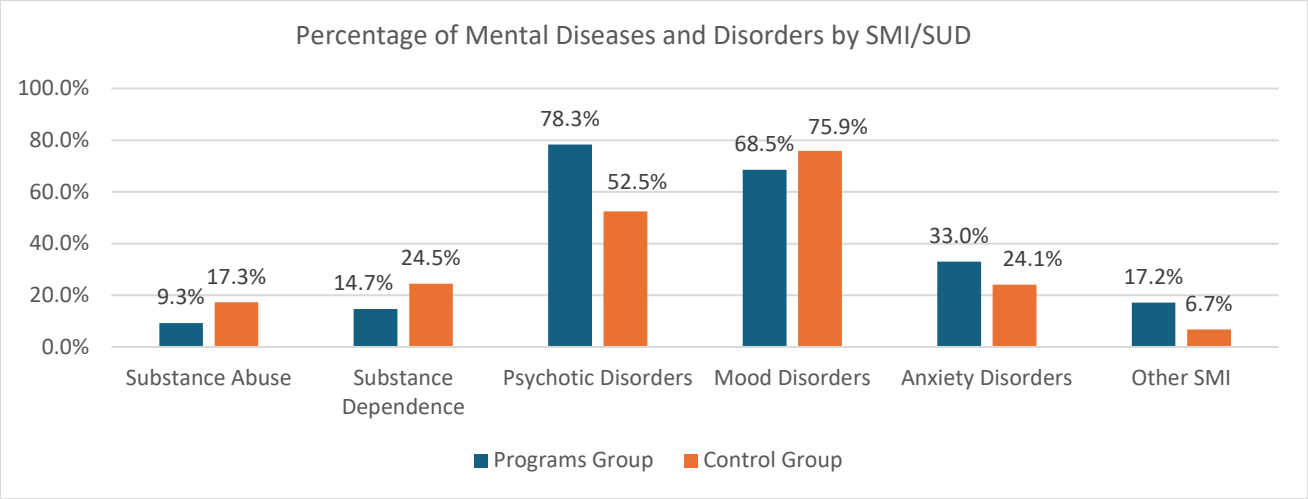

Figure 47: Percentage of Diseases and Disorders of the Respiratory System by SMI/SUD

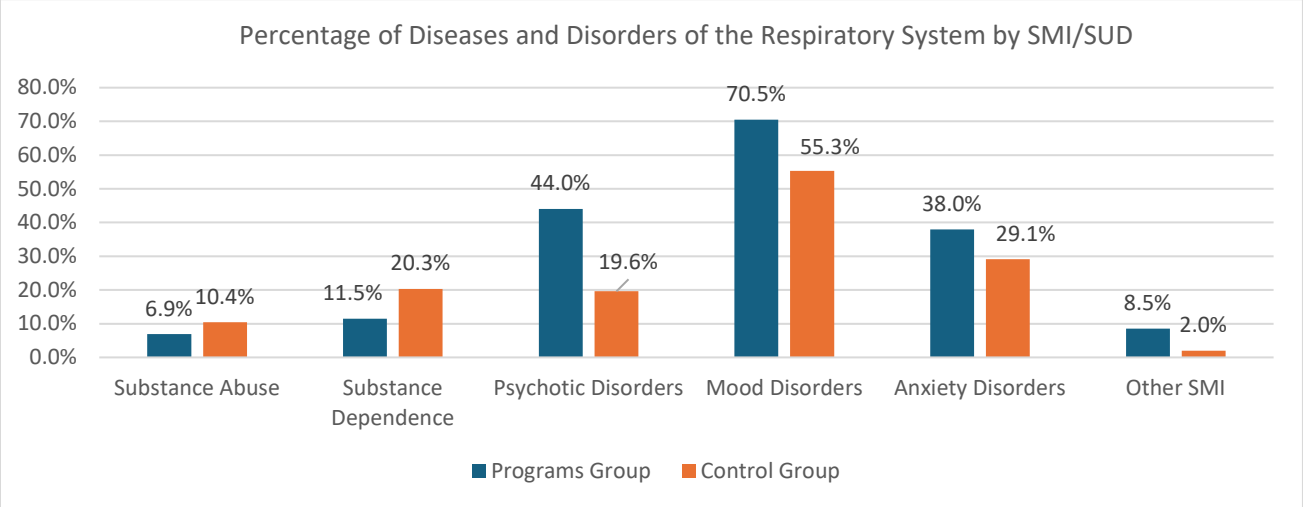

Figure 3: Percentage of Diseases and Disorders of the Musculoskeletal System and Connective Tissue by SMI/SUD

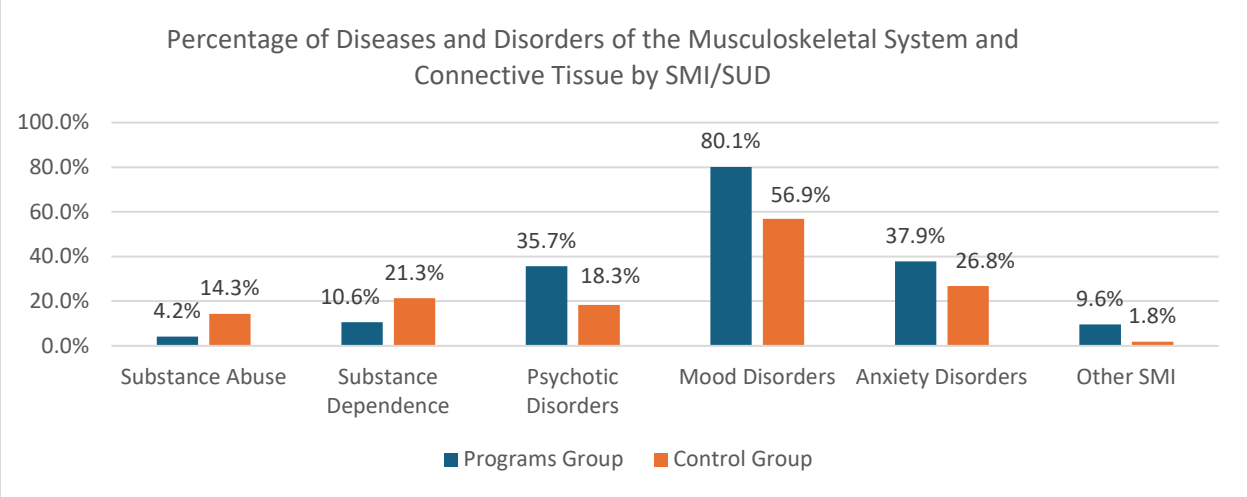

Figure 4: Percentage of Infectious and Parasitic Diseases by SMI/SUD

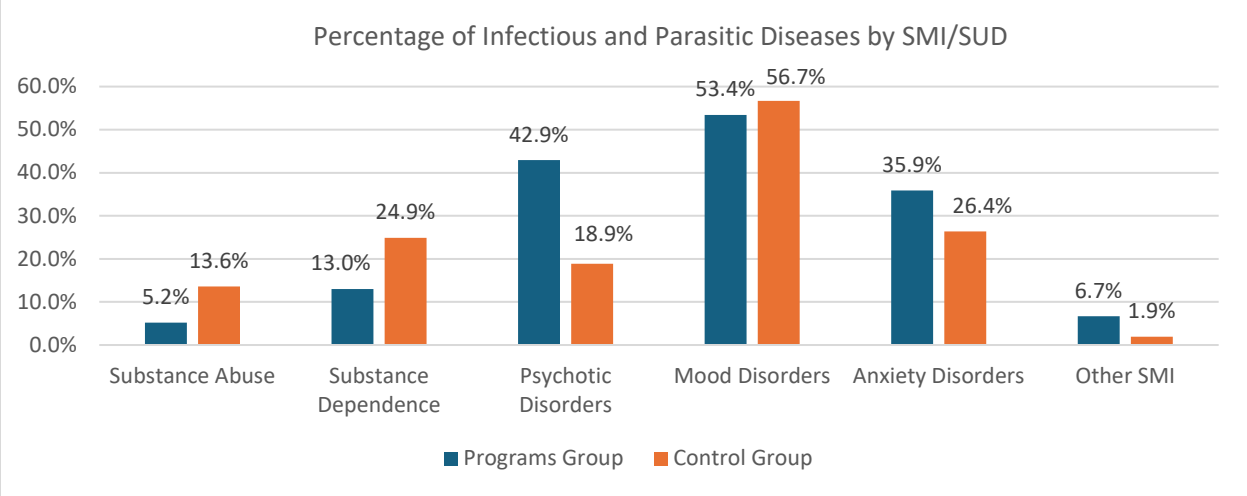

Figure 5: Percentage of Alcohol/Drug Use and Induced Mental Disorders by SMI/SUD

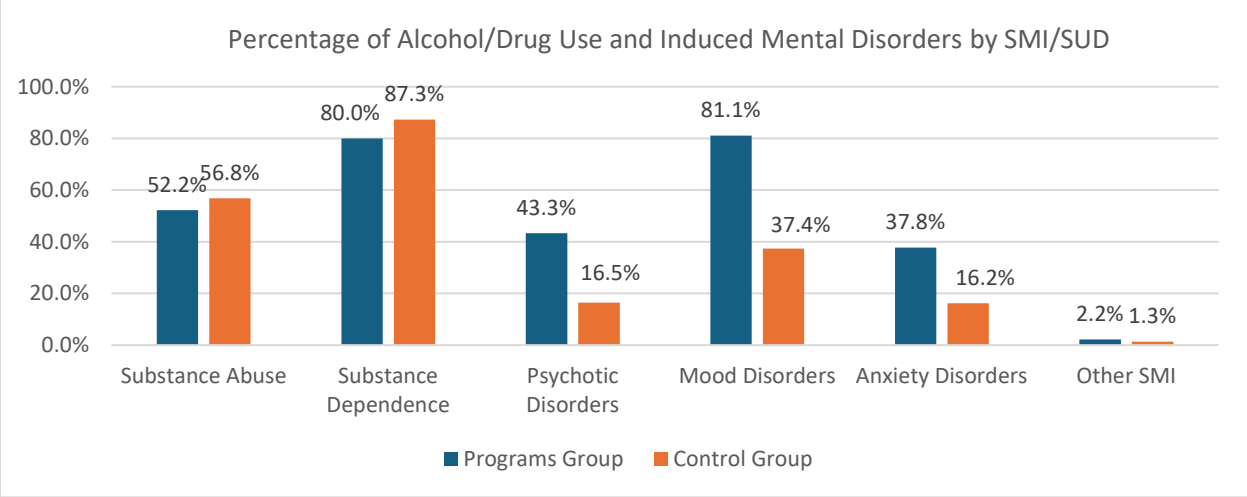

Figure 6: Percentage of Pregnancy, Childbirth, and Puerperium by SMI/SUD