



Indiana Health & Human Services System Market Profile: 2024



Health & Human Services Market Profile Overview

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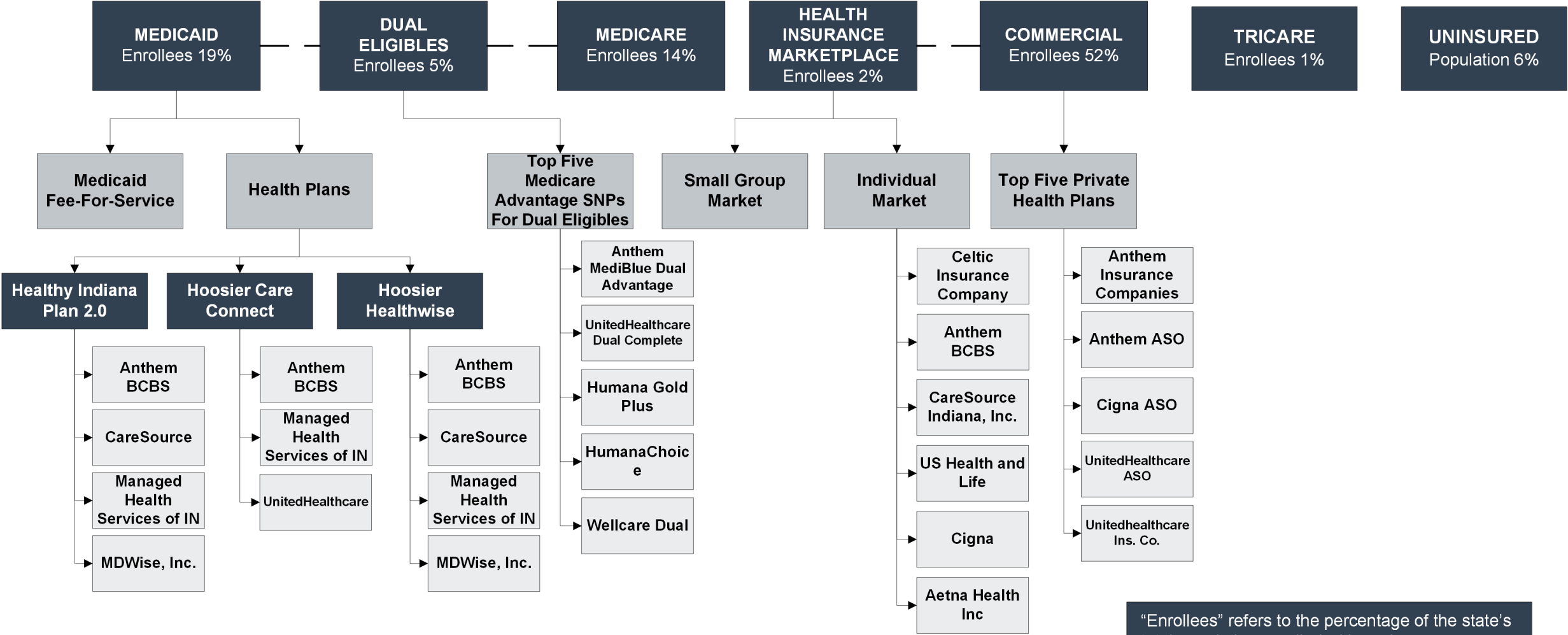
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A. Executive Summary

A.1. Indiana Physical Health Care Coverage by Payer

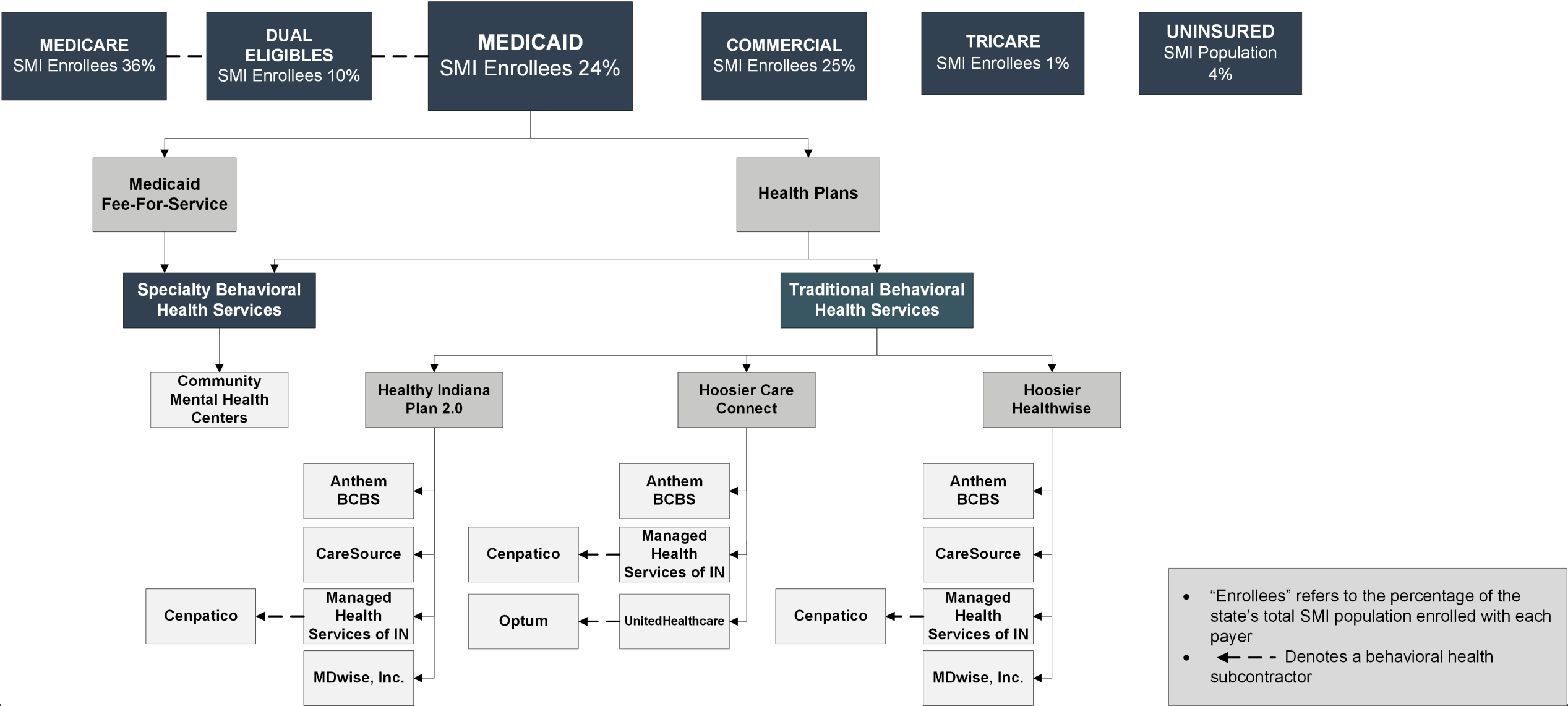
Total Indiana Population- 6,833,037
Estimated SMI Population- 546,643



Totals may not equal 100% due to rounding.

“Enrollees” refers to the percentage of the state’s total population enrolled with each payer.

A.1. Indiana Behavioral Health Care Coverage by Payer



A.2. Health & Human Services Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Hoosier Care Connect health plans are responsible for coordinating care for their enrollees.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home		None
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Indiana currently operates ten CCBHCs.

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Office of Primary Care in the Indiana State Department of Health is responsible for providing physical health services to the safety-net population.

Mental Health Services

- The Division of Mental Health and Addiction (DMHA) within the Indiana Family and Social Services Administration provides mental health and addiction treatment services to the safety-net population by contracting with community mental health centers (CMHCs) and other provider organizations.

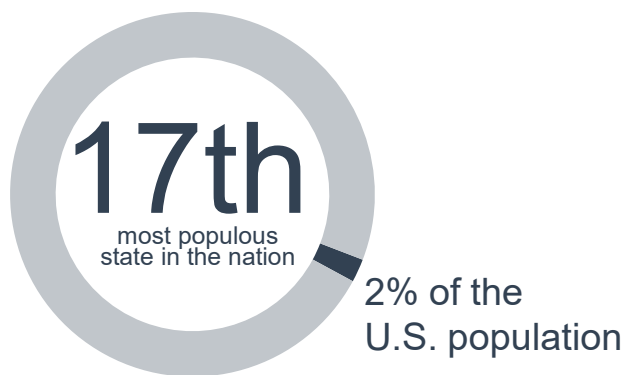
Addiction Treatment Services

- The Division of Mental Health and Addiction (DMHA) within the Indiana Family and Social Services Administration provides mental health and addiction treatment services to the safety-net population by contracting with CMHCs and other provider organizations.

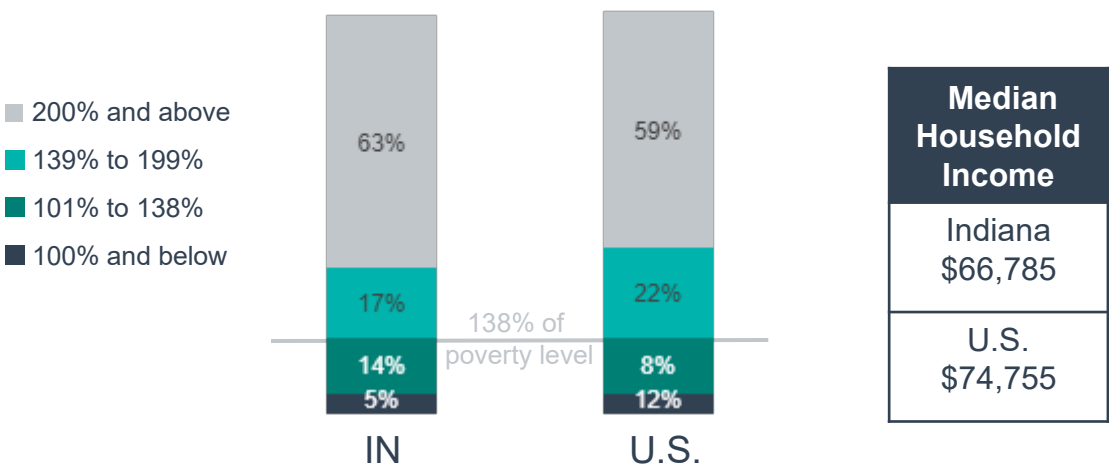
B. Indiana Health Financing System Overview

B.1. Population Demographics

Total Indiana Population- 6,833,037
Estimated SMI Population- 546,643



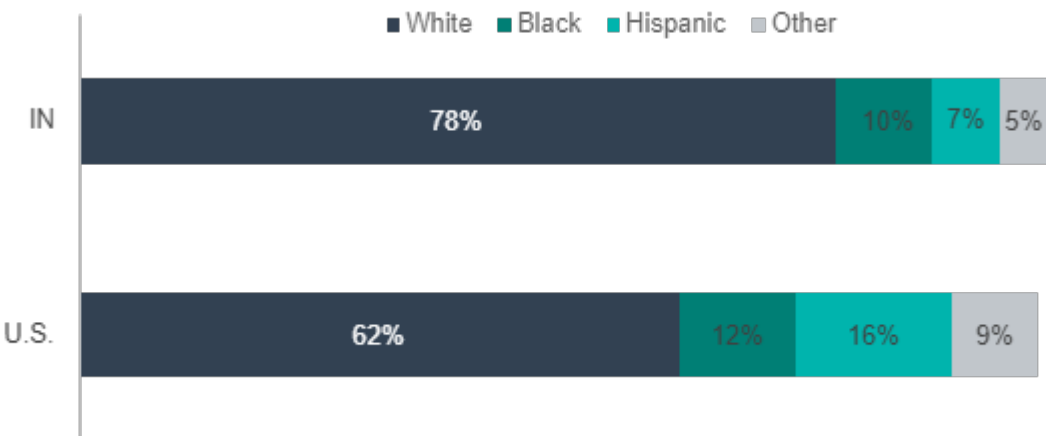
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age



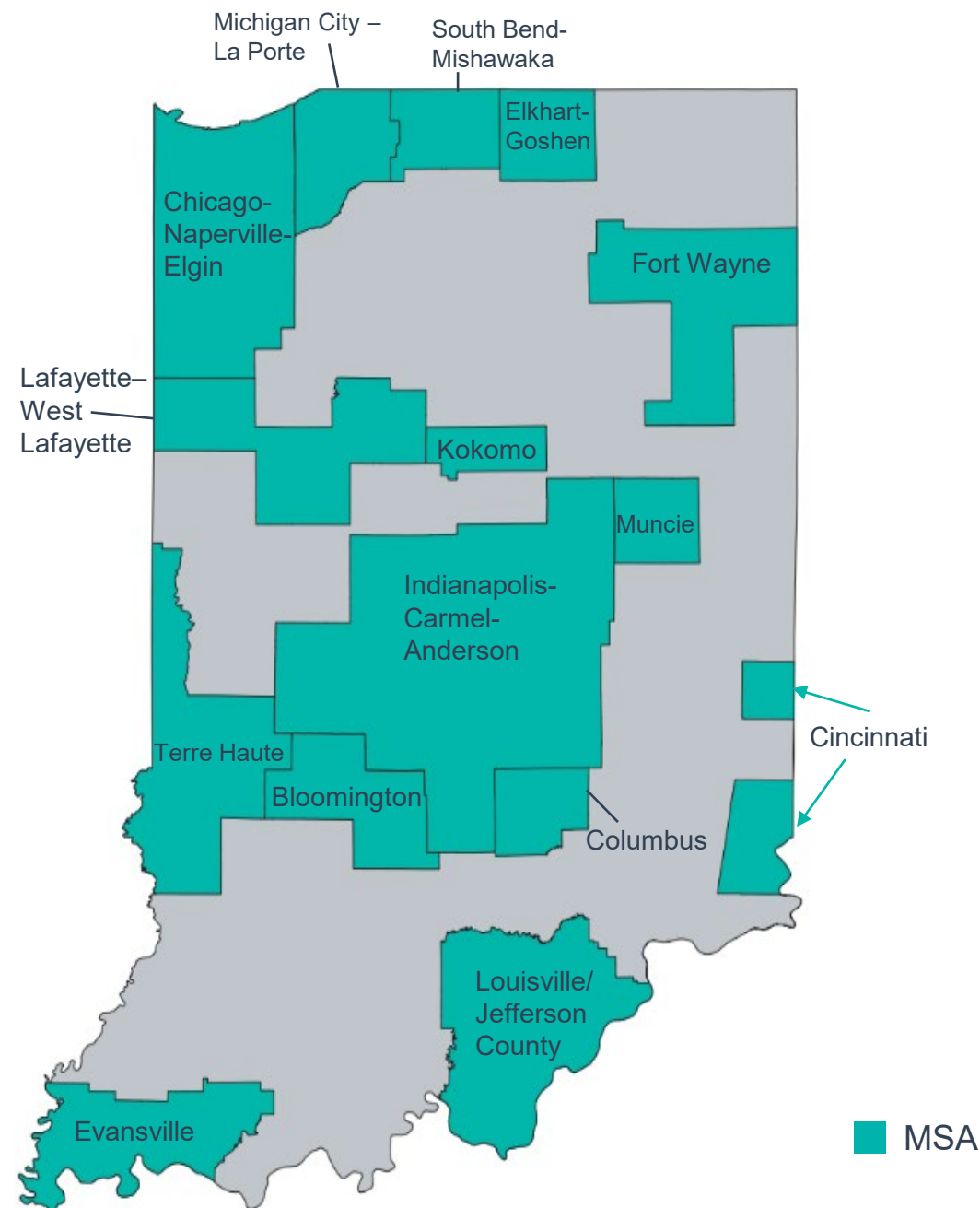
Indiana & U.S. Racial Composition



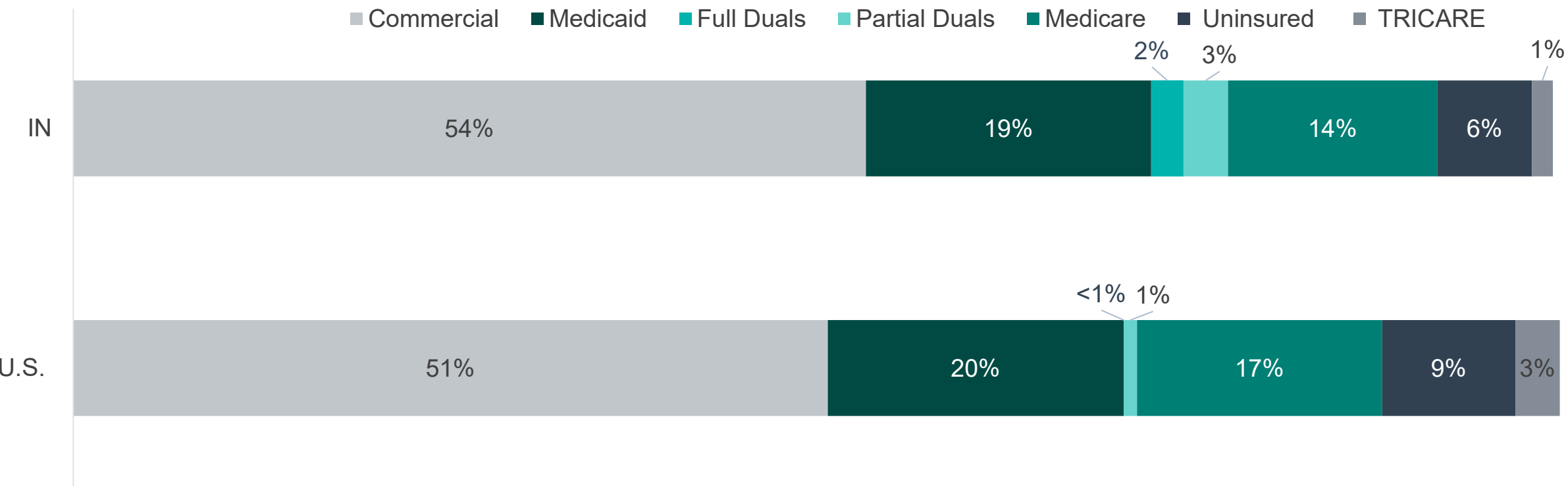
Totals may not equal 100% due to rounding.

B.2. Population Centers

Metropolitan Statistical Areas (MSAs)		
MSA	MSA Residents	Percent Of Population
Total MSA Population	17,603,054	-
Chicago-Naperville-Elgin, IN-IL-WI	9,441,957	-
Cincinnati, OH-KY-IN	2,271,479	33%
Indianapolis-Carmel-Anderson, IN	2,141,779	31%
Louisville-Jefferson County, KY-IN	1,365,557	20%
Fort Wayne, IN	457,842	7%
South Bend-Mishawaka, IN-MI	324,490	5%
Evansville, IN-KY	314,038	5%
Lafayette-West Lafayette, IN	226,564	3%
Elkhart-Goshen, IN	206,409	3%
Terre Haute, IN	168,787	2%
Other MSAs	684,152	10%

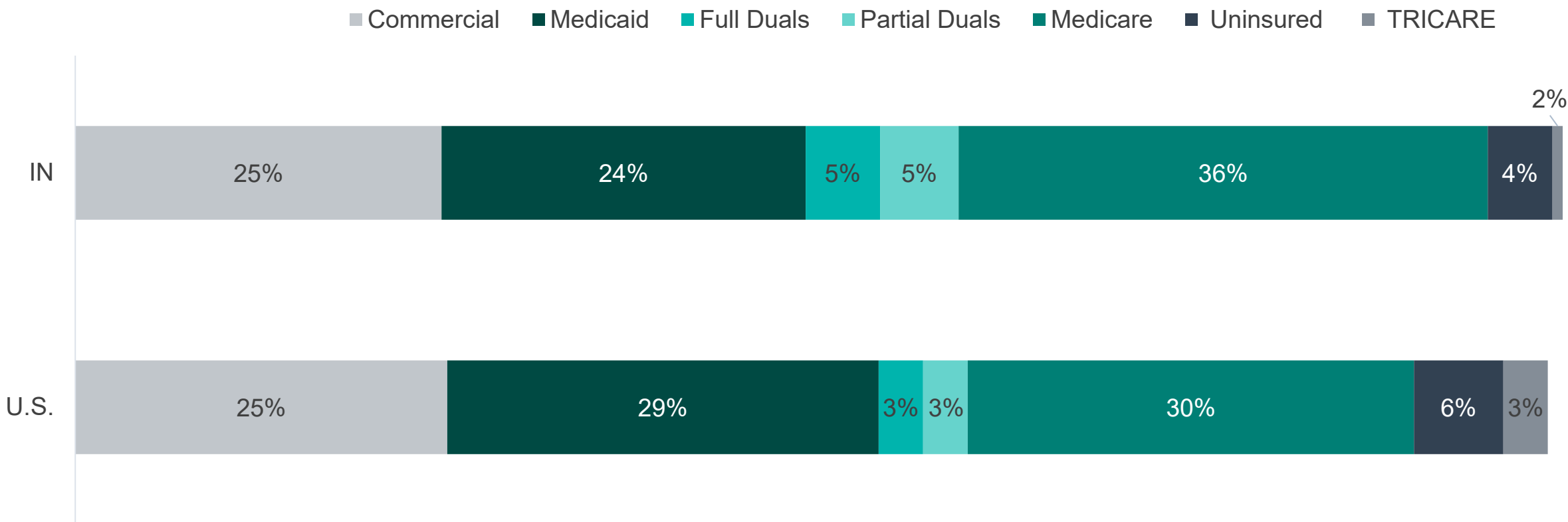


B.3. Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding.

B.3. SMI Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding.

B.4. Largest Indiana Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
Anthem Insurance Companies	Commercial	2,044,593
Medicare Fee-for-Service (FFS)	Medicare	682,495
Anthem ASO	Commercial administrative services only (ASO)	393,940
Anthem MediBlue Dual Advantage	Medicare Advantage	390,885
Medicaid FFS	Medicaid	351,447
Anthem Blue Cross and Blue Shield	Medicaid managed care – Healthy Indiana	339,223
Anthem Blue Cross and Blue Shield	Medicaid managed care – Hoosier Healthwise	316,365
UnitedHealthcare ASO	Commercial ASO	260,330
MDWise	Medicare managed care – Hoosier Healthwise	209,158
Managed Health Services	Medicaid managed care – Hoosier Healthwise	182,281

*Medicaid enrollment as of March 2023; TRICARE as of December 2023; Commercial as of March 2023; Medicare enrollment as of March 2023

B.4. Largest Indiana Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicare FFS	Medicare	682,495	154,926
Anthem Insurance Companies	Commercial	2,044,593	85,873
Anthem MediBlue Dual Advantage	Medicare Advantage	390,885	82,086
Medicaid FFS	Medicaid	351,447	40,768
Anthem Blue Cross and Blue Shield	Medicaid managed care – Healthy Indiana	339,223	39,350
Anthem Blue Cross and Blue Shield	Medicaid managed care – Hoosier Healthwise	316,365	36,698
Care Improvement Plus South Central Insurance Company	Medicare Advantage	146,947	33,357
UnitedHealthcare	Medicare Advantage	130,314	29,581
MDWise	Medicaid managed care – Hoosier Healthwise	209,158	24,262
Arcadian Health Plan, Inc	Medicare Advantage	101,464	23,032

*Medicaid enrollment as of March 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Insurance Marketplace Percent	3%
Type of Marketplace	Federal
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group health plans available

2024 Individual Market Health Plans
1. Anthem Blue Cross Blue Shield 2. CareSource Indiana, Inc. 3. Celtic Insurance Company/ MHS/Ambetter 4. US Health and Life 5. Cigna 6. Aetna Health, Inc
2024 Small Group Market Health Plans
None

B.6. Accountable Care Organizations

Medicare Shared Savings ACOs	
1.	AHN Accountable Care Organization
2.	American Health Network of Ohio Care Organization
3.	Ascension Care Management Health Partners Evansville, LLC
4.	Ascension Care Management Health Partners Indianapolis, LLC
5.	Baptist Health Care Partners, LLC
6.	Caravan Health ACO 22, LLC
7.	Caravan Health ACO 23, LLC
8.	CareConnectMD ACO, Inc
9.	CHA ACO, LLC
10.	CHSPSC ACO 2, LLC
11.	CHSPSC ACO 9, LLC
12.	Community Healthcare Partners ACO
13.	Doctors ACO, LLC
14.	Franciscan ACO
15.	Healthcare Solutions Network, LLC
16.	Indiana Lakes ACO
17.	Ingalls Care Network, LLC
18.	Inspire Health Partners, LLC
19.	Mercy Health Select, LLC
20.	Quality Independent Physicians
21.	The Accountable Care Organization, Ltd
22.	Trinity Integrated Care, LLC
23.	University of Chicago Care Network Accountable Care Organization, LLC
24.	VillageMD Chicago ACO, LLC

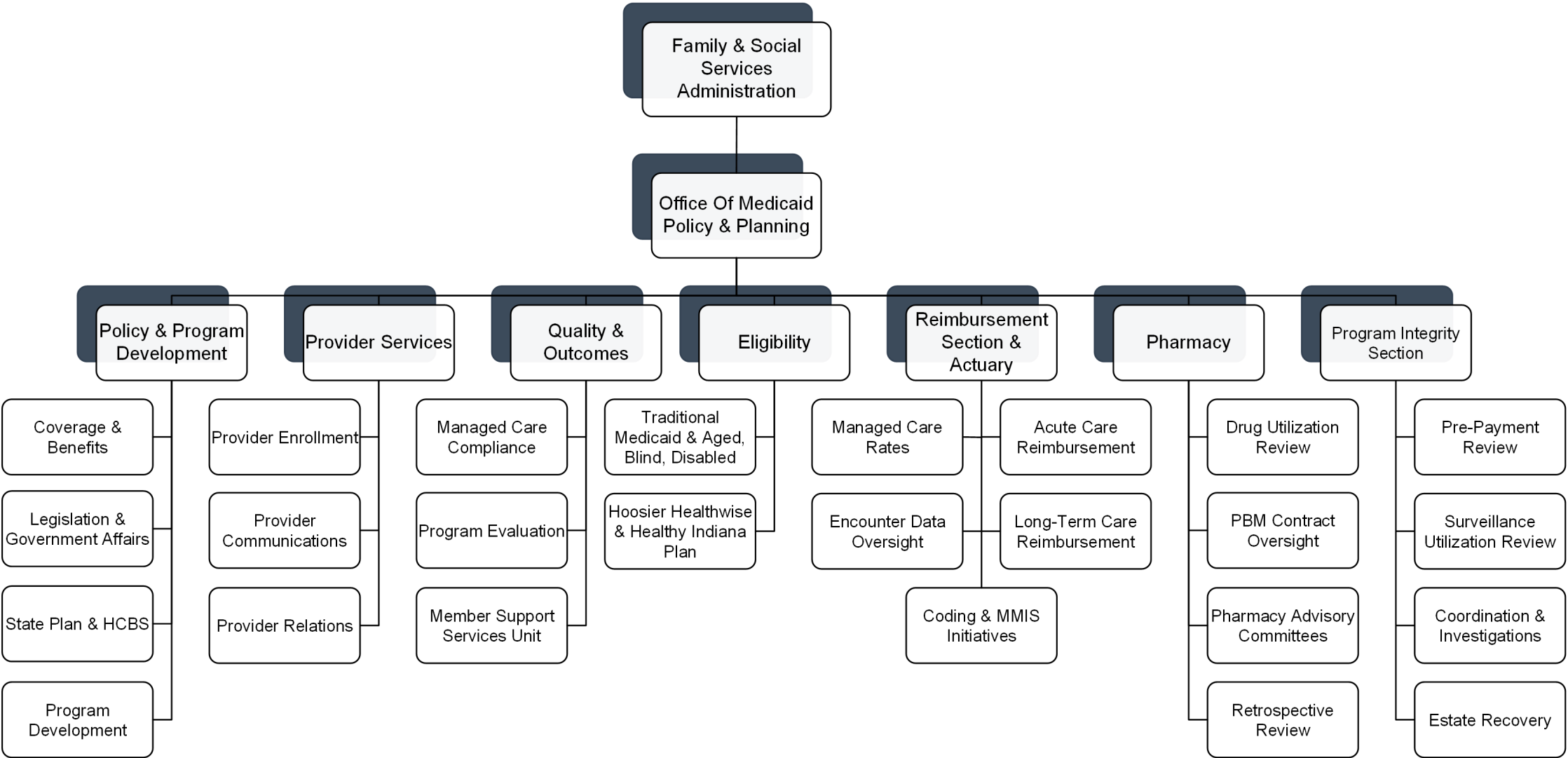
ACO REACH Model	
1.	Indiana University Health ACO, Inc

End-Stage Renal Disease ACOs	
1.	Fresenius Seamless Care of Indianapolis

Commercial ACOs	
ACO	Commercial Insurer
Franciscan ACO, Inc	Anthem Blue Cross Blue Shield, Cigna, UnitedHealthcare

C. Medicaid Administration, Governance & Operations

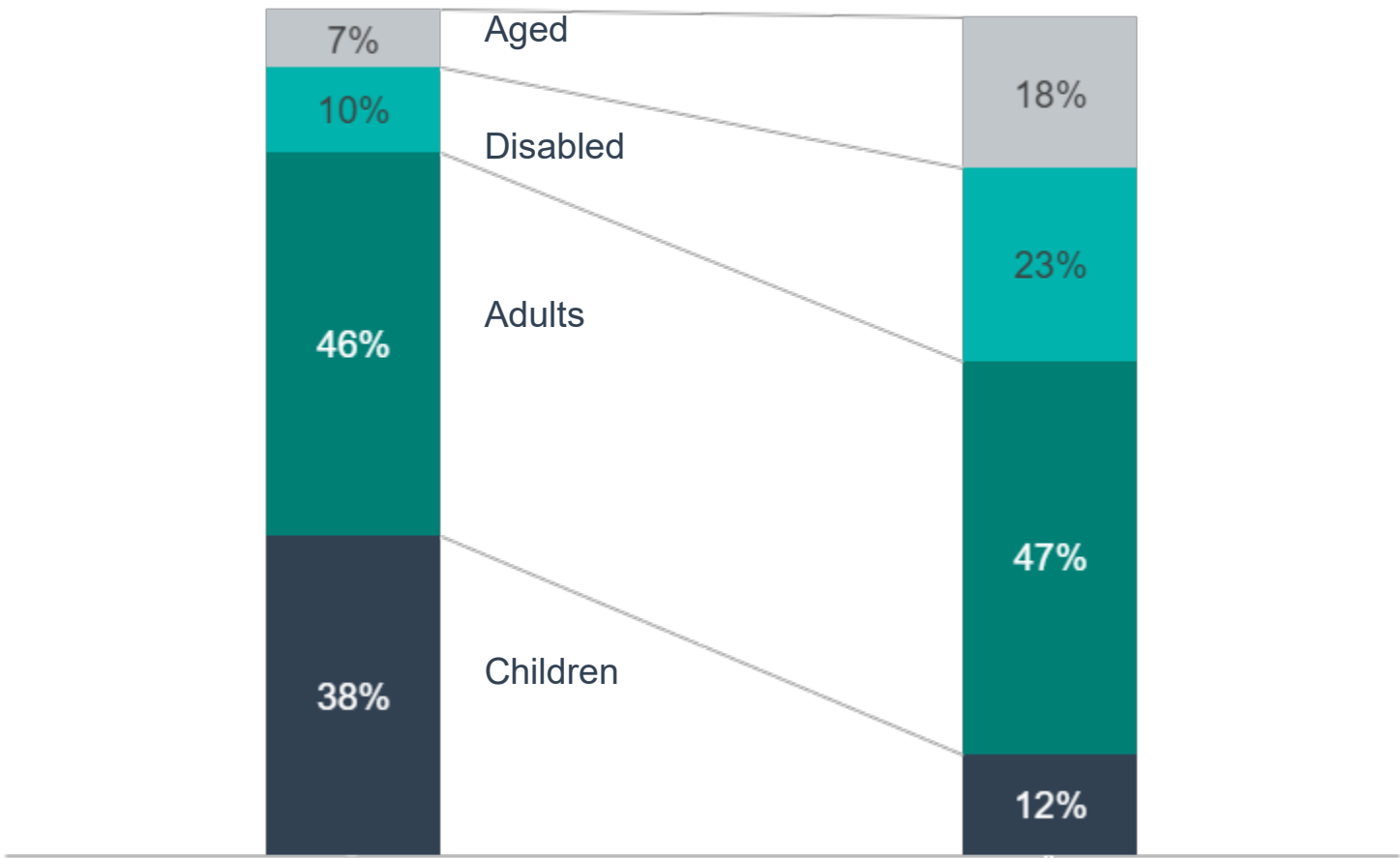
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Daniel Rusyniak, MD	Secretary	Family & Social Services Administration (FSSA)	daniel.rusyniak@fssa.in.gov
Kim Opsahl	Deputy Secretary & Chief of Staff	FSSA	kimberly.opsahl@fssa.in.gov
Cora Steinmetz	Medicaid Director	FSSA, Office of Medicaid & Policy Planning	cora.steinmetz@fssa.in.gov
Lindsey Lux Kleman, MHA	Chief of Staff & Deputy Director	Office of Medicaid & Policy Planning	lindsey.lux@fssa.in.gov
Holly Cunningham Piggott, MPM	Director of Care Programs	Office of Medicaid & Policy Planning	holly.cunninghampiggott@fssa.in.gov
Michael Cook	Director, Provider Services	Office of Medicaid & Policy Planning	michael.cook@fssa.in.gov
Nonis Spinner	Director, Eligibility & Member Services	Office of Medicaid & Policy Planning	nonis.spinner@fssa.in.gov
Kathy Leonard, FSA	Director, Reimbursement & Actuarial Services	Office of Medicaid & Policy Planning	kathleen.leonard@fssa.in.gov

C.2. Medicaid Program Spending By Eligibility Group



Percent of Total Medicaid Population

Percent of Total Medicaid Spending

Based on FY 2021 data

Totals may not equal 100% due to rounding.

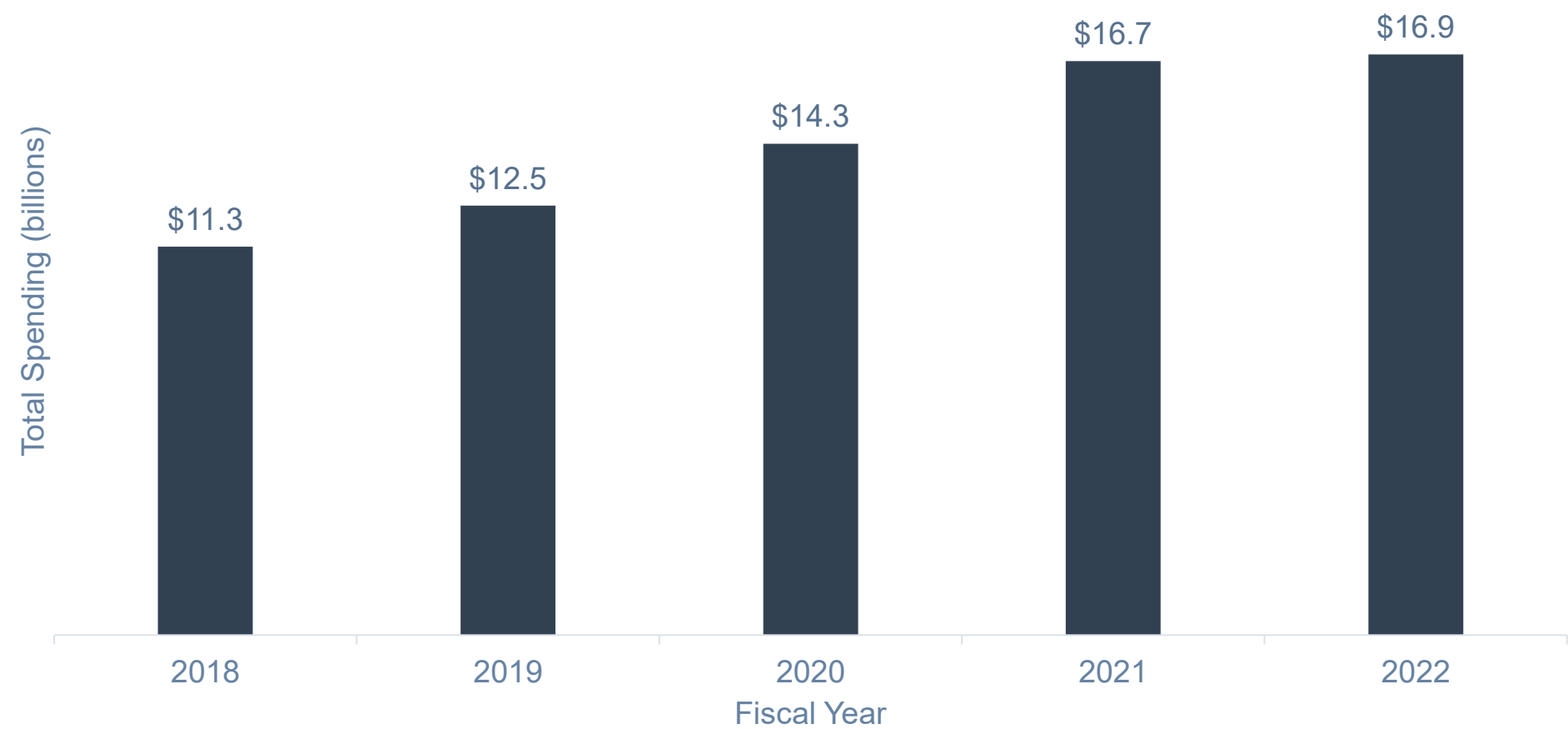
Medicaid Spending Per Enrollee, FY 2021		
	U.S.	IN
All populations	\$8,651	\$8,852
Children	\$3,584	\$2,883
Adults	\$5,462	\$9,424
Expansion adults	\$7,486	\$9,020
Blind and disabled	\$23,935	\$19,590
Aged	\$18,514	\$23,217

C.2. Medicaid Program Spending: Budget

Budget Item	SFY22 Spending	Percent Of Budget
Managed care and premium assistance	\$8,369,000,000	49%
Institutional LTSS	\$3,039,000,000	18%
Home- and community-based LTSS	\$2,250,000,000	13%
Hospital	\$1,438,000,000	9%
Other acute services	\$794,000,000	5%
Medicare premiums and coinsurance	\$409,000,000	2%
Physician	\$220,000,000	1%
Clinic and health center	\$197,000,000	1%
Drugs	\$161,000,000	1%
Dental	\$23,000,000	<1%
Other practitioner	\$11,000,000	<1%
Budget Total: \$16,911,000,000		

Federal & County Financial Participation	
FY 2024 Federal Medical Assistance Percentage (FMAP)	65.6%
CY 2024 Newly Eligible FMAP (expansion population)	88.0%
Counties contribute to state Medicaid share	Yes

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	February 2015
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of the Federal Poverty Level (FPL); 17% of FPL for adults and caretaker relatives Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded when determining eligibility.
Legislation Used To Expand Medicaid	Senate Enrolled Act 461, First Regular Session, 117 th General Assembly
Number Of Individuals Enrolled In The Expansion Group (October 2023)	614,714
Number Of Enrollees Newly Eligible Due To Expansion	614,714
Benefits Plan For Expansion Population	• The state uses multiple benefit packages to serve the Medicaid expansion population. See section D.3. for more information. • Medically frail individuals must be offered the full array of state plan services. • Individuals with SMI or chronic addiction disorder are who are considered medically frail

C.4. Medicaid Program Benefits

Federally Mandated Services	
1.	Inpatient hospital services other than services in an institution for mental disease (IMD)
2.	Outpatient hospital services
3.	Rural Health Clinic services
4.	Federally Qualified Health Center (FQHC) services
5.	Laboratory and x-ray services
6.	Nursing facilities for individuals 21 and over
7.	Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8.	Family planning services and supplies
9.	Free standing birth centers
10.	Pregnancy-related and postpartum services
11.	Nurse midwife services
12.	Tobacco cessation programs for pregnant women
13.	Physician services
14.	Medical and surgical services of a dentist
15.	Home health services
16.	Nurse practitioner services
17.	Non-emergency transportation to medical care

Indiana's Optional Services	
1.	Podiatry services
2.	Optometry services
3.	Chiropractic services
4.	Other practitioners' services
5.	Private duty nursing
6.	Medical supplies
7.	Clinic services
8.	Dental services
9.	Physical, occupational, and speech therapy
10.	Prescribed drugs
11.	Dentures, prosthetic devices, and eyeglasses
12.	Diagnostic, screening, and preventive services
13.	Inpatient services in IMDs for persons over 65
14.	Intermediate care facility services
15.	Public institution services for I/DD
16.	Hospice care
17.	Respiratory care
18.	Care in religious non-medical institutions
19.	Nursing facility services for persons under 21

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (May 2024)	351,704	1,559,598
SMI Enrollment	- Indiana does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI. As a result, the majority of the SMI population is enrolled in managed care. <i>OPEN MINDS</i> estimates 82% of the SMI population in managed care; 18% in FFS	
Management	- Office of Medical Policy and Planning - Prior Authorization and Utilization Management are handled by DXC Technology.	Physical & Traditional Behavioral Health: - Hoosier Care Connect: Three health plans - Hoosier Healthwise: Four health plans - Healthy Indiana Plan 2.0: Four health plans - Specialty Behavioral Health: Office of Medicaid Policy and Planning
Payment Model	FFS	- Hoosier Care Connect & Healthwise: Capitated rate - Healthy Indiana Plan 2.0: Capitated rate with deductible and benefit limits - Specialty Behavioral Health: FFS
Geographic Service Area	Statewide	Statewide

Total Medicaid: 1,911,302 | Total Medicaid With SMI: 221,71

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment		
Total Medicaid population distribution		As of May 2024: 18% in fee-for-service (FFS), 82% in managed care
SMI population inclusion in managed care		• Indiana does not specifically preclude individuals with SMI from enrolling in managed care; therefore, the majority of SMI population is enrolled in managed care. • Estimated 18% of population in FFS, 82% in managed care
Dual eligible population inclusion in managed care		• Dual eligibles are excluded from managed care and mandatorily enrolled in FFS. Additionally, they have an option for a D-SNP, which is managed care. • Estimated 100% of population in FFS, 0% in managed care
Long-term services and supports population inclusion in managed care		• The LTSS population is excluded from managed care and enrolled in FFS.
Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	All managed care population: Included in the health plan’s capitation rate
Specialty behavioral health	Covered FFS by the state	All managed care population: Excluded from the health plan’s capitation rate, covered FFS by the state
Pharmaceuticals	Covered FFS by the state	All managed care programs: Included in the health plan’s capitation rate
Long-term services and supports (LTSS)	Covered FFS by the state	Covered FFS by the state

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Hoosier Care Connect health plans are responsible for coordinating care for their enrollees.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home		None
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Indiana currently operates ten CCBHCs.

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	X		
Medicaid expansion			X
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Individuals in foster care		X	
Other populations	• End-stage renal disease or breast and cervical cancer waiver recipients • Hospice services in an institutional setting • Individuals receiving home- and community-based services (HCBS) • Refugees • Emergency Services only	• American Indians/Alaska Natives • Wards of the state • Former foster care children • Children receiving adoption assistance	• Individuals receiving Supplemental Security Income (SSI) • Pregnant individuals • Medically frail individuals • M.E.D. Works enrollees (persons with disabilities who hold jobs)

D.2. Medicaid FFS Program: Overview

- As of May 2024, FFS enrollment was 351,704.
- Indiana calls its FFS program Traditional Medicaid.
- Prior authorization and utilization management claims are handled by DXC Technology.

D.2. Medicaid FFS Program: Behavioral Health Benefits

FFS Mental Health Benefits	FFS Addiction Treatment Benefits	FFS Medicaid Rehabilitation Option (MRO) Services
1. Standard and intensive outpatient services 2. Neuropsychology 3. Psychological testing 4. Outpatient mental health hospital services 5. Inpatient psychiatric services provided to eligible individuals between age 22 and 64 only in a certified psychiatric hospital of 16 beds or more 6. Bridge appointments 7. Partial hospitalization 8. Psychiatric residential treatment facilities for individuals under age 21 9. Peer recovery services 10. Crisis intervention 11. MRO services 12. Inpatient psychiatric facility for individuals under age 22	1. Screening and brief intervention 2. Outpatient addiction services 3. Inpatient substance abuse services provided to eligible individuals between 22 and 64 years old only in a certified psychiatric hospital of 16 beds or more 4. MRO services	1. Adult intensive rehabilitation services (AIRS) addiction counseling 2. Behavioral health counseling and therapy 3. Behavioral health level of need re-determination 4. Case management 5. Child and adolescent intensive resiliency services 6. Crisis intervention 7. Intensive outpatient treatment 8. Medication training and support 9. Peer recovery 10. Psychiatric assessment and intervention 11. Skills training and development 12. Psychosocial rehabilitation

Note. MRO services must be provided by community mental health centers.

D.2. Medicaid FFS Program: SMI Population

- Indiana does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.
- As of May 2024, *OPEN MINDS* estimates 18% of the SMI population is enrolled in FFS.
- Adult Mental Health and Habilitation (AMHH) services are provided for individuals with SMI or co-occurring mental illness and addiction disorders for those who are age 19 or older, who are living in the community, and who need help on a regular basis.
- The Behavioral and Primary Healthcare Coordination (BPHC) program provides full Medicaid benefits to individuals ages 19 and over with SMI who have an income below 300% FPL, and who do not otherwise qualify for Medicaid.
- AMHH and BPHC services are authorized under section 1915 (i) state plan amendments and are provided exclusively by the state's 25 community mental health centers.

D.2. Medicaid FFS Program: Pharmacy Benefit

Indiana FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	Yes, OptumRx.
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes
State Uses A PDL For Mental Health Drugs	Yes, all anxiolytics, antidepressants, and antipsychotic drugs are included on the pharmacy PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, opioid agonists and tobacco cessation are included on the pharmacy PDL.
Coverage Of Antipsychotic Injectable Medications	Yes, antipsychotic injectable medications are covered as a pharmacy benefit.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	• Mental health treatment drugs are preferred drugs. However, safety edits and limits may include, but not are limited to, drug interactions, frequency of refills, dose optimization, age, days supplied, and quantities dispensed. • Addiction treatment drugs are subject to prior authorization.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Indiana operates the Right Choices Program (RCP) to monitor an individual's pharmacy utilization and determine if the individual would benefit from increased care coordination. Every individual enrolled in the RCP program is restricted to one physician, one pharmacy, and one hospital.

D.3. Medicaid Managed Care Program: Overview

- As of May 2024, managed care enrollment was 1,559,598.
- Indiana has three statewide managed care programs:
 - **Hoosier Care Connect (HCC)**: Three statewide health plans provide services to the aged, blind, and disabled non-dual eligible population on a full-risk capitated basis. There were 95,155 enrollees as of May 2024.
 - **Hoosier Healthwise (HHW)**: Four statewide health plans provide services to children and pregnant women on a full-risk capitated basis. There were 768,012 enrollees as of May 2024.
 - **Healthy Indiana Plan 2.0 (HIP 2.0)**: Four statewide health plans provide services to parent and caretaker relatives and persons eligible for the state's alternative Medicaid expansion program at a capitated rate. Individuals are responsible for cost-sharing (see next slide). There were 696,431 enrollees as of May 2024.
- Enrollees in managed care receive all physical health, traditional behavioral health, and pharmacy services through the health plans. Specialty behavioral services are excluded from the health plan's capitation rate and covered FFS by the state. They must be provided by CMHCs.
- There are four health plans available statewide that serve the HHW and HIP 2.0 populations. Additionally, two of these health plans also serve the HCC population, while an additional plan serves only the HCC population.

D.3. Medicaid Managed Care Program: Healthy Indiana Plan 2.0

- HIP 2.0 is Indiana's alternative Medicaid expansion. Four health plans operate statewide.
- HIP 2.0 covered individuals include:
 - All non-disabled adults between the ages of 19 and 64 with income below 138% of the FPL;
 - Parents and caretaker relatives who are not aged, blind, or disabled;
 - Women who become pregnant while enrolled in HIP 2.0 and choose to remain in the program; and
 - Native Americans who choose to receive services through HIP 2.0 instead of Medicaid FFS.
- HIP 2.0 health plans offer four benefit packages: HIP Basic, HIP Plus, HIP State Plan-Plus, and HIP State Plan-Basic (see [slide 37](#)).
- Each individual must make contributions to a Personal Wellness and Responsibility (POWER) account, which is modeled after health savings accounts.
 - Monthly contributions to the account cannot exceed 2% of an individual's income but cannot be less than \$1.00. Members pay one of five contribution amounts ranging from \$1 to \$20. These five amounts are referred to as "bands" and were instituted to address fluctuations in enrollee income.
 - POWER account enrollees who indicate that they are tobacco users during the plan selection period may be subject to an increased contribution amount in the following year if they are still smoking.
 - POWER account funds are used to pay the first \$2,500 of covered claims, mimicking a deductible. Claims beyond the initial \$2,500 will be covered through capitation payments or other payments made by the state.
 - Penalties are levied against persons who fail to make payments to their POWER accounts.
 - A portion of unused POWER account funds can be applied to subsequent year payments, with increases in roll-over funds for receiving recommended preventive services.
 - The HIP Workforce Bridge Plan will allow individuals to use \$1,000 of their POWER Account for up 12 months after leaving the program if they are transitioning into marketplace plans or employee-sponsored health insurance plans.
- An SMI component of the Health Indiana Plan was approved in March 2023.

D.3. Medicaid Managed Care Program: Healthy Indiana Plan 2.0 – SMI/SUD Component

- The SMI component of Healthy Indiana Plan was approved in March 2023.
- The state will monitor the new approaches and flexibilities in Indiana’s Medicaid program to reimburse for acute inpatient stays in IMDs for Medicaid enrollees with SMI.
- Over the demonstration period, the state hopes to achieve several goals including:
 - Reduced utilization and length of stay in emergency departments (EDs) among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings
 - Reduced preventable readmissions to acute care hospitals and residential settings
 - Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state
 - Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED, including through increased integration of primary and behavioral health care
 - Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities
- The SMI/SUD component is effective through December 2025.

Milestones	
Milestone 1	Ensuring quality of care in psychiatric hospitals and residential settings
Milestone 2	Improving care coordination and transitioning to community-based care
Milestone 3	Increasing access to the continuum of care, including crisis stabilization services
Milestone 4	Earlier identification and engagement in treatment, including through increased integration

D.3. Medicaid Managed Care Program: Healthy Indiana Plan 2.0 Coverage Options

HIP 2.0 Coverage Options			
Plan	Eligibility	Enrollee Cost Sharing Requirements	Benefits Provided
State Plan-Plus and State Plan-Basic	- Medically frail individuals - Caretakers eligible for traditional Medicaid - Pregnant women	- Medically frail and caretaker relatives with income below 100% of the FPL: Copayments (State Plan-Basic) - Medically frail and caretaker relatives with income above 100% of the FPL: Monthly contribution to POWER account (State Plan-Plus) - Pregnant women: No cost-sharing - There are no penalties for missing contributions; however, individuals with income above 100% of the FPL will accrue debt to the state and be subject to copayments.	- State plan benefits - Enrollees are eligible for specialty behavioral health and addiction services under both packages
HIP Basic	Individuals with income less than 100% of the FPL	- Copayments for services - No monthly payments to POWER account	Alternative benchmark plan

D.3. Medicaid Managed Care Program: Healthy Indiana Plan 2.0 Coverage Options

HIP 2.0 Coverage Options			
Plan	Eligibility	Enrollee Cost Sharing Requirements	Benefits Provided
HIP Plus	- Individuals with income less than 100% of FPL - Individuals with income up to 138% of FPL	- Flat monthly contribution to POWER account based on income bracket cannot exceed 2% of income - Individuals with income above 100% of FPL are subject to a six-month lock-out if they do not make POWER account contributions - Individuals with income below 100% of FPL who do not make contributions are moved to HIP Basic - No copayments except for non-emergency use of the emergency department	- Alternative benchmark plan - Some state plan benefits

D.3. Medicaid Managed Care Program: Health Plan Characteristics

Anthem Blue Cross & Blue Shield	Managed Health Services Of Indiana	CareSource Indiana
1. Profit status: For-profit 2. Parent company: Anthem 3. Behavioral health subcontractor: None 4. Pharmacy benefits manager: CarelonRx 5. Managed care programs: Healthy Indiana Plan 2.0, Hoosier Care Connect, Hoosier Healthwise 6. Enrollment share: 53%	1. Profit status: For-profit 2. Parent company: Centene Corporation 3. Behavioral health subcontractor: Cenpatico 4. Pharmacy benefits manager: None 5. Managed care programs: Healthy Indiana Plan 2.0, Hoosier Care Connect, Hoosier Healthwise 6. Enrollment share: 11%	1. Profit status: Non-profit 2. Parent company: CareSource 3. Behavioral health subcontractor: None 4. Pharmacy benefits manager: CareSource RxInnovations and Express Scripts 5. Managed care programs: Healthy Indiana Plan 2.0, Hoosier Healthwise 6. Enrollment share: 11%
MDwise, Inc.	UnitedHealthcare	
1. Profit status: Non-profit 2. Parent company: McLaren 3. Behavioral health subcontractor: None 4. Pharmacy benefits manager: MedImpact 5. Managed care programs: Healthy Indiana Plan 2.0, Hoosier Healthwise 6. Enrollment share: 23%	1. Profit status: For-profit 2. Parent company: UnitedHealthcare 3. Behavioral health subcontractor: Optum 4. Pharmacy benefits manager: Optum 5. Managed care programs: Hoosier CareConnect 6. Enrollment share: <1%	

Totals may not equal 100% due to rounding.

D.3. Medicaid Managed Care Program: Behavioral Health Overview

- Traditional behavioral health services and behavioral health pharmacy for all managed care programs are the responsibility of the health plans.
- Specialty behavioral health benefits are excluded from the health plans and are provided FFS by the state for Hoosier Healthwise (HHW), Hoosier Care Connect (HCC), Healthy Indiana Plan (HIP) State Plan-Basic, and HIP State Plan-Plus enrollees.
 - Specialty behavioral health benefits are Medicaid Rehabilitation Option (MRO) services and section 1915 (i) state plan home- and community-based behavioral health services.
 - These services are not available to HIP Basic or HIP Plus enrollees.
- MRO services and certain section 1915 (i) state plan services must be provided by community mental health centers (CMHCs).
- The state added addiction treatment benefits for the HIP 2.0 population in 2018. Some benefits are included in the health plan's capitation rate, while others are covered FFS.
- Psychiatric residential treatment facility (PRTF) services are excluded from managed care and are covered FFS by the state.
 - Individuals who are admitted to a PRTF are disenrolled from managed care and receive all Medicaid services through the FFS system during their PRTF stay.
 - After discharge, these individuals are enrolled in the appropriate managed care program.
- An SMI component of Healthy Indiana Plan, was approved in March 2023. See [slide 36](#) for details.

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

Behavioral Health Benefits Covered By The Health Plans	Behavioral Health Benefits Excluded From Managed Care & Covered FFS By The State
1. Standard and intensive mental health outpatient services 2. Inpatient mental health services at a freestanding inpatient psychiatric facility for individuals between age 22 and 65 (must be 16 beds or less) 3. Inpatient addiction disorder services at a freestanding psychiatric facility 4. Residential treatment in IMDs 5. Addiction treatment outpatient services 6. Partial hospitalization 7. Crisis intervention services 8. Peer recovery services	1. Psychiatric residential treatment facility (PRTF) services 2. Section 1915 (i) home- and community-based services a. AMHH services b. BPHC services c. Child mental health wraparound services 3. MRO services a. Adult intensive rehabilitation services (AIRS) addiction counseling b. Behavioral health counseling and therapy c. Behavioral health level of need re-determination d. Case management e. Child and adolescent intensive resiliency services f. Crisis intervention g. Intensive outpatient treatment h. Medicaid training and support i. Peer recovery j. Psychiatric assessment and intervention k. Skills training and development l. Opioid treatment program

D.3. Medicaid Managed Care Program: SMI Population

- The SMI population is mandatorily enrolled in managed care unless they meet FFS criteria for exemption.
- As of May 2024, *OPEN MINDS* estimates that 82% of the SMI population is enrolled in managed care.
- Adult Mental Health and Habilitation (AMHH) section 1915 (i) state plan services are provided for individuals who are age 19 or older; are living in the community; need help on a regular basis; or have SMI or co-occurring mental illness and addiction disorders.
- The Behavioral and Primary Healthcare Coordination (BPHC) section 1915 (i) state plan program provides full Medicaid benefits to individuals ages 19 and over with SMI, who have an income below 300% FPL, and who do not otherwise qualify for Medicaid.
- These services are authorized under a section 1915 (i) state plan amendment and are provided exclusively by the state's 25 CMHCs, as required under a concurrent section 1915 (b) waiver.
- The Medicaid expansion population—if medically frail—must be offered the full array of state plan benefits. Medically frail individuals include adults with SMI and chronic addiction disorders.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

Indiana Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	Health plan
Responsible For Financing Mental Health Pharmacy Benefit	Health plan
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	Health plans may set their own PDL if it includes an appropriate selection of drugs from therapeutic drug classes that are accessible and sufficient in amount, duration, and scope to meet the medical needs of members.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	The health plans may set their own utilization controls, including age/gender limits, quantity limits, and prior authorization.
Health Plan Allowed To Implement Pharmacy Lock-In Program	Indiana operates the Right Choices Program (RCP) to monitor an individual's pharmacy utilization and determine if the individual would benefit from increased care coordination. Every individual enrolled in the RCP program is restricted to one physician, one pharmacy, and one hospital.

D.4. Medicaid Program: Care Coordination Initiatives

			
Accountable Care Organization (ACO) Program	Affordable Care Act Health Home	Patient-Centered Medical Home	Other Care Coordination Initiatives
None	None	None	The Behavioral and Primary Healthcare Coordination (BPHC) program provides enhanced care coordination to persons with SMI who qualify, or do not otherwise qualify, for Medicaid.

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Healthy Indiana Plan	• Authorizes the state’s alternative Medicaid expansion program that includes cost-sharing and community engagement requirements. • In 2018, the state added inpatient stays in institutions for mental disease (IMDs) and residential treatment available for all Indiana Health Coverage Program members. • In 2019, the community engagement workforce requirements went into effect. • In January 2020, the state submitted an extension request through December 2030. Additionally, the state added an amendment to reimburse for acute inpatient stays for individuals diagnosed with SMI.	1115	None	02/01/2015	12/31/2030
Indiana End-Stage Renal Disease	Authorizes the state to provide wraparound benefits including supplemental coverage for kidney transplant services to Medicare-enrolled individuals with end-stage renal disease who are otherwise ineligible for Medicaid.	1115	None	01/01/2008	12/31/2024
Medicaid Rehabilitation Options (MRO) (IN-03)	Authorizes the state to contract with 25 community mental health centers (CMHCs) as the sole providers of MRO services to individuals with behavioral health conditions.	1915 (b)	None	06/01/2019	05/31/2024*

*This waiver is still listed as approved on the CMS site. No additional information is available.

D.5. Medicaid Program: Demonstration & Care Management Waivers(cont.)

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination Services (IN-02)	Authorizes the state to contract with CMHCs as the sole providers of the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination Services programs. These programs are authorized through a state plan amendment.	1915 (b)	None	04/01/2020	09/30/2023
Indiana Community Integration and Habilitation and Family Supports (FSW) (IN-05)	These waivers provide services, including case management, to persons with developmental disabilities or related conditions ages zero and above who meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care.	1915 (b)	None	01/01/2022	07/15/2025
Hoosier Care Connect (IN-04)	Authorizes the Hoosier Care Connect managed care program, and care coordination requirements for the aged, blind, and disabled population.	1915 (b)	None	04/02021	03/31/2023*

*This waiver is still listed as approved on the CMS site. No additional information is available.

D.5. Medicaid Program: Behavioral & Primary Healthcare Coordination Services

- The Behavioral and Primary Healthcare Coordination (BPHC) program provides enhanced care coordination to persons with SMI.
- BPHC eligibility criteria includes:
 - Individuals who are Medicaid eligible, meet the needs-based criteria for the 1915 (i) BPHC benefit, and have an income that does not exceed 150% of the FPL.
 - Individuals who are not otherwise eligible for Medicaid, meet the needs-based criteria, and have an income that does not exceed 150% of the FPL. As a result of qualifying for BPHC, these individuals are also eligible for full Medicaid benefits.
 - Needs-based eligibility: Individuals who receive a score of three or higher on an approved assessment tool, are not at-risk to harm themselves or others, have a BPHC eligible mental health diagnosis, and have a documented need for primary and behavioral health care coordination.
- Care coordination services must be provided by the CMHCs. These services include:
 - Assessment of the eligible recipient to determine service needs;
 - Referral and related activities to help the recipient obtain needed services; and
 - Monitoring, follow-up, and evaluation.
- BPHC does not include the delivery of medical, clinical, or other direct services.

D.5. Medicaid Program: Adult Mental Health Habilitation

- The Adult Mental Health Habilitation Services (AMHH) program provides HCBS to individuals with SMI. The program is authorized through a concurrent state plan amendment and 1915 (b) waiver.
 - AMHH services provided to individuals and their families include an assessment of the individual's needs and strengths, the development of an individualized integrated care plan, and assistance to help the individual achieve their habilitative goals.
- Eligible adults include those who:
 - Are enrolled in Medicaid;
 - Are over the age of 19 with a primary mental health diagnosis;
 - Reside in a facility that meets the criteria for HCBS; and
 - Have met the maximum benefit for rehabilitative services, do not have access to habilitation services, and are at-risk for institutionalization without habilitation focused supports.
- Services covered include:
 - Adult day services
 - Home- and community-based habilitation and support
 - Respite care
 - Therapy and behavior support services
 - Addiction counseling
 - Peer support services
 - Supported community engagement services
 - Care coordination
 - Medication training and support

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2024 Enrollment Cap	Operating Unit	Concurrent Management Authority
IN Aged and Disabled (0210.R07.00)	Individuals who are physically disabled or disabled in other ways birth to 64, and individuals who are ages 65 and older.	47,680	Division of Aging	No
IN Family Supports (0387.R04.00)	Individuals with autism or intellectual and developmental disabilities (I/DD) of any age.	31,777	Division of Disability and Rehabilitative Services (DDRS)	No
IN Community Integration and Habilitation (0378.R04.00)	Individuals with a developmental disability who would normally require care in an intermediate care facility.	10,969	DDRS	No
IN Traumatic Brain Injury (4197.R05.00)	Individuals diagnosed with a Traumatic Brain Injury (TBI) of any age	200	Division of Aging	No
IN PathWays for Aging (2407.R00.00)	Individuals ages 65 or older and individuals with physical and other disabilities ages 60-64 years who meet nursing facility level of care.	None	Family and Social Services Administration (FSSA)	No

D.6. Medicaid Program: New Initiatives- PathWays for Aging

- Hoosiers over 60 using Medicaid received notices in early 2024 advising them to choose a Managed Care Entity (MCE) under the state's Pathways for Aging Program.
- The program goes live in July 2024. Plans are available from:
 - Anthem Blue Cross and Blue Shield
 - Humana Healthy Horizons
 - UnitedHealthcare Community Plan of Indiana
- Each MCE will provide services statewide. Having multiple plans allows members to switch plans to fit their needs and allows integration with Medicare services for those who are eligible.
- PathWays health plans will have an open network until dictated by the state. Thus, the member can continue to use their providers, if the provider remains an IHCP approved provider, no matter the health plan selected.
- State officials hope changing from fee-for-service care will incentivize the growth of home- and community-based services.
 - Indiana spends 23% of its Medicaid funding on home- and community-based services, compared to the national average of 53%

E. Medicare Financing & Service Delivery System

E.1. Medicare Financing & Service Delivery System

Medicare System Characteristics		
Characteristics	Traditional Medicare (FFS)	Medicare Advantage
Enrollment (August 2023)	706,182	638,276
SMI Enrollment	<i>OPEN MINDS</i> estimates 47% of the population in Medicare Advantage, 53% in Traditional Medicare.	
Management	- Part A: Inpatient hospital, skilled nursing facility care, nursing home care, hospice and home health care - Part B: Clinical research, ambulance services, durable medical equipment, mental health and limited outpatient prescription drugs	Medicare Advantage Plans provide Part A and Part B benefits, plus additional benefits based on plan chosen
Payment Model	Part A & B cover up to 80%, remaining costs can be paid out of pocket	Fixed amounts paid based on health plan chosen
Geographic Service Area	Statewide	Statewide

Total Medicare: 1,344,458 | Total Medicare With SMI: 305,191

E.1. Medicare Financing & Service Delivery System

Medicare Financial Delivery System Enrollment	
Total Medicare population distribution	As of August 2023: 47% Medicare Advantage, 53% in traditional Medicare.
SMI population inclusion in managed care	Estimated 47% of population in Medicare Advantage, 53% in traditional Medicare.
Medicare population inclusion in Chronic special needs plan or (C-SNP).	Estimated that less than 1% of population is enrolled in C-SNP plans.
Medicare population inclusion in Institutional Special Needs Plan (I-SNP).	Estimated that less than 1% of population is enrolled in I-SNP plans.

E.2. Medicare System: Overview

- Medicare enrollment as of August 2023 was 1,344,458.
- About 14% of the state's population is enrolled in Medicare, the same as the total U.S. population.
 - *OPEN MINDS* estimates approximately 36% of the state's Medicare population has a SMI.
- For 2024, Indiana residents can choose from among at least 44 Medicare Advantage plans, and up to 77 plans, depending on where they live.
- Indiana passed legislation in early 2024 with strong support in both chambers that, if signed into law, will require Medigap insurers to make all plans available to under-65 beneficiaries, as of 2025. It will also prohibit higher under-65 premiums for Medigap plans A, B, and D, and limit under-65 premiums for other Medigap plans to no more than 200% of the age-65 premiums.
- In Indiana, there are 21 stand-alone Part D plans for sale for 2024, with premiums as low as \$0/month.
- As of mid-2023, there were 1,108,226 Indiana Medicare beneficiaries who had Part D prescription coverage. About 46% had coverage under stand-alone Part D plans, while about 54% had Part D prescription coverage as part of their Medicare Advantage plans.
- Many Medicare beneficiaries receive financial assistance through Medicaid with the cost of Medicare premiums, prescription drug expenses, and services not covered by Medicare – such as long-term care.

E.3. Medicare ACOs

Medicare Shared Savings ACOs	
1.	AHN Accountable Care Organization
2.	American Health Network of Ohio Care Organization
3.	Ascension Care Management Health Partners Evansville, LLC
4.	Ascension Care Management Health Partners Indianapolis, LLC
5.	Baptist Health Care Partners, LLC
6.	Caravan Health ACO 22, LLC
7.	Caravan Health ACO 23, LLC
8.	CareConnectMD ACO, Inc
9.	CHA ACO, LLC
10.	CHSPSC ACO 2, LLC
11.	CHSPSC ACO 9, LLC
12.	Community Healthcare Partners ACO
13.	Doctors ACO, LLC
14.	Franciscan ACO
15.	Healthcare Solutions Network, LLC
16.	Indiana Lakes ACO
17.	Ingalls Care Network, LLC
18.	Inspire Health Partners, LLC
19.	Mercy Health Select, LLC
20.	Quality Independent Physicians
21.	The Accountable Care Organization, Ltd
22.	Trinity Integrated Care, LLC
23.	University of Chicago Care Network Accountable Care Organization, LLC
24.	VillageMD Chicago ACO, LLC

ACO REACH Model	
1.	Indiana University Health ACO, Inc

End-Stage Renal Disease ACOs	
1.	Fresenius Seamless Care of Indianapolis

E.4. Medicare System: New Initiatives

- There are no new or pending initiatives currently.

F. Dual Eligible Financing & Service Delivery System

F.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	PACE
Enrollment (December 2023)	152,741	815
Estimated SMI Enrollment	32,075	171
Management	Office of Medical Policy and Planning	Three programs in select counties
Payment Model	FFS	Blended capitated rate
Geographic Service Area	Statewide	Select ZIP codes

Total Dual Eligible Enrollment: 153,556 | Total Dual Eligible Enrollment With SMI: 32,246

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

F.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	December 2023 Enrollment	Estimated SMI Enrollment
Anthem MediBlue Dual Advantage	Anthem, Inc	Medicare Advantage D-SNP	390,885	82,086
Humana Gold Plus	Humana, Inc	Medicare Advantage D-SNP	19,520	4,099
HumanaChoice	Humana, Inc	Medicare Advantage D-SNP	3,854	809
Aetna Medicare Assure Premier	Aetna/CVS	Medicare Advantage D-SNP	3,113	654
Franciscan Senior Health and Wellness	Franciscan Health	PACE	313	66
Ascension Complete St Vincent D-SNP	Centene	Medicare Advantage D-SNP	291	61
Saint Joseph PACE	Saint Joseph Health System	PACE	260	55
PACE of Northeast Indiana, LLC	N/A	PACE	58	13
Reid Hospital & Health Care Services, Inc	N/A	PACE	45	10
Zing Choice	Zing Health	Medicare Advantage D-SNP	29	6

F.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- As of December 2023, dual eligible enrollment was 153,556.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- Dual eligibles are required to enroll in Medicaid FFS to receive Medicaid benefits.
- D-SNP enrollment as of December 2023 was 417,692, SMI enrollment for D-SNP was 87,715.

F.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives- PathWays for Aging

- Hoosiers over 60 using Medicaid received notices in early 2024 advising them to choose a Managed Care Entity (MCE) under the state's Pathways for Aging Program.
- The program goes live in July 2024. Plans are available from:
 - Anthem Blue Cross and Blue Shield
 - Humana Healthy Horizons
 - UnitedHealthcare Community Plan of Indiana
- Each MCE will provide services statewide. Having multiple plans allows members to switch plans to fit their needs and allows integration with Medicare services for those who are eligible.
- PathWays health plans will have an open network until dictated by the state. Thus, the member can continue to use their providers, if the provider remains an IHCP approved provider, no matter the health plan selected.
- State officials hope changing from fee-for-service care will incentivize the growth of home- and community-based services.
 - Indiana spends 23% of its Medicaid funding on home- and community-based services, compared to the national average of 53%
- These plans will offer aligned enrollment for dual eligible individuals and will be affiliated with Medicaid managed care entities. The D-SNP and the managed care entity will need to unify member materials, grievances, and appeals

G. Long-Term Services & Supports Financing & Service Delivery System

G.1. LTSS Financing & Service Delivery System

- Indiana does not operate a managed long-term services and supports system. All beneficiaries in need of LTSS are enrolled in FFS.

LTSS Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (December 2020)	N/A
Estimated SMI Enrollment	N/A
Management	Fee-for-service
Payment Model	Fee-for-service
Geographic Service Area	Statewide

Total LTSS Enrollment: 153,556 | Total LTSS Enrollment With SMI: 32,246

G.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults			X
Disabled children			X
Blind individuals			X
Aged individuals			X
Dual eligibles	X		
Individuals with I/DD	X		
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Other HCBS Recipients	X		
Other populations	• End-stage renal disease or breast and cervical cancer waiver recipients • Hospice services in an institutional setting • Refugees • Emergency Services only		

G.2. LTSS Medicaid Financing & Delivery System: Overview

- Indiana does not operate a managed long-term services and supports (MLTSS) system. All beneficiaries in need of MLTSS are covered FFS.
- Beneficiaries that qualify for managed care (i.e., the aged, blind, or disabled population) in need of services can enroll in Hoosier Care Connect.
 - **Hoosier Care Connect** (HCC): Two statewide health plans provide services to the aged, blind, and disabled non-dual eligible population on a full-risk capitated basis. There were 101,548 enrollees as of February 2022.
 - Enrollees in HCC receive all physical health, traditional behavioral health, and pharmacy services through the health plans. Specialty behavioral services are excluded from the health plan's capitation rate and are covered FFS by the state. Services must be provided by CMHCs.

G.3. Medicaid LTSS Program: Health Plan Characteristics

- Indiana does not operate a MLTSS program. All beneficiaries in need of MLTSS receive services FFS.
- Beneficiaries that meet the criteria for managed care (i.e., aged, blind, or disabled) may enroll into one of the HCC plans: Anthem Blue Cross Blue Shield, Managed Health Services of Indiana, or United Health Communities.

G.4. Medicaid LTSS Program: Program Benefits

Federally Mandated Services	
1.	Inpatient hospital services other than services in an institution for mental disease (IMD)
2.	Outpatient hospital services
3.	Rural Health Clinic services
4.	Federally Qualified Health Center (FQHC) services
5.	Laboratory and x-ray services
6.	Nursing facilities for individuals ages 21 and over
7.	Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8.	Family planning services and supplies
9.	Free standing birth centers
10.	Pregnancy-related and postpartum services
11.	Nurse midwife services
12.	Tobacco cessation programs for pregnant women
13.	Physician services
14.	Medical and surgical services of a dentist
15.	Home health services
16.	Nurse practitioner services
17.	Non-emergency transportation to medical care

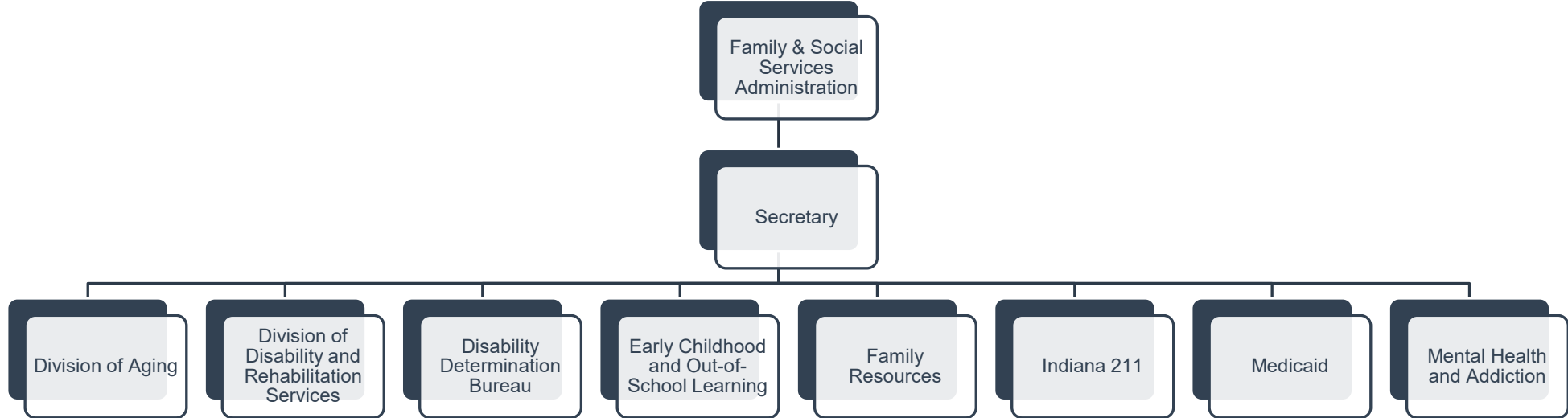
Indiana's Optional Services	
1.	Podiatry services
2.	Optometry services
3.	Chiropractic services
4.	Other practitioners' services
5.	Private duty nursing
6.	Medical supplies
7.	Clinic services
8.	Dental services
9.	Physical, occupational, and speech therapy
10.	Prescribed drugs
11.	Dentures, prosthetic devices, and eyeglasses
12.	Diagnostic, screening, and preventive services
13.	Inpatient services in IMDs for persons over age 65
14.	Intermediate care facility services
15.	Public institution services for I/DD
16.	Hospice care
17.	Respiratory care
18.	Care in religious non-medical institutions
19.	Nursing facility services for persons under age 21

G.5. LTSS Medicaid Financing & Delivery System: New Initiatives-PathWays for Aging

- Hoosiers over 60 using Medicaid received notices in early 2024 advising them to choose a Managed Care Entity (MCE) under the state's Pathways for Aging Program.
- The program goes live in July 2024. Plans are available from:
 - Anthem Blue Cross and Blue Shield
 - Humana Healthy Horizons
 - UnitedHealthcare Community Plan of Indiana
- Each MCE will provide services statewide. Having multiple plans allows members to switch plans to fit their needs and allows integration with Medicare services for those who are eligible.
- PathWays health plans will have an open network until dictated by the state. Thus, the member can continue to use their providers, if the provider remains an IHCP approved provider, no matter the health plan selected.
- State officials hope changing from fee-for-service care will incentivize the growth of home- and community-based services.
 - Indiana spends 23% of its Medicaid funding on home- and community-based services, compared to the national average of 53%
- These plans will offer aligned enrollment for dual eligible individuals and will be affiliated with Medicaid managed care entities. The D-SNP and the managed care entity will need to unify member materials, grievances, and appeals

H. State Behavioral Health Administration & Finance System

H.1. Department Of Mental Health & Addiction Governance: Organization Chart



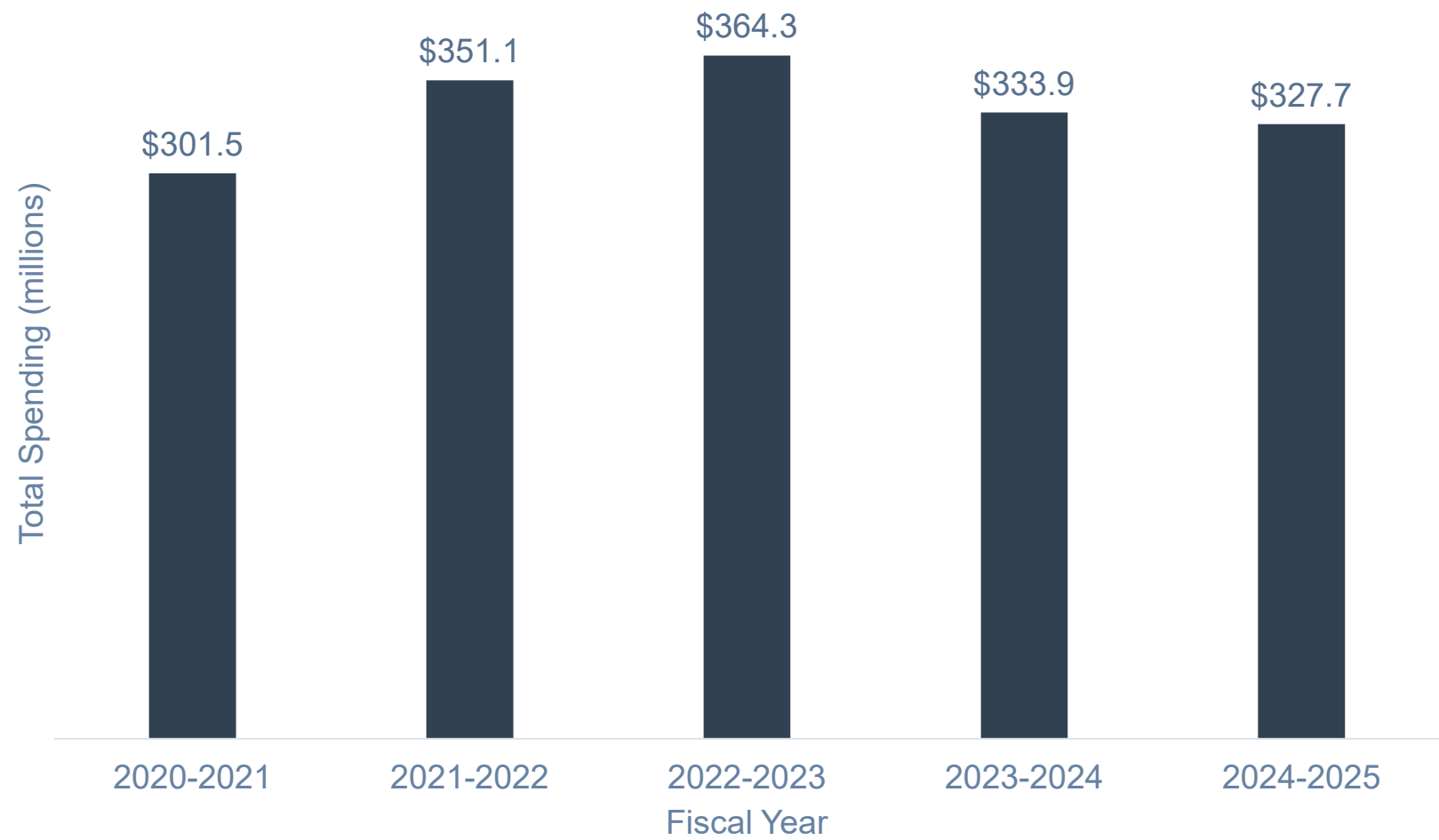
H.1. Department Of Mental Health & Addiction Governance: Key Leadership

Name	Position	Department	Email
Daniel Rusyniak, MD	Secretary	Family & Social Services Administration	daniel.rusyniak@fssa.in.gov
Jay Chaudhary	Director	Division of Mental Health and Addiction	jay.chaudhary@fssa.in.gov
Rebecca Buhner	Deputy Director, Chief of Staff	FSSA	Rebecca.Buhner@fssa.IN.gov
Sirrilla Blackmon	Executive Director	Division of Mental Health and Addiction	sirrilla.blackmon@fssa.in.gov
Vacant	Executive Director, Addiction Strategy and Services	Division of Mental Health and Addiction	N/A
Katrina Norris	Executive Director, State Psychiatric Hospital Network	Division of Mental Health and Addiction	katrina.norris@fssa.in.gov

H.2. Department Of Mental Health & Addiction Governance: Spending

Budget Item	SFY 2023-2025 Budget Request	Percent Of Budget
State Psychiatric Facilities	\$179,299,604	54%
Seriously Mentally Ill	\$90,811,518	28%
Forensic Treatment Services	\$25,000,000	7%
Seriously Emotionally Disturbed	\$14,571,352	4%
Substance Abuse Treatment	\$5,357,131	3%
Community Mental Health Centers	\$7,200,000	2%
Mental Health Administration	\$3,800,593	1%
Addiction Prevention	\$1,672,675	1%
Budget Total: \$327,712,873		

H.2. Department Of Mental Health & Addiction Governance: Spending Over Time



*Fiscal years 2019-2021 actual budget; 2022-2024 budget request

H.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	Location	Beds
Evansville Psychiatric Children’s Center	Evansville	28
Evansville State Hospital	Evansville	168
Logansport State Hospital	Logansport	192
Madison State Hospital	Madison	120
Neuro Diagnostic Institute	Indianapolis	159
Richmond State Hospital	Springfield	190
Total		857

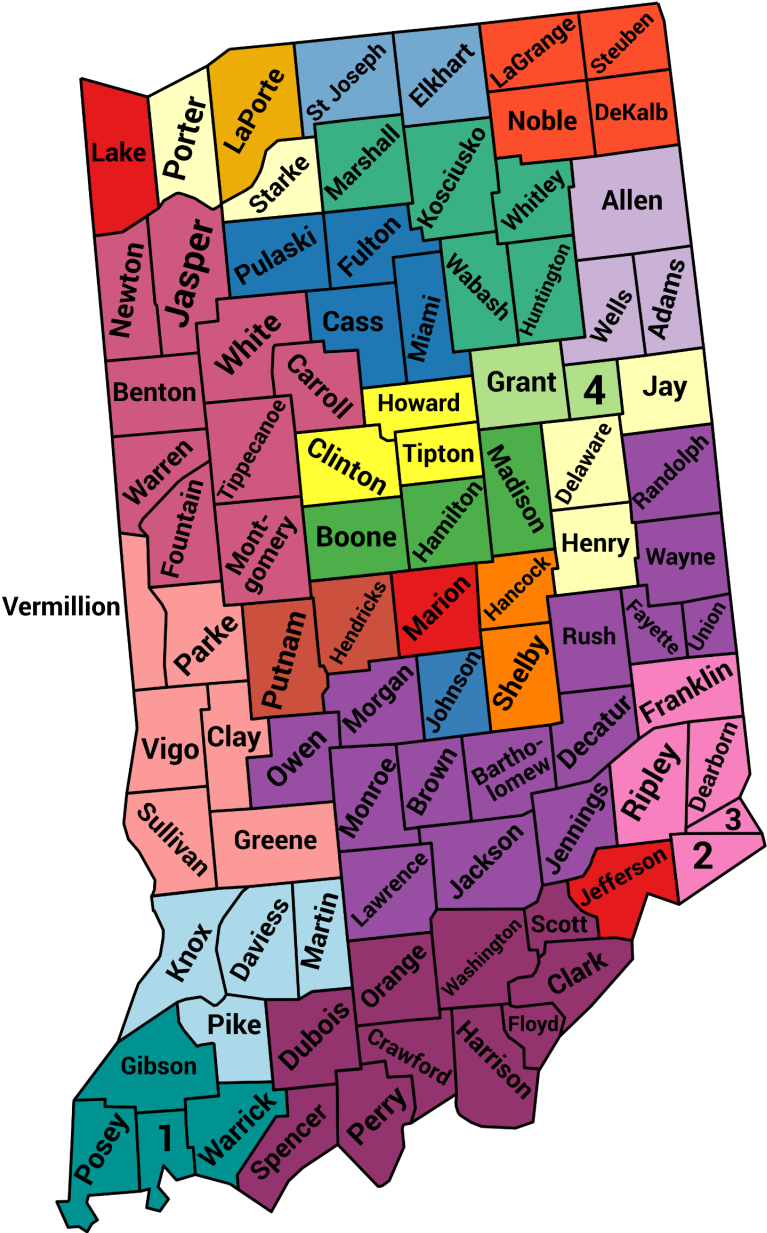
H.4. Behavioral Health Safety-Net Delivery System

- The Division of Mental Health and Addiction within the Indiana Family and Social Services Administration provides mental health and addiction treatment services to the safety-net population by contracting with community mental health centers (CMHCs) and other provider organizations.
- The CMHCs also provide services to the Medicaid population, including primary care treatment within their scope of practice.
 - Medicaid rehabilitation option (MRO) services and specialty services for persons with SMI must be provided by the CMHCs.

H.4. Behavioral Health Safety-Net Delivery System: CMHC Service Areas

*See corresponding tables on following slides.

 Counties with more than one CMHC



- 1 Vanderburgh
- 2 Switzerland
- 3 Ohio
- 4 Blackford

H.4. Behavioral Health Safety-Net Delivery System: CMHC Service Areas (cont.)

Community Mental Health Center		Counties In Service Area
	Adult and Child Mental Health Center, Inc.	Johnson, Marion
	Aspire Indiana, Inc.	Boone, Hamilton, Madison, Marion
	Centerstone of Indiana, Inc.	Bartholomew, Brown, Decatur, Fayette, Jackson, Jefferson, Jennings, Lawrence, Monroe, Morgan, Owen, Randolph, Rush, Union, Wayne
	Community Fairbanks Behavioral Health	Hancock, Marion, Shelby
	Community Fairbanks Behavioral Health - Howard	Clinton, Howard, Tipton
	INcompass Healthcare	Dearborn, Franklin, Ohio, Ripley, Switzerland
	Cummins Behavioral Health Systems, Inc.	Hendricks, Putnam
	Edgewater Systems for Balanced Living, Inc.	Lake
	4C Health	Cass, Fulton, Miami, Pulaski
	Radiant Health	Blackford, Grant
	Hamilton Center, Inc.	Clay, Greene, Parke, Sullivan, Vermillion, Vigo
	LifeSpring, Inc.	Clark, Crawford, Dubois, Floyd, Harrison, Jefferson, Orange, Perry, Scott, Spencer, Washington

H.4. Behavioral Health Safety-Net Delivery System: CMHC Service Areas (cont.)

Community Mental Health Center		Counties In Service Area
	Meridian Health Services Corporation	Delaware, Henry, Jay
	Northeastern Center, Inc.	DeKalb, Lagrange, Noble, Steuben
	Oaklawn Psychiatric Center, Inc.	Elkhart, St. Joseph
	The Otis R. Bowen Center	Huntington, Kosciusko, Marshall, Wabash, Whitley
	Parkview Health	Adams, Allen, Wells
	Porter-Starke Services, Inc.	Porter, Starke
	Family Health Center	Daviess, Knox, Martin, Pike
	Sandra Eskenazi Mental Health Center	Marion
	Regional Health Systems	Lake
	Southwestern Indiana Mental Health Center, Inc.	Gibson, Posey, Vanderburgh, Warrick
	Swanson Center	La Porte
	Wabash Valley Alliance, Inc.	Benton, Carroll, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, White

H.5. Behavioral Health System: New Initiatives

- There are no new or pending initiatives currently.

I. Appendices

I.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.2% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicaid	11.6% of persons enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicare	22.7% of persons in the Medicare population, not dually eligible for Medicaid	Figuroa, J. F., Phelan, J., Orav, E. J., Patel, V., & Jha, A. K. (2020). Association of mental health disorders with health care spending in the Medicare population. Retrieved July 2023 from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948#:~:text=Results%20Of%204%20358%20975,had%20no%20known%20mental%20illness

I.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	21% of persons in the Medicare population dually eligible for partial Medicaid benefits	ATI Advisory. (2022). A Profile of Medicare-Medicaid Dual Beneficiaries. Retrieved March 2023 from https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf
	16% of persons in the Medicare population dually eligible for full Medicaid benefits	
Other Public	4.5% of persons served by the Veterans Administration health care system or the TRICARE military health system	U.S. Census Bureau (2022). Table HHI-01. Health Insurance Coverage Status and Type of Coverage--All Persons by Sex, Race and Hispanic Origin: 2017 to 2021. Retrieved March 2023 from https://www2.census.gov/programssurveys/demo/tables/health-insurance/time-series/hic/hhi01.xlsx
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(l) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC’s mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2024, the FPL is \$14,580 for an individual and \$30, 000 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit-by-unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A “whole person” care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination; and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment; and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants; but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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