October 2024

INDIANA BEHAVIORAL HEALTH COMMISSION

FINAL REPORT

TABLE OF CONTENTS

INTRODUCTION

LETTER FROM THE CHAIR OF THE INDIANA BEHAVIORAL HEALTH COMMISSION

Jay Chaudhary
Chair, Indiana Behavioral Health Commission

There are two types of problems with the behavioral health system: *scarcity* problems and *engineering* problems. Scarcity problems are created by more demand for services than capacity to provide those services. Engineering problems are about inputs, outputs, throughputs, supply chain issues, bottlenecks, information sharing, and other system inefficiencies.

The recommendations in this report address both dimensions. Certified Community Behavioral Health Clinics, if supported and implemented properly, will serve communities in a more targeted and efficient way while increasing services provided. Targeting resources to children with higher acuity needs will help some of our most vulnerable families and have a positive downstream effect on the rest of the system by relieving the pressure caused by these difficult cases. Reinforcing mental health parity will create more access to services while easing administrative burdens on providers.

Both types of problems are inextricably linked and bi-directionally causal: engineering issues cause scarcity and vice-versa. Fixing engineering problems can increase the capacity of the system and reduce scarcity. The state and providers have an ongoing obligation to zealously shepherd taxpayer dollars by continuously improving operational efficiency.

The inescapable fact is, however, that the significant scarcity problem in our behavioral health system cannot be overcome by increased efficiency alone—more resources are required. We have provided a roadmap and recommendations to the General Assembly about the manner and amount of increased resources needed. We recognize that they are juggling many competing demands, but without increased financial support, Indiana's progress on behavioral health will not continue.

We also must address the skyrocketing demand for behavioral health services. Full disclosure, I strongly considered ending my letter here. The Commission was given a narrow task by the legislature—to make recommendations about improving access to care—and we fulfilled it. Perhaps nothing else needs to be said in this space.

But I kept noticing a striking pattern throughout the Commission's work. All of us—dedicated, experienced professionals committed to improving the behavioral healthcare system—would pause during our discussions about payment systems or workforce pipelines or evidence-based practices and reflect on the vital importance of improving the overall wellbeing of our constituents and communities. We kept our recommendations focused and targeted, but we all know that there are bigger challenges that we cannot ignore.

In his 2018 novel *There There*, Tommy Orange describes the approach to the problems that centuries of oppression have wrought in Native communities: "Kids are jumping out of burning buildings, falling to their deaths. And we think the problem is that they are jumping."

We appear to be living through a particularly socially isolated and precarious time. Less Americans than ever report having even one close friend. Self-reported stress and anxiety (the only kinds that matter, really), are at or near all-time highs. Trust in institutions is lower than ever. We are worried about our children, our economic prospects, the health of our communities, and our future as a country. This is not a unique or insightful observation—thousands of books, articles, and podcasts talk about this at great length. It is part of the zeitgeist—just something that everyone knows.

Is this something that state government can meaningfully impact? Maybe not—broader social and cultural forces are significant drivers of these problems. Government alone cannot—and should not—harness or control these forces.

Consider another example, however. For the last 20 years, Indiana has aggressively pursued a two-pronged economic development strategy: creating a "favorable business climate" through tax and regulatory reform while providing robust economic incentives to attract good employers. The logic is sound—good jobs create prosperous communities—and recent results have been impressive, with record setting investments and a nationally-recognized entrepreneurial ecosystem.

What if we used the same approach towards individual and community well-being? Can we create a “favorable thriving climate” for Hoosier families? Can we build resilient communities by investing in projects and partnerships that promote a more holistic conception of wellness? Can we attack social isolation and precarity with the same ferocity as our pursuit of economic development?

Or, to bring it back to this report, can we afford not to? The last Commission report revealed that untreated mental illness costs the state more than $4 billion each year. The legislature can, and should, supercharge Indiana’s behavioral health care system and ensure many more Hoosiers have access to needed care by following the recommendations in this report. If they do so, Indiana will be a better place for it: happier, more connected, less-stressed, and more economically competitive. Access to quality behavioral health care is a fundamental part of a thriving state.

We must recognize, however, that we cannot treat our way out of this crisis. We have an obligation to try and put out the fire.

-- Jay Chaudhary

PS. On a personal note, submitting this report to the General Assembly is one of my last official acts in state service. It has truly been the professional honor of a lifetime to serve Hoosiers in this capacity. I have been blessed with guidance, support, and wisdom by far too many people to name during these five years. Our progress over the last several years is the result of cross-sector alignment and commitment to improving Hoosier mental health. If we want the progress to continue, we must stay committed and aligned.

BEHAVIORAL HEALTH COMMISSION MEMBERS

Michelle Clarke

Director of Student, School, and Family Engagement at Indiana Department of Education

“I am honored to serve on the Indiana Behavioral Health Commission. This group is comprised of some of the most intelligent and passionate people I know, and I have learned so much from my participation. I am so thankful this commission exists as it is an opportunity to shape the future of mental healthcare in Indiana, ensuring that Hoosiers of all ages receive the support and help they need to thrive. I look forward to the presentation of the recommendations that came from this group and the impact it will have on the well-being of all who live and work in Indiana.”

Senator Michael Crider

Indiana State Senator - District 28

“I have enjoyed working with the current group of leaders to develop the priority recommendations contained in this report. Indiana is making significant progress and much of the credit goes to the work done by the Behavioral Health Commission!”

Zoe Frantz

President and CEO of Indiana Council of Community Mental Health Centers

“I am grateful to be a part of the Behavioral Health Commission as the President and CEO of the Indiana Council, representing all 24 Community Mental Health Centers in our state. Why this commission is so important to me is we have seen first-hand the impact the commission has had on improving the accessibility and quality of mental health and substance use services in the state. Whether it be in helping to increase public awareness and education or develop policy and sustainable funding, the collaborative work has made an economic and social impact as well as it has improved the well-being of those we serve.”

BEHAVIORAL HEALTH COMMISSION MEMBERS

Representative Victoria Garcia-Wilburn

Indiana State Representative - District 32

"My time serving on the Behavioral Health Committee provided me with invaluable opportunity to connect with peers in the field regarding issues that impact Hoosiers daily lives. Behavioral health is and always will be one of my top priorities. I will continue to strive to help millions of Hoosiers gain access to the care that they require. I am dedicated to advocating for affordable mental and behavioral healthcare and am grateful for the opportunity to collaborate with the Commission. I look forward to continuing this important work in the upcoming session."

Senator Andrea Hunley

Indiana State Representative - District 46

"Every Hoosier deserves a healthcare system that works for them. Serving on the Indiana Behavioral Health Commission, I teamed up with an incredible group of experts—folks from all corners of healthcare, policy, and funding. We took a hard look at the challenges in our state, listening directly to patients and providers. The result? A set of strong, actionable recommendations to push Hoosier healthcare forward and ensure everyone gets the care they deserve."

Representative Cindy Ledbetter

Indiana State Representative - District 75

"As a psychiatric nurse practitioner and a legislator serving on the Behavioral Health Commission, I have been able to use my expertise and knowledge to help meet the needs of Hoosiers. During my time on the Behavioral Health Commission, I have been able to collaborate with other like-minded professionals which has allowed us to address and work to remove the barriers to mental health services in Indiana."

BEHAVIORAL HEALTH COMMISSION MEMBERS

Steve McCaffrey

President and Chief Executive Officer of Mental Health America of Indiana, Principal and Chief Policy Officer of Sextons Creek

”The work and recommendations of the Indiana Behavioral Health Commission have helped move Indiana forward to an improved mental health and addiction recovery infrastructure. Indiana's ranking by Mental Health America's the State of Mental Health in America has improved dramatically! Still, this is just the beginning as we must continue the work of the Commission and advocate for its continuation before the Indiana General Assembly.‘

David Reed

Deputy Director of Child Welfare Services at Indiana Department of Child Services

“Everyone benefits when we have communities with the right resources, and access to high-quality mental health services that can meet the needs of all Hoosiers is a critical component necessary for families and individuals to thrive. The Commission’s efforts have played a vital role in improving access to quality care, and it was such an honor to participate in this important work. While the work is challenging, it’s gratifying to see Indiana taking a comprehensive approach to ensuring that everyone has access to the right resources, when and where they need them. My hope is that the recommendations of the Commission will be carefully considered and that Indiana continues to invest in improving the quality of behavioral health services for all.”

BEHAVIORAL HEALTH COMMISSION MEMBERS

Kellie Streeter

President of the Knox County Board of Commissioners, Administrator of the Daviess County Health Department

“As a representative of County Governments, I have taken great pride in working with other Commission members to craft a report for our Indiana General Assembly that addresses the critical behavioral health needs of all Hoosiers. We examined in-depth the mental health needs of our children, older adults, and those with intellectual and developmental disabilities. I believe that there is no greater act than serving others in our State and this report will continue to propel awareness and support for all people who need mental health and addiction services.”

Jason Tomcsi

Associate State Director for Communications at AARP Indiana

“While the physical health of older Hoosiers takes center stage, their mental and emotional health are equally vital, yet often overlooked. With the continued growth of our aging population, I believe the work that the Behavioral Health Commission is doing is more important than ever.”

Dr. Rachel Yoder

Director of the Triple Board (Pediatrics/Psychiatry/Child Psychiatry) Residency Program at Indiana University School of Medicine and Provider of Outpatient Care within the Riley Child and Adolescent Psychiatry Clinic

“I am honored to serve as a member of the Indiana Behavioral Health Commission. As a child psychiatrist, educator, and consultant for Hoosier primary care physicians, I see every day the struggle Hoosier families experience in obtaining appropriate and timely mental health care. I’m heartened by the commission’s thoughtful and comprehensive work, it’s past significant accomplishments, and its commitment to continue to pursue accessible and evidence-based mental health care for all Hoosier families.”

EXECUTIVE SUMMARY

The Indiana Behavioral Health Commission (hereinafter “BHC” or “the Commission”) was reestablished by Senate Enrolled Act 1 (SEA1) of the 2023 legislative session, with a final report due to the General Assembly no later than October 1, 2024.[1] As directed by the General Assembly, the BHC examined Indiana’s behavioral health care system, with a special focus on exploring the needs of children, older adults, and individuals with intellectual and developmental disabilities. The Commission also examined the implementation of the 988 Crisis Response System and the Certified Community Behavioral Health Clinic (CCBHC) model, in addition to reviewing the progress that has been made on the recommendations in the Commission's previous report submitted on October 1, 2022.[2]

The following is a summary of the Commission’s work, with the primary recommendations including, but not limited to, the following (additional detail and recommendations are provided within this report, with specific requests for the General Assembly outlined in the Legislative Summary located in Appendix A):

PART I:

Foundations: Infrastructure and Reimbursement

1. Progress on the 988 Crisis Response System and CCBHC

Since the 2022 BHC Report, Indiana has made tremendous progress on the 988 and CCBHC efforts and requires further investment and attention to continue that progress. The Commission **recommends the 2025 General Assembly build upon and accelerate that progress by making smart, targeted, and effective investments in Indiana’s Behavioral Health infrastructure**. To continue Indiana’s progress towards a high-quality and sustainable behavioral health infrastructure, the Commission recommends increasing the Community Mental Health Fund appropriation to cover the additional costs necessary to sustain the 988 and CCBHC expansions. The state estimates that the total cost to sustain both initiatives is around $100M in State Fiscal Year (SFY) 2026 and $120M in SFY 2027, notwithstanding the identification of other fund sources to offset these costs.

2. Reimbursement: Medicaid Rate Matrix and Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA), signed into law in 2008, establishes that insurance coverage for mental health and addiction treatment should be no more restrictive than insurance coverage for other medical care. Despite improvements to mental health and addiction insurance coverage over the past 16 years, provider reimbursement remains an issue that may still reveal parity compliance issues. As a result, the Commission recommends **enacting parity legislation that requires provider parity reimbursement indexed to Medicare rates, ensures parity for youth services that may not have comparative Medicare rates, deems carve-outs to be in-network, considers consumer co-pays and the administrative burden, and considers giving enforcement authority to the Indiana Department of Insurance.**

PART II:

People: Building the Workforce

In order to build and expand the Behavioral Health and Human Sciences (BHHS) , the Commission recommends **(1) leveraging other treatment and healthcare providers to expand access to behavioral health, (2) increasing the behavioral health pipeline by sustainably funding psychiatry residency positions,** and **(3) addressing structural barriers to the broader behavioral health workforce development in the long-term.**

PART III:

Special Considerations: Behavioral Health Services for Children, Older Adults, and Individuals with Intellectual and Developmental Disabilities

1. Children

In order to improve the mental health of all Hoosier youth and adolescents, the Commission recommends systematically bolstering the continuum of care through **(1) supporting the state's on-going and future initiatives to support children with high acuity needs, (2) promoting the Comprehensive School Mental Health Framework, (3) expanding multisystemic therapy for adolescents with**

severe mental health needs to reduce risk of incarceration and residential treatment, (4) increasing education on developmental stages of children, and (5) reviewing systems standards and requirements for staff qualifications.

2. Older Adults

In order to improve the mental health of Hoosiers fifty-five (55) years of age or older, the Commission recommends **(1) standardizing data collection on older adults with behavioral health challenges, (2) encouraging age-friendly health systems, (3) creating an operational rate for group homes for older adults with Serious Mental Illness,** and **(4) creating a facility for older adults that provides integrated medical and psychiatric services.**

3. Individuals with Intellectual and Developmental Disabilities

In order to improve the accessibility of behavioral health care and the mental health of Hoosiers with Intellectual and Developmental Disabilities, the Commission recommends **(1) creating a joint waiver for dual diagnosis braided payments, (2) changing the "Behavioral Consultant" title for bachelor's degree level wrap facilitator,** and **(3) creating a Division of Mental Health and Addiction (DMHA) and Division of Disability and Rehabilitation Services (DDRS) clinical liaison position.**

PART IV:

Financial Stability

The Commission commends the $100M investment in the behavioral health system in the 2023 legislative session. To fund the recommendations of the Commission and promote the long-term sustainability for this critical work, and for the behavioral health system as a whole, the Commission proposes the General Assembly consider additional appropriations. A list of other possible funding options for behavioral health infrastructure investments are included in Appendix F for consideration.

PART V:

Continuing the Commission

The Commission recommends continuing the Behavioral Health Commission in future years to ensure the many behavioral health initiatives and system goals raised in this report remain a priority for the state of Indiana.

PROCESS DESCRIPTION

In 2023, SEA1 reestablished the BHC to prepare a report addressing:

1. Progress on the division’s implementation of the 988 Crisis Response System and the Certified Community Behavioral Health Clinic model

2. Progress on the Commission's previous report submitted on October 1, 2022

3. An in depth examination of the mental health of youth and adolescents, as well as the systems in place for treatment and care of youth and adolescents, the mental health of individuals fifty-five (55) years of age or older, the level of mental health care available to individuals with intellectual and developmental disabilities

4. A review of the associated data

The BHC began their meetings in November 2023 and met a total of six times. The meetings brought in subject matter experts and focused on how to best meet the needs of specific populations within Indiana, including children, older adults, and individuals with intellectual and developmental disabilities.

Based on presentations from the subject matter experts, research and follow-up conversations regarding needs and ongoing work, the Commission members submitted recommendations for consideration by the full Commission. The final report and recommendations were presented and voted on by the Commission on August 23, 2024. The Commission-approved recommendations and strategies are incorporated into this report.

PART I:

Foundations: Infrastructure and Reimbursement

SECTION 1.1

988 Crisis Response System and CCBHC Model Implementations

The 2022 BHC report's headline recommendations were for Indiana to build new behavioral health care infrastructure with two core components:

1. Using the nationwide implementation of 988 to build a new comprehensive Crisis Response System, and
2. Expanding the CCBHC model to become the primary model for behavioral health care delivery in Indiana.

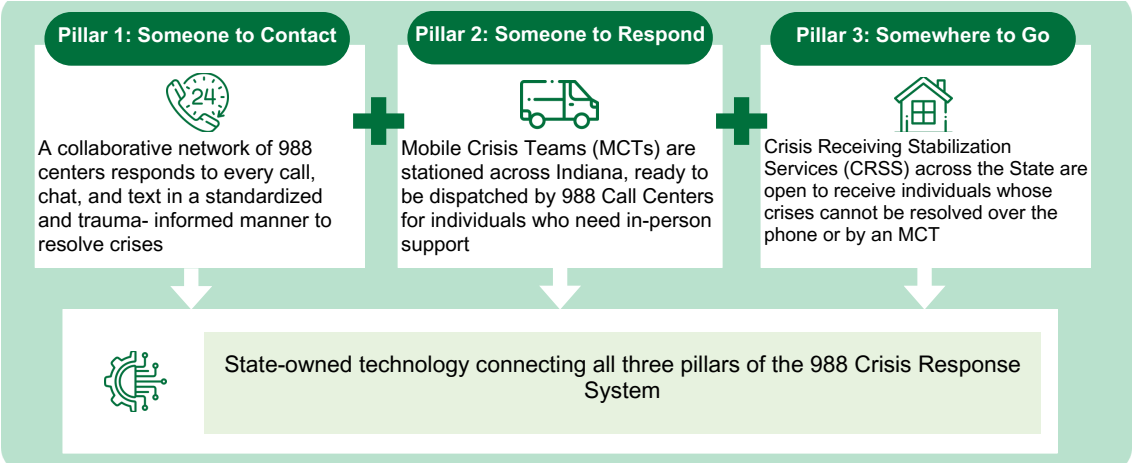
As a direct result of the 2022 BHC report, the 2023 General Assembly passed SEA1, which created a new fund—the Community Mental Health Fund (CMHF)—with an initial investment of $50M/year to support building the 988 and CCBHC systems. SEA1 also directed DMHA to apply for participation in the federal CCBHC Medicaid Demonstration Program and implement the CCBHC model statewide.

Two years later, Indiana has made tremendous progress on these efforts, and requires further investment and attention to continue that progress.

A 988 Crisis Response System

In July 2022 the DMHA launched 988 in compliance with the National Suicide Hotline Designation (NSHD) Act of 2020, which required the Federal Communications Commission (FCC) to designate 988 as the new three-digit number for the national Suicide Prevention and Mental Health Crisis hotline. DMHA has made tremendous strides towards fulfilling the 2022 BHC report's recommendation to use the 988 transition to build a comprehensive Crisis Response System that provides care and support for anyone experiencing suicidal, mental health, and/or substance use crises to meet their needs.

What is the 988 Crisis Response System?



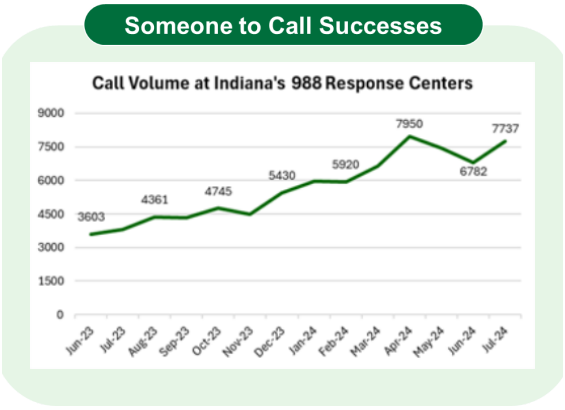
When the 2022 BHC Report was published, DMHA had begun implementation of Pillar 1 (Someone to Contact) by contracting with 988 Response Centers to field crisis calls, chats, and texts from individuals throughout the state. Pillars 2 and 3 were not yet established. As a direct result of the investments made through SEA1, Indiana has emerged as a nationwide leader in 988 calls and is on track to have MCTs available to serve 91% of the state population and 20 CRSS operating 24/7 by July 2025.

Pillar 1: Someone to Contact

Since go-live in 2022, Indiana has invested significantly to establish five 988 Response Centers responding to 988 calls, chats, and texts, the enabling technology that allows Crisis Specialists to connect individuals to the appropriate level of crisis response, and a marketing campaign to socialize Hoosiers to 988 across the state. Since July 2022, Indiana has retained a top national answer rate as call volume to 988 has continuously increased, with a 115% growth from June 2023 to July 2024. This growth is expected to continue.

Indiana's Progress on Pillar 1

Indiana has worked diligently to become a leader in the crisis space, with the 988 Call Centers boasting an **in-state answer rate of 92%** in spite of a continuously growing call volume. This answer rate puts the state in **the top 10 of the nation.**



An Indiana crisis data dashboard is currently in development that will make call center volumes reported by the five Indiana 988 Response Centers public. Volumes reported from call centers have historically been higher than reported nationally, indicating up to 11K calls per month.

Pillars 2 and 3: Someone to Respond and Somewhere to Go

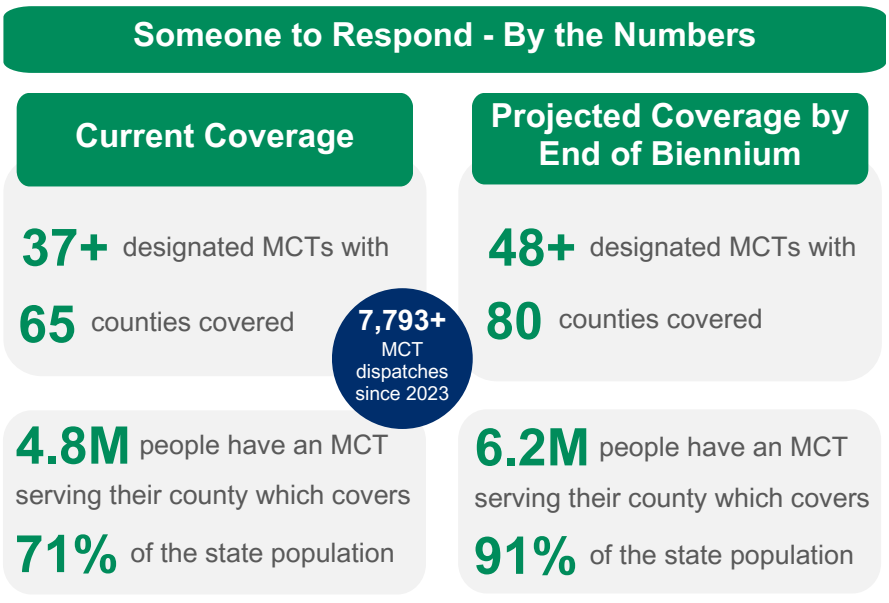
Indiana has dramatically grown the number of MCTs and CRSS across the state. MCTs are composed of peers and behavioral health professionals skilled in providing in-person, crisis care to people in their community. MCTs are dispatched by 988 Response Centers when an individual's crisis cannot be resolved over a call, texts, or chats.

As of July 2024, 65 out of 92 counties are currently covered by a MCT, with an estimated 5 additional teams needed for full 92-county coverage by the end of the next biennium. This marks significant progress from the number of MCTs that were available in July 2023, let alone in July 2022 when 988 went live. As of July 2024, Indiana had 14 designated MCTs (of which 12 were active) and 7 undesignated MCTs working on building up their own infrastructure to become active. By the end of 2025, DMHA expects that all MCT providers currently working towards Medicaid provider designation will achieve designation, meaning they have met all state and federal requirements.

MCTs have already made a substantial impact across the state, even as Indiana makes its way towards system maturity. As of June 2024, notably, 3,080 dispatches to MCTs were made in the first half of 2024, with approximately 1% escalated to law enforcement and approximately 10% resulting in emergency departments. This early measure of success is an indicator that the 988 Crisis Response System is already working as designed, as reducing the number of cases escalated to law enforcement and emergency departments is a target outcome of the 988 Crisis Response System. Furthermore, nearly all of the individuals interviewed in the Irsay Institute's Analyses of the Early Operation of Crisis Mobile Team reported that MCTs were critical for the people in the State of Indiana.

Mobile Crisis in Action

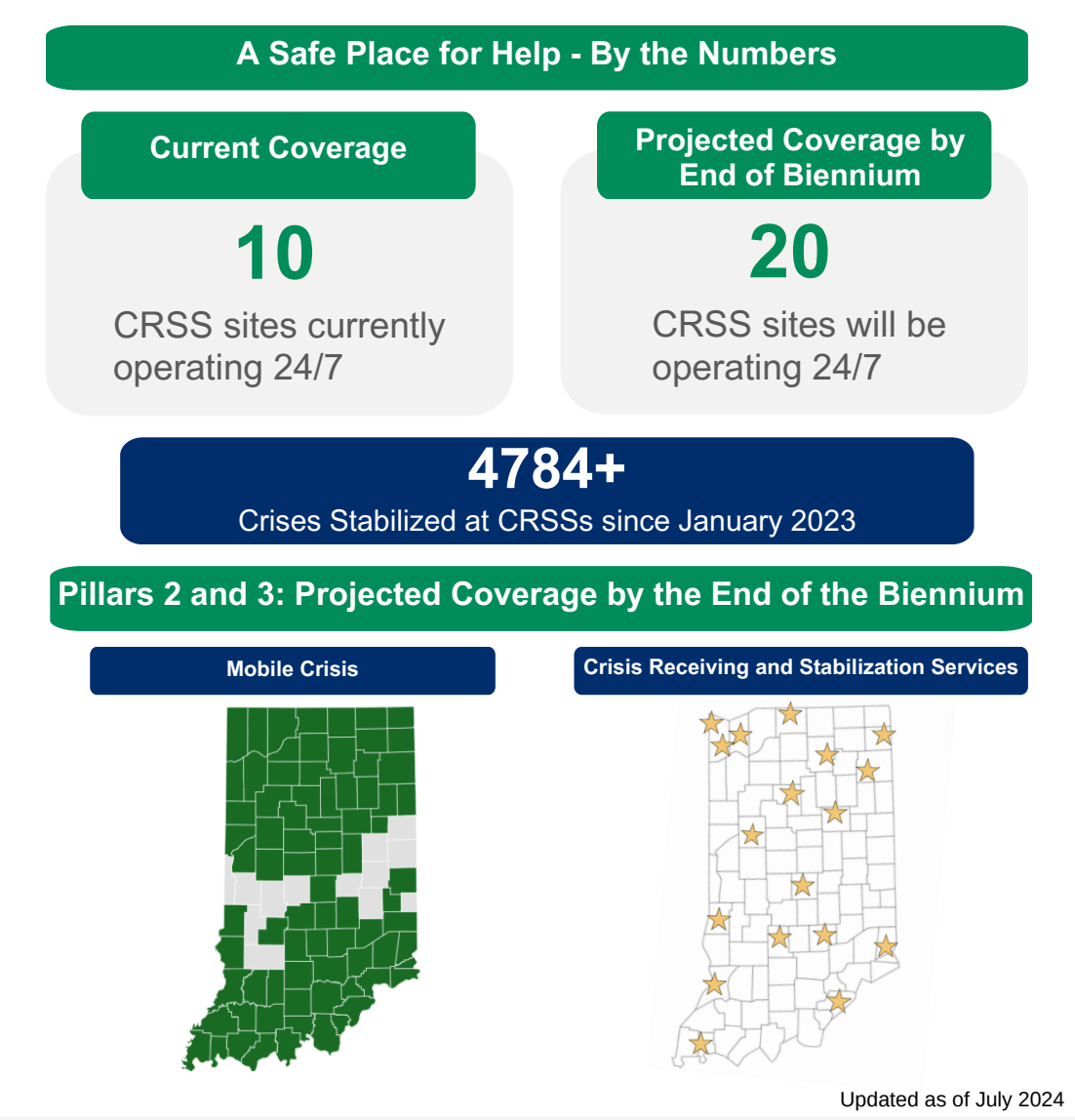
"...through these partnerships, we're able to respond to, ...[on] average about 120, 130 calls a month for our crisis teams. They're able to respond to those folks….and we can respond wherever the crisis is happening. And I just think that's meeting people in the moment, and where they are, I think is…a huge success." — MCT provider



Updated as of July 2024

CRSS are facilities providing short-term (under 24 hours) observation and crisis stabilization services to individuals in a home-like, non-clinical environment. CRSS in Indiana must adhere to the No Wrong Door policy, which ensures that individuals in crisis will receive support when they are brought to a CRSS and will not be turned away.

As of July 2024, there are 14 CRSS operational throughout the state, with 10 currently operating 24/7. Since January 2023, CRSS in Indiana have stabilized over 4,784 crises.



Many of the services established in Pillars 2 and 3 will ultimately be sustained through CCBHC—however, to ensure continued access for all Hoosiers, some additional investment will be needed this biennium.

The potential impact of the 988 Crisis System's pillars in action is visualized through the journey of an individual, David, navigating through a crisis.

Meet David

David is an individual with mental illness navigating the behavioral health system. His journey reflects many of his peers' experiences, though experiences may vary with a higher level of acuity.

New mental health challenges
- Stress and mental health issues
- Private episodes of psychosis

Ordinary childhood
- Standard upbringing
- High school graduate

Limited support & resources
- Private episodes have caused family to withdraw from him
- Has never seen a counselor or therapist before

Lifelong Hoosier
- 23 year old male
- Born and raised in Indiana

Subsequent results
- Recently lost his job
- Can't afford to meet basic needs
- On the verge of homelessness

David's Initial Encounter

VISION

***Months,* not years to go through treatment in the community**

David never enters the criminal justice system. David is diagnosed with a serious mental illness and starts treatment at a CCBHC.

4. David receives care. David is offered mental health services and support from community-based institutions.

3. Mobile Crisis Team (MCT) is dispatched. They arrive and de-escalate the situation.

2. Community reacts. The gas station owner, familiar with mental health issues and resources, contacts 988.

1. David's journey begins in public. David is at a gas station and starts acting in a way that makes the owner uncomfortable.

This map visualizes David's future experience to receiving the care he needs in an enhanced behavioral health landscape, from systems such as a robust 988 crisis system, an MCT, and a CCBHC.

B CCBHC

Similar to many states, Indiana's Community Mental Health Center (CMHC) system and the underlying financial structure currently do not allow behavioral health providers to cover the costs for providing evidence-based, integrated, and whole person care. This current system is funded through many siloed sources, resulting in an expensive and confusing system that negatively incentivizes providers to fit the provision of care to billable services.

Many other states have successfully addressed these challenges by transitioning to the federally supported CCBHC model, which shifts the way that providers are paid to allow for increased sustainability, ability to meet community needs, and transparency into outcomes and cost of care.

In 2022, the BHC recommended that Indiana take action to establish the CCBHC model as the primary mechanism for behavioral health care delivery, support that transition with sufficient legislative appropriations, and pass legislation requiring FSSA to apply for the Centers for Medicare and Medicaid Services (CMS) Section 223 CCBHC Medicaid Demonstration Program (hereinafter "Demonstration Program"). SEA1 of the 2023 legislative session established guidance and appropriations for DMHA to carry out this charge.

What is CCBHC?

As directed by SEA1, DMHA is expanding the Certified Community Behavioral Health Clinic (CCBHC) model statewide to transform the current behavioral health system. CCBHCs are specially-designated clinics that provide a comprehensive range of mental health & substance use services.

The CCBHC model is a proven outpatient model that:

- **Ensures access to integrated services** including 24/7 crisis response and medication-assisted treatment
- **Meets strict criteria** regarding access, quality reporting, staffing, and coordination with social services, justice, and education systems
- **Receives funding** to support the real costs of expanding services to fully meet the need for care in communities

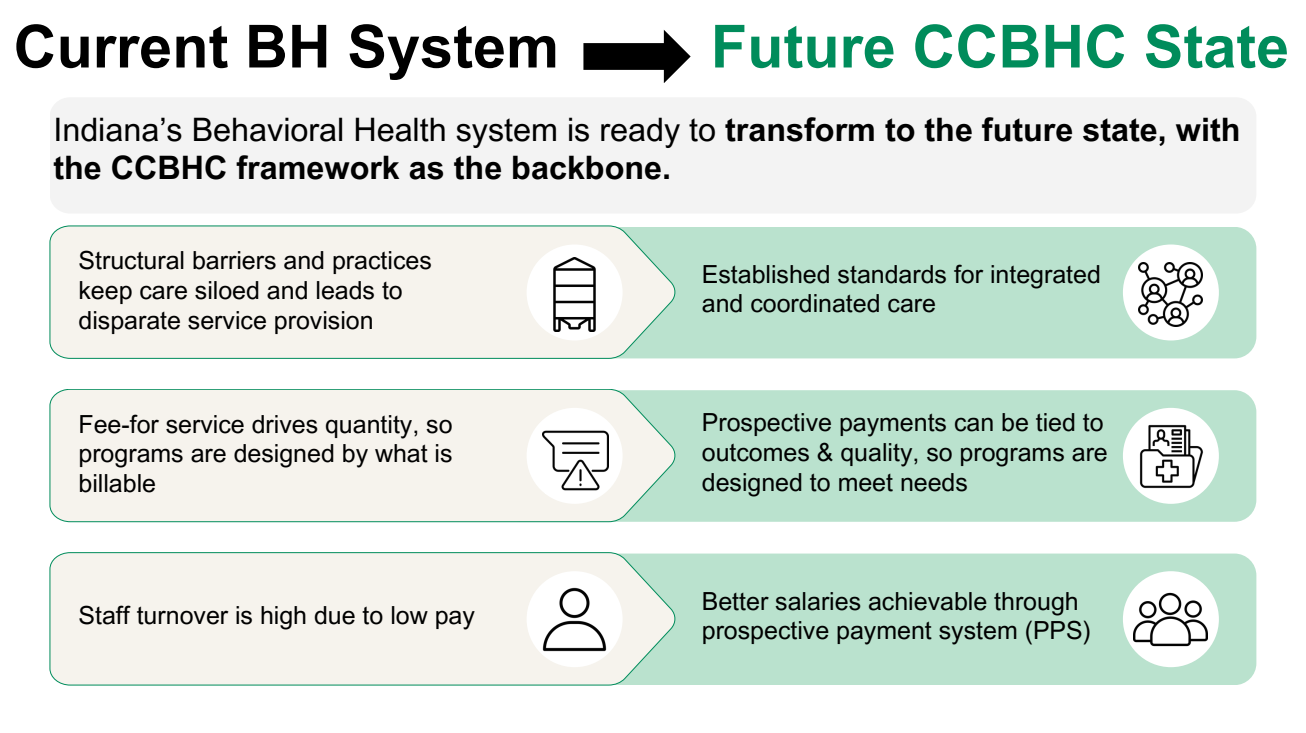
WHO can access CCBHC services?

- Anyone who requests care for mental health or substance use
- Accessible regardless of one's ability to pay, place of residence, or age
  - Includes developmentally appropriate care for children and youth

Nine Core Services

- Crisis Services
- Screening, Diagnosis, & Risk Assessment
- Psychiatric Rehabilitation Services
- Outpatient Primary Care Screening & Monitoring
- Targeted Case Management
- Peer, Family Support, & Counselor Services
- Community-Based Mental Health Care for Veterans
- Person- & Family- Centered Treatment Planning
- Outpatient Mental Health & Substance Use Services

Many states have successfully addressed challenges Indiana faces in access, quality, and integration of care by transitioning to the CCBHC model.



According to a 2024 report issued by the National Council for Mental Wellbeing, states that have expanded their use of CCBHCs have seen outcomes in numerous areas, including through access to care, workforce investment, and populations served.[3] The data shows that:

- CCBHCs are serving an estimated 3 million people nationwide.
- CCBHC status enables clinics on average to serve more than 600 more people per clinic than prior to CCBHC implementation. Medicaid CCBHCs expanded their number of people served by an average of 33% per clinic.
- As a result of becoming a CCBHC, clinics on average created an estimated more than 11,000 new behavioral health jobs, or a median of 15 new positions per clinic — critical to the ongoing workforce shortage and rising demand for services.

Additional information on national costs savings and impacts of CCBHCs can be seen in the National Council for Mental Wellbeing's 2024 CCBHC Impact Report, included as Appendix E.

CCBHC Demonstration Program

Guided by the 2022 BHC and SEA1 directives, DMHA released two solicitations in 2023 to (1) gather stakeholder input on its plan for CCBHC implementation and (2) competitively select current behavioral health providers to serve as Pilot Sites for Indiana's application for the CCBHC Demonstration Program.

In June 2024, Indiana was one of ten states selected to participate in the Demonstration Program, securing the enhanced federal funds to implement the CCBHC model in Indiana. Since then, Indiana has continued collaborating with and providing technical assistance to the eight Demonstration Pilot Sites to ensure they meet all CCBHC criteria and are ready to begin fully offering CCBHC services to Hoosiers in accordance with State and Federal requirements in early 2025.

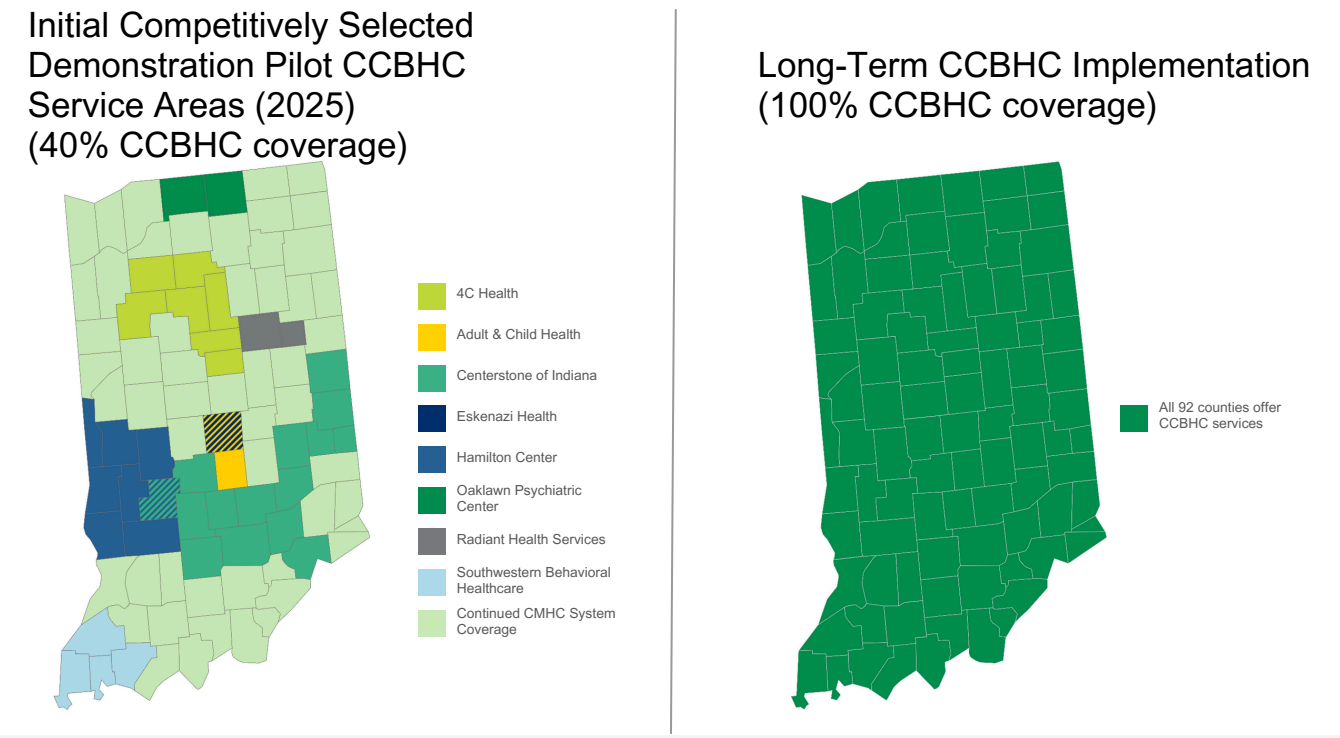
CCBHC Implementation Plan

Indiana will initially implement the model in the eight competitively selected, geographically diverse providers serving 39 counties **(40%) of the state.**

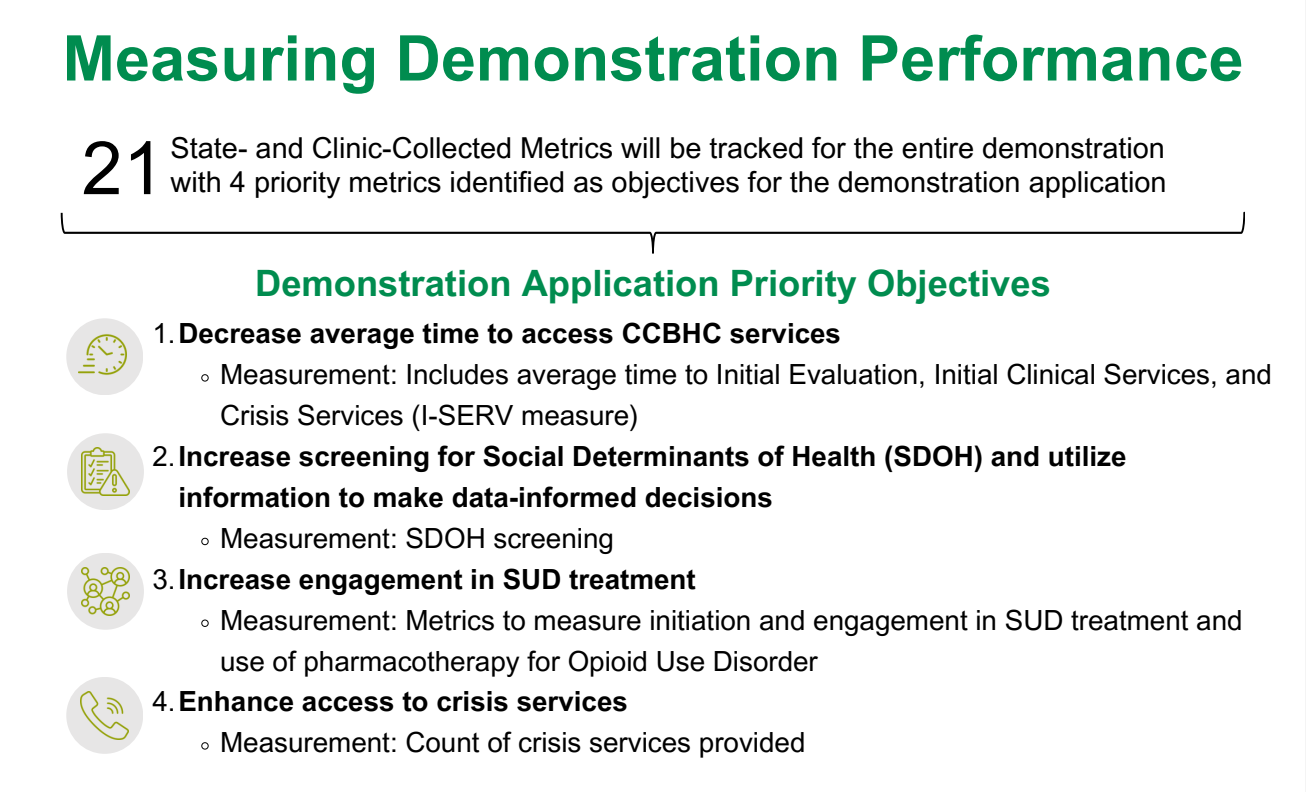
To make steps towards statewide coverage, Indiana plans to double our CCBHC footprint to cover 80% of the state by adding sites to the Demonstration around January 2027.

Indiana's long-term goal is to implement CCBHC as the primary behavioral healthcare model statewide and ensure that all Hoosiers in every county have access to CCBHC services. In effect, this means growing CCBHC coverage to all 92 counties (100% of the state) long-term.

The map below visualizes the (1) initial CCBHC coverage and continued CMHC service coverage during the Demonstration (before the CCBHC model is expanded statewide), and (2) long-term plan for statewide CCBHC coverage.



CCBHC Measurement and Accountability
Under the CCBHC Demonstration Program, Indiana is required to report on the fiscal and health-related impacts of the CCBHC implementation to national evaluators, including reporting on 21 different health outcomes measures and four targeted goals established by Indiana.



To support this effort, Indiana will leverage its existing relationship with the Wellbeing Informed by Science and Evidence (WISE) in Indiana, a state university partnership between the Indiana Clinical and Translational Sciences Institute (CTSI) and FSSA to engage Indiana's nationally recognized academic experts to evaluate and inform Indiana practices, programs, and policies.

WISE Indiana will collect and report data related to the cost, quality, and scope of services provided by CCBHCs, as well as evaluate the impact of the Demonstration Program on the federal and state costs for a full range of behavioral health services and health outcomes associated with the CCBHC implementation to the state and national evaluation team.

Indiana has also established an oversight committee to ensure appropriate progress towards outcome measure goals and guide the state's CCBHC implementation and related programmatic decisions, informed by WISE Indiana's evaluation.

While CCBHCs are required to serve individuals regardless of their insurance status or enrollment in Medicaid, the CCBHC transition will most immediately and directly serve the Medicaid population with a behavioral health diagnosis. It is estimated that over 50,000 members will receive services from the first eight Pilot Sites in the CCBHC demonstration. That number is anticipated to rise rapidly as the CCBHC model expands beyond the initial Pilot Sites.

A look at the Medicaid population to be served under the demonstration

C Financial Roadmap

Financial Integration of Crisis Response and CCBHC

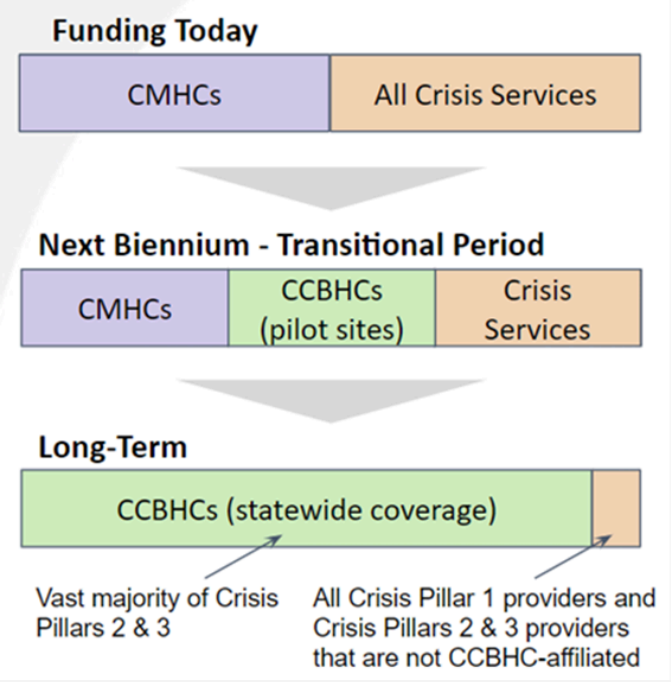
Although the Crisis Response System and the CCBHC model are being built concurrently, Indiana is taking steps to ensure that the two systems are integrated. Over the medium and long term, the bulk of Crisis Response Services will be paid for and delivered through the CCBHC network.

The next biennium is a transitional period as Indiana continues to build and connect its CCBHC and 988 Crisis Response Systems. To date, the State has used one-time federal Covid-relief funds to help bridge the gap, investing the funds to build state and provider systems, and support providers in growing their service offerings as CCBHC and crisis providers.

Once this transition is complete, there will still be a need to sustain Pillar 1 and a few discrete crisis response providers that are not affiliated with the CCBHC model[4] outside of the CCBHC rates.

988 Crisis Response System Costs for SFY 2026 and 2027

As 988 has been codified into State law through IC 12-21-8-1.2, Indiana has an obligation to sustain 988 as part of the behavioral health crisis infrastructure. The first two years of implementation allowed Indiana to assess and establish the true cost to sustain the 988 Crisis System:



1. $**11M** - annual cost to fund all five Crisis Response Centers[5]
   - Pillar 1 will require separate funding from the CCBHC System in perpetuity

2. **$17M** - estimated annual cost to operate the required number of MCTs to maintain statewide coverage and support individuals in-person[6]
   - CCBHC will absorb most of these costs in the long-term, as the vast majority of current fee-for-service MCT providers become CCBHC- affiliated and funded

3. **$24M** - estimated annual cost to operate the current number of CRSS
- CCBHC will absorb most of these costs in the long-term

4. **$8M** - estimated annual cost to connect all three pillars of the Crisis Response System, including: the telephony platform, customer relationship management (CRM) software, State staff salaries, system technical support and evaluation, and a statewide marketing campaign to promote 988[7]
- Infrastructure costs will require separate funding, however the state can and should continue to leverage additional funding, including administrative funding available from CMS for costs that can be tied to Medicaid administration

Indiana's CCBHC transition was supercharged by selection for the Demonstration program, which provides a minimum of four-year enhanced Medicaid Federal Medical Assistance Percentage (FMAP) for developed PPS rates approved in the demonstration, which increases Indiana's Medicaid FMAP from 66% to 78%, and is estimated to allot the State over $200M per year in additional federal funds.

Current Funds Available

Indiana's current CMHC system is primarily supported by State SMI appropriation.

Funds	Amount
Severe Mental Illness (SMI) appropriation	$90 million / year (in last several budgets)

As Indiana transitions to CCBHC, this funding will gradually be repurposed to offset the state portion of CCBHC costs, ideally at a rate proportional to the shift to CCBHC.

Funds	Amount
Community Mental Health Fund (established by SEA1 in 2023)	Baseline of $50 million per year (SFY 2024 and 2025) to build the Crisis Response and CCBHC systems

These funds have been expended for these purposes and are largely responsible for Indiana's progress over the last two years.

Funding Needed

Indiana legislators and advocates widely acknowledged that the 2023 CMHF appropriation of $50M per year was an initial investment, likely requiring further appropriations to expand the 988 and CCBHC systems statewide. To continue Indiana's progress towards a high-quality and sustainable behavioral health infrastructure, **the State estimates the total cost is around $100M in SFY26 and $120M in SFY27. This includes:**

1. $60M for SFY26 and $55M for SFY27 to maintain crisis footprint, including 988
2. $40M for SFY26 and $65M for SFY27 to fully fund the State's share of the CCBHC Demonstration Program for:
    a. 40% CCBHC coverage (8 Pilot Sites) from July 1, 2025 to December 31, 2026
    b. 80% CCBHC coverage from January 1, 2027 to June 30, 2027

The total cost for both 988 and CCBHC continuation, beyond what can be paid for with the continuation of the current Community Mental Health Fund ($50M per year), is estimated to be $50M in SFY26 and $70M in SFY27.

The push towards 100% CCBHC coverage is anticipated to occur in 2027; funding necessary for this expansion will be a part of the 2027 legislative session funding requests. By the next biennium, the state will have data on the actual costs, utilization, and impact of CCBHCs in Indiana to provide to the General Assembly to support such funding requests.

Recommendations

1. The General Assembly should continue the existing Community Mental Health Fund appropriation of $50M per year.

2. The General Assembly should increase the Community Mental Health Fund **and/or** implement one of the other recommended funding options detailed in Appendix F to cover the additional costs.

3. The Commission should analyze and report on fiscal progress, cost savings, impact, and coverage of CCBHCs in their next report and develop a roadmap for full-state coverage by CCBHCs, including the amount of funding that will need to be requested in the 2027 legislative session.

Four notes about these numbers:

1. A feature of CCBHC is continuous financial and operational monitoring and refinement. These numbers are based on well-informed estimates as of August 2024. As the state continues to build towards demonstration go-live in early 2025, some of these estimates could shift.

2. The estimated costs over the next biennium exceed the current CMHF appropriation because:

   - Indiana used mostly one-time federal Covid-relief funds to build the initial 988 crisis system infrastructure and begin developing the CCBHC infrastructure. While most of the 988 Crisis System Pillars 2 and 3 will be sustained by the CCBHC model in the future, the next biennium is a transitional period where less federal funding is available, creating the need to backfill for the one-time Covid-relief funds. This estimate assumes that, during the next biennium, some currently one-time funded Pillar 2 and 3 crisis providers will become a part of the CCBHC network, meaning their crisis offerings will be paid for by the CCBHC PPS rates, thus reducing the predicted costs for these pillars.

   - The past biennium has been focused on rapidly standing up a 988 Crisis System infrastructure and supporting various providers as they begin to grow their service offerings as crisis providers and CCBHCs. However, the CCBHC model goes live on January 1, 2025, requiring funding to support the actual delivery of a more comprehensive array of services. Furthermore, funding is necessary to sustain the current 988 Crisis System providers in this transitional period before they become a part of the CCBHC network and to integrate the two systems.

3. These are the estimated costs to continue to implement the CCBHC and 988 models before identifying other possible fund sources to offset the amount of additional funding needed. DMHA is committed to creative leveraging and braiding of multiple alternative funding sources to mitigate state fiscal impacts. However, DMHA expects that the vast majority of these costs will require additional state appropriations. Specifically:

   - The State is actively identifying potential federal grants and other fund sources for 988/crisis services but expects that no more than 10% of these costs will be able to be covered outside of a state appropriation.
   - The estimated CCBHC cost is the State’s share of the Medicaid rates that will be paid to CCBHC providers. These costs must be funded by state dollars and cannot be offset by federal grants. A standard appropriation to fund the State’s share of the Medicaid rates will become increasingly important as Indiana expands the CCBHC model statewide.

4. The funding request included this section focuses on the funding amount needed this biennium for the 988 Crisis Response System and the CCBHC Model Implementation. Identifying long-term sustainable funding options will be important for sustaining these initiatives, and for implementing and sustaining other recommendations in this report. A summary of potential sustainable funding options is included in Appendix F.

Estimated MCT Cost Savings from Diverting Individuals in Crisis from Emergency Medical System (EMS) and Law Enforcement (LE) Responses[8]

$4.7M to $5.1M Total Estimated Cost Savings from Diverting Individuals in Crisis

MCT Dispatches[9]

Cost for one MCT dispatch (Medicaid rate)	$ 199
Est. Annual Number of MCT dispatches diverted from an EMS or LE response (annualized based on number of responses to date)	2,281

Estimated Cost Savings per MCT Diversion from Emergency Medical Services

Avg. Cost for One EMT Dispatch[10]	$ 2,154
Avg. Cost for One Day in a Hospital ER[11]	$ 95
Avg. Cost for an EMT Dispatch that leads to a One Day ER stay	$ 2,249
Est. Cost Savings per MCT Diversion	$ 2,050
Est. Cost Savings if all MCT dispatches diverted an individual from an EMT Dispatch and One Day ER Stay	**$ 4,675,990**

Estimated Cost Savings per MCT Diversion from Law Enforcement

Avg. Cost per LE Response[12]	$ 2,383
Avg. Cost for One Day in a Jail[13]	$ 54
Avg. Cost for an LE Response that leads to a One Day Jail Stay	$ 2,437
Est. Cost Savings per MCT Diversion	$ 2,237
Est. Cost Savings if all MCT dispatches diverted an individual from an LE Response and One Day Jail Stay	**$ 5,103,857**

A note about these numbers:
The annual estimated diversionary cost savings ranges, based on assuming all MCT diversions avoided either (1) EMS responses or (2) law enforcement responses. Cost savings are expected to increase, as MCT use is expected to grow and MCT costs will be mostly covered by CCBHC long-term.

Assumptions and relevant data sources (all of which are Indiana-specific) are detailed in the endnotes. The State will have more readily available data from formal program evaluation to share in the next BHC report.

What about the next biennium and beyond?
The ultimate decisions about the long-term viability of CCBHC will be made by the 2027 General Assembly as they craft the state's budget for State Fiscal Years 2028 and 2029. There are far too many assumptions, variables, and unknowns at this time to helpfully project what will be asked of that deliberative body.

However, the 2027 budget makers will have 18-24 months of actual Indiana fiscal and quality data, as well as a detailed program evaluation from the finest Indiana-based academic partners looking at the impact of CCBHC on healthcare and criminal justice costs, among other things.

Indiana has been nationally recognized for our alignment and commitment to building a new behavioral health infrastructure. SEA1 in 2023 was a historic and transformational piece of legislation that has already driven monumental progress. The Commission urges the 2025 General Assembly to build upon and accelerate that progress by making these smart, targeted, and effective investments in Indiana's Behavioral Health infrastructure.

SECTION 1.2

Reimbursement: Medicaid Rate Matrix and Parity

Fundamentally, the "product" of the behavioral health care industry is the time and talent of a skilled, specially trained workforce. That time must be paid for, and the vast majority of behavioral health service providers cannot keep up with the costs. For example, Riley Children's Health—a large and sophisticated children's hospital—reported to the Commission that they lose one dollar for every dollar that they spend on providing behavioral health care services.

Therefore, the single most impactful lever that the Indiana General Assembly has to increase access to behavioral health care is to ensure that behavioral healthcare professionals are paid at a level commensurate with their training, experience, and importance. The following recommendations will get Indiana much closer to achieving that goal.

A Medicaid Rate Matrix

A "Medicaid Rate Review" refers to the process that Indiana follows to set reimbursement rates for Medicaid and other non-Medicaid services, based on FSSA's objectives of transparency, alignment, sustainability, person-centeredness and equity. A rate review is performed using a methodology that complies with regulatory requirements specific to the rate(s) being reviewed. Under the rate matrix approach, each Medicaid rate is reviewed at least every four years using an evidence-based rate methodology that includes input from providers and other stakeholders. Rate reviews result in recommendations for rate increases, rate decreases, or a combination of both.

In accordance with the current rate matrix[14] and established cadence, rates for behavioral health services will be reviewed in SFY2025 and updated in SFY2026.

Recommendation

Proceed with FSSA's Medicaid Rate Matrix work for behavioral health services and implement the recommendations resulting from the Rate Matrix review.

B Enacting Mental Health Parity Legislation

’President George W. Bush signed the Mental Health Parity and Addiction Equity Act (Federal Parity Act) into law on October 3, 2008. The Federal Parity Act aims to ensure that insurance coverage for mental health and addiction treatment should be no more restrictive than insurance coverage for other medical care.

This was necessary because up until that time, insurance coverage for mental health and substance use disorder treatment had been more restrictive than coverage for medical services. This often included hard caps on treatment, such as annual inpatient day limits for psychiatric hospitalization and annual visit limits for how often someone could see a therapist. These caps were in place for all mental health benefits whereas only a few medical benefits would have similar caps. Cost sharing was usually more expensive as well.

Despite the clarity of the law (mental health should receive equal treatment under the law as medical/surgical benefits), compliance and enforcement has been spotty at best, for a variety of reasons. The health insurance and healthcare regulatory regime is an extraordinarily complex patchwork of federal, state, employer, and industry actors. Three giant federal agencies just released a new regulation called “Requirements Related to the Mental Health Parity and Addiction Equity Act,” which aims to clarify and increase the federal government’s enforcement of Parity in several ways:[15]

- Insurers now must analyze data and prove that there are not “material differences” between mental health care and medical care in terms of denial rates, out-of-network utilization, network adequacy, and reimbursement rates. “Material differences” are when data shows that a “limitation is likely to have a negative impact on access to mental health or substance use disorder benefits as compared to medical/surgical benefits.”
- Insurers are prohibited from relying on biased sources to design mental health benefits.
- Insurers cannot use data from before the Federal Parity Act existed for setting reimbursement rates.
- Insurers must provide “meaningful benefits” for covered mental health conditions. This means that insurers must cover what is “a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice.”
- Insurers must define mental health conditions in a way that is consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Robust federal action is required because most insurance plans are employer sponsored, thus falling under the regulatory purview of the federal Department of Labor.

States can also take assertive, bold action to increase parity compliance, and the Commission urges the Indiana General Assembly to do so. There are three components of parity regulation, all of which are riddled with their own types of complexity and nuance:

- **Rates:** How much do insurers reimburse for mental health services, and are those rates substantially equivalent to a comparable medical/surgical services?
- **Non-quantitative treatment limitations (NQTLs):** Basically, how hard or easy is it to get paid? Even if, on paper, a service is covered adequately, are there restrictive processes that make actual reimbursement more difficult than their medical/surgical counterparts? Examples of NQTLs include prior authorization requirements, formulary designs for prescription drugs, onerous network "tiering" practices, and others.
- **Network adequacy:** Often included as a NQTL, but worth mentioning separately. Even if there is coverage on paper, and other NQTLs are not too burdensome, there are often major issues with ostensibly available and in-network providers not having capacity to take on new patients.

The proposed legislation takes steps towards addressing each of these issues, along with equipping the Indiana Department of Insurance with more regulatory authority. Ensuring Mental Health Parity is a long and twisting journey that involves the federal government, states, and industry to all do their party. The Indiana General Assembly can contribute to the cause by enacting the legislation described below.

Recommendation

The General Assembly should enact parity legislation that (1) requires provider parity reimbursement indexed to Medicare rates, where applicable, (2) ensures parity for youth services that may not have comparative Medicare rates (3) deems carve-outs to be in network, (4) considers consumer co-pays and the administrative burden, and (5) increases the enforcement authority of the Indiana Department of Insurance.

The draft Mental Health Provider Reimbursement and Credentialing legislation is included in Appendix D.1. A summary of the proposed legislation is included below:

1. The proposed Mental Health Provider Reimbursement and Credentialing bill establishes three things:

    a. Insurers will be deemed in compliance with the Federal Parity Act if they can show that their reimbursement rates for mental health providers are at least as favorable as their reimbursement rates for other medical providers.
    b. The Department of Insurance will conduct a deeper examination of any insurer whose reimbursement rates for mental health providers are at least ten percent lower than their reimbursement rates for other medical providers.
    c. If a provider or facility that provides both medical services and mental health services is credentialed by an insurer to be part of its medical provider network, it shall also be considered credentialed to be part of its mental health network. This is relevant in instances when an insurer hires a third-party vendor to manage its mental health benefits. Oftentimes the third-party vendor requires the provider or facility to go through the credentialing process all over again even though it has already done so with the overall insurer.

For the sake of determining if reimbursement rates are “at least as favorable” or “at least ten percent lower,” the reimbursement rates will be compared to Medicare rates. So, if on average an insurer pays inpatient mental health facilities 115% of what Medicare pays and pays inpatient medical facilities 110% of what Medicare pays, that would be at least as favorable. But, if an insurer pays inpatient mental health facilities 105% of what Medicare pays and pays inpatient medical facilities 120% of what Medicare pays, that is more ten percent lower and would require further examination by the Department of Insurance.

PART II:

People: Building the Workforce

SECTION 2.1

Leveraging Other Treatment and Healthcare Providers to Expand Access to Behavioral Health

While Indiana has made demonstrable progress to increase the recruitment, retention, and quality of BHHS professionals at large, there are a number of short-term and long-term initiatives that the Indiana General Assembly and other stakeholders should support to continue to enhance the BHHS workforce. Many of these recommendations underscore the opportunities for improvement proposed in the Playbook for Enhancing Indiana's Mental Health and Behavioral Health Workforce ("the Workforce Playbook").[16] The Workforce Playbook is the culminating efforts of a team of expert advisors who researched the regulatory environment, education landscape, and perspectives on the BHHS workforce. Where relevant and applicable, the BHC recommends pursuing the recommendations aimed at policy makers.

A Increase the BBHS workforce by supporting primary care providers serving children and adults with mental health needs through provider psychiatry consultation programs

One of the primary challenges of increasing access to behavioral health care is lack of trained professionals. Many strategies to increase the workforce will take years to implement, so it is crucial that Indiana pursue strategies that can help in the shorter-term in tandem with longer- term investments. One of these shorter-term strategies is harnessing primary care to deliver care when appropriate. Primary care providers play a critical role in the overall health and well-being of individuals for the following reasons:

- Primary care is accessible to all patients regardless of geography or ability to pay
- Their role as first contact providers of comprehensive and continuous care who have established relationships with their patients makes them well-suited to identify and treat any mental illness

- Visiting a primary care physician may carry less stigma for many patients

There are two established and well-utilized programs within Indiana that increase workforce by supporting primary care providers in caring for the mental health needs of their patients, including the:

1. Indiana Behavioral Health Access Program for Youth (Be Happy), and the
2. Indiana Consultations for Healthcare Providers in Addiction, Mental Health, and Perinatal Psychiatry Program (CHAMP)

Both programs are free statewide, provider-to-provider consultation phone lines in which primary care providers receive guidance from board-certified psychiatry specialists around diagnostic clarification and treatment planning. They also assist with identifying community resources and provide free continuing education.

Despite being established and well-utilized programs, Be Happy and CHAMP do not currently have sustainable funding sources; CHAMP grant support from DMHA will expire in July of 2025 and Be Happy grant support from Health Resources and Services Administration will expire in September of 2026.

Recommendations

1. The General Assembly should support sustainable funding for Be Happy and CHAMP programs.

2. The General Assembly should consider a model which requires insurance carriers operating within Indiana to proportionally share in program cost based on covered lives/month and involves development of a board with representatives from relevant state entities (e.g., DMHA, Indiana Department of Health (IDOH)), health insurance carriers, and providers to administer insurance assessments, manage funds, and ensure ongoing services. This model has been used successfully in other states to support similar programs.

Appendix D.2 includes a draft language for a Behavioral Healthcare Funding Act to create a program designed to stabilize and enlarge funding for Be Happy, CHAMP, the Adolescent Addiction Access (AAA) Program, and to make funding possible for similar programs intending to address the shortage of resources in behavioral healthcare for residents of the state.

B Include occupational therapists as treatment extenders

As Indiana moves forward with implementation of the CCBHC model, the General Assembly and stakeholders should include Occupational Therapists in plans to expand access to behavioral and mental health care as provider extenders. Key to the success of the CCBHC model is an adequate number of providers with expertise in addressing trauma and promoting recovery, with Occupational Therapists clearly outlined to serve this role by the Substance Abuse and Mental Health Services Administration (SAMHSA) in their CCBHC Certification Criteria.[17] This strategy also aligns with the 2022 BHC Report, which recommended to increase the capacity of providers to address and improve the overall health and well-being of all Hoosiers.

Recommendation

Occupational therapy is a federally recognized discipline for reimbursable services through the CCBHC model. Indiana should continue to investigate methods to recognize and utilize Occupational therapists in the mental and behavioral health system including funding mechanisms through federal grants and long-term funding.

C End collaborative practice agreements between Advanced Practice Registered Nurses (APRNs) and physicians

As highlighted in the 2022 BHC Report, the lack of an adequate workforce is one of the biggest obstacles to improving the behavioral health of Hoosiers. While the issue of workforce requires long-term solutions that include the cooperation of the public and private sectors, as well as all levels of our education system, Advanced Practice Registered Nurses (APRNs) are qualified clinicians who are positioned to help with this workforce crisis right now.

Under Indiana law, APRNs are unable to practice without mandatory physician contracts — known as a “collaborative practice agreement.” The contracts require APRNs to submit a portion of their patient charts for a review by a physician. But rather than real-time, professional collaboration, the physician review of patient charts can occur months later, offsite, and has no immediate impact on patient care. In fact, that time spent on unnecessary ineffective chart reviews means there is less time physicians can spend with patients.

Often, the physician will charge a fee as a condition for signing the collaborative practice agreement. These fees can run thousands of dollars per month, which flows down as costs to patients and families.

APRNs diagnose, treat, and prescribe medications for mental health and substance abuse disorders. By removing the mandated contracts, Indiana could improve access to care, reduce costs, reduce family stress, and enhance patient outcomes. Additionally, APRNs are more likely to provide care in rural-based communities and their mandatory contracts with physicians lessens the number of available clinicians in severely under-served communities across the state.

Nearly 8,000 APRNs in Indiana are well-positioned to help address the workforce crisis, offering high-quality care, especially in underserved areas. More than half of states, the District of Columbia and two U.S. territories have removed these outdated barriers. In states like Arizona, Nevada, and North Dakota the number of APRNs practicing in those states increased. For example, Arizona saw an increase of more than 70% of APRNs in rural parts of the state within five years of enacting policy changes.[18]

The Commission heard throughout its meetings that physicians were often overburdened and doing the best they could with the limited time they have with patients. It is this workload that often makes it difficult for APRNs to find physicians to collaborate with. By removing this administrative burden, APRNs could help ease this workload on physicians and increase access to care for Hoosiers.

HB 1059 from the 2024 session of the Indiana General Assembly provides an example of statutory language.[19]

Chair Commentary on APRNs

The recommendation to remove the collaborative practice requirement was the subject of much discussion and was not a unanimous recommendation. The extension of full practice authority to non-physician practitioners is generally opposed by physician groups who point to the substantial difference in training and education requirements for physician and non-physician professionals.

Ultimately, as a deliberative body, the Commission had a respectful and frank discussion of the tradeoffs involved and voted to support this recommendation.

Recommendation

The General Assembly should end collaborative practice agreements between APRNs and physicians to ensure consumers direct access to clinicians.

D Secure sustainable funding for first responder mental health and resiliency training

According to a U.S. Department of Health study, firefighters are more likely to attempt suicide than the public.[20] The Center for Disease Control and Prevention has also found that occupational stress in first responders can be associated with increased risk of serious mental health issues.[21] These mental health issues range from anxiety and depression to post-traumatic stress and possibly suicide.

In recognition of this fact, DMHA and the Indiana Law Enforcement Academy (ILEA) entered into a partnership funded with ARPA dollars to provide no-cost mental health and resiliency training to all ILEA trainees for a two-year period. The state should build off this progress and offer this service to all first responders, including by maximizing federal grant opportunities and supplementing with state appropriations.

Recommendations

1.The General Assembly should fund ongoing mental health and resiliency support for law enforcement and first responders statewide.

2. The state should explore developing additional mental health training opportunities to help individuals identify, understand, and respond to signs of mental health and substance use challenges in their specific discipline and setting, similar to First Responder Mental Health and Resiliency Training. This may include discipline-specific mental health training for nurses or practitioners serving patients in primary care of hospital settings, or for teachers in school-based settings, or other individuals providing community-based supports.

SECTION 2.2

Increasing the BHHS workforce pipeline by sustainably funding psychiatry residency positions

Indiana is among states with the lowest ratio of psychiatrists per capita. Implementing a sustainable funding mechanism for psychiatry residency programs is integral to growing Indiana's psychiatrist workforce. Indiana has four psychiatry residencies that have the capacity to expand residency positions but do not have sufficient funding to do so. Mechanisms used by other states to support psychiatry residency positions are included below:

- Nevada established a grant program, funded by state appropriations, that awards grants to institutions
- New Mexico created a new Graduate Medical Education (GME) expansion fund supported by an $1.1 million annual appropriation

Recommendations

1. The General Assembly should implement a sustainable funding mechanism such as legislative appropriation for psychiatry residency positions. Directed appropriations to the GME Board or the Medical Residency Education Fund may be used to target the public expansion of psychiatry residencies in Indiana.

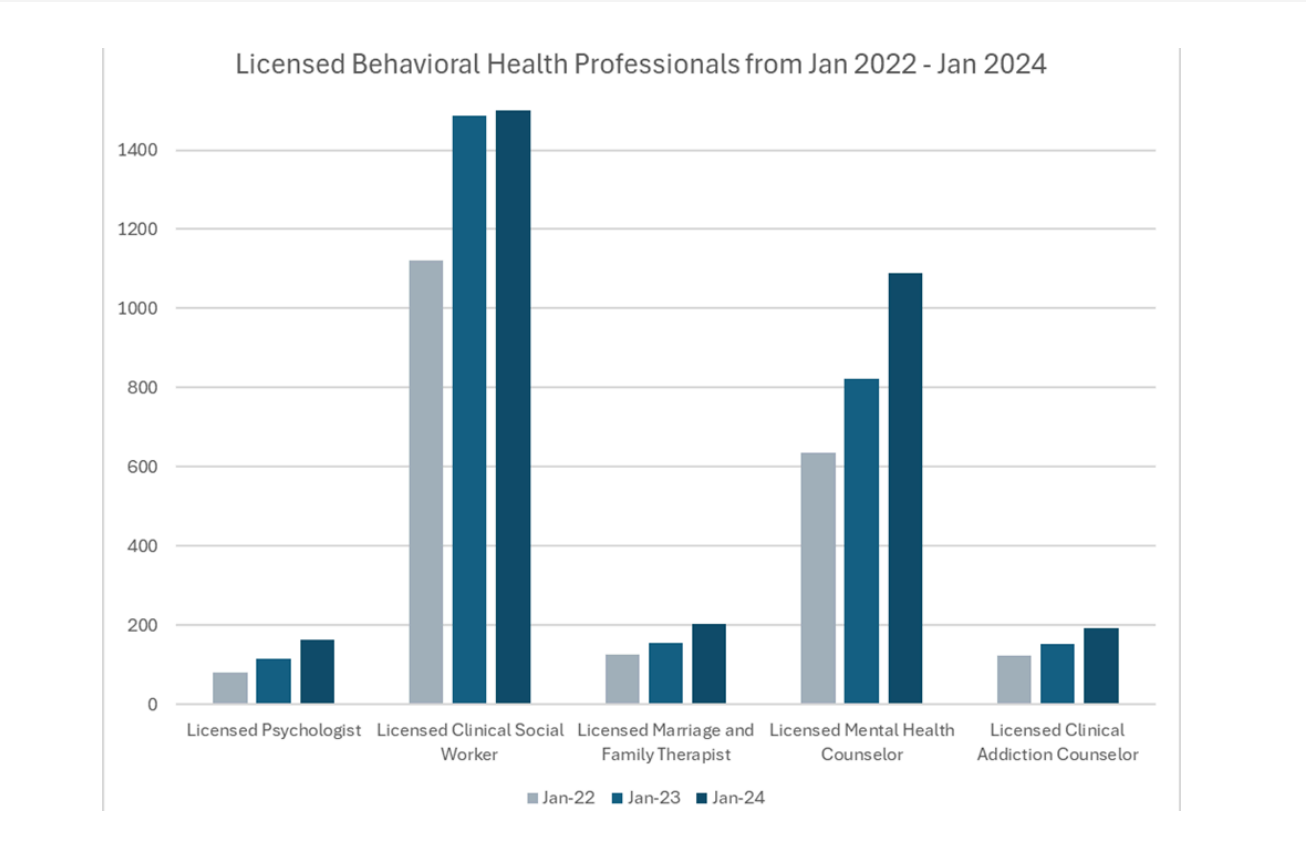
2. The state should explore developing additional mental health training opportunities to help individuals identify, understand, and respond to signs of mental health and substance use challenges in their specific discipline and setting, similar to First Responder Mental Health and Resiliency Training. This may include discipline-specific mental health training for nurses or practitioners serving patients in primary care of hospital settings, or for teachers in school-based settings, or other individuals providing community-based supports.

SECTION 2.3

Addressing longer-term, structural barriers to BHHS Workforce Development

A Address key barriers to licensure

Thanks to increased investment and alignment across state government and the provider community, Indiana has made significant progress towards increasing the number of licensed BHHS professionals. As evidenced by the chart below, the number of licensed BHHS professionals has increased year-over-year during the last three years. Despite these improvements, the lack of adequate workforce remains a structural barrier to implementing many of the Commission's recommendations.



Currently, many Indiana BHHS licenses require specific courses or course content to be completed, documented in a transcript, and submitted with a licensure application. According to the Workforce Playbook, 58% of BHHS licensees reported difficulty in understanding the licensure process as one of the most difficult aspects of their training, before and after graduation.

Recommendations

1. As proposed in the Workforce Playbook, the General Assembly should appropriate funding to help streamline the process for individuals receiving an initial license. The funding could support the creation of a new Education and Reciprocity Coordinator position for the BHHS Board to liaise with academic institutions and support streamlined licensing. This position would be charged with:

- Reviewing existing regulations related to licensing and removing redundant requirements. This could include streamlining the requirement for applicants to graduate from an accredited program and complete specific coursework as accreditation is a confirmation of required content.
- Reviewing all degree programs determined by the BHHS Board as requiring specific courses or course content to qualify an individual for licensure application and identifying opportunities for program alignment with licensure requirements.

2. The General Assembly should appropriate additional funding to the Indiana Professional Licensing Agency (IPLA) to ensure adequate funding for operational costs. This is to ensure the IPLA has sufficient resources to offer timely processing of applications and reviews. Without adequate resources to review applications for licensure from BHHS professionals, IPLA could cause bottlenecks in the licensing process and prevent the timely licensure of BHHS professionals.

3. The General Assembly should conduct statutory and budget language changes to ensure BHHS licensing fees are going to the IPLA to build infrastructure support for BHHS license processing.

4. Review timelines related to temporary license, reciprocity, and eligibility to provide reimbursable services. This review should:

- Ensure the process for temporary license is highly efficient and the length of the license is adequate to allow the completion of all supervision requirements. This could include making the temporary license 2 years.
- Evaluate the current process, improve timelines, and eliminate barriers preventing clinicians fully licensed in other states from practicing in Indiana. This could include setting a specific “turn-around” timeline for reciprocal license applications.
- Evaluate Other Behavioral Health Professional (OBHP) qualifications to define “equivalent experience” and “minimum competency” standards in a way that allows MRO provider agency the ability to access reimbursement for services by treatment extenders as quickly as possible with quality and safety prioritized.

B Address the impact of High Education Costs and Low Wages on Recruitment and Retention

Recommendation

As discussed in Part I, the General Assembly should enact parity legislation, as this will ensure adequate funding for BHHS professionals through the Medicaid Rate Matrix, including for Certified Peer Support Professionals (CPSP) and Community Health Workers (CHW). Ensuring adequate funding during the next biennium’s Medicaid Rate review and including the CPSPs (qualified treatment extenders with lived experience) and CHWs (qualified entry level behavioral health workforce) in the Matrix will assist with talent pipeline development and improve capacity for clinicians.

C Strengthen the BHHS Talent Pipeline and Pathways to Practice

Recommendations

1. As proposed in the Workforce Playbook, the General Assembly should incentivize the pathway to practice by enacting a state income tax credit for qualified licensed BBHS that participate in clinical training with interns and conduct clinical supervision for individuals completing clinical experience hours required for BHHS licenses. Other states have implemented a similar preceptorship income tax credit, leading to and have seen significant outcomes. In Colorado, for example, health care professionals who provide preceptorship during the applicable tax year may be eligible to receive a $1,000 tax credit. Since its inception in 2017, 540 students have been precepted and 93% of preceptors reported that the credit made it more likely that they would precept in the future, and 38% reported hiring a student who rotated in their practice. The preceptorship income tax credit recognizes that resources are required to support future BHHS seeking licensure and intends to incentivize licensed BHHS to step-up as preceptors.

2. Include career areas that have a high social impact level in high school graduation pathways. Current graduation pathways heavily emphasize science, technology, engineering, and mathematics careers that translate to higher demand. Including behavioral health as a possible career pathway will build visibility and encourage pipeline development.

3. Emphasize behavioral health as a priority in the state's strategic planning for education and workforce development efforts, including efforts driven by the Department of Education, Division of Workforce Development, Commission for Higher Education, and Department of Health. This may include appointing a designee to leadership of the aforementioned organizations to elevate behavioral health workforce priorities and considerations. This may also include development of "social impact" flags on publicized job opportunities to promote visibility.

4. Formalize clinical supervision by way of an official mechanism. This can be accomplished by establishing an endorsement, credential/designation, or administrative process to recognize qualified supervisors that ensures adequate training and preparation.

BHHS licensees note challenges in identifying qualified supervisors and a general lack of confidence in their skills and ability to supervise others. 44 states have a formal process in place, while Indiana does not have a formalized approach to training or credentialing/designation for clinical supervisors of BHHS licensees.

Formalizing clinical supervision will establish the professional qualifications, training, and continuing education requirements for supervisors. The BHHS Board establishing an administrative process to require licensees interested in providing supervision are required to submit documentation to meet qualification requirements before the delivery of any supervision hours. The Commission recommends close coordination between DMHA and the BHHS Board to streamline the administrative process.

5. Increase competencies for unlicensed BHHS workforce by establishing supervision standards.

Clear supervision standards will support unlicensed BHHS workforce in growing in their careers and give supervisors the resources they need.

Several states and national organizations (e.g., National Association of Social Workers) have developed guidance documents for individuals interested in or currently serving as supervisors.

The Commission recommends guidance documents be created or solicited by the BHHS Board and made available on the PLA/BHHS board website. The Commission also recommends supporting the BHHS Board, who requires resources to produce guidance documents for Indiana

6. Implement enhanced marketing to support recruitment, provide up-to-date information on licensing, and to reduce the stigma associated with behavioral health careers. One roadblock to recruiting behavioral workforce is a lack of information promoting career pathways and available opportunities to be in the behavioral health workforce. Targeted efforts to build visibility and consistent messaging will support more qualified staff joining and staying in the workforce. This could include continued promotion of the Bowen Center’s Playbook to enhance the workforce.

PART III:

Special Considerations: Behavioral Health Services for Children, Older Adults, and Individuals with Intellectual and Developmental Disabilities

SECTION 3.1

Children's Mental Health

Ask any stakeholder what part of the children's behavioral health system needs the most attention and investment, and they will invariably mention the part that they are in the most frequent contact with. School administrators who are burdened with paying for out of state residential treatment facilities point to the need to invest in the residential treatment system. Juvenile justice stakeholders, who are often the landing point for some of the most acutely ill and challenging youth, advocate for more robust, longer term institutional placements. Many of the young people with experience in the system advocate for more peer-led, community-based services.

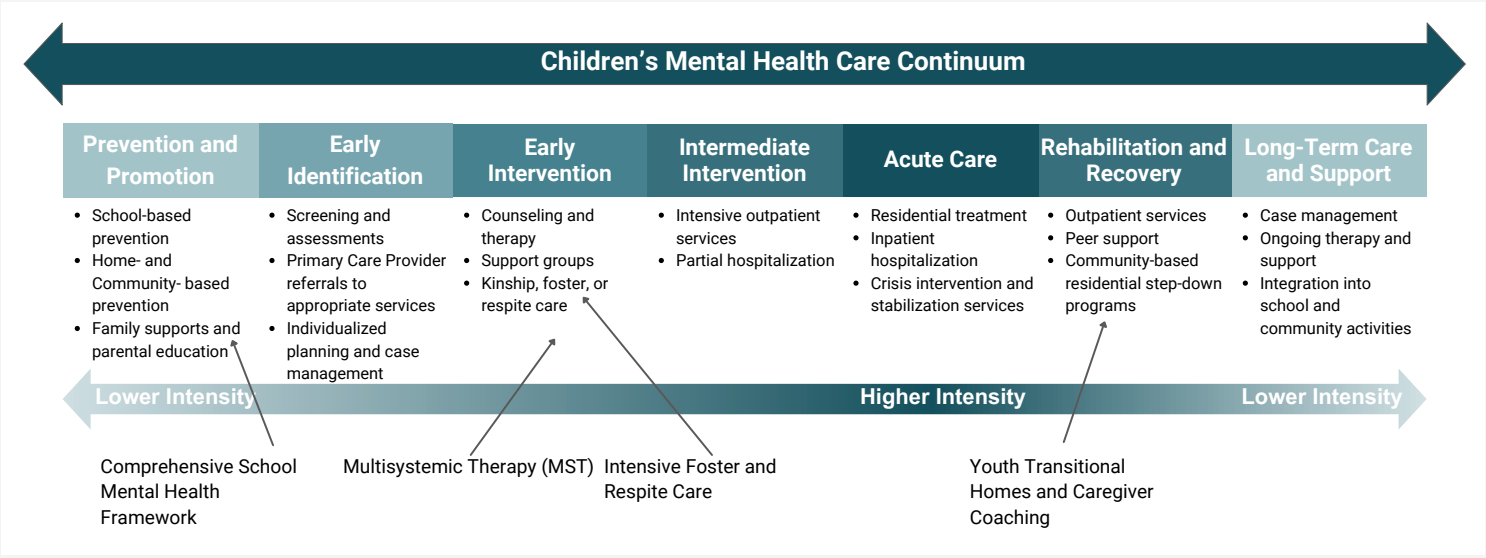
The challenge of this from a systems perspective is that they are all correct! The entire continuum needs frequent and robust examination and investment, especially in light of rapidly increasing demand for children's behavioral health services. In acknowledgment of this fact, the Commission's high-level recommendation is for lawmakers to systematically bolster the entire children's continuum of care, a process that will likely take several budget cycles.

Crucially, many of the recommendations in Part I will improve children's behavioral health access. The comprehensive crisis response system and CCBHC are both "lifespan" initiatives, meaning that they will serve both youth and adults. Mental health parity and increased reimbursement rates will enhance and improve access and quality of behavioral health care across Indiana.

With that backdrop, the Commission recommends that Indiana take action to systematically bolster the current continuum of care for youth and adolescents seeking mental health supports with an initial focus on children with the highest acuity needs and other targeted initiatives.

The continuum of mental health care for youth and adolescents is the range of treatment programs and services available for those experiencing mental health challenges based upon when in their journey they are able to seek treatment and

the level of care required to meet their needs. As Indiana bolsters its care continuum, the goal is to reach more individuals preventatively to reduce the need for higher intensity, higher cost levels of care and reduce the need for involvement with other State systems, such as the juvenile justice or DCS systems.



A Support on-going and future work through the Children with High Acuity Needs project (CHANP) and related initiatives

Nationwide, families and communities are experiencing a growing number of children facing significant and complex mental and behavioral health challenges that frequently present as multiple diagnoses which may lead to difficulties accessing necessary medical, mental health, education and other services. These challenges often encompass difficulties in emotional regulation, forming positive connections, navigating daily activities, and engaging in self-harming behaviors.[22]

This trend is also apparent in Indiana. Since August 2022, leaders from the Family and Social Services Administration (FSSA), Department of Child Services (DCS), Department of Education (DOE), Department of Correction (DOC), and Governor Holcomb's Office have spearheaded a multi-agency effort to ensure Indiana's system of care is best equipped to meet the needs of this population, children with high acuity needs. While there is no single definition for a child with high acuity needs, these children typically require increased care and supervision due to safety concerns, have a history of unsuccessful placements and interventions, and often present with multiple diagnoses, including behavioral and mental health issues, as well as intellectual or developmental disabilities. Many of these children have experienced childhood trauma, often influenced by family dynamics, leading to tendencies for disruptive behavior towards peers and family members.

Children with high acuity needs are often engaged with more than one of the state agencies mentioned above. For example, a youth could currently be receiving services through their local school and FSSA and be at risk of being placed in foster care through DCS.

In order to meet the needs of these children, a cross-agency rapid response team was established to promptly address emergency circumstances involving children with high acuity needs and their caregivers. To date, this team has staffed over 20 cases. Additionally, to address long-term system improvements, the group assembled subject matter experts with diverse backgrounds from across the state system to gain a comprehensive understanding of the strengths and weaknesses of Indiana's current system of care and to inform opportunities for improvement. This included more than thirty intentional interviews with subject matter experts. These collaborative efforts culminated in the identification of 35 improvement opportunities, which were streamlined and prioritized through system and journey mapping into the four workstreams discussed below. These four workstreams address various needs throughout the system of care from prevention to family reunification and community reintegration.

Cross-Agency Navigator Workstream

Children with high acuity needs and their families may need help understanding and accessing the services available to them across the state. Cross-Agency Navigators will bridge the gaps by deploying navigators with multi-agency expertise to enhance care coordination across State and local services such as education, mental health, IDD, child welfare, juvenile justice, and physical health. First launching as a pilot, this service will be utilized in both a downstream and upstream setting. It will be available to children discharging from the Neuro Diagnostic Institute (NDI) to improve an individual's successful transition back into their community and to children in school settings to reduce the likelihood of a crisis that removes an individual from their community.

Intensive Foster and Respite Care Workstream

In the existing continuum of care for children with high acuity needs, foster families are not always equipped to support children with high acuity needs because they lack (1) intensive supports to help them manage the behaviors that children with high acuity needs may exhibit, and (2) access to intensive respite care services. Intensive Foster Care is designed to bridge these gaps by providing enhanced training and support, including respite care, to both children with high acuity needs and their foster or kinship families.

Children and youth with high acuity needs may exhibit behaviors that require enhanced supports. A void in such supports may lead to disruptions in placements that may further escalate behaviors, lead to crisis situations, and/or necessitate treatment in settings not appropriate for their needs, often outside of their community.

This program creates a network of trained foster care parents to provide the appropriate level of support in their homes for children with high acuity needs, ultimately increasing the level of specialized, community-based care. Intensive Foster Care providers will provide this training as well as directly provide and/or provide referrals to additional support services.

Gatekeeper Process Review Workstream

Gatekeepers support individuals throughout their involvement with the State Psychiatric Hospital, beginning with screening for admission and continuing through the discharge process. For children with high acuity needs, quality gatekeepers are critical to ensure appropriate placement in the least restrictive setting. The existing placement and discharge processes into and out of state psychiatric hospitals are not optimal, contributing to a lack of state psychiatric hospital beds for youth that need them and youth remaining in state hospitals for longer than is medically necessary. The goal of the Gatekeeper Process Review is to identify and implement opportunities to improve the quality and consistency of state psychiatric hospital gatekeeping services for children and adults to help ensure that all individuals are receiving appropriate care in the least restrictive setting possible for a medically necessary treatment duration. The review will examine the current pediatric gatekeeper process to identify operational, policy, and statutory changes needed to improve and streamline the state psychiatric hospital gatekeeping process.

Youth Transitional Homes & Caregiver Coaching Workstream:

The Youth Transitional Homes and Caregiver Coaching program will offer a new option in the continuum, designed as an intermediary level of support for youth who are either ready to step down from residential care back into their community or who could be maintained in the community to prevent escalation to more restrictive settings. By requiring active caregiver coaching and focusing on equipping families with the tools they need to be successful in the home environment, the program ensures both the child and their family are fully prepared for a successful and more sustainable transition back to the community. Different from traditional group homes, Youth Transitional Homes are not intended for long term placements, require caregiver involvement, are community-integrated with a focus on school, in-home, and community-based supports and services, and specifically target youth stepping down from or at risk of returning to a residential placement.

Youth may accomplish their treatment goals in residential care, but returning home can disrupt their progress due to changes in routine and reduced intensive daily supports. A successful transition back home requires more than just the youth’s progress; it demands well-prepared caregivers. Caregiver coaching is essential to maintaining the youth’s progress, addressing home challenges, and reducing the risk of setbacks. Triggers within the home environment may not be fully addressed during residential care. With guidance from the program’s professional team, caregivers can learn to model positive behaviors and strategies that will help ensure success when the youth return home. By offering a

community-integrated care option with active caregiver involvement, this program aims to support the youth's effective transition back home, reducing the likelihood of needing further residential care.

This program provides community-integrated homes that require caregiver involvement with the ultimate goal of preparing youth and families for the youth to successfully remain with their caregivers and in their community.

The next iteration of the Behavioral Health Commission should focus on analyzing the children's mental health care continuum across urban, rural, and mixed communities, specifically looking at the children with high acuity needs and juvenile justice youth populations. The Commission should look to collaborate with the Juvenile Detention Initiative (JDAI), Youth Justice Oversight Committee (YJOC), and Children with High Acuity Needs workgroup.

Recommendation

The Indiana General Assembly and the new Gubernatorial administration should support and fund the continuation of the on-going and future work to improve Indiana's systems of support for children with high acuity needs and their families.

Chair Commentary on Residential Settings

Several stakeholders asked the commission to recommend a substantial increase in the number of residential beds for Indiana youth. It is clear that there are problems finding an in-state placement for Indiana children in need, and we appreciate the perspective of the stakeholders that urged us to make this a priority.

In the end, we decided not to recommend this approach. The scope and scale of the problem is unclear, as are the reasons about why placements are sometimes difficult to find. Are there not enough beds, or are current providers refusing to accept children with higher acuity needs? In other words, do we need more beds, or do we need some sort of mechanism to ensure that our current placements are being maximized?

To that end, the Commission did discuss the concept of "no eject/no reject" contracting with residential providers. These are arrangements where the state offers a significantly higher rate in exchange for providers agreeing to accept and keep any referrals sent their way. The upside of these arrangements is that they can serve as a pressure release valve for the rest of the system, providing a short-term fix for the seemingly intractable cases that take up a disproportionate amount of time and resources. On the other hand, these arrangements are fraught with ethical landmines (i.e. do higher rates incentivize more, potentially unnecessary, placements?) and have had a mixed track record in other states.

In light of the extraordinary complexity of this potential solution, the Commission declined to take a firm position. However, we do encourage the CHANP group, along with other stakeholders, to continue exploring this possibility.

B Promote the Comprehensive School Mental Health Framework

The Comprehensive School Mental Health (CSMH) Framework is a comprehensive approach integrated within the Multi-Tiered Systems of Support (MTSS) aimed to provide a continuum of social, emotional, behavioral, and mental health supports and services to support students, families, educators, and all stakeholders within the school community.

The framework addresses six core components:

1. School climate and culture, focused on relationship building and conditions for learning.
2. Mental health and wellbeing, focused on reducing stigma and mental health related prevention and intervention.
3. Social and emotional development, focused on social emotional learning competencies.
4. Positive discipline, focused on restorative practices.
5. School safety, focused on bullying and violence prevention and crisis planning.
6. Educator & student wellness, focused on mind-body-emotional wellness amongst educators and students.

The implementation process begins with building awareness before moving to an exploration phase in which a variety of data is collected and assessments are conducted to understand strengths, gaps, and challenges across educator and student awareness and skills and resources available. The subsequent preparation phase focuses on creating implementation plans, establishing champions to lead the work, identifying infrastructure to complete the work (ex. staffing), creating curricula, and outlining a sustainability plan. The initial and continual implementation phases focus on conducting the CSMH curricula and professional development activities while also analyzing data to understand progress made and support plans for future sustainability.

Implementing the CSMH framework can foster better academic outcomes, greater access to care, positive school climate and safety, greater emphasis on early identification and intervention, better psychosocial outcomes, greater youth, family, educator, and peer engagement, and a strong continuum of services.

Recommendation

FSSA, IDOE, and the General Assembly should ensure that all schools in Indiana have the resources to implement the Comprehensive School Mental Health Framework to address the social, emotional, behavioral, and mental health needs amongst students and their communities.

C Expand multisystemic therapy for adolescents with severe mental health needs to reduce risk of incarceration and residential treatment

Multisystemic Therapy (MST) is an intensive, evidence-based therapy for adolescents who are at risk of out-of-home placement via incarceration or residential placement due to causing harm to themselves or others. In MST, therapists provide intensive, individualized care. They:

- Meet with family members multiple times a week
- Are on call 24/7 to families, who can access their therapist in times of crisis
- Work with schools, parole officers, and community members to create workable solutions for families

MST programs have a track record of success, maintaining the majority of adolescents within their home. MST programs also result in significant cost savings of $3 for every $1 spent. The average net savings per youth is $1,617 for MST compared to usual services.

MST currently exists in 13 Indiana counties with FSSA-DMHA providing start-up support for two years with training/guidance for organizations developing MST programs. Services can be billed through Medicaid, and for those who qualify for Family Preservation services DCS funding can also be utilized. However, the billing rates for Medicaid are not sufficient to cover MST, they are not representative of the severity and comprehensive nature of the work and are not sufficient to ensure expansion of MST throughout the state.

Recommendations

1.Indiana DCS should adopt a policy that MST should be considered the first-line approach for juvenile delinquency cases.

2.MST should be a covered CCBHC service.

3. Indiana Medicaid should submit a state plan amendment to:
a. Include the MST-specific Healthcare Common Procedure Coding System (HCPCS) Code – H2033 – in the state plan.

b. Adopt an appropriate enhanced reimbursement rate for this code. Eleven states, including Ohio and Kentucky have adopted an enhanced reimbursement rate for MST

NOTE: The state plan amendment process requires appropriations from the legislature to cover the state share of the costs and approval by the State Budget Committee

D Increase education on developmental stages of children

Parents and other caregivers are the most important factors influencing a child's overall mental health and well-being and should therefore be equipped and empowered to have the most beneficial and healthy approaches to child development. The state cannot achieve this goal alone but can embed child-development friendly materials into different touchpoints with children and families.

Recommendation

All state agencies that interact with children and families should develop strategies to promote caregiver education regarding the developmental stages of children. For example, Indiana could use CDC's Learn the Science free materials in probation, problem-solving courts, and the Department of Correction. Seizing the opportunity to improve parents' ability to parent will benefit those parents and children now and long-term.

E Review child serving systems for redundant or unnecessary administrative burdens

Indiana's child serving systems necessarily involve multiple state agencies, as well as numerous state and federal funding sources. Each of these agencies and funding sources have different administrative and personnel requirements that place significant burdens on providers of services to children in Indiana. As a consequence, providers serving children in Indiana must spend resources that could be better used on providing services to navigate excessive administrative burdens.

Recommendation

All child serving agencies at the state should crosswalk and review their policies, procedures and service standards and eliminate redundant and/or contradictory requirements.

F Written Letter from the Youth Advisory Board

In 2022, the Indiana Family and Social Services Administration's Division of Mental Health and Addiction (DMHA) and the Indiana Department of Health (IDOH) came together to create the Indiana Youth Advisory Board (IYAB), Indiana's first state-level, public health, youth-led board consisting of youth ages 14-24 from across the state. As the IYAB, we engage youth in advocacy and decision-making, aiming to improve the overall health of young people in Indiana. The board's focus areas include improving mental health, access to care and services, minority health, and sexual and reproductive health. The board voted to establish four committees that require youth voices and action while representing these areas we deemed as needing the most change. We advocate for changes to ensure future generations do not face the same issues we struggle with today.

We, as the IYAB, understand the importance of establishing programs and resources aimed at providing mental health support, as many of us and our peers have experienced mental health struggles. Social media, the pandemic, gun violence, climate change, and turbulent social climates have been key factors impacting our mental health.

Social media contributes to low self-esteem and damaged self-images by constantly portraying unrealistic beauty standards and leading us to compare our lives and ourselves to others. Having lived through a pandemic, many of us have also had to learn how to navigate losing loved ones, feeling lonely, and enduring toxic household environments with no safe place to go. Along with this, we find that gun violence is prevalent in our communities and schools. Considering we feel unsafe within our homes and communities, we also fear climate change and the ongoing environmental crises of the world have youth contemplating what their future on Earth will be.

In addition, the continuing turbulent social climate has left marginalized and underrepresented youth feeling unheard, unseen, and excluded from the

conversation. To cope with these hardships, youth are encouraged to reach out and seek help. However, many of us are unaware of available resources, and finding the courage to seek help can be extremely difficult.

Mental health care is often inaccessible to youth due to reasons such as location, cost, lack of parental approval, language barriers, and a shortage of culturally sensitive providers. Youth require quality, accessible mental health care from providers who speak their language and understand their cultural backgrounds. These challenges represent just a few pieces of the puzzle when considering the ongoing obstacles that youth face.

We, as the IYAB, work tirelessly to participate in conversations and provide solutions. Since our inception, the IYAB has actively advocated for youth mental health needs, reduced stigma surrounding mental health, and amplified youth perspectives. We have achieved this by presenting at events such as the Commission on Improving the Status of Children in Indiana, the Indiana Mental Health Round Table in 2023 and 2024, the Indiana Society for Public Health Education (InSOPHE) conference, and the Adolescent Health Conference to share our insights. In addition to these presentations, we have developed toolkits and promotional materials for initiatives like 988, Believe in You, and Wear Orange Campaigns.

We need your help to solve these issues. Our solutions include the following:

1. Reducing the stigma surrounding mental health and seeking help starts with fostering open dialogue about mental health in schools, families, and communities. This can be achieved through launching awareness campaigns, providing training for school staff, implementing mental health curricula in schools, and ensuring that youth perspectives are prioritized in developing these initiatives. These efforts will educate youth about available resources and foster a sense of connection by reassuring them that they are not alone.

2. Alongside reducing stigma, improving access to mental health services is crucial for supporting youth across the state. Youth services should comprise culturally competent providers who reflect the diversity of their communities, ensuring all youth feel safe and understood regardless of background. Efforts should also prioritize addressing mental health in marginalized communities that often lack resources. While many youth have insurance, cost remains a barrier for many seeking care. Therefore, expanding free or reduced-cost services for youth of all

economic backgrounds is essential to improve accessibility. These initiatives aim to ensure that necessary services are available to youth when they are ready to seek help.

3. Lastly, none of these changes can occur without incorporating the youth perspective. As young people, we possess a powerful voice and understand best what is needed for our mental health. Too often, youth feel marginalized and powerless. Providing them the opportunity to express their genuine perspectives and genuinely listening to them can instill hope in a generation that sometimes feels hopeless. It's crucial that youth from all backgrounds have a meaningful platform where their voices are not just heard but value —simply including a 'token youth' on a team is inadequate, as one individual cannot represent the diverse views of all youth. Our solution is to engage with youth, through bodies like the IYAB or other youth boards, in decision-making processes. Failing to consult with youth risks implementing harmful programs and policies that affect their overall health and well-being. Youth offer a unique and essential perspective in crafting solutions to ensure a brighter future for generations to come. A world where youth support youth is key to creating a better tomorrow.

As members of the IYAB leadership committee, we envision a world where youth can access the help they want and need, ensuring they don't have to face mental health struggles alone. We are Jayma Girdler and Lucia Mercado, and we have been with the board since its inception, collaborating closely with the leadership team to advocate for necessary changes. However, we cannot achieve this alone. We urge all of you reading this to join us in making a meaningful impact. Without collective action, we jeopardize the well-being and future of youth. Let's be agents of change, shaping a better future rather than being constrained by the past.

Sincerely,

Jayma Girdler

Lucia Mercado

Educators have continued to see a rise in the acuity and severity of children's mental and behavioral health issues in the past few years, especially following the pandemic. Children are exhibiting dysregulated and violent behaviors at ages as young as pre-k and early elementary. These behaviors range from infrequent classroom disruptions to verbal threats and violence. Finding actionable ways to address these behaviors and provide students with access to services has become a top priority of educators and administrators alike.

Often when children exhibit concerning behaviors, this can be due to a larger underlying issue such as trauma, an undiagnosed mental health disorder, issues in the home, or an intellectual disability. Especially in early childhood, it is common for children to cope with their issues by displaying dysregulated behaviors.[23] It is important that we recognize that these students need very individualized attention and care to address their specific struggles.

As these children get older, they are often accessing smartphones and social media, and we are seeing an increase in student's usage of both in and out of the classroom. The link is obvious to us.

For the most acute behaviors, many students benefit from placement in a day or residential treatment program. These programs afford students an environment in which they can receive more individualized and intensive treatment. However, schools do not have adequate regional access to these treatment programs. We have also had issues placing a student in certain facilities because they do not accept students with certain diagnoses, behaviors, and cognitive levels. Even when we get a student placed in one of these facilities, transportation is almost always a barrier, and students often struggle integrating back into the classroom following their limited time in the program.

Our students and schools are also being affected by the shortages in the workforce. We are having to ask counselors and psychologists to perform additional tasks outside of their normal and preferred duties due to overall school staffing shortages. There is roughly one psychologist for every 2,698 students which also makes it difficult for these professionals within our school to provide services to any students given the already elevated evaluation workload.[24] We understand that this workforce issue impacts mental and behavioral health providers outside of just the educational setting. We are hopeful that with many stakeholders coming together,

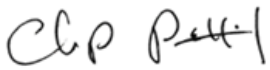
we will strengthen the workforce. For all of these reasons, we want to express our support of the work being done by the Behavioral Health Commission, particularly the awareness spurred by the Commission.

And, of course, recommendations for action items to get us closer to attaining greatly improved access and quality of services. The work makes us hopeful that we can continue to positively impact Hoosier students and families.

Signed,

Stefanie Hanes
Director of Special Education
Paramount Schools of Excellence

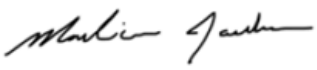
Dr. Paul Ketcham
Superintendent
Batesville Community Schools



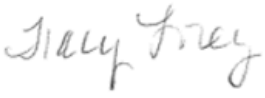
Dr. Chip Pettit
Superintendent
Duneland Community Schools

Dr. Todd Hitchcock
Superintendent
Shelby Eastern Schools

Dr. Tracey Shafer
Superintendent
Danville Community Schools



Marlin Jackson
Founder & CEO
Fight for Life Foundation



Dr. Tracy Lorey
Superintendent
Greater Jasper Consolidated Schools

Chair Commentary on Social Media

There has been a robust national conversation about the intersection of social media and youth mental health. The Commission discussed this topic but declined to make a recommendation. This is not a commentary on the merits of the discussion, but rather a reflection of our focused task: to make recommendations about what the Indiana legislature should do. The 2024 General Assembly banned phones during instructional time, so one of the primary levers has already been activated.

The commission heard from two parents (Bob Wood and LaDonna Hughes) of elementary age children at St. Richards Episcopal School, who have been leading a voluntary effort with the parents of their children's classmates to commit to "no smartphones until high school." We are grateful to Mr. Wood and Ms. Hughes for sharing their time and story. Ultimately, we concluded that the appropriate mechanism for initiatives and interventions involving children and technology is through voluntary, local and community driven efforts, instead of top-down government action.

SECTION 3.2

Older Adults

By 2030, more than one out of every five people in the United States will be 55 or older. By 2035, there will be more people over the age of 55 in the United States than under 18. Indiana must plan for this changing demographic, and this is especially true when it comes to servicing the behavioral health needs of older Hoosiers. The following are policy recommendations to help Indiana improve the behavioral health system for older adults.

A Standardize data collection on older adults with behavioral health challenges

Indiana currently lacks a position that's singularly focused on collecting the behavioral health data of older adults. As the population of older Hoosiers continues to grow, it is critical to have the data from all incomes and populations across all state agencies that interact with this population. Data on older adults needs to be included in any collection for research, planning, and evaluation.

By collecting data from across state agencies, Indiana will be able to identify disparities in behavioral health care access and outcomes, ensuring that interventions can be tailored to meet the needs of older Hoosiers.

Data can be better utilized to understand trends in older adults to inform policies and resource allocation, leading to more effective support systems.

Recommendation

Indiana should create a position within FSSA's DMHA or IDOH specifically dedicated to collecting data of older adults with behavioral health challenges. This position could also help to inform policy and program development across FSSA and IDOH.

B Encourage age-friendly health systems

The AARP Public Policy Institute (PPI) releases a Long-Term Services and Supports (LTSS) Scorecard which seeks to measure state LTSS system performance and rank states in comparison to one another, seeking to raise the profile of LTSS and drive action both federally and within states.[25]Unlike research that focuses on a particular aspect of LTSS system performance, the Scorecard compares state LTSS systems across multiple dimensions of performance, reflecting the importance and interconnectedness each has on the overall LTSS system.

Indiana has historically ranked towards the bottom of the list, but in the 2023 edition, Indiana saw significant improvement in its scores. In fact, Indiana's highest score was in the indicator of Age-Friendly Health Systems where it was ranked number one.

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement in partnership with the American Hospital Association and the Catholic Health Association of the United States.[26] It helps hospitals, doctor's offices, retail pharmacy clinics, nursing homes, and home-care providers deliver age-friendly care.

Encouraging more health systems, including behavioral health facilities, in the state to be age-friendly will help continue the momentum the state showed in the LTSS Scorecard.

The 4Ms Framework is person-centered and functions to make complex care manageable for both providers and older persons.[27] Aging people may accumulate more conditions that can make things more complex. Age-Friendly Health Systems facilitate health care discussions that support disease management in the context of the whole person.

Recommendation

Indiana should encourage more health systems to become age-friendly, including by creating a dashboard that demonstrates progress on these metrics.

C Create an operational rate for group homes for older adults with Serious Mental Illness

Many aging individuals with Serious Mental Illness require residential or group living settings to maintain adequate care and keep them out of institutions. The current group home system for individuals with SMI is not equipped to accommodate the aging demographic, and there are not enough beds to meet demand due to a lack of sustainable resources for overhead costs and room and board.

Recommendations

1. FSSA should create—and the General Assembly should fund— a group home room and board rate for all SMI group homes to meet the needs of current beds and ensure no additional beds would close.

2. The General Assembly should appropriate ongoing capital funding to support group homes that are adding additional beds and renovating current homes to meet the needs of the aging population.

D Create a facility for the aging population that provides integrated medical and psychiatric services, with a focus on those with criminal justice system backgrounds

The aging population frequently presents with dual diagnoses, encompassing both mental health and physical health conditions, which would benefit from a facility that provides integrated medical and psychiatric services. Currently, nursing homes often deny admission to individuals with psychiatric needs, especially with criminal justice records. Establishing a facility in Indiana that addresses both needs for this high-acuity, aging population could reduce state costs by preventing extended stays in state hospitals. With state support, this initiative could be implemented in collaboration with nursing homes and community mental health centers to ensure comprehensive care.

Recommendation

Indiana, in collaboration with skilled nursing providers and community mental health providers, should create an SMI nursing home that provides medical psych services, especially to individuals with criminal justice backgrounds.

SECTION 3.3

Individuals with Intellectual and Development Disabilities

The Behavioral Health Commission is particularly grateful to Kelly Hartman, a long time Intellectual Disabilities service provider for her insights and contributions to this section of the report. Kelly and the other experts the Commission heard from all identified the same barrier to supporting the mental health needs of people with Intellectual and Developmental Disabilities: siloed systems that do not allow for easy navigation, therefore forcing people to "choose" between the I/DD system and the mental health system.

While the primary source of this barrier can only be remedied at the federal level, the Commission nonetheless recommends the following actions to make the process easier for Hoosiers with I/DD and their families.

A Work towards a joint waiver for dual diagnosis braided payments

The I/DD patient population mix in Indiana is challenged to serve its mental health needs currently due to the way services are paid for in the state of Indiana, where a primary diagnosis drives the waiver and payee relationship. Allowing the other diagnoses and needs of these individuals to have challenges with these being addressed.

A longer-term solution to the challenge of siloed and fragmented care is a Medicaid waiver program that allows funding for I/DD and mental health be braided and combined to meet the unique needs of dually diagnosed individuals, rather than forcing them to choose a "primary diagnosis."

In the short-term, the CCBHC model allows for more flexibility for providers to meet the mental health needs of their entire potential patient population. In particular, the Commission heard from Southwestern Behavioral Health, who have used a state grant to create a "one-stop shop" for children with complex needs, including intellectual and developmental disabilities.

Southwestern reported that a substantial portion of this programming will be sustained by CCBHC, but that additional funding would be necessary to fill in the gaps. A dual-diagnosis waiver can fill that role.

Recommendations

1.Indiana's CCBHC rollout should include programming to meet the unique needs of dually diagnosed individuals.

2.The General Assembly should appropriate ongoing funding for programs like South western's "one-stop shop," with a long-term goal of using lessons learned to create a Medicaid waiver that allows for braiding of I/DD and mental health funding.

B Change the title of bachelor's degree level wrap facilitator to a different term than Behavioral Consultant

The use of the term Behavioral Consultant in supporting the I/DD population comes from a long history beginning with the federal ICF/MR federal guidelines state administrative code (460 IAC 9-1-1) used in licensure and compliance of group homes. Thus, in the mid 90's when HCBS services experienced growth with the deinstitutionalization movement in our state, the term Behavioral Consultants was used as the primary title for the provision of Behavioral Support Services. This is true on the Family Supports (FSW) waiver, Community Integration and Habilitation (CIH) waiver, and Traumatic Brain Injury (TBI) waiver as well as supported group living. In BDS services - this professional must have a minimum of a master's degree.

However, there are youth with dual diagnoses who also receive services funded by DMHA through the Child Mental Health Wraparound program. Therein, providers use the title "Behavior Consultant" or "Behavior Clinician" as well. Conversely, these professionals have a minimum of a bachelor's level in wrap around facilitation. It is very confusing to individuals in services, their families, and other team members.

The primary reason for asking that providers of CMHW to NOT use this title, aside from confusion at the point of service delivery, is that in the absence of cross-team collaboration, it is clinically contraindicated to have two behavioral professionals working on different goals, or even worse, different approaches.

Recommendations

1.Indiana should establish more clarity in roles, requirements and potential outcomes.

2.Further, this may be an opportunity to look at unnecessary duplication of services.

C Create a DMHA and DDRS clinical liaison position

Nationwide, states are struggling to build capacity in systems of care to effectively meet the needs of people who have a diagnosis of an intellectual/developmental disability and a co-occurring mental health diagnosis. Because program eligibility is determined by a "primary diagnosis," an individual in need of support is forced to choose one path or the other. Programs, quality and availability of services vary from state to state. While there are efforts to seek resolution with CMS, many people who are "dually diagnosed" are not getting the comprehensive, effective supports necessary to succeed or maintain stability in HCBS service models. There are several states that are finding success with having "state side" resources to help support this need for capacity building. Louisiana, Missouri, and Pennsylvania to cite a few states are making progress by looking at people as people and not as diagnoses. While in Indiana there is a thirst for this capacity building, program design needed to meet the needs of people with dual diagnosis is impossible in context of federal rules and funding.

Recommendation

Indiana should consider hiring a shared position (with buy-in from both DMHA and DDRS) as a first step in identifying opportunities to create strategies, deliver consistent training on national best practices (that are ever evolving) and act as a resource to both divisions and their respective providers. This shared position may be a Behavioral Consultant role, which could be charged with strategically look at alleviating duplicative service deliver with a focus on fiscal efficiencies and accountability.

PART IV:

Financial Sustainability

SECTION 4

Financial Sustainability

Many of the recommendations in this report require sustained investment across multiple biennium budget cycles. Therefore, the Commission encourages the General Assembly to consider dedicated, sustainable, renewing funding sources for behavioral health. The Commission commends the CMHF appropriation in 2023, which made the progress described in this Report possible. The Commission recommends the General Assembly appropriate or secure additional funding to support the recommendations in this Report. Rather than recommend a specific approach, the Commission presents a list of possible sustainable funding options for consideration in Appendix F.

Critically, because all of the following options are considered state funds, any of them could serve as the state match portion for Medicaid programs, therefore significantly multiplying their impact.

PART V:
Continuing the Commission

SECTION 5

Continuing the Commission

The Commission recommends continuing the Behavioral Health Commission in future years to ensure the many behavioral health initiatives and system goals raised in this report remain a priority for the state of Indiana.

Recommendations

1. The General Assembly should reestablish the Behavioral Health Commission in the 2025 legislative session with a final report due to the legislature by October 1, 2026.

2. The next Commission should 1) analyze the children's mental health care continuum across urban, rural, and mixed communities, specifically looking at the children with high acuity needs and juvenile justice youth populations, 2) collaborate with the Juvenile Detention Initiative (JDAI), Youth Justice Oversight Committee (YJOC), and Children with High Acuity Needs workgroup, 3) analyze and report on the fiscal progress, cost savings, impact and coverage of CCBHCs, and 4) develop a roadmap for full-state coverage for CCBHCs including the amount of funding that will need to be requested in the 2027 legislative session.

ENDNOTES

ENDNOTES

1. Senate Enrolled Act No.1 (2023) https://iga.in.gov/pdf-documents/123/2023/senate/bills/SB0001/SB0001.06.ENRH.pdf
2. Indiana Behavioral Health Commission Report (2022) https://www.in.gov/fssa/dmha/files/INBHC-Report.pdf
3. The National Council for Mental Wellbeing CCBHC Impact Report (2024) (included as Appendix E).
4. In July 2022, DMHA rolled-out Fee-For-Service (FFS) reimbursement for providers designated to operate as a Mobile Crisis Response Provider in alignment with strict service delivery requirements. DMHA expects that CCBHC PPS rates will cover most of these costs in the long-term; however, while the CCBHC model is being expanded under the Demonstration Program, FFS offerings will help ensure statewide coverage for Pillar 2.
5. DMHA is actively developing a plan to pursue additional Medicaid funds by claiming the Primary Care Access Program (PCAP), a CMS-endorsed methodology. If successful, DMHA will be able to obtain approximately $2M per year of the $11M it costs to run the 988 Response Centers annually.
6. In July 2022, DMHA rolled-out Fee-For-Service (FFS) reimbursement for providers designated to operate as a Mobile Crisis Response Provider in alignment with strict service delivery requirements. DMHA expects that CCBHC PPS rates will cover most of these costs in the long-term; however, while the CCBHC model is being expanded under the Demonstration Program, FFS offerings will help ensure statewide coverage for Pillar 2.
7. In the long-term, DMHA is planning to pursue an Advanced Planning Document (APD) to try to obtain FMAP for some of the system technology.
8. A range for the estimated cost savings from diversion is given, assuming all diversions either avoid (1) EMS responses or (2) law enforcement responses. There is not readily available data on how long an individual who may call 988 would end up staying in an ER or jail setting, given the large variance in needs. The State will have more readily available data from formal program evaluation to share in the next BHC report.
9. Data from April - June 2024 was used to estimate cost and number of diversions. For summative cost savings purposes, the total number of diversions is annualized.
10. The average cost of dispatching an ambulance varies drastically, depending on the types of services required, geographic (urban/rural), mileage, provider, and other factors. As such, a pure average has been used. Several other Indiana-specific data points validate this range/average.
11. Assumes one night/day stay in a Hospital ER, ranging from a routine to high severity triage. A pure average was used as CDC data does not indicate confidence in the percentage breakdown of triage status. Some diverted EMS responses may have otherwise resulted in longer than a one day stay, so this may be an underestimate.
12. The average cost of a law enforcement response is calculated using the weighted average of the cost a law enforcement response to a property crime and violent crime incident in Indiana, multiplied by the percentage reported number of incidents of each, respectively.
13. Assumes one night/day stay in a jail setting. Some diverted LE responses may have otherwise resulted in longer than a one day stay, so this may be an underestimate.
14. FSSA Medicaid Rate Matrix (2023) https://www.in.gov/fssa/files/Rate-Review-Medicaid-Matrix.pdf
15. Analysis of Mental Health Parity Final Rule (2024) https://www.thekennedyforum.org/blog/analysis-of-the-mental-health-parity-final-rule/
16. The Playbook for Enhancing Indiana's Mental Health and Behavioral Health Workforce can be accessed at the following link: https://go.iu.edu/8pSo_gl=1*9na997*_gcl_au*MTcxODUzODgxLjE3MjU5OTc1NzI.*_ga*OTAwNzg3MzcyLjE3MjU5OTc1NzE.*_ga_61CH0D2DQW*MTcyNTk5NzU3MC4xLjAuMTcyNTk5NzU3MC42MC4wLjA.
17. Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria (2023) https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
18. Response: Full practice authority for nurse practitioners needed to address physician shortage (2021) https://www.medicaleconomics.com/view/response-full-practice-authority-for-nurse-practitioners-needed-to-address-shortage

ENDNOTES

19. House Bill 1059 Advanced practice registered nurses (2024) https://iga.in.gov/legislative/2024/bills/house/1059/details
20. Occupational stress and suicidality among firefighters: Examining the buffering role of distress tolerance (2018) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6397653/
21. Vital Signs: Health Worker–Perceived Working Conditions and Symptoms of Poor Mental Health — Quality of Work life Survey, United States, 2018–2022 (2023) https://www.cdc.gov/mmwr/volumes/72/wr/mm7244e1.htm#:~:text=Results%3A%20From%202018%20to%202022,11.6%25%20to%2019.0%25)%20increased
22. Youth Risk Behavior Surveillance System Data Summary & Trends Report: 2011-2021 (2023) https://www.cdc.gov/yrbs/dstr/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf
23. Early Childhood Mental Health (2024) https://developingchild.harvard.edu/science/deep-dives/mental-health/
24. Indiana's Youth Mental Health Crisis (2024) https://youthfirstinc.org/indianas-youth-mental-health-crisis/
25. AARP Indiana Scorecard Report (2023) https://ltsschoices.aarp.org/scorecard-report/2023/states/indiana
26. Age-Friendly Health Systems (2024) https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly/
27. 4Ms Framework of an Age-Friendly Health System (2024) https://www.ihi.org/networks/initiatives/age-friendly-health-systems

APPENDICES

APPENDICES

APPENDIX A

Indiana Behavioral Health Commission Report - Legislative Summary Report
https://www.in.gov/fssa/dmha/files/INBHC-Report-Appendix-A.pdf

APPENDIX B

2024 WISE Report for the Behavioral Health Commission
[Link Forthcoming]

APPENDIX C

Update on Other 2022 Behavioral Health Commission Report Recommendations
https://www.in.gov/fssa/dmha/files/INBHC-Report-Appendix-C.pdf

APPENDIX D

Model Legislation

1. **Model Mental Health Provider Reimbursement and Credentialing Legislation**
   https://www.in.gov/fssa/dmha/files/INBHC-Report-Appendix-D.1.pdf
2. **Model for a Behavioral Healthcare Funding Act**
   https://www.in.gov/fssa/dmha/files/INBHC-Report-Appendix-D.2.pdf

APPENDIX E

National Council for Mental Wellbeing 2024 CCBHC Impact Report
https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

APPENDIX F

Funding Options for Financial Sustainability
https://www.in.gov/fssa/dmha/files/INBHC-Report-Appendix-F.pdf