Indiana's Application to Participate in the Section 223 **CCBHC** Demonstration Program

Indiana Division of Mental Health and Addiction and Office of Medicaid Policy & Planning

MARCH 19, 2024

Characteristics of Medicaid Population to Be Served

Section I: Overview

Indiana is working to advance Certified Community Behavioral Health Clinics (CCBHCs) as the primary mechanism for community behavioral health care delivery in the state. To achieve the best outcomes, CCBHCs should be deeply knowledgeable of, and responsive to, the needs of the specific communities they serve.

Indiana's approach to CCBHC implementation is driven by its understanding of behavioral health needs in the state. Through participation in the CCBHC demonstration, the State aims to achieve positive changes in outcomes at the population level. The proposed activities and the impact measurement plan described in Section E of the Project Narrative are aimed to address the following needs and gaps identified in the state and described in this attachment:

- Timely access to care
- Expanded treatment for substance use disorder (SUD)
- Addressing social drivers of health (SDOH)
- Increased access to crisis services, in coordination with 988
- Integrated physical and behavioral health
- Increased access to suicide prevention services through CCBHCs
- Increased access to evidence-based care for children and youth

Below, we provide a summary of selected statistics that paint a picture of state needs and the Medicaid population to be served through Indiana's CCBHC demonstration. In addition, we share some information on Indiana's behavioral health workforce assets and gaps, because we understand that the workforce is the cornerstone of providing high-quality care through the CCBHC model. In addition to achieving positive outcomes for Hoosiers, Indiana seeks to bolster a more sustainable, competent, and culturally reflective workforce through the implementation and scaling of the CCBHC model.

Section II: Behavioral Health Needs in Indiana

Indiana Demographics, Insurance Status and Health Outcomes

Indiana's population is diverse, including White (80.7%), Black or African American (9.8%), Hispanic or Latino (7.3%), and Asian (2.6%) residents. Approximately 37% of the population lives in rural areas. The median age of Indiana residents is 38.6 years, slightly younger than the national median.[1] Approximately 29% of the Indiana population is low-income (under 200% federal poverty).[2] Only about 22% of residents hold a bachelor's degree or higher, compared to 32% nationally. Uninsured rates are lower than national averages (see Table 1).

Table 1: Overview of Indiana Insurance Coverage as Compared to United States, 2022 [3]

	Employer	Medicaid	Medicare	Uninsured
United States	48.7%	21.2%	14.6%	8.0%
Indiana	52.1%	20.5%	15.0%	6.8%

Despite relatively high rates of health insurance coverage, according to *County Health Rankings and Roadmaps,* Indiana faces challenges, including higher rates of premature death, poor physical and mental health, and a higher percentage of adults reporting fair or poor health compared to the national average. Access to health care is a concern, with fewer primary care physicians and mental health providers per capita, and more preventable hospital stays than the national average. Selected comparisons are noted in Table 2.

Table 2: Comparison to National Averages on Key Indicators [4]		
	Indiana	**United States**
Premature Death *(Deaths under age 75, per 100,000)*	8,600	7,300
Adults Reporting Poor or Fair Health	15%	12%
Poor Physical Health Days (of the previous 30 days)	3.3	3.0
Poor Mental Health Days (of the previous 30 days)	4.9	4.4
Primary Care Physicians (per resident)	1,500:1	1,310:1
Mental Health Providers (per resident)	530:1	340:1
Preventable Hospital Stays *(Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees)*	3,174	2,809

These factors highlight the need for targeted interventions like CCBHC to increase care coordination, improve access to integrated behavioral and physical health care and address underlying SDOH.

Substance Use

Opioid misuse continues to be an important public health issue for Indiana, with poor outcomes driven by polysubstance use and fentanyl. Drug overdose deaths involving opioids continue to rise dramatically, from 1,098 deaths in 2018 to 2,205 deaths in 2021. The number of visits to Emergency Departments due to any opioid overdose were 8,193 visits in 2021, representing an increase of more than 1,000 visits from the previous year.[5]

In state fiscal year (SFY) 2022, 34.8% of Hoosiers who received SUD treatment had reported using opioids (including heroin, non-prescription methadone and other opiates/synthetics) as a primary, secondary or tertiary substance. Among these opioid users, methamphetamine use was highest (52.8%), followed by marijuana use (34.2%) and alcohol use (18.2%).[6]

Access to SUD care is a challenge in Indiana. Approximately 8.4% of Hoosiers met the criteria for a substance use disorder (SUD) but only a fraction of those needing treatment accessed care. accessed care. Research indicates 7.8% of all Hoosiers needed but did not receive SUD treatment in the past year.[7]

Alcohol and tobacco use continue to be an issue in Indiana. Adult alcohol use decreased slightly to 50.7% in 2022; with 54.8% men and 44.5% women using alcohol in the past month.[8] Men in Indiana drink alcohol at a higher rate than the national average (national average for men: 51.4%). Adult smoking in Indiana declined from 25.6% in 2011 to 16.2% in 2022, but remains above the national average of 14%.[9]

Mental Health

In 2021, about 24% of Hoosier adults ages 18+ reported having any mental illness (AMI) in the past year. About 6% of Hoosiers in 2021 reported having serious mental illness (SMI) in the past year. Approximately 9% of Hoosier adults reported having at least one major depressive episode. About 15.4% men and 29.7% women reported being told they had a form of depression. Depression rates for women are still higher than pre-pandemic levels.[10]

Indiana's per capita suicide rate is higher than the national average (15.02 per 100,000 population), and suicide is a leading cause of death for Hoosiers aged 10-44.[11] While youth suicide rates have decreased since 2021, youth mental health remains a concern. In 2022, 35.7% of students in 7th-12th grade reported in the past year they felt so sad or hopeless for two or more weeks in a row they stopped doing usual activities. This represents an increase from the last surveyed year, 2020.[12]

Co-Occurring Disorders

People with a mental health disorder are more likely to experience addiction, as these conditions frequently co-occur. Nearly 4% of Indiana adults had a past-year diagnosis of both serious mental illness (SMI) and SUD.[13] This is a core population that will be served through the CCBHC demonstration. The integrated care offered by CCBHCs, including pharmacotherapy and therapeutic best practices for the treatment of substance use disorders and mental health conditions, will help address the needs of this population of focus.

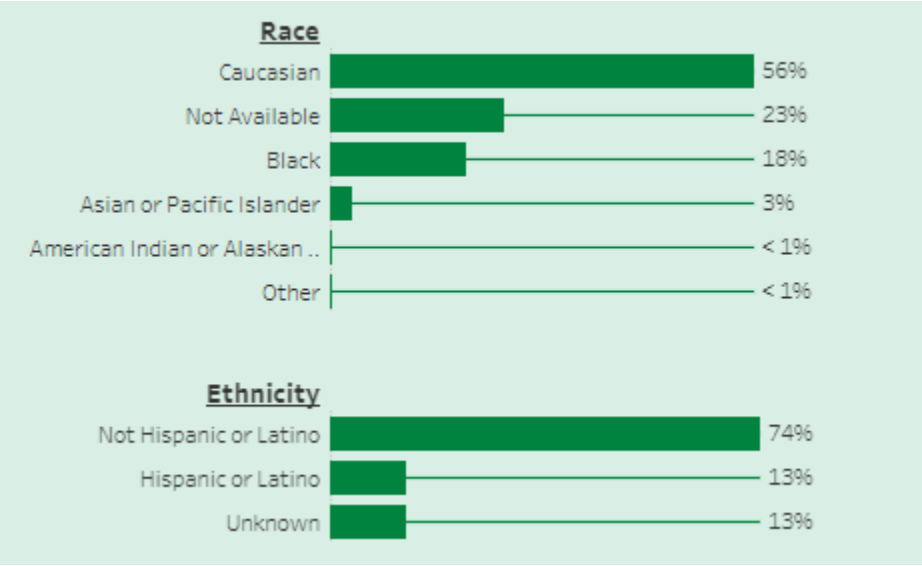
In addition, individuals with intellectual and developmental disabilities (IDD) often have co-occurring behavioral health needs. Results of a 2021 needs assessment conducted by Indiana University found that nearly 8 out of 10 individuals surveyed with Autism Spectrum Disorder (ASD) had at least one co-occurring diagnosis (78.2%; N = 475). Of those with a co-occurring diagnosis, a mental health disorder was common, including diagnoses such as anxiety disorder, bipolar disorder, and obsessive-compulsive disorder.[14] Indiana has incorporated the START model (community crisis prevention and intervention services) into its list of recommended evidence-based practices (EBPs) for CCBHCs to help proactively address unmet needs among the IDD population with co-occurring mental health disorders.

Section III: Summary of Behavioral Health Needs for Indiana's Medicaid Population

There are over 1.7 million Hoosiers who are Medicaid members.[15] Claims data analysis conducted by Indiana Family and Social Services Administration (FSSA) estimates that one in three Medicaid members has a behavioral health diagnosis.

Many Medicaid members receive behavioral health care through Indiana's Community Mental Health Center (CMHC) system, which is comprised of 24 CMHCs serving individuals and families experiencing behavioral health needs. CMHCs serve all individuals regardless of payer or ability to pay, with a focus on individuals and families with the highest behavioral health needs. Many CMHCs are heavily reliant on a financing mechanism called the Medicaid Rehabilitation Option (MRO), which primarily supports life skills training services provided by unlicensed staff. Approximately 79% of CMHC services are currently paid for via MRO. MRO is carved out of Medicaid managed care while clinic services, including therapy and psychiatric services, are carved in. The state views the CCBHC demonstration process as an opportunity to modernize payment models and rebalance the mix of services provided by community behavioral health providers to promote increased access to clinical services.

Medicaid beneficiaries in Indiana are more racially and ethnically diverse than the state as a whole. The race and ethnicity of Indiana Medicaid members are as follows:



Source: Indiana Medicaid Enrollment Dashboard[16]

Leveraging the CMS Core Measure Set is foundational to understanding the needs of the Medicaid population. Core measures will help the State ensure that the CCBHC demonstration is creating significant impact and improvements in health outcomes among the priority population of Medicaid beneficiaries. Indiana has begun drawing baseline data from the Core Measure Set from CY 2022 and will continue this process, which will guide the State's CCBHC implementation and ultimately feed into the national demonstration evaluation. A sample of baseline data for selected key CCBHC measures/Medicaid core measures is provided in the following table. These will be incorporated into Indiana's implementation strategy and impact measurement approach during the demonstration.

Data in Table 3 was drawn specifically from the Indiana CMHC system, and reflects the Medicaid population served by CMHCs. Several of these baseline figures exceed national averages for the measures, reflecting the ability of Indiana CMHCs to provide care that meets the needs of individuals with complex behavioral health needs. Through statewide scaling of the CCBHC

model and implementation of the Medicaid prospective payment system (PPS) rate, the State aims to increase the fiscal stability of the community behavioral health system and expand the reach of these capable providers to offer high-quality care to more Medicaid beneficiaries.

Table 3: CY 2022 Data – Selected CCBHC Quality Measures		
Indiana Strategic Objective	**Related Core Measure**	**Indiana Baseline for Likely CCBHC Clients** (DMHA clients with Medicaid IDs served in CY 2022)
High-Quality, Evidence-Based Care for Children	Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)	Initiation Phase: 56.5% Maintenance Phase: 61.2%
Increased Access to and Engagement in SUD Treatment	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Initiation: 40.1% Engagement: 23.9%
Increased Engagement in Mental Health Treatment	Antidepressant Medication Management (AMM-AD)	Treatment for 12 weeks: 55.2% Treatment for 6 months: 35.3%
Integrated Physical and Behavioral Health	Hemoglobin A1c Control for Patients With Diabetes (HBD-AD)	Poorly controlled (>9.0 A1c): 97.9%
Increased Engagement in Mental Health Treatment	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	Patients with schizophrenia on antipsychotics for at least 80% of their treatment period: 55.4%
High-Quality, Evidence-Based Care for Children	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Patients with a new antipsychotic medication prescription that had psychosocial care as first-line treatment: 78%

Table 3: CY 2022 Data – Selected CCBHC Quality Measures *(continued)*		
Indiana Strategic Objective	**Related Core Measure**	**Indiana Baseline for Likely CCBHC Clients**
Timely Access to High-Quality Care and Improved Care Coordination	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	7-day follow-up: 48.4% 30-day follow-up: 75.8%
	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	7-day follow-up: 46.2% 30-day follow-up: 66.8%
	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	7-day follow-up: 29.1% 30-day follow-up: 49.3%
	Follow-Up after Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	7-day follow-up: 41.1% 30-day follow-up: 61.2%

	Follow-Up after Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	7-day follow-up: 54.1% 30-day follow-up: 80.6%
	Follow-Up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	7-day follow-up: 45.4% 30-day follow-up: 67.6%

Access to behavioral health care is a longstanding challenge for Medicaid beneficiaries in Indiana. An analysis of T-MSIS data presented to Congress in 2022[17] related to SUD treatment in Medicaid noted that Indiana was one of only six states or territories that experienced a statistically significant decrease in the percentage of beneficiaries who received SUD treatment in an outpatient setting. Indiana was also one of only four states or territories with a statistically significant decrease in the number of beneficiaries treated for SUD and who received follow-up care after inpatient or residential treatment. This points to the need for a more robust and well-developed system of care for the most vulnerable Hoosiers, which can be achieved through scaling of the CCBHC model.

Medicaid data for Indiana from 2017 to 2021 shows that the number of beneficiaries in Indiana receiving a behavioral health service with various behavioral health conditions remained at the same level; however, the number of total Medicaid beneficiaries identified with a behavioral health condition increased. This highlights an increased identification of behavioral health needs in the population, and a need to expand access to evidence-based behavioral health services and integrated care that addresses SDOH, a priority for Indiana's CCBHC design.[18]

Through CCBHC implementation, Indiana seeks to integrate behavioral health and physical health care. Medicaid data for Indiana shows that from 2017 to 2021 there was a 22% increase of individuals who have a behavioral health and physical health diagnosis, presenting an opportunity for integrated care delivered via a CCBHC to lead to better outcomes for Medicaid beneficiaries.[19]

Section IV: Communities Served by Selected CCBHC Demonstration Sites

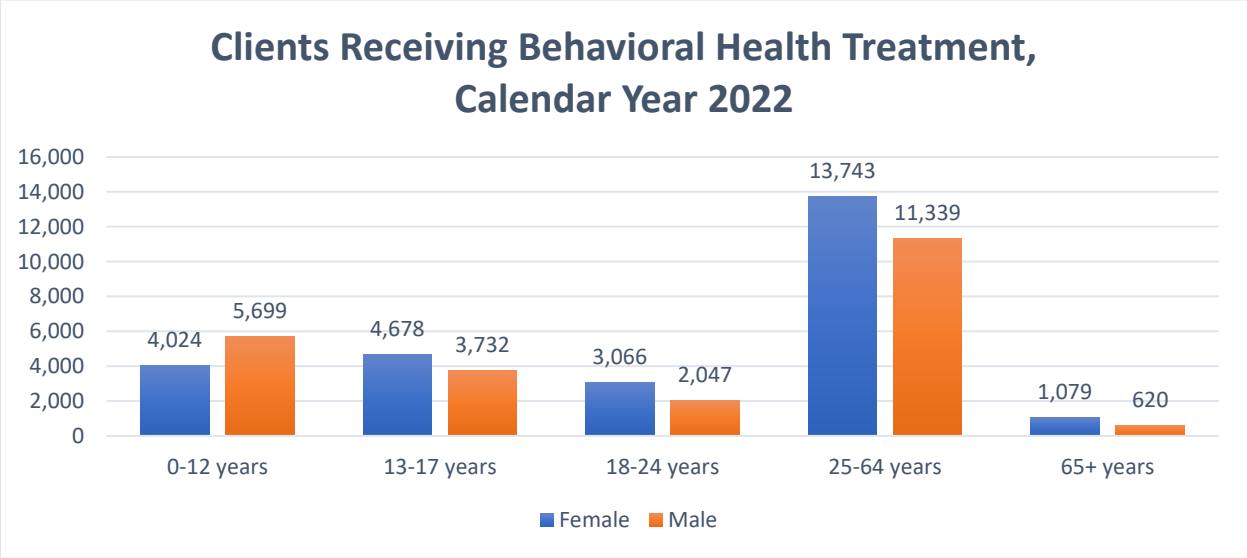
In preparation for the demonstration, the State reviewed data on behavioral health needs specific to the communities and populations served by the eight selected CCBHC demonstration sites. All eight demonstration sites are CMHCs that currently provide mental health and substance use care to Hoosiers in communities throughout the state.

The eight sites selected to participate in the CCBHC demonstration program serve 39 out of Indiana's 92 counties, representing urban, suburban, and rural populations. Additional information on the geographic service areas for each of the eight prospective CCBHC demonstration sites can be found in Attachment 4.

Baseline data was drawn from a review of Division of Mental Health and Addiction (DMHA) data and Medicaid claims from CY 2022 (the most recent complete year available at the time of the application). Information on the Medicaid members served by the eight selected demonstration sites (n = 50,046) is provided below. These figures include adults and children/youth.

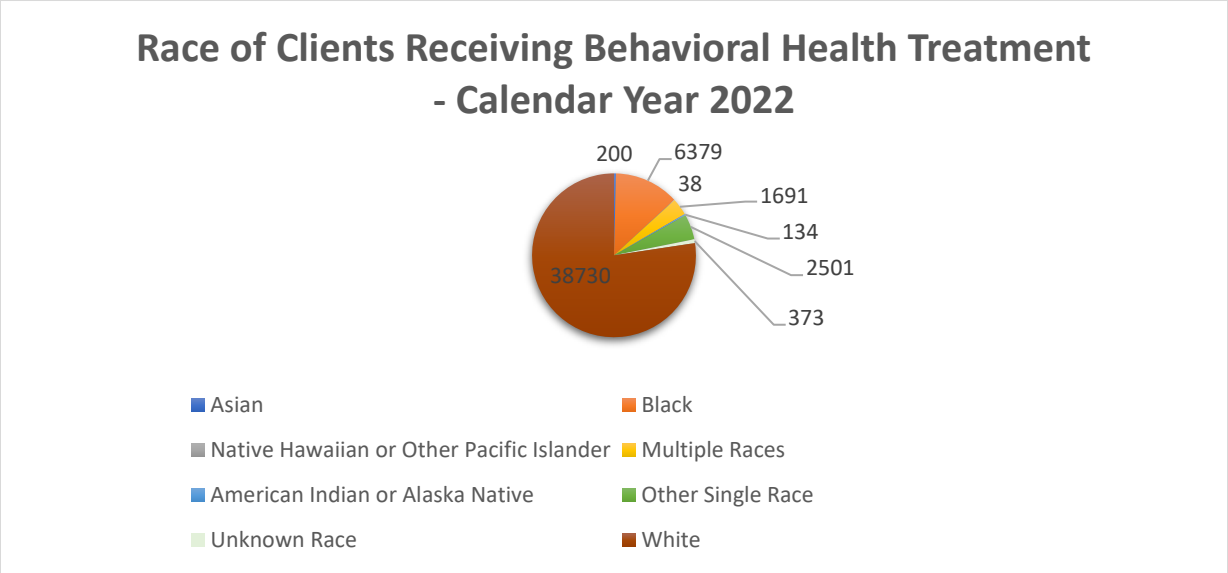
Demographics

As depicted below, the sites served clients across the lifespan, with approximately 60% of individuals served between the ages of 18-64. Nearly 36% of individuals served were under the age of 18, likely due to the extensive school-based services provided by several sites. Older adults were the least likely age demographic to be served (3%).



Approximately 53% of Medicaid members served in CY 2022 were female and 47% were male. Very few individuals (less than 20 people) identified as a different gender (non-binary or otherwise).

The racial demographics of Medicaid members served by the sites in CY 2022 are depicted below.



Approximately 77% of individuals served identified as White, 13% identified as Black, 5% as Another Single Race, and 3% as Multiple Races. Less than 1% of individuals served identified as either Asian, Native Hawaii/Pacific Islander, or American Indiana/Alaska Native. Several of the selected sites serve predominantly rural areas (see Attachment 4) with a large percentage of White residents (as high as 99.4% in one county), which may be reflected in these figures. Six percent (6%) of Medicaid members served identified as Hispanic/Latino.

Health Needs

The integration of physical and behavioral health is an important goal for the State. As noted below, the Medicaid members served by the demonstration sites in CY 2022 self-report numerous chronic conditions that can lead to reduced quality and length of life.

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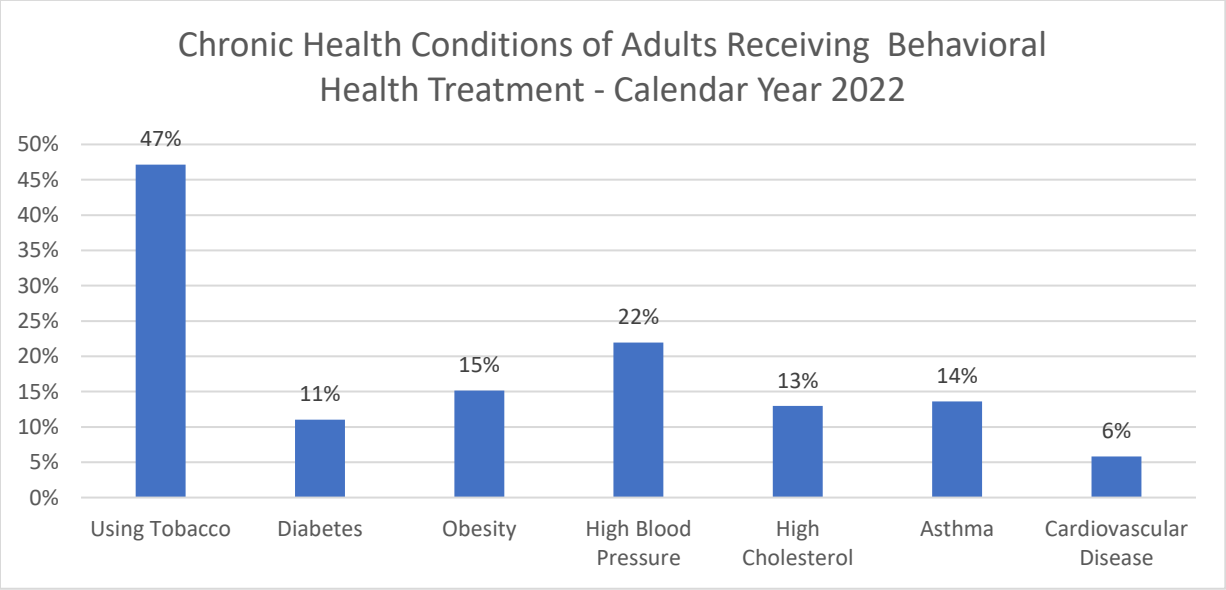


Data from CY 2022 indicates that 47% of Medicaid members served by the demonstration sites report tobacco use, and a significant portion (6-22%) report chronic diseases associated with or exacerbated by smoking. This 47% smoking rate is dramatically higher than the statewide average of 16.2% noted above.

It is important to note that these figures are self-reported and may be unreliable. For example, the statewide obesity rate for Indiana 37.7%[20], which suggests that obesity is underreported in the chart above. However, this demonstrates the potential benefit of care coordination and primary care screening services that are central to the CCBHC model.

Utilization

Baseline data indicates that the Medicaid members served by the eight demonstration sites in CY 2022 collectively had 8,567 hospitalizations and 62,836 emergency department visits.

Section V: Indiana's Behavioral Health Workforce

Workforce development efforts led by the State are focused on ensuring that Indiana has the right mix of professionals and services to drive good outcomes. The number of mental health clinicians in Indiana has been increasing over time but still remains significantly lower than national averages. Indiana has just 207.4 mental health clinicians per 100,000 population, ranking 43rd in the country.[21] The state is ranked 48th for psychiatrists specifically (10,303.6 Hoosiers for every 1 psychiatrist).[22] Nearly the entire state is designated as a mental health professional shortage area (Mental Health HPSA).[23] Workforce challenges not only impact Hoosiers' ability to access needed services in a timely manner, but also reduce providers' capacity to deliver effective, high-quality care and contribute to high rates of burnout and turnover.

The Indiana University School of Medicine, Bowen Center for Health Workforce Research & Policy analyzed the landscape of fully licensed and associate Behavioral Health and Human Services (BHHS) providers[1] during the 2020 and 2022 licensure renewal periods.[24,25] Notable findings regarding Indiana's behavioral health workforce include:

- **Addiction Counselors:** From 2020 to 2022, the rate of counselors working in SUD treatment facilities and methadone clinics doubled (11.9% to 21.1% and 5.0% to 9.8%, respectively), suggesting an increased need for addiction-related services. Conversely, 40 counties had no reported addiction counselor FTE, up from 11 in 2020. This strongly speaks to the need to expand access to SUD services in rural and underserved areas.
- **Social Workers:** Among social workers, approximately 70% were licensed clinical social workers, 29% social workers, and the remaining were associates. From 2020 to 2022, the rate of social workers working in private practice decreased (19.7% vs. 12.0%) and increased in CMHCs or mental health clinics (18.0% vs. 27.2%). Encouragingly, the number of Indiana counties with no reported social worker FTE did not increase and remained at just two counties.
- **Marriage and Family Therapists (MFT)**: Among MFTs, approximately 90% were licensed MFTs and the remaining were associates. Around half of MFTs worked in private practices, and one-fifth in CMHCs or mental health clinics. An increasing number of MFTs reported planning to increase their hours spent in patient care (14.7% vs. 16.4%), while a decreasing number planned to decrease their hours (4.0% vs. 1.7%), suggesting that MFTs were attempting to meet the population's greater need for counseling services. Further, the number of counties with reported MFT FTE increased from 27 to 35 counties.
- **Mental Health Counselors**: Among mental health counselors, approximately 80% were licensed counselors and the remaining were associates. Compared to other provider types, mental health counselors experienced fewer and less significant changes from 2020 to 2022, including a slight increase in the proportion of Black and Hispanic counselors and a decrease in counties with no reported counselor FTE from nine to five counties.

[1] Including addiction counselors, social workers, marriage and family therapists, and mental health counselors.

In addition to understanding the provider landscape, it is important to assess their competencies and skills to provide high-quality care. The Bowen Center conducted an analysis of 57 employers representing CMHCs and hospitals to better understand the transition from post-secondary education to practice.[26] Among employers who reported employing individuals completing their supervision periods, 61% indicated that licensees lacked a number of professional skills, particularly a lack of general preparedness around health care fundamentals and skills and a lack of professional knowledge related to the patient population, mental illness, and basic intervention skills. Coupled with provider shortages, the gap in professional competencies contributes to a workforce with limited capacity to deliver appropriate care. Indiana will seek to address this gap through the creation of the new Center of Excellence (CoE), which will offer training and support to community behavioral health care providers, including all eight demonstration sites and additional prospective CCBHCs.

Among employers that employed individuals in their supervision periods, 68% reported that supervising licensees was expected as part of clinical staff duties and 70% reported there was no incentive, financial or non-financial, for providing supervision. The lack of appropriate compensation for staff to provide supervision on top of their clinical responsibilities may impact both the supervision that licensees receive and the care that staff provide if they are stretched too thin.[27] With added responsibilities but lower compensation, recruitment and retention of quality staff and licensees can be difficult, exacerbating the workforce shortage as staff transition to other states or career paths. Through the adoption of a Medicaid PPS rate for CCBHC services, the State aims to address this issue and bolster recruitment and retention at CCBHCs.

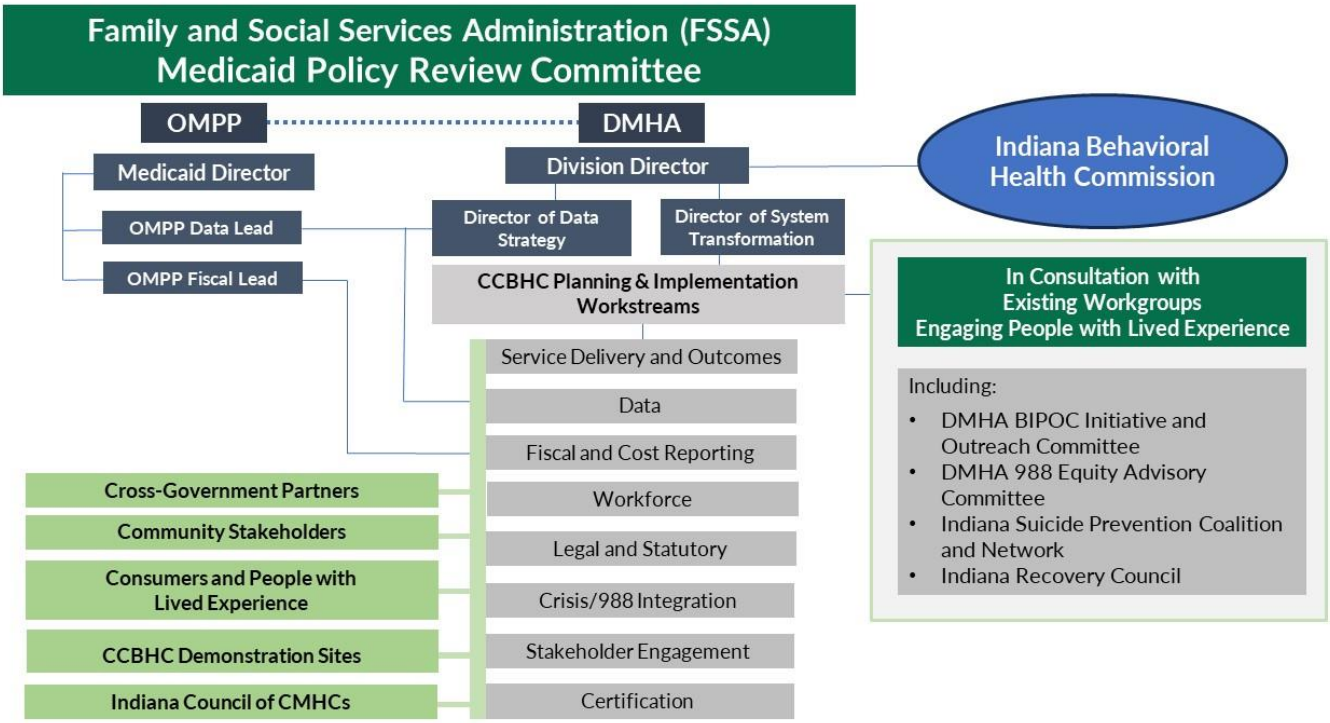
Program Narrative

Section A: Solicitation of Input by Stakeholders in Developing CCBHCs

Indiana has been working diligently and strategically to advance Certified Community Behavioral Health Clinics (CCBHCs) as the primary mechanism for community behavioral health care delivery in the state. Indiana began work towards CCBHC implementation in 2016 through a state planning grant, which resulted in a conscious decision by the State to further develop the statewide behavioral health infrastructure before pursuing a demonstration. In the ensuing years, Indiana has built a unified movement bridging state government, behavioral health care providers, community partners, local/county leaders, and consumers/families. Indiana is now prepared to launch a successful demonstration program with the buy-in and contributions of key leaders in all branches and levels of government, including the Governor and the executive branch, the judiciary, and bi-partisan support from the legislature.

Over the course of several years, Indiana's Family and Social Services Administration (FSSA) has created advisory, planning and implementation structures for CCBHC development and scaling. These efforts have educated and engaged diverse constituencies on the benefits of the CCBHC model. FSSA has created a robust planning structure that bridges the Division of Mental Health and Addiction (DMHA) and the Office of Medicaid Policy and Planning (OMPP), while engaging stakeholders and aligning with the work of Indiana's Behavioral Health Commission (BHC), as depicted in Figure 1 and described on the following page.

Figure 1 – Indiana CCBHC Demonstration Planning Structure



The FSSA Medicaid Policy Review Committee steers CCBHC planning efforts in Indiana. FSSA executive level leadership have been fully engaged in demonstration planning, including the FSSA Chief Medical Officer who has served as executive sponsor for this application and will continue to play a leadership role in demonstration implementation. The FSSA Chief Medical Officer sits on the Medicaid Policy Review Committee, along with the FSSA Chief Financial Officer, as well as the DMHA Division Director and the Medicaid Director. This group steers CCBHC planning efforts in Indiana and works to align changes to policies across FSSA. This group will serve as the executive oversight body for the CCBHC demonstration. All impact measures and design decisions for the demonstration have been vetted by the Medicaid Policy Review Committee.

The Indiana BHC, chaired by the Director of DMHA, has been instrumental in strategic efforts to plan a future system with CCBHC at the core. Established in 2021, BHC membership includes individuals with lived experience of behavioral health conditions, consumer advocacy groups, elected officials, behavioral health providers including current Community Mental Health Centers (CMHCs), and state government leaders representing Medicaid, law enforcement, education, and child welfare. All BHC meetings are open to the public for additional input and perspective.

DMHA's Director of System Transformation serves as the "conductor" for state CCBHC efforts, leading strategic implementation of the CCBHC model statewide in conjunction with the creation, growth, interoperability, and sustainability of Indiana's 988 crisis response system. The Director of System Transformation intentionally oversees both the CCBHC and crisis response systems to ensure an integrated vision comes to fruition for Indiana. She has helped coordinate a CCBHC demonstration planning process whereby nine senior/executive DMHA leaders have led CCBHC-focused planning workstreams (noted in Table 1) that have engaged over 85 individuals in discussions to inform CCBHC demonstration and implementation planning.

Table 1 – Overview of CCBHC Planning Workstreams

Workstream	Scope
Service Delivery and Outcomes	Define required and recommended evidence-based practices (EBPs); Develop plan to provide training for implementation and fidelity monitoring
Data	Develop systems for CCBHC data collection at the state and clinic level; Provide associated technical assistance (TA)
Fiscal and Cost Reporting	Establish cost reporting mechanisms and provide associated TA; Develop Medicaid prospective payment system (PPS) methodology
Workforce	Align workforce development and retention strategies with state CCBHC efforts
Legal and Statutory	Research and implement necessary changes to state administrative code; Develop approach for CCBHC State Plan Amendment (SPA) during demonstration
Crisis/988 Integration	Integrate CCBHC model with 988/crisis response system
Stakeholder Engagement	Seek input on CCBHC implementation from diverse stakeholders; Ensure consistent messaging with stakeholders and the public
Certification	Establish CCBHC certification standards and process

DMHA and OMPP senior leaders and staff have participated in all planning workstreams. **Cross-government** workstream participants include: Indiana Division of Disability and Rehabilitative Services; Division of Aging; Department of Child Services (DCS); Office of Court Services; Logansport State Psychiatric Hospital; and FSSA Communications and Public Affairs. **Community stakeholders and service providers** engaged include: the Indiana Council of Community Mental Health Centers (ICCMHC); multiple CMHCs serving diverse urban and rural communities; providers specializing in children's behavioral health care; foster care providers; residential behavioral health treatment providers; the Indiana Primary Health Care Association;

and the Indianapolis Coalition for Homelessness Intervention and Prevention. **Organizations led by consumers and people with lived experience** that have participated in planning workstreams include: the National Alliance on Mental Illness (NAMI); Mental Health America of Indiana; Indiana Recovery Network; and several peer-led Recovery Community Organizations (RCOs).

Overall, workstream participants have represented 11 different government entities, 14 service provider agencies/associations and six community-based or consumer-focused organizations. Workstream meetings were held virtually and via hybrid format and engaged individuals living and working in rural and urban communities throughout the state. Oversight from the Medicaid Policy Review Committee and cross-workstream collaboration has helped ensure the State's planning approach is not siloed.

Individuals with **lived experience of behavioral health conditions and their family members** have provided input throughout the planning process. Indiana has leveraged existing advisory groups as noted in Figure 1 and described below in Table 2. This feedback has been critical in understanding current challenges in the behavioral health system, such as accessing timely care. It has also helped the State design a CCBHC implementation plan that will advance a vision for a comprehensive range of mental health and substance use disorder (SUD) services.

Table 2 – Individuals with Lived Experience and Family Members – Summary of Advisory Groups Engaged in CCBHC Planning Efforts

Group	Composition	Example of Engagement
DMHA BIPOC (Black, Indigenous, and other People of Color) Initiative and Outreach Committee	Comprised of DMHA staff, BIPOC leaders, and organizations who intentionally serve BIPOC communities in areas connected to mental health, prevention, and addiction.	Consulted on engagement of BIPOC-led organizations in CCBHC model and care coordination; Advised strategy to engage CBOs to be a part of the CCBHC ecosystem of care.
DMHA 988 Equity Advisory Committee	Includes over 70 individuals representing diverse racial, ethnic, gender identities and faith communities, people with disabilities, and individuals with lived experience of behavioral health conditions.	Advises efforts to build an accessible and equitable statewide crisis response system; Led to community engagement efforts and focus groups facilitated by Black Onyx Management Consultants, an Indiana-certified minority-owned business enterprise (MBE) (see below).
Indiana Suicide Prevention Coalition and Indiana Suicide Prevention Network	Includes service providers and people with lived experience. DMHA facilitates veteran-specific, racial identity-specific and youth-specific subgroups.	Advises efforts to integrate evidence-based suicide prevention into CCBHC services.
Indiana Recovery Council	Advisory group comprised entirely of individuals in Indiana with lived experience.	Provides input on workforce development efforts to build workforce of Certified Peer Support Professionals.

Engagement of Populations of Focus

Indiana has solicited input from the population of focus, including adults with serious mental illness (SMI), others with any mental illness (AMI), children and youth with serious emotional disturbance (SED) or emerging mental health challenges, and those with SUD and their families. It is estimated that DMHA and OMPP engaged over 180 individuals with lived experience in CCBHC and crisis system planning conversations in 2023 alone.

This engagement has directly informed decision-making around CCBHC implementation, including but not limited to: the development of trauma-informed crisis services; the provision of culturally and linguistically accessible CCBHC services; workforce development for peer support professionals; integration of peers into mobile crisis response; and capacity-building to better position peer-led and BIPOC-led community based organizations (CBOs) and RCOs as designated collaborating organizations (DCOs). Engagement highlights are summarized in Table 3.

Table 3 – State Activities to Seek Input from Populations of Focus

Adults with Behavioral Health Needs
• Co-hosted two in-person meetings with ICCMHC focusing on peer services and DCO opportunities that prominently featured individuals with lived experience • Sought extensive input from individuals with lived experience on DMHA training curriculum and standards for RCOs and Certified Peer Support Professionals, which will enhance CCBHC core service focused on peer support • Engaged focus groups of current and former service users at two of the selected CCBHC demonstration sites • Engaged diverse service users to provide input on crisis services via focus groups facilitated by Indiana-certified MBE
Children with Behavioral Health Needs (and Families)
• Engaged members of youth suicide prevention steering committee in discussion around CCBHC
Consumer and Family-Led Organizations
• Participated in NAMI conference on criminal justice diversion • Engaged 18 Regional Recovery Hubs (led by and employing individuals with lived experience) in CCBHC education and planning efforts

During the demonstration, Indiana will continue to expand its efforts to solicit input from populations of focus. For example, the 988 Equity Group and DMHA's dedicated veterans' liaison will work to engage veterans with SMI and SUD around the topics of suicide prevention and crisis services provided via CCBHCs. The Indiana Recovery Council, noted in Table 2, will serve as a continuing advisory council to DMHA, and will receive quarterly progress updates. DMHA will engage CCBHC demonstration site governing boards and advisory councils to seek continuous feedback on CCBHC implementation and its impact on the lives of people served.

Throughout the planning process, Indiana has worked to promote transparency and public awareness of state CCBHC efforts. FSSA has a CCBHC webpage that provides an overview of the CCBHC model and certification criteria, frequently asked questions, and resources for providers and the public. FSSA Communications will work to ensure the public and key stakeholders receive clear, consistent messaging about the demonstration.

Coordination with Governmental Agencies and Tribal Entities

Indiana's whole-of-government approach to CCBHC includes leadership from the Governor's office as well as executive leadership of FSSA. The FSSA Secretary has communicated long-term commitment to the CCBHC model, publicly setting forth a realistic multi-year timeline for implementation. One of the strategic pillars of FSSA has been to build mental health and SUD service capacity, with CCBHC at the core. Activities under this umbrella include launching 988 and enhancing crisis response systems, building capacity among CMHCs to transition to CCBHC, decreasing intersections between the mental health and justice systems, and expanding mental health services for children. The CCBHC demonstration aligns with these strategic initiatives.

Both DMHA and OMPP have set CCBHC implementation as one of the highest priority strategic goals for each division. These efforts demonstrate alignment across state government. DMHA, as

the single state authority, has taken the lead on provider certification and capacity-building efforts. OMPP, Indiana's Medicaid, has been a strong partner, and the OMPP Director of Reimbursement and Actuarial Services has been deeply involved in PPS rate development and cost reporting.

Indiana has engaged local government leaders in planning. A key juncture for local government engagement was the Indiana Supreme Court's Mental Health Summit in 2023, which highlighted CCBHC. This event brought together over 900 stakeholders from all counties in Indiana, including judges, prosecutors, public defenders, chief probation officers, sheriffs, and County Commissioners. The summit helped raise awareness of the model and local leaders continue to maintain a high level of engagement. DMHA continues to work with the justice system, including a partnership on an award-winning project that has reduced the wait time for admission to the State Psychiatric Hospital for competency restoration services from four months to two weeks. One of the CCBHC demonstration sites supports this effort, providing alternative-setting competency restoration services including therapy, medication and resources to address social needs.

Recognizing that CCBHC services reach across the lifespan, DMHA has numerous partnerships with child-serving agencies, including the Department of Education (DOE) and the Department of Child Services (DCS). All of the selected CCBHC demonstration sites have school-embedded personnel that provide services to children, and DMHA collaborates with DOE on the SAMHSA-funded Project AWARE (Advancing Wellness and Resiliency in Education) initiative. Project AWARE practitioners were engaged as part of CCBHC readiness assessment activities in 2023. DMHA also partners with DCS in serving children, adolescents, and families through in-home and community-based programs. DCS leaders have participated in CCBHC planning activities.

Indiana has also taken steps to engage federal agencies, including the Department of Veteran Affairs (VA). DMHA is working with prospective CCBHCs to formally engage the VA and ensure coordinated care for veterans and members of the armed forces, as described in Section B.

The State of Indiana has one federally recognized tribe, the Pokagon Band of Potawatomi, which OMPP consults with as part of its community engagement efforts. In addition, one of the selected CCBHC demonstration sites has engaged the Miami Nation of Indians, a nonprofit tribal council, and offered no-cost Mental Health First Aid and suicide prevention training. Furthermore, a 2024 goal of the 988 Equity Committee (described in Table 2) is to engage tribal communities in the state to better understand community needs.

Section B: State Capacity to Support CCBHC and Certification of Clinics as CCBHCs

CCBHC Readiness

Indiana has made strategic investments in assessing state data systems, building CCBHC readiness among its statewide network of 24 CMHCs, and enhancing crisis service capacity, totaling **more than $216M** since 2020. Over half of that amount ($136M) has been invested directly in Indiana's network of CMHCs to build provider readiness for CCBHC implementation and scaling, including grants for electronic health record (EHR) investments and baseline CCBHC data collection; mobile crisis teams; "Community Catalyst" innovation programs to improve outcomes; and workforce innovation. This figure includes over $38.6M provided to the eight selected demonstration sites. These figures reflect additional investments in capacity-building and do not

include any funding conveyed through provider contracts and Medicaid claims. Indiana is a fiscally conservative state, which makes its sustained level of investment even more notable. To achieve this level of investment, Indiana has leveraged American Rescue Plan (ARPA) funds, Covid emergency funds, home and community-based service (HCBS) waiver funds, CMS Transformation Transfer Initiative (TTI) funds, mental health and substance use block grant funds, SAMHSA crisis infrastructure support and workforce grants, state appropriations, and other sources to support CCBHC.

After a multi-year initiative that has bridged the whole of state government and secured the buy-in of critical community and provider stakeholders, Indiana is prepared to enthusiastically move forward with a CCBHC demonstration. A significant milestone was met in 2023, with the bi-partisan passage of Senate Enrolled Act (SEA) 1, which allows the State to move forward with adopting CCBHC as the primary means of behavioral health care delivery, and dedicates $100M to CCBHC and 988 implementation via the creation of the Community Mental Health Fund. Furthermore, the Indiana provider community is fully behind the modernization of the system with CCBHC at the core. ICCMHC has made CCBHC central to its policy platform and was instrumental in the passage of SEA 1. Key milestones in Indiana's CCBHC evolution and growth are provided in Table 4.

Table 4 – Key Milestones in Indiana CCBHC Development

2016-2018	• Indiana received CCBHC state planning grant in 2016. • State invested in integrated behavioral health models, working with 12 CMHCs to integrate primary care screening and care coordination, preparing to transition to a model like CCBHC. • Indiana made investments in SUD service infrastructure (including Opioid Treatment Program expansion and peer recovery infrastructure), but opted not to apply for the CCBHC demonstration.
2019	• DMHA leadership re-engaged CMHCs in discussions around the CCBHC model.
2020	• First Indiana CMHCs received CCBHC Expansion grants from SAMHSA.
2021	• Indiana BHC established. • DMHA completed assessment of state data systems to drive capacity-building.
2022	• Passage of HB 1222, which directed DMHA to develop a plan to expand the use of CCBHCs. • DMHA released influential "roadmap" report for CCBHC expansion. • BHC recommended CCBHC as the primary mechanism for behavioral health care delivery.
2023	• Passage of SEA 1, which allowed the state to pursue a CCBHC demonstration application. • Indiana Supreme Court hosted statewide criminal justice summit highlighting CCBHC. • Between 2020-2023, 19 Indiana CMHCs received SAMHSA CCBHC grants. • DMHA led a system-wide CCBHC readiness assessment, with partnership from ICCMHC. • DMHA led new state investments for mobile crisis teams at CMHCs and Bridge Grants to build CMHC data infrastructure in anticipation of a potential demonstration. • Eight CCBHC demonstration sites selected through a two-step, competitive process.
2024 *(to date)*	• Provisional state CCBHC certification process launched; two sites provisionally certified. • PPS methodology finalized. • CCBHC demonstration application submitted.

Indiana's efforts to educate legislators has created an environment supportive of long-term sustainability and scaling of the CCBHC model. With the support of the National Council for Mental Wellbeing and in partnership with ICCMHC, DMHA issued a "roadmap" for adopting the CCBHC model statewide, including alignment with 988. This report also set out a timeline for Medicaid SPA development, which has been incorporated into CCBHC planning efforts. The

Legal and Statutory planning workstream has since developed a timeline, process and implementation plan for Indiana's CCBHC SPA by 2027.

This influential paper also helped guide provider engagement and public awareness-building, leading to appropriations totaling $100M via SEA 1 in 2023. This was framed as a "down payment" on the multi-year system investments needed to fully launch and integrate CCBHC and 988. Further appropriations are expected and will help support sustainability beyond federal dollars to ensure the success of the CCBHC demonstration.

Indiana has made strategic investments in clinic infrastructure and TA to build providers' capacity to meet CCBHC requirements, regularly engaging with the National Council for Mental Wellbeing for webinars and other CCBHC-specific TA. As a result, Indiana's community behavioral health providers are deeply knowledgeable about CCBHC requirements and overall demonstrate a high level of CCBHC readiness. DMHA has conducted several provider readiness assessments specific to CCBHC criteria and related guidelines. These assessments have provided meaningful information about clinic strengths and gaps. State readiness efforts are summarized in Table 5.

Table 5 – Strategic Initiatives to Enhance CCBHC Readiness
System-Level Assessments and Investments to Support CCBHC Readiness
● An assessment of the CMHC intake experience was performed in 2021, with the goal of reducing documentation burden and increasing speed of access while meeting CCBHC requirements. ● Beginning with a systems assessment in 2022, DMHA has taken steps to modernize its data infrastructure. ● Indiana has invested in workforce development with a special focus on building the peer workforce in preparation for expanded peer services through CCBHCs. This includes peer certification and training. ● Indiana has worked to launch 988 and align crisis services across the state, including the designation of mobile crisis teams at CCBHC demonstration sites.
Investments to Support CCBHC Readiness Among Providers
● Nineteen (19) out of 24 CMHCs statewide have received at least one SAMHSA CCBHC Expansion grant, including all eight of the selected demonstration sites. ● In 2023, DMHA issued Bridge Grants to 23 CMHCs, including the selected demonstration sites, to support infrastructure development and initiate collection of selected CCBHC clinic-level quality measures. Meant to serve as a "bridge" to a potential CCBHC demonstration, these grants were issued in close partnership with ICCMHC, further solidifying partnership and buy-in with the provider community.
Readiness Assessments Among Providers
● Indiana conducted a universal CCBHC readiness assessment of all 24 CMHCs, including qualitative and quantitative data. Findings have been incorporated into planning for the demonstration. ● Indiana launched an assessment and coaching project focused that has assessed all 24 CMHCs' ability to meet federal CLAS (Culturally and Linguistically Appropriate Services) Standards, with ongoing coaching. ● In the fall of 2023, DMHA issued a Request for Services (RFS) to gather information about readiness to participate in the demonstration program from interested provider organizations.

Indiana has selected eight prospective CCBHCs for participation in the demonstration program, all of which show a high level of readiness to meet certification criteria:

Table 6 – Indiana's CCBHC Demonstration Sites	
Adult & Child Health	Centerstone of Indiana
4C Health	Radiant Health Services
Hamilton Center	Sandra Eskenazi Mental Health Center (Eskenazi Health)
Oaklawn Psychiatric Center	Southwestern Behavioral Healthcare

More information on each site is provided below and in Attachment 4. As described in Attachment 1, the selected demonstration sites show a high level of CCBHC readiness, with all sites scoring 1 or 2 on all criteria elements. All demonstration sites are committed to implementing the CCBHC model in accordance with the state-specific criteria adopted by Indiana, which incorporate SAMHSA requirements and additional requirements aligned with areas of state discretion.

All selected demonstration sites have participated in weekly TA calls since January 2024 to prepare for certification. These calls have focused on cost reporting, EBPs, data collection, and the certification process. While Indiana's recent focus has been building readiness among the eight selected CCBHC demonstration sites, its strategic statewide efforts have boosted CCBHC readiness among all 24 CMHCs in the state. Furthermore, DMHA's investments in mobile crisis response, peer recovery services, behavioral health workforce development, and capacity-building among CBOs serving diverse populations have boosted readiness for DCO and care coordination partnerships among an even broader group of entities.

Demonstration Site Selection and Certification Processes

Indiana has taken a purposeful approach to demonstration site selection, with a phased process that has taken into account providers' ability to fully meet CCBHC requirements. Last year, in preparation for this demonstration application, the Certification planning workstream reviewed the updated SAMHSA CCBHC certification criteria and *State Discretion Guidance* with the goal of incorporating additional requirements aligned with state priorities. A draft of proposed certification criteria was issued publicly in July 2023 and a Request for Information (RFI) was released to gather input on the State's proposed criteria. Over 40 responses were received, and this feedback was used to further refine Indiana's CCBHC certification criteria.

A CCBHC Request for Services (RFS), published in October 2023, set forth Indiana's CCBHC certification criteria and asked all potential demonstration sites to address how they met or exceeded the criteria, and if not, what type of support they needed to do so. All 24 CMHCs in the state, as well as several federally qualified health centers (FQHCs) and health systems, submitted information in response to the RFI and applied for the RFS. With a large pool of RFS applicants to select from, DMHA undertook a detailed review process that considered geographic reach, responsiveness to community needs, care coordination partnerships, and readiness to meet the criteria so as not to delay the start of the demonstration. Eight sites were selected, representing one-third of Indiana's existing CMHC system. This will enable the State to pilot CCBHC in diverse geographies with diverse providers and fine-tune its approach prior to scaling statewide. We are confident that the eight selected providers have a full understanding of what will be required of them as demonstration sites and are fully prepared to partner with the State.

Indiana has developed a rigorous CCBHC certification process to ensure that all state-certified CCBHCs are capable of providing required services and high-quality, accessible care aligned with community needs. DMHA has bucketed criteria into three categories: (1) Criteria able to be met through attestation; (2) Criteria able to be met through proof of CARF or Joint Commission accreditation; and (3) Criteria to be evaluated via site visit and review of charts and other documentation. The CCBHC certification process is led by the DMHA Quality Improvement (QI) team. It incorporates site visits, chart reviews, and structured interviews with CCBHC leaders and staff. It includes verification of policies, procedures, staff training records, and other

documentation. DMHA has developed a robust Excel tool to collect information and track provider compliance with CCBHC criteria. At each site visit, DMHA leads a wrap-up meeting summarizing findings and any areas for remediation, which are then documented via follow-up letter. Gaps will be addressed through tailored TA and remediation plans with timeframes as needed.

As of the date of this application, DMHA has provisionally certified two of the eight demonstration sites (4C Health and Eskenazi Health). The provisional certification process identified a few areas in need of remediation for both sites. These sites have adopted remediation plans that will bring them into full compliance by 7/15/2024. We expect all eight demonstration sites to be provisionally certified by 8/1/2024 and any remediation plans to be fully completed no later than 12/1/2024, enabling a demonstration start date of 1/1/2025. All CCBHCs proposed to be a part of the state's demonstration program will be compliant with the CCBHC certification criteria by the proposed start date of the state demonstration program.

CCBHC Diversity and Populations Served

Selected demonstration sites serve 39 out of Indiana's 92 counties, representing urban, suburban, and rural populations (see Figure 2, below). Centerstone of Indiana, 4C Health, Radiant Health and Southwestern Behavioral Healthcare all serve rural counties as part of their service areas. Adult & Child Health and Eskenazi Health serve the Indianapolis metropolitan area, while Oaklawn serves South Bend and Elkhart in northern Indiana. All serve designated Medically Underserved Areas (MUAs) and/or Medically Underserved Populations (MUPs).[28] All 39 counties served through the demonstration are designated Mental Health Professional Shortage Areas (Mental Health HPSAs).[29] For additional detail on the selected sites, see Attachment 4.

Indiana is comprised of 57 rural and 35 urban counties,[30] and this skew toward rural communities has significant impacts on social drivers of health (SDOH) and access to care. Rural counties tend to have lower income levels, employment, and educational attainment. A significant proportion of individuals across the demonstration service area either receive Medicaid benefits or are uninsured (up to 33% and 15%, respectively). These rates are considerably higher than Indiana statewide rates of 20.5% (Medicaid) and 6.8% (uninsured).[31]

Like many states, Indiana has seen increased behavioral health needs in recent years. Drug overdose mortality rates across service areas ranged from 21.2 to 32.5 per 100,000 individuals, with a majority being opioid-involved and fentanyl-involved. Depressive disorders and anxiety were among the top mental health diagnoses, followed by SMI among adults and SED among youth. Notably, while suicide mortality rates tended to be higher in the demonstration service areas compared to the state, one site in northern Indiana saw a decrease in suicide rates since 2019, parallel to the implementation of efforts to strengthen the crisis care continuum.

While the population in Indiana is predominantly White, ranging from 60-99.3% across CCBHC demonstration site service areas, certain counties have significant proportions of Black and Hispanic/Latinx individuals (up to 24% and 11%, respectively). Many sites serve higher proportions of BIPOC individuals compared to their respective counties, and several serve communities whose primary language is not English. Spanish tends to be the most common non-English language spoken, but a diverse range of language translation services are provided across the eight sites. One clinic in central Indiana serves the largest community of Burmese refugees in the United States, while another in northern Indiana noted a recent influx of Ukrainian refugees

and Arabic-speaking individuals. Data is not available at the county level on sexual orientation and gender identity; however, it is estimated that 5.4% of Hoosier adults identify as LGBTQ+.[32]

Indiana and the selected demonstration sites are committed to addressing disparities and ensuring that under-served and historically marginalized populations can access high-quality care through CCBHCs. All demonstration sites have access to tailored coaching on federal CLAS Standards, and CCBHC certification requires staff training for cultural competence. Demonstration sites are expected to collect data on demographics and use population health strategies to stratify data based on race, ethnicity, and other characteristics to identify and address health disparities.

CCBHCs are required to provide information, documents or messages in a manner that is responsive to all literacy levels and disabilities. Adults with disabilities tend to experience increased challenges accessing care, resulting in worse health outcomes, such as those related to depression, obesity, diabetes, and heart disease. Several counties served by demonstration sites have a greater prevalence of individuals with disabilities compared to the state (13.8%),[33] ranging from 15.95-23.9%. Among Indiana veterans, 23.9% also have a service-related disability.

Poverty is higher in a majority of the demonstration service areas compared to the state rate of 12.6%,[34] regardless of an urban or rural designation, reaching up to 39% in one county containing a Federal Promise Zone. Another rural region served by one clinic has nearly one-third of residents living below 200% of the federal poverty line (FPL). One clinic found that among children living below 100% FPL, more than one in five had a mental, behavioral, or developmental disorder.

To improve health outcomes in this context, Indiana is prioritizing SDOH screening as a state impact measure (see Section E) to better understand community needs and ultimately inform state investments in services, such as housing or other supports. Currently, demonstration sites offer targeted case management and supported employment services to help address social needs. DMHA is also implementing a community engagement initiative to build the capacity of diverse BIPOC-serving CBOs to collaborate with CCBHCs during the demonstration. Furthermore, state impact measures related to increasing initiation in SUD treatment and increasing timely access to crisis services noted in Section E are informed by community needs and demonstrate Indiana's commitment to ensuring Hoosiers are able to receive necessary care in a timely manner.

State Efforts to Support the Delivery of High-Quality Behavioral Healthcare

Indiana is committed to working with CCBHCs to improve delivery of high-quality behavioral health care. Beginning in 2022, DMHA engaged external consultants to assess CMHCs for CCBHC readiness (using SAMHSA's updated criteria) and alignment with federal CLAS Standards. Having assessed providers' CCBHC readiness at several points in the planning period, the state has designed TA specifically to address the gaps noted in these structured assessments. A summary of current and planned support for participating demonstration sites is provided below.

EBP Implementation Support and Training: Beginning in 2024 and continuing through Demonstration Year 1 (DY 1), all sites will receive no-cost TA from the Indiana University (IU) School of Medicine to address challenges related to EBP implementation. DMHA has worked with this IU team of doctoral-prepared researchers and psychologists to develop and administer a SUD-focused EBP monitoring program in the past. DMHA and IU are in the process of assessing each

clinic's specific needs for EBP training support and fidelity monitoring, and will launch a clinical learning community for demonstration sites focused on EBP fidelity and implementation in 2024.

DMHA will also play a central role in facilitating access to high-quality EBP training across the state, beyond the IU partnership. In 2024, DMHA will release a competitive request for proposals (RFP) to launch a new Center of Excellence (CoE) for EBPs, which will offer training and support to community behavioral health care providers, including prospective CCBHCs. A centralized CoE approach to training will enhance the professionalism of behavioral health providers and promote a culture of continuous learning and improvement in the field. CoE offerings will align with EBP requirements/recommendations noted in Table 7. Fidelity measurement will include flexibility as necessary, especially for rural sites (e.g., telehealth access for Assertive Community Treatment [ACT] services). The CoE will combine didactic and experiential learning practices and also incorporate peer learning communities. The CoE will use a hub-and-spoke model to help ensure local access to training in communities throughout the state. Selected trainings will also be recorded and available on-demand to further promote access by CCBHC staff.

Coaching on CLAS Standards: In 2023, Indiana launched an assessment and coaching project focused on CLAS requirements. All demonstration sites have already completed a CLAS implementation analysis to identify specific implementation gaps and remediation needs. This tailored analysis guides TA and coaching for each site provided by a diverse team of CLAS experts. Each demonstration site will receive a two-day staff training tailored to identified gaps.

Building the Peer Workforce: Indiana is committed to building the workforce of Certified Peer Support Professionals and integrating these staff into CCBHCs and mobile crisis teams. Indiana has made it a strategic priority to promote the inclusion of people with lived experience into CCBHCs and mobile crisis teams. DMHA offers a crisis-specific training program that has trained 36 peers and 30 peer crisis team supervisors on trauma-informed crisis services to date.

DMHA has engaged Indiana's recovery infrastructure leads, including Regional Recovery Hubs, Recovery Cafes, and RCOs, in CCBHC planning efforts. Recovery organizations offer connection to others with lived experience with services including both individual and group peer support, harm reduction, referrals to treatment, housing, and transportation. DMHA has facilitated partnerships between the eight demonstration sites and their Regional Recovery Hubs.

Improving Care for Veterans: All eight CCBHC demonstration sites collect data on veterans, serve the veteran population, have partnerships with veteran-serving organizations, and have staff who have participated in Star Behavioral Health Training (SBHT) to ensure competency in serving veterans' needs. SBHT was created through a unique collaboration by the Purdue University Military Family Research Institute, the Indiana National Guard, the National Guard Bureau, and FSSA. This training, referral, and dissemination program helps service members and their families locate trained civilian behavioral health professionals who understand service-related challenges.

A systemwide assessment in 2023 found that the most frequently noted gap in required CCBHC care coordination partnerships was the VA system. Several demonstration sites have echoed this, noting a lack of capacity for local VA staff to enter into formal partnerships. As a result, DMHA, working with ICCMHC, has taken a leadership role in engaging the VA system at the state and federal level and is currently serving as a liaison between the VA and CCBHCs in the state. DMHA

will continue to engage stakeholders to ensure awareness of opportunities for care collaboration, focusing on CCBHC and VA shared goals of access, choice, and person-centered care.

Promoting Partnerships for CCBHC Services and Care Coordination: Indiana is providing TA to facilitate CCBHC partnerships for care coordination and DCOs. ICCMHC has developed model DCO agreement language and a training in consultation with DMHA that incorporates CCBHC requirements and expectations for collaboration and data sharing. DMHA has launched a project to engage CBOs and educate them on opportunities to work within the CCBHC framework. This collaboration is critical for care coordination, and engagement of individuals with lived experience as valued advisors and partners. Members of DMHA's BIPOC Initiative and Outreach Committee and the 988 Equity Committee are assisting with the planning and implementation of this work.

PPS Billing and Data Systems: Indiana is providing TA and resources to demonstration sites related to PPS billing and data infrastructure/quality monitoring, as described in Section C. Indiana will provide direct TA and billing guidance to the demonstration sites. Indiana is currently developing the payment systems necessary to begin paying the PPS rate to demonstration sites on 1/1/2025. DMHA and OMPP will work together to update the behavioral health provider reference modules to reflect CCBHC and billing changes.

CCBHC Collaboration with 988 and Crisis Response Systems

Indiana has prioritized investment in the 988/crisis system and sees CCBHCs as integral to these efforts. CCBHCs will offer crisis services, as well as comprehensive outpatient behavioral health services, to individuals identified and reached through a more developed statewide crisis system. State impact measures in Section E are aligned with Indiana's strategic priorities for 988/crisis system expansion and integration with CCBHCs.

State crisis system investments total over $161M since 2020, focusing on the three pillars of crisis response (988, mobile crisis, and crisis stabilization). The FSSA 988/Crisis Workgroup steers 988 planning and implementation across the state, coordinating with efforts to refine CCBHC certification standards for crisis services and develop CCBHC-based mobile crisis teams. DMHA's Director of System Transformation is charged with ensuring the coordination and integration of the state's CCBHC and crisis system efforts.

Indiana centrally runs its 988 Response Centers, furnishing technology and tracking performance standards. Indiana 988 is consistently in the national top 5 for in-state answer rates since the State assumed this active role. In 2023, Indiana received over 45,000 calls to 988 and logged over 5,000 mobile crisis runs, numbers that are expected to grow during the demonstration. This centralization uniquely positions Indiana to integrate and align 988 with CCBHCs.

DMHA's crisis system development has gone through several phases: first focused on establishing 988 Response Centers, next focused on mobile crisis and crisis receiving and stabilization services (CRSS) capacity, and now shifting to interoperability and alignment with CCBHC. All of the selected sites will have mobile crisis teams during the demonstration and a memorandum of understanding (MOU) with Indiana's 988. DMHA is currently working towards implementing a software system where Indiana 988 crisis call center workers can schedule same-day appointments with community-based providers, including CCBHCs. This solution would connect to CCBHC

EHRs, automatically logging bed availability and referrals to mobile crisis. A longitudinal client record will help providers and the state break the cycle of crisis.

CCBHC Community Needs Assessments

The eight demonstration sites have conducted a community needs assessment (CNA) within the past six months. Every CCBHC in Indiana will be required to update its assessment at least every three years as part of the recertification process. DMHA and OMPP have reviewed each site's CNA in conjunction with proposed staffing plans as part of the certification and PPS rate setting processes. CNA findings were also taken into account in the development of required and recommended EBPs for CCBHCs (Table 7).

Findings from clinic-level CCBHC CNAs have been incorporated into this application in the description of CCBHC diversity and communities served (see above). At the clinic-level, demonstration sites have incorporated findings into their staff recruitment plans (e.g., seeking to hire additional bilingual Spanish staff to better meet the needs of a growing Spanish-speaking population in their service area) and in their community partnership development efforts (e.g., a finding related to high levels of housing instability among the populations served led one clinic to conduct additional outreach to housing service providers in their service area).

Indiana sees the CNA as foundational to the CCBHC model and has allowed CCBHCs to incorporate costs associated with conducting needs assessments during the PPS rate calculations. Indiana will implement a quarterly review of CNAs and how continuous quality improvement (CQI) plans are addressing gaps to meet the communities' needs. These quarterly reviews will provide regular progress monitoring and identify specific points to monitor ahead of the recertification process. The State will set expectations that CCBHCs incorporate feedback loops for community partners to provide input into the CNA.

Selection of Evidence-Based Practices

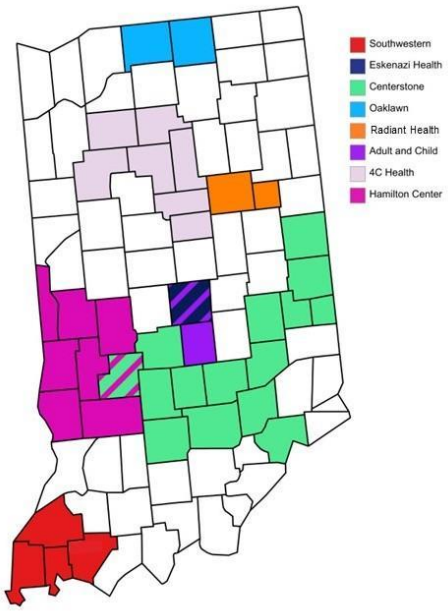
Indiana has selected 10 mandatory and 13 recommended EBPs for use by demonstration sites, summarized in Table 7. This list of EBPs was developed with leadership from the Service Delivery and Outcomes (SDO) planning workstream, with extensive stakeholder input from providers, state agency leaders, and clinicians. The SDO workstream has been engaged since 2023 to provide input to the State on how best to define quality measures and outcomes, and scale clinical best practices. DMHA also solicited input on EBPs through the RFI and RFS processes, and selected several EBPs that were already widely in use and appropriate for the populations served (including adults with SMI, children with SED, and individuals with SUD). DMHA has been leading efforts to collect and share training and resources (e.g., fidelity checklists) for each of the selected EBPs and has shared these resources with participating demonstration sites. During the demonstration period, DMHA will fine-tune and adjust its approach to EBPs based on assessment of fidelity and operationalization challenges.

Table 7 – Indiana CCBHC Evidence-Based Practices

Evidence-Based Practice (EBP)	Population Indicated	Status
Motivational Interviewing	All Populations	Required
Cognitive Behavioral Therapy (CBT)	All Populations	Required
Dialectical Behavior Therapy (DBT)	Adults and Adolescents	Required

Trauma-Focused Cognitive Behavioral Therapy	All Populations	Required
Integrated Dual Diagnosis Treatment	Adults	Required
Assertive Community Treatment (ACT)	Adults	Required
Parent Management Training	Children	Required
Brief Strategic Family Therapy	Children and Adolescents	Required
Behavior Management Strategies*	All Populations	Required
Integrated Community Based Treatment*	Children and Adolescents	Required
Solution-Focused Brief Therapy	All Populations	Recommended
Illness Management and Recovery	Adults	Recommended
Matrix Model	Adults	Recommended
Seeking Safety	Adults and Adolescents	Recommended
Table 7 – Indiana CCBHC Evidence-Based Practices (continued)		
Evidence-Based Practice (EBP)	**Population Indicated**	**Status**
Cognitive Behavioral Therapy for Psychosis	Adults and Adolescents	Recommended
Cognitive Behavioral Therapy for Obsessive Compulsive Disorder	All Populations	Recommended
Coordinated Specialty Care for First Episode Psychosis	Adults and Adolescents	Recommended
Eating Disorder Treatment*	All Populations	Recommended
Functional Family Therapy	Adolescents	Recommended
Parent Child Interaction Therapy	Children	Recommended
Multisystemic Therapy	Adolescents	Recommended
Cognitive Behavior Intervention for Therapy in Schools (CBITS)	Children and Adolescents	Recommended
START Model	All Populations	Recommended
* Several EBPs selected by Indiana are general categories of best practice interventions. In these cases, the clinics have latitude to implement services that meet the needs of the populations served.		

These EBPs were shared with all demonstration sites during the PPS rate setting process so that each clinic could incorporate EBP implementation and training costs into their cost reports. These EBPs were selected to ensure the availability of a spectrum of high-quality behavioral health care for mental health, SUD, and co-occurring disorders. In addition, the START Model has been identified as a recommended EBP to better meet the needs of individuals with co-occurring intellectual and developmental disabilities (IDD) and mental health concerns. CCBHC sites are also encouraged to implement other EBPs that may be necessary based on their CNA.



One EBP of note in Indiana's approach is ACT. DMHA recognizes ACT's effectiveness, but it has been subject to eroding state funding over time. CCBHC PPS will be an opportunity to "resurrect" ACT and improve outcomes. During the demonstration, DMHA will monitor ICST (incompetence to stand trial) referrals from the courts to determine whether increased access to ACT among the SMI population reduces ICST treatment orders.

Indiana is committed to advancing high-quality behavioral health care through CCBHC implementation. DMHA will provide consistent guidance, oversight, and training opportunities to help ensure that EBPs are used consistently, are person/family-centered, are trauma-informed, and are implemented with fidelity to the model. DMHA has set out training options/expectations, and demonstration sites will be required to provide proof of adequate staff training for required EBPs.

CCBHC Service Areas

Indiana's CCBHC demonstration program will serve 39 out of Indiana's 92 counties (see Figure 2), representing urban, suburban, and rural populations. Additional information about the demonstration clinics, including counties served, is provided in Attachment 4. All demonstration sites currently provide CCBHC services in all counties in their service areas. Four sites have some overlap in service areas: Centerstone of Indiana and Hamilton Center both serve Owen County, and Eskenazi Health and Adult & Child Health both serve Marion County. Clinics with overlapping services areas have existing partnerships and established protocols for working with each other. Indiana state CCBHC criteria sets the expectation that CCBHCs must utilize the CNA to define their services for the determined service area. If two CCBHCs are in the same service area, coordination of services and community need justifying the necessity of both CCBHCs are required.

Meaningful Input from People with Lived Experience in CCBHC Governance

DMHA has issued a recommendation to all demonstration sites regarding CCBHC governance and meaningful involvement of individuals with lived and living experiences of mental health and/or substance use disorders and their families, including youth. DMHA has recommended CCBHCs use Option 1 as described in the criteria (*At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families*). Each CCBHC must describe how this requirement is being met or provide a transition plan with a timeline to do so. This representation and oversight surrounding decision-making will enhance the quality of services throughout Indiana's behavioral health infrastructure. All CCBHCs will be expected to appoint individuals on governing boards that represent specific community populations being served by the clinic and reflect diversity in terms of culture, race, language, and other factors, unless the organization's governance structure prohibits this (as in the case of Eskenazi Health, a municipal corporation, which will pursue Option 2). DMHA believes that leadership by individuals with lived experience offering authenticity of voice is critical in ensuring the system is accessible and incorporates firsthand knowledge of the barriers to care -- and solutions -- for those navigating behavioral health systems and services.

State-Specific Requirements

Indiana has, in accordance with *State Discretion Guidance,* implemented additional requirements that go beyond the minimum set forth in SAMHSA's CCBHC criteria. These additions are reflected in state-specific certification requirements and have been incorporated into the provisional certification process for CCBHCs. They set expectations for clinics that will help advance the State's priorities for CCBHC implementation, including: integrating CCBHC quality measures into clinic data collection; ensuring CCBHCs are driven by community needs; developing a highly trained behavioral health workforce, including peers; leveraging care coordination to drive positive outcomes; increasing access to evidence-based care; and building a robust, responsive crisis response system in local communities.

For example, Indiana has added more detailed requirements related to staff training topics and frequency, implemented more stringent requirements for timely access to services including mobile crisis response, and set out expectations for state Health Information Exchange (HIE) participation among all certified CCBHCs. Indiana's required EBPs and quality measures are set forth in the state criteria, and described in Sections B and E. Additional highlights of Indiana's changes to SAMHSA's CCBHC criteria are noted in the narrative sections of Attachment 1.

Adding CCBHCs to the Demonstration

Indiana's long-term goal is to ensure that all Hoosiers in every county have access to behavioral health services provided by a CCBHC. Indiana will adhere to all notification and documentation requirements described in the *Guidance on Addition of CCBHCs to Section 223 State Demonstration Programs*. For example, Indiana will provide to SAMHSA for any new sites: the list of new CCBHCs to be added with the date of addition; timelines for conducting a CNA; descriptions of the certification process; descriptions of how the State is preparing new CCBHCs to use data to support CQI and quality measurement; and other information as required by the Guidance. All added sites will receive assistance to ensure they are using encounter codes to identify CCBHC service-level details on claims.

All new CCBHCs being added will be certified by DMHA prior to joining the demonstration, and the approved PPS methodology will be used for any added CCBHCs. Indiana will engage prospective CCBHCs leading up to their entry to bolster readiness. This includes a review of CNAs prior to certification. Indiana's certification process will include a site visit, which will be conducted in a timely manner to allow for gap remediation before final decision on inclusion in the next DY. Indiana's goal is to have the CoE focused on EBP training active in time to support new sites that may be added in DY 2. The number of CCBHCs added in any given year will be determined based on administrative capacity, availability of appropriated funds, and prospective site readiness.

Table 8 – Process for Adding New Demonstration Sites

Days prior to start of DY	Milestones
180 days	• DMHA to publicly announce plans to add CCBHCs to the demonstration. • Application to be released, to include cost report.
90 days	• DMHA to announce site selection based on readiness and state capacity.
60 days	• DMHA to conduct certification and PPS rate development for selected sites.
30 days	• DMHA to submit plan for added sites to SAMHSA/CMS, to include start date for new sites and PPS rates.

Section C: Development of Enhanced Data Collection and Reporting Capacity

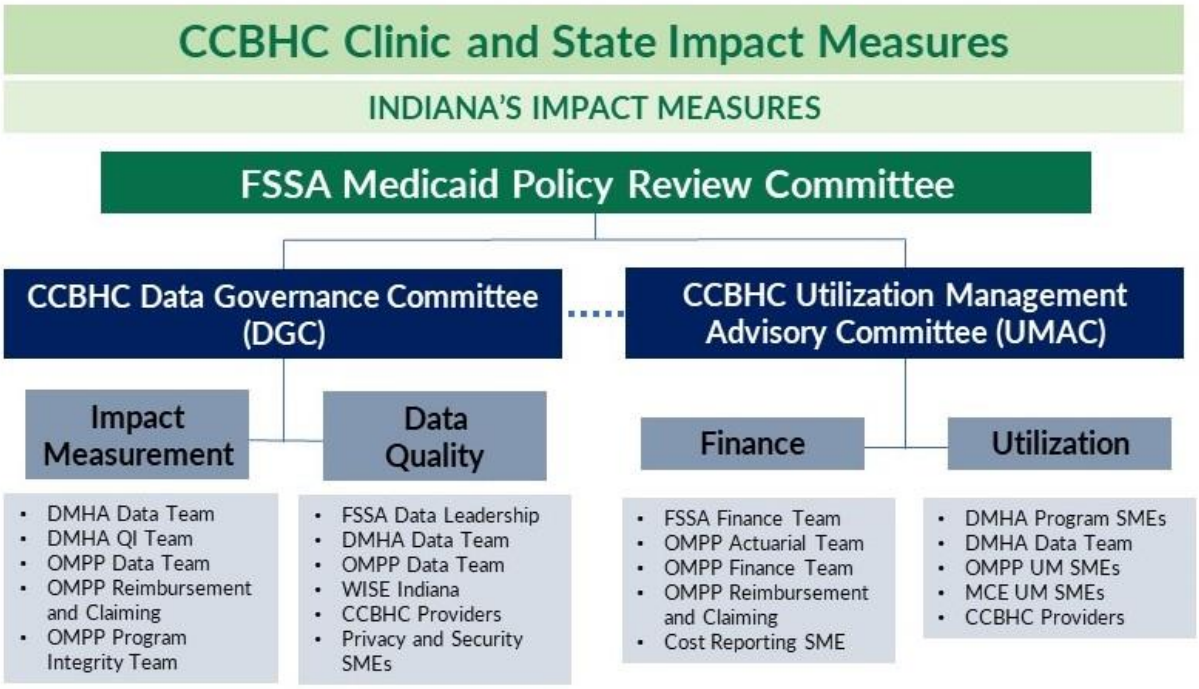
Efforts to Enhance Data Collection and Reporting Capacity

FSSA executive leadership understands the CCBHC demonstration as an opportunity to align OMPP and DMHA under shared goals. FSSA's larger vision is that the CCBHC clinic-level and state-level quality measures will serve as the "north star" for data, finance, utilization, policy, and evaluation teams to pursue across divisions as Indiana implements the demonstration and advances towards statewide scaling of the CCBHC model.

Over the past several years, Indiana has assessed needs at the state and provider level and taken strategic steps to increase capacity at the state and provider level to meet data-related CCBHC requirements and integrate CCBHC/PPS into Medicaid. This includes efforts to build data collection and reporting capacity in support of meeting PPS requirements, quality reporting requirements, and demonstration evaluation reporting requirements.

Implementation and Advisory Structures for the Demonstration*:* Indiana has created a cross-agency implementation structure for the CCBHC demonstration program, depicted in Figure 3 on the following page and described below.

Figure 3 – CCBHC Demonstration Implementation Structure



The **FSSA Medicaid Policy Review Committee** is charged with directing and facilitating cross-cutting changes to policy across FSSA. This group has served as the steering committee for the State's CCBHC planning process, and it will continue to serve as the steering and executive oversight body for the CCBHC demonstration. It includes FSSA's Chief Medical Officer and Chief Financial Officer, as well as the DMHA Division Director and the Medicaid Director. CCBHC implementation will be a priority effort in 2024. DMHA's Director of System Transformation will also attend all CCBHC-related meetings in her role as the "conductor" for state CCBHC efforts. The Medicaid Policy Review Committee will convene quarterly to review progress on objectives, review data related to quality measures and key impact measures, adjust goals and objectives of the key implementation committees described below, and provide other advisement to the CCBHC demonstration program as necessary.

The **CCBHC Data Governance Committee (DGC)** will convene quarterly to review key quality measures and progress on objectives for impact. It will be charged with advising and driving efforts to identify, measure, and track progress on CCBHC data reporting requirements and outcome measures. This group will review demonstration program data (state-collected and clinic-collected) at quarterly intervals to: guide program implementation; support high-quality data reporting to SAMHSA, CMS and national evaluators; and identify data quality issues and TA needs at the site level. This group will advise the design of quality dashboards at the state and clinic level, and regularly review outcomes to drive decision-making during implementation. The DGC will include **two subgroups**: one focused on **Impact Measurement** and one focused on **Data Quality**. The DGC will set objectives for these two subgroups, which will meet monthly or more frequently as projects require. Both will focus on opportunities to better use data to identify and address health disparities, including disparities by race/ethnicity, geography, and payor.

The **CCBHC Utilization Management Advisory Committee (UMAC)** will convene quarterly to review progress on objectives related to building a sustainable fiscal infrastructure for CCBHC

scaling. It will be charged with collaboratively developing utilization management (UM) policies aligned with FSSA goals for quality and impact. Indiana will initially launch the demonstration with a carve-out of CCBHC services from managed care. In DY 1, the UMAC will focus on the initial carve-out phase, and then shift to preparing to transition to a CCBHC carve-in before the end of the demonstration period. The UMAC will include **two subgroups**: one focused on **Finance** and one focused on **Utilization**. The UMAC will set objectives for these two subgroups, which will meet monthly or more frequently as projects require.

Both the DGC and the UMAC will complete quarterly progress reports for the Medicaid Policy Review Committee. Reports will include: review of quality and impact measures, aggregated and by demonstration site; data quality overview and discussion of any ongoing issues; claiming and billing overview and issues; and topics related to data privacy, security, and legal considerations.

PPS Requirements: Shifting from fee-for-service to a PPS model requires several changes in the Medicaid claiming system. DMHA and OMPP have been meeting regularly to discuss and map requirements in preparation to submit this demonstration application. These design meetings have included OMPP and DMHA fiscal and data staff. This team has been working with the State's Medicaid Management Information System (MMIS) vendor to modify the Medicaid IT system to support the new CCBHC provider specialty and assure new PPS rate functionality by the proposed 1/1/2025 demonstration start date. In addition, the State's actuarial vendor that has advised PPS rate development will continue to be engaged and participate in UMAC Finance subcommittee meetings described above.

FSSA has engaged with Medicaid managed care entities (MCEs) in the development of this application. As described in Part 3, Indiana will pursue a full carve-out of the CCBHC PPS for near-term feasibility; however, this does not represent the State's long-term vision. A full carve-out provides time for Indiana to implement the CCBHC model, learn lessons, and approach a managed care carve-in at a later date once rules, guidance for CCBHC services, rates, and billing logic are well developed. Beginning the demonstration period with a full carve-out will also help ensure the eight demonstration sites are able to be paid via PPS beginning on 1/1/2025. Indiana will evaluate the impact of potential changes to state Medicaid funding of community behavioral health systems to ensure continued access to care, efficient use of resources, and long-term fiscal sustainability of the CCBHC PPS. Planning in DY 1 and DY 2 will enable the State, providers, and MCEs to make informed decisions based on demonstration program data and develop a considered approach to claim tracking, billing, and utilization management to enable a full managed care carve-in by DY 3.

Quality Reporting Requirements*:* Indiana will collect and track all required state-collected measures and all required clinic-collected measures for CCBHCs during the demonstration. In addition to the five required clinic-level measures and 12 state-level measures, Indiana will collect *two optional clinic-level measures* - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) and Suicidality Risk Assessment (SRA/SRA-A). Indiana will also collect *one optional state-collected measure* - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH). These optional measures were selected with input from the SDO and Data planning workstreams to align with the needs of the populations of focus. DMHA will use DARMHA (Data Assessment Registry Mental Health and Addiction), DMHA's main data collection system (described in greater detail below), for clinic-collected measures. In preparation for the demonstration, Bridge Grant investments from DMHA in 2023 were

accompanied by requirements to collect data on key measures and metrics, including time to service, depression screening, and depression remission at six months. Data submitted by providers has informed CCBHC baseline data while giving the State a bird's eye view on gaps in the system.

OMPP's Medicaid data vendor runs regular reports on the CMS Medicaid Adult and Child Core Set Measures, which encompass several of the required CCBHC measures. During the demonstration period, DMHA will provide a list of CCBHC clients with Medicaid IDs and the vendor will produce a quarterly report on these core measures specific to Medicaid beneficiaries served by the demonstration sites. Analysis of this data will be incorporated into quality dashboards shared with demonstration leadership (including the Medicaid Policy Review Committee, the DGC, and the UMAC), as well as CCBHC demonstration sites.

To prepare for CCBHC implementation, DMHA has been working to mature its data infrastructure and use of data in decision-making. These efforts include creating a division Data Strategy program area with a team of data analytics staff and hiring a vendor to assess all of DMHA's data systems and make recommendations. To put recommendations into effect, DMHA has been working with FSSA data leaders to standardize data collection, streamline data systems, address data quality issues, document IT/data policies, and develop a data education plan to assist DMHA staff on data-driven decision-making.

CCBHCs have also made strides to enhance their data collection and reporting capacity at the clinic level. As noted above, all CCBHC demonstration sites have received Bridge Grants from DMHA requiring them to collect and submit CCBHC-like data, including the first contact date, PHQ-9 score, and date of screen via DARMHA since July 2023. All CCBHC pilot sites currently administer the Patient and Youth/Family Experience of Care Surveys consumer satisfaction surveys annually. Demonstration sites have worked in partnership with DMHA to address data quality issues. DMHA created several data quality reports and facilitated access to training and TA for all CCBHC demonstration sites, to ensure they are able to meet certification requirements for performance measurement and reporting, CQI processes, and implementing and optimizing Health Information Technology (HIT) infrastructure. Review of CQI plans is incorporated in the certification process for all CCBHCs, and DMHA provides follow-up support and coaching to address areas of deficiency.

National Evaluation Requirements*:* To support participation in the national demonstration, Indiana will leverage its existing relationship with WISE Indiana (Wellbeing Informed by Science and Evidence in Indiana), which is 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 enables FSSA to engage academic experts across Indiana including CTSI partners IU, Notre Dame University, and Purdue University. WISE Indiana will serve on the DGC's Data Quality subgroup and support the State's participation in the national evaluation. FSSA's Science Officer in the Division of Strategy and Technology will serve in an advisory role.

In DY 1, Indiana will focus on launching core systems at the state and clinic level for data tracking and quality measurement sufficient to implement the program and participate fully in the national demonstration. Indiana will also lay the foundation for further innovation and scaling of the CCBHC model. For example, in 2024, Indiana will launch a strategic planning process to integrate CCBHC into Medicaid managed care, with the goal of integrating CCBHC PPS into managed care

capitation by DY 3. In 2024, DMHA will also work with ICCMHC to finalize an RFP to identify a software vendor to develop a new data platform, modeled off Missouri's population data management health system, with the goal of bringing a new, innovative shared solution to performance measurement, care coordination, and population health management online by DY 2.

Enhanced Systems for Data Collection and Reporting

Indiana has taken steps across DMHA, OMPP and at the provider level to enhance data systems in preparation for a potential CCBHC demonstration. These systems will help ensure that Indiana is able to collect and monitor data related to access, quality, services, and outcomes and use it to drive implementation, as well as cost and billing data to ensure the PPS is administered correctly and improved outcomes can be tracked over time. A summary of data systems and how they will be used during the demonstration is provided below.

DARMHA: The main information management system for DMHA is the DARMHA web-based system, which has been in use since 2009. All eight CCBHC demonstration sites use DARMHA regularly to share assessment and block grant data, and have used it as a portal to report required measures associated with their Bridge Grants. In addition, all organizations receiving mobile crisis funding have used DARMHA to report on key measures associated with quality and access. DARMHA allows submission of data via direct entry, import, and web services. DARMHA historically includes client-level data for all clients that fit the definition of a DMHA Supported Consumer (defined as clients who are at or below 200% FPL, have an eligible behavioral health diagnosis, and a functional impairment due to their behavioral health diagnosis). In CY 2022, there were 156,923 DMHA Supported Consumers, and of those, 138,618 had Medicaid. DARMHA includes demographics, behavioral health diagnoses, health conditions, EBPs utilized, encounters, SAMHSA National Outcome Measures, and assessment information for these individuals.

CCBHC providers are accustomed to submitting data to DARMHA. Using this system to track demonstration data will be helpful for the providers, while also allowing DMHA to receive client-level data. During the demonstration, CCBHCs will submit data on all clients receiving CCBHC services, as defined by individuals who receive at least one of the triggerable codes in Attachment 6. This will include DMHA Supported Clients, including Medicaid beneficiaries and those who exceed 200% FPL. CCBHCs will report information on demographics, behavioral health diagnoses, health conditions, EBPs utilized, encounters, information on SDOH screening, and PHQ-9 scores. DMHA will support data reporting for participating sites by pulling the clinic-collected measures from DARMHA, then providing the list of CCBHC clients to OMPP to run the state-collected CCBHC measures using claims data.

In preparation for the CCBHC demonstration, DMHA has added new data fields to the DARMHA encounter list such as First Contact Date, PHQ-9 date and score, and SDOH screening information. CCBHC-related encounters were added to the eligible encounter list. DMHA is also building out new reports to inform practice at the site level. DARMHA currently provides reports to inform providers when clients need a particular screener or assessment, and this practice will continue, with adjustments to better align with CCBHC requirements. DMHA will collaborate with OMPP to create reports and quality dashboards that will be shared with providers at least quarterly to reflect their progress on interim measures at the clinic level, aggregated, and with comparisons to state average benchmarks.

Medicaid Data: Indiana will utilize the Medicaid claims system to look at service utilization, costs, and reimbursement for behavioral health services. New Medicaid data elements to help with CCBHC tracking will include a CCBHC provider specialty, specific National Provider Identifiers (NPIs) for CCBHCs, the CCBHC billing code of T1040, the Q2 modifier to track service-level details of CCBHC demonstration encounters, as well as a modifier to track services provided by a DCO. Claims will also be utilized to run the state-collected measures. CCBHC measures included in the CMS Core Set will be reported quarterly and incorporated into quality dashboards used by the State and clinics in implementation. OMPP will assist with collection and reporting of CMS-64 fiscal data, ensuring that CCBHC cost and billing information is captured and reported in accordance with federal data quality standards. Claims data is reported monthly.

Managed Care: Indiana will initially launch the demonstration with a full carve-out of CCBHC services from managed care. This decision is driven by Indiana's current behavioral health care financing model, which is in need of reform. The Medicaid Rehabilitation Option (MRO) is accessed by all CMHCs in the state, and primarily supports life skills training provided by unlicensed staff. MRO services, while critical to care access, have come to dominate Indiana's behavioral health service mix (currently 79% of CMHC services are paid by MRO). MRO is carved out of managed care while clinical services, including therapy and psychiatric services, are carved in. Indiana is taking a deliberate approach to rebalancing service mix and sees the CCBHC model as critical to this effort. The UMAC will review data related to cost, quality, service mix and access during the demonstration to inform decision-making for the system at large. Indiana will undertake a data-driven strategic planning process in DY 1 and DY 2, developing a plan to carve-in CCBHC beginning in DY 3. As a result, Medicaid MCEs will become fully integrated into data collection and monitoring efforts over the course of the four-year demonstration.

Shared Population Health Data Platform: Indiana is working with ICCMHC to develop a statewide shared population health management platform. Modeled off of Missouri's shared CCBHC data platform, the new platform will aggregate data, including outcome measures, from multiple sources such as claims and clinical data. This shared resource will enable the State to monitor both fiscal and outcomes data associated with CCBHC implementation, support providers in their CQI efforts, and consistently track the following from multiple data sources:

- State-collected and clinic-collected CCBHC quality measures
- Emergency room visits (broken down by mental health issue, SUD issue, health issue, overdose, suicidal ideation, suicide attempt)
- Hospitalizations (broken down by mental health issue, SUD issue, health issue)
- Medicaid claiming and Core Set measures
- Cost information
- Crisis system data
- Deaths and sentinel events

The system will provide alerts for CCBHC clinicians to know which clients need a screening, service, or follow-up. Key benefits of this shared approach include: (1) Ability to benchmark across clinics to improve performance and outcomes; (2) Creating efficiencies in data reporting requirements by automating the submission of required outcomes data; and (3) All participating CCBHCs will have near real-time access to data to inform clinical and operational decisions.
DMHA released an RFI in December 2023 seeking companies who offer population health management software, and is targeting an RFP process to select a vendor with the goal of piloting

this unified system beginning in DY 2. Once the State has selected a vendor, DMHA will initiate a funding request for the system through the CMS Advance Planning Document process. If the request is not approved, a contingency approach would leverage the Medicaid data vendor for compiling the state-collected measures and DMHA would use state resources to create a data warehouse and dashboards for the project. Either scenario would enable visibility into the quality measures for participating providers, ICCMHC, the State, and key stakeholders such as legislators.

Building CCBHC Capacity in Data and Continuous Quality Improvement: DMHA has assisted CCBHCs with preparing to use data to inform and support CQI processes within CCBHCs, including fidelity to EBPs, and person-centered, recovery-oriented care during the demonstration. The eight selected sites use seven different EHR systems; however, all are capable of collecting required data and clinic-level measures. Participating sites offer a variety of CCBHC and non-CCBHC services, and all have implemented or plan to implement CCBHC-specific EHR functionality that enables integration of inpatient, outpatient, and community-based services. Participating sites also have EHR/HIT solutions related to population health management, disparity reductions, CQI, measurement, and reporting.

DMHA has hosted data "office hours" for all participating demonstration sites since January 2023, a practice that will continue. During these sessions, DMHA's Executive Director of Data Strategy has provided tech specs that will enable CCBHCs to send accurate CCBHC data to DARMHA. These TA sessions are pragmatic, detailed, and based on the needs identified by demonstration sites. For example, demonstration sites have requested and received advice from the State on mapping SDOH data from allowed screeners to DARMHA SDOH fields.

As of the date of this application, all demonstration sites are provisionally in compliance with criteria 5.b regarding CQI plans. DMHA reviews sentinel events for each site and provides feedback to be incorporated in each site's CQI plan. In accordance with CCBHC criteria, each CQI plan addresses how the CCBHC will review known significant events including: (1) Deaths by suicide or suicide attempts of people receiving services; (2) Fatal and non-fatal overdoses; (3) All-cause mortality among people receiving CCBHC services; and (4) 30-day hospital readmissions for psychiatric or substance use reasons. This information will be verified during the certification process, which includes DMHA review of written CQI plans for all sites. DMHA will provide support and coaching as needed to ensure sites are able to meet CCBHC requirements.

To promote EBP fidelity, DMHA encourages providers to offer consultation and coaching to staff paired with training. Demonstration sites provide training on EBPs to staff and supervisors. All CCBHCs will receive tailored TA on EBP implementation and fidelity monitoring from IU in DY 1, with longer term plans to launch a statewide CoE for EBPs. As part of the certification process, DMHA staff members conduct site visits that include chart reviews and interviews with leadership and staff. The results of these coaching sessions, site visits, and chart reviews, and any plans of correction, are documented and used to inform the State's evaluation of adherence to the models.

Reporting Interim Measures to CCBHCs

Indiana will review performance measures quarterly to assess progress and impact, and use this information to improve management of the demonstration project. CCBHC state and clinic-level data will be shared quarterly with all CCBHC pilot sites in dashboard format to inform implementation, including aggregated all-site and site-specific data. The DGC Impact

Measurement subgroup will oversee the preparation of reports including both state-reported and clinic-reported measures. Data sharing with CCBHCs will help clinics address gaps in services and appropriate EBPs to ensure members receive the highest quality behavioral health care. The State's long-term vision is that all CCBHCs in the state will have near real-time access to key quality data via the shared population health management platform described above.

DMHA's Executive Director of Data Strategy will serve as the primary liaison to the data/HIT leads at the demonstration sites, answering questions, communicating policies and specifications, sharing requests from the national evaluation team as needed, and seeking input to inform the State's implementation of the demonstration. DMHA and OMPP will work together to develop and issue an Indiana CCBHC Measures Technical Manual that gives clarity to all CCBHC providers and stakeholders on how data will be collected, compiled, reported, and used to inform state implementation and national evaluation efforts.

CCBHC Billing

Each CCBHC participating in the demonstration has used the CMS cost-reporting template and an established code list (see Attachment 6) to provide cost information for PPS rate-setting. This code list was developed by DMHA, with substantive input from OMPP, ICCMHC, and others to ensure accuracy and inclusiveness for services aligned with the nine core CCBHC services. It also aligns with Indiana's required and recommended EBPs for CCBHCs, such as ACT. For each day in which services are provided to a recipient, the CCBHC will bill one unit of the encounter code, T1040 (Medicaid-certified CCBHC services, per diem), without a modifier, for that recipient. CCBHCs must identify the T1040 code on claim line one, with all services provided to a recipient represented by their appropriate encounter code in other claim lines. In order for the PPS rate to be paid, one of the encounter codes identified among the other claim lines must be one of the valid billable encounter codes identified on the established code list. This code will be paid at the PPS rate that is specific to each individual CCBHC.

The CCBHC must submit appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Code (HCPC) codes that are aligned with CCBHC services. Providers are required to bill each service actually rendered on that day on separate claim lines. The State will identify service-level detail through a Medicaid fee-for-service claims submission process where each T1040 claim that is submitted will also include encounter codes to identify all services provided by the CCBHC. The T1040 code will be required for claim line 1, and all other services provided will be captured in other claim lines. CCBHC providers will utilize the Q2 modifier for all encounter codes on a claim line to identify the service-level details of each demonstration encounter. A modifier has been created for identifying services provided by DCOs.

CCBHCs have received training and TA associated with assembling and preparing data for the cost reporting process. DMHA and OMPP offered a cost report training for all selected demonstration sites in December 2023, and ICCMHC offered a larger cost reporting training in January 2024 with all CMHCs in the state to build long-term capacity to participate in the CCBHC program among the provider community. DMHA and OMPP have engaged the State's actuarial consultant for design of the cost reporting requirements, to establish initial rates, and to deliver TA to prospective CCBHCs. All demonstration sites have submitted cost reports and received feedback and guidance to remedy issues. At the end of DY 1, DMHA and OMPP will review DY

1 actual costs and visit data and rebase the rate as needed. Rebasing for DY 3 will similarly occur again after the close of DY 2. At this time, Indiana has not made a determination of the PPS rate methodology after DY 3, other than the required PPS rate rebase for DY 6.

Moving forward, DMHA and OMPP will work with the State's MMIS vendor to update the behavioral health provider reference module to reflect CCBHC and billing changes. This team will develop TA and written guidance materials related to the billing logic. DMHA and OMPP will monitor claims from CCBHCs on an ongoing basis and provide clarification and education when errors are made to ensure accurate claims submissions by CCBHCs.

Evaluator Access to Demonstration Program Data

Indiana is prepared to meet all CCBHC data collection and reporting requirements, including all required state-collected and clinic-collected measures in Appendix B of the CCBHC certification criteria. Indiana will ensure that the national evaluation team has access to cost reports, data on quality measures, and Medicaid claims. In addition, encounter data, patient records, patient experience of care data, state documents, and consumer survey data will also be made available as requested by the evaluators. WISE Indiana can facilitate recruitment for interviews and focus groups with State staff, CCBHC staff, and individuals served by CCBHCs as requested. These interviews and focus groups will be covered under the IU Institutional Review Board (IRB).

Deidentified client data will flow from the CCBHCs to the State, and a unique identifier will be used to link a client's records together. Historical data can be provided as needed. A data dictionary will be made available. Most data that evaluators will need to access are collected and stored by DMHA and OMPP in a structured query data (SQL) database. Data can be submitted in any format requested by the evaluators, including the formats of comma separated value (CSV) or flat files. Indiana has provided data to numerous entities, including federal partners, universities, and research organizations, and will work to ensure data is provided timely in the correct format.

In summary, Indiana's existing data systems – including EHRs at the CCBHCs, MMIS, and DARMHA – put the state in strong position to meet all data collection and reporting requirements associated with participation in the demonstration program, including all required metrics in Appendix B. This includes data reporting on: (1) Characteristics of people served; (2) Staffing; (3) Access to services; (4) Use of services; (5) Care coordination; (6) Costs; and (7) Outcomes. Moving forward, the State will further enhance its capacity for population health management and coordination across sites through the development of a shared data platform. This will enable the State to monitor both fiscal and outcomes data associated with CCBHC implementation, and support providers with CQI and efforts to address health disparities.

Section D: Participation in the National Evaluation of the Demonstration Program

Capacity and Willingness to Assist HHS in Accessing Relevant Data

Indiana is prepared to support federal evaluators' efforts to collect and analyze qualitative and quantitative data regarding topics relevant to the national evaluation design, such as:

- Activities the CCBHCs implemented to increase access to care

- Service utilization among CCBHC clients
- Care coordination services provided to CCBHC clients
- CCBHC staffing recruitment and retention
- DCO and care coordination partnerships
- Quality measures
- PPS structure and costs

Baseline data is available to support evaluation on several of these topics. For example, baseline data indicates that Medicaid beneficiaries served by the eight demonstration sites in CY 2022 collectively had 8,567 hospitalizations and 62,836 emergency department visits.

FSSA will leverage its ongoing relationship with WISE Indiana to support national demonstration evaluation efforts. In addition to serving on the DGC (described above), WISE Indiana will work with the State to ensure that the national evaluation team is able to access data related to the cost, quality, and scope of services provided by CCBHCs, as well as the impact of the demonstration programs on the federal and state costs for a full range of behavioral health services (including inpatient, emergency, and ambulatory services paid for through non-demonstration sources).

WISE Indiana has extensive experience working with FSSA to analyze Medicaid claims, encounter data, patient records, patient experience data, and chart-based/registry data. Since launching in 2019, WISE Indiana has partnered with FSSA on nearly 50 projects. A 2023 research paper published by WISE Indiana in the *JAMA Health Forum* summarized a cross-sectional study of more than 400,000 Indiana residents where untreated mental illness was associated with $4.2 billion in annual societal costs.[35] These findings were also published in a report from the BHC, adding further momentum to the state's CCBHC transformation and crisis system efforts.

Data leads from DMHA and OMPP will collaborate with WISE Indiana to provide the national evaluation team with input on data sources and performance measures. They will ensure that claims from CCBHCs can be identified and correspond to CMS-64 reporting and quality measure counts of clients for CCBHCs, that cost reports and CCBHC quality measures are submitted in a timely fashion, and that staff are available for any follow-up questions regarding submissions.

Indiana has experience working with national evaluators and can provide data in a variety of ways, in accordance with data definitions and protocols shared by the national evaluation team. For example, OMPP has supported evaluation efforts on the Indiana Pregnancy Promise program, an effort funded by the CMS Maternal Opioid Misuse Grant. The OMPP finance data team and health economists associated with WISE Indiana can support efforts to identify other sources of funding (i.e., other than the demonstration) to help evaluators assess cost implications in a holistic way.

Comparison Group

Indiana has not yet participated in discussions with the national evaluation team about comparison groups. FSSA data leads and WISE Indiana will work with national evaluators to identify potential comparison groups. This could include matching populations by geographic area or by demographics within the Medicaid population as a whole. Comparison could also be made by looking at data for Medicaid beneficiaries who received care from CCBHCs and beneficiaries who received care from other Indiana CMHCs, representing care as usual. We look forward to working with the evaluation team to determine the most appropriate approach to select comparison groups.

IRB Approach

The IU IRB will serve as IRB for this effort. FSSA has a long-standing relationship with the IU IRB for review and oversight of human subjects research. Each IU IRB has at least five members with varying backgrounds who are sufficiently qualified to provide advice and counsel in safeguarding the rights and welfare of human subjects. Indiana will prepare requests for IRB approval to collect and report on process and outcome data, as necessary. To obtain IRB approval, the State plans to coordinate with the national evaluation team prior to submitting a request for approval. FSSA's Science Officer and WISE Indiana have been consulted in the course of the development of this application, and they have committed to assisting in the IRB submission and approval process.

Section E: Projected Impact of the State's Participation in the Demonstration Program

Indiana's Selected Priority Measures of Impact

Goals for the Demonstration: Indiana envisions a future where all Hoosiers can access high-quality, community-based mental health and SUD services through a CCBHC. Through its participation, Indiana will pursue the following federal program goals:

Goal 1: Provide the most complete scope of services required in the CCBHC Criteria to individuals who are eligible for medical assistance under the state Medicaid program.
Goal 2: Improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program.

Indiana selected these goals with input from the FSSA Medicaid Policy Review Committee and Data and SDO planning workstream participants described in Section A. These goals were selected for their alignment with state behavioral health needs (summarized in Attachment 3), and state priorities for improving the community behavioral health system, including: (1) Increasing access and availability of CCBHC services; (2) Increasing retention in services; (3) Addressing SDOH among individuals with behavioral health needs; (4) Increasing initiation in SUD treatment; (5) Increasing access to evidence-based care; and (6) Building a robust, responsive crisis response system in local communities. Goal 1's focus on CCBHC's complete scope of services and Goal 2's focus on access and engagement, are well-aligned with Indiana's strategy to improve behavioral health outcomes for Medicaid beneficiaries through CCBHC's holistic, person-centered, integrated model.

Indiana has identified four priority impact measures for the demonstration. These measures are drawn from Appendix B of the SAMHSA CCBHC certification criteria and align with the federal government's overarching goals for the program, as noted in Table 9. Indiana's impact measurement efforts will focus on Medicaid populations served by CCBHCs.

Table 9 – Summary of Indiana's Priority Impact Measures

	State Goal for Impact	Primary Measure*	Secondary Measure	Aligned with Federal Goal
1	Decrease average time to access CCBHC services.	I-SERV	Early drop-out	Goal 2
2	Increase screening for SDOH and use information to make data-informed decisions.	SDOH Screening	N/A	Goal 1
3	Increase initiation in SUD treatment.	IET-AD	N/A	Goal 2
4	Enhance access to crisis services.	I-SERV	Crisis service utilization	Goal 1
* All primary measures drawn from Appendix B.				

For each impact goal, Indiana has provided information below about (1) Measures; (2) State efforts to date; (3) Relevant baseline data; (4) Projections for impact during the demonstration period; and (5) Plans for data collection, documentation, tracking and analysis to measure progress.

Impact Measure 1: Decrease average time to access CCBHC services.

Measures: I-SERV (including sub-measures of average time to: Initial Evaluation, Initial Clinical Services, Crisis Services); Early drop-out (state analysis of encounter data)

State Efforts to Date: Access to care, especially access to clinical services, has been a consistent challenge in Indiana's community behavioral health system. Feedback gathered during the planning process from populations of focus indicated that it can take an unacceptably long time to access services. To more consistently evaluate time to service, in July 2023, DMHA added First Contact Date to clinic reporting requirements in DARMHA. This is an essential data point to calculate time to initial evaluation and initial clinical service. Early drop-out (defined as dropping out before the fourth service) has not typically been analyzed by DMHA, but we see the demonstration as an important opportunity to measure CCBHC's impact on engagement.

Baseline Data: Pulling data from episodes that started 7/1/23-12/31/23, for the eight demonstration sites, the average time between **first contact and initial evaluation is 12 days**. The average time between **first contact and initial clinical service is 23 days**. DMHA will also monitor early drop-out rate. Analyzing the above data, **31% of new clients dropped out before the fourth service**.

Projections for Impact: Access to care was identified as a challenge from the state needs assessment and baseline data gathered from participating demonstration sites, and therefore a priority for the State to assess CCBHC's impact. Prompt access to care allows individuals to receive timely assessments, personalized treatment plans, and early interventions. When people seeking care experience shorter wait times, they are more likely to stay engaged in treatment. This in turn increases treatment adherence and reduces the risk of drop-out, leading to improved outcomes at the population level.

The following targets are designed to monitor providers' attainment of state-specific certification requirements, which require people receiving services from the CCBHC to be provided with an appointment for routine outpatient clinical services within 10 business days of the request. While we expect implementation of the CCBHC model to improve timely access, we also recognize that access is a complex issue to address at the provider level that touches on staffing, payment, administrative burden, and other factors. With this in mind, DMHA has set the following incrementally increasing goals for impact during each DY.

Impact Measure #1: Decrease average time to access CCBHC Services	
DY 1	Decrease average business days between first contact and initial clinical service to 20 days.
DY 2	Decrease average business days between first contact and initial clinical service to 17 days.
DY 3	Decrease average business days between first contact and initial clinical service to 14 days.
DY 4	Decrease average business days between first contact and initial clinical service to 10 days.

Plan for data collection, documentation, tracking, and analysis to measure progress: Clinic-submitted data via DARMHA will be the primary source of data for this impact measure. To assure data quality, providers have direct access to several reports in DARMHA that will allow them to review data quality (including first contact date, initial evaluation encounter, and CCBHC service). This report can also be used to identify clients who may need follow-up. The DGC will oversee efforts to collect, analyze, and disseminate timely outcomes data to state leaders and the eight CCBHC sites. Quality dashboards will be developed describing aggregate and clinic-level performance. Providers will receive updates on their performance related to state benchmarks at least quarterly, and be able to run reports on demand. Benchmarks will be calculated using data collected across the eight demonstration sites. The DGC will complete quarterly progress reports for the Medicaid Policy Review Committee that will analyze and track data related to this impact measure to inform strategy.

Impact Measure 2: Increase screening for SDOH and use information to make data-informed decisions.

Measure: SDOH Screening

State Efforts to Date: Since 2009, DARMHA has required the Adult Needs and Strengths Assessment (ANSA) for all adults receiving care from CMHCs at admission, every six months, and at discharge. While this approach will change for participating CCBHCs during the demonstration program to reduce administrative burden, widespread ANSA data collection has resulted in robust baseline data that can be leveraged for impact measurement. During the demonstration, DMHA will add more SDOH questions in DARMHA so that it can track not only whether an SDOH screening is completed, but also the identified social needs of CCBHC clients. This knowledge can inform future programming and help identify potential health disparities.

Baseline Data: Three CCBHC-required SDOH items have been included in the ANSA: interpersonal safety, housing instability, and transportation needs. Of the 31,906 Medicaid beneficiaries served in CY 2022, **27,427 (86%) were assessed**. Of those assessed, **6,732 had an interpersonal safety need**, **6,322 had a transportation need**, and **5,396 had housing instability**.

Projections for Impact: State needs assessment and baseline data demonstrate a clear need to address SDOH. By gathering information about SDOH more consistently, providers can enhance patient outcomes and promote health equity. While screening levels are already relatively high among participating demonstration sites, CCBHC providers will be transitioning to new SDOH screening tools and/or processes. We anticipate there may be a potential decline in DY 1, but aim to exceed current numbers by DY 3.

Impact Measure #2: Increase screening for SDOH	
DY 1	At least 80% of clients are screened.

DY 2	At least 85% of clients are screened.
DY 3	At least 90% of clients are screened.
DY 4	At least 95% of clients are screened.

Plan for data collection, documentation, tracking, and analysis to measure progress: In DY 1, DMHA will add two more measures related to screening for SDOH needs to DARMHA: food insecurity and difficulties with utilities. This will enable DMHA to analyze more complete information on CCBHC clients' social needs. In DY 2, SDOH data will be incorporated into the quality dashboards developed for providers and state leaders so that health disparities can be identified. These activities will help track CCBHC progress on consistent screening for SDOH, while also providing information on client needs. DMHA will use information gathered to drive TA for CCBHCs around care coordination, and inform FSSA strategic investments in addressing housing, transportation, food, utility, and other needs.

Impact Measure 3: Increase initiation in SUD treatment.

Measure: Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)

State Efforts to Date: Indiana has made significant investments in its SUD service infrastructure, including SUD treatment program expansion and investment in the Indiana Recovery Network peer recovery infrastructure. However, drug overdose deaths involving opioids have continued to rise dramatically from 1,098 deaths in 2018 to 2,205 deaths in 2021.[36] Increasing initiation of evidence-based treatment for SUD is imperative.

Baseline Data: OMPP's data vendor ran the IET-AD measure for CY 2022 DMHA Supported Consumers with Medicaid IDs. The results for this population were **40.14**% initiated treatment within 14 days of diagnosis and **23.91**% initiated and engaged in ongoing treatment within 34 days of the initiation visit. The results for the dual-eligible population (Medicare and Medicaid) were **30.61%** initiated treatment within 14 days of diagnosis and **11.84%** initiated and engaged in ongoing treatment within 34 days of the initiation visit.

Projections for Impact: CCBHCs reduce barriers and prevent delays in accessing SUD treatment, including evidence-based medications for opioid use disorder (MOUD). Indiana has set the following impact projections based on a review of baseline among demonstration sites and comparison to NCQA 2022 national benchmark data for Medicaid HMOs on this measure (45%).[37] Indiana's baseline data indicates opportunities to enhance initiation of SUD treatment to reach national benchmarks.

Impact Measure #3: Increase initiation in SUD treatment	
DY 1	**41.35%** of Medicaid beneficiaries receiving care from a CCBHC initiate treatment within 14 days of a SUD diagnosis.
DY 2	**42.57%** of Medicaid beneficiaries receiving care from a CCBHC initiate treatment within 14 days of a SUD diagnosis.
DY 3	**43.79%** of Medicaid beneficiaries receiving care from a CCBHC initiate treatment within 14 days of a SUD diagnosis.
DY 4	**45.0%** of Medicaid beneficiaries receiving care from a CCBHC initiate treatment within 14 days of a SUD diagnosis.

Plan for data collection, documentation, tracking, and analysis to measure progress: This measure is part of the CMS Core Set. The State's Medicaid data vendor will pull data on this measure on a quarterly basis for Medicaid clients served by the demonstration sites. Key metrics will be incorporated into reports for the Medicaid Policy Review Committee, the DGC, and participating demonstration sites.

Impact Measure 4: Enhance access to crisis services.

Measure: I-SERV (sub-measure focused on Crisis Services); Crisis service utilization

State Efforts to Date: Indiana is building statewide crisis services in coordination and alignment with 988. All pilot site CCBHCs are, or will begin by the start of demonstration, operating mobile crisis and crisis receiving and stabilization services (CRSS). We anticipate utilization to increase as more Hoosiers become aware of 988, DMHA works to increase interoperability between 988 and 911/law enforcement response, and the relationship between 988 and CCBHCs deepens.

Baseline Data: Even though there was no Medicaid funding for mobile crisis services until July 2023, pilot mobile crisis teams served **4,483 individuals (3,268 via mobile crisis** and **1,215 individuals via CRSS)**. In CY 2023, the average time between first contact and crisis service among pilot mobile crisis teams was **1.04 hours**.

Projections for Impact: Indiana is expanding crisis services throughout the state, in close partnership with CCBHCs. As new mobile crisis teams come onboard, it will take time for each team to optimize operations. Indiana's baseline of 1.04 hours for mobile crisis response is within federal guidelines. In light of the anticipated rapid increase in the number of mobile teams, Indiana's goals for the demonstration are to maintain stability in the state's average response time. Indiana's goals for utilization are based on a 5% approximate increase in individuals provided crisis services by CCBHC mobile crisis teams and crisis stabilization units. The 5% yearly growth was established off trends in pilot mobile crisis team and CRSS growth trajectories year over year.

Impact Measure #4: Enhance access to crisis services	
DY 1	**Over 4,700 individuals served** by pilot mobile crisis teams or CRSS.
DY 2	**Over 4,900 individuals served** by pilot mobile crisis teams or CRSS.
DY 3	**Over 5,100 individuals served** by pilot mobile crisis teams or CRSS.
DY 4	**Over 5,350 individuals served** by pilot mobile crisis teams or CRSS.
Each Year	**Crisis response time remains stable through this growth.**

Plan for data collection, documentation, tracking, and analysis to measure progress: The State will capture crisis service utilization through analysis of Medicaid claims. As described under Impact Measure #1, I-SERV data will be collected via DARMHA and enable providers to run reports for data quality and to inform program implementation. Quality reports that include aggregated and clinic-level performance will be shared with providers and state leaders at least quarterly.

Tracking CCBHC Quality Measures

Table 10 – Additional CCBHC Quality Measures

While the four impact measures above will be priorities for Indiana, the State will monitor data associated with all required CCBHC quality measures to inform program implementation. Indiana will also track optional CCBHC measures noted in Table 10. Indiana selected these additional optional measures because they align with state needs, including: integrated physical and behavioral health; increased access to suicide prevention services through CCBHCs; and increased access to evidence-based care for children and youth. Indiana will analyze data on outcomes at the CCBHC and state level to demonstrate impact and return on investment.

Tobacco Use and Physical Health (TSC): Via this measure, Indiana will track CCBHC efforts to provide integrated physical/behavioral health care.
Suicide Prevention (SRA, SRA-A): The SRA measure is linked to Indiana's efforts to increase access to evidence-based suicide prevention services through CCBHCs.
Increasing Access to Evidence-Based Care for Children and Adolescents (APP-CH): This measure will enable the State to monitor whether children/youth accessing care are receiving safer, first-line psychosocial interventions.

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