MONTANA SECTION 1115 HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART) DEMONSTRATION APPLICATION
Public Notice – July 8, 2021

The Montana Department of Public Health and Human Services (DPHHS) is providing public notice of its intent to: (1) submit to the Centers for Medicare and Medicaid Services (CMS), on or before September 30, 2021, a written 1115 Demonstration application to request federal authority to test new benefits for Medicaid members with behavioral health needs and to reimburse for acute inpatient and residential stays at institutions for mental disease (IMD) for individuals diagnosed with substance use disorders (SUD) and serious mental illness (SMI) and (2) hold public hearings to receive comments on the 1115 Demonstration application. DPHHS is seeking an effective term of five years for the Demonstration from January 1, 2022, to December 31, 2026. All proposed requests are subject to approval by CMS.

I. Program Description

A. Overview

DPHHS is requesting a Section 1115 Demonstration to build upon the strides made by the state over the last decade to establish a comprehensive continuum of behavioral health—mental health and SUD—services for its Medicaid members. This Demonstration is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through Governor Gianforte's Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative. The HEART Initiative, included in the recently passed H.B. 701, will invest significant state and federal funding to expand the state's behavioral health continuum. The demonstration will support the state's broader efforts to strengthen its evidence-based behavioral health continuum of care for individuals with SUD, SMI and SED; enable prevention and earlier identification of behavioral health issues; and monitor the quality of care delivered to members with behavioral health needs across outpatient, residential and inpatient settings through improved data collection and reporting.

Montana is seeking through this demonstration:

- To add new Medicaid services that are described in greater detail below including:
  - Evidence-based stimulant use disorder treatment models, including contingency management;
  - Tenancy support; and
  - Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.
- Expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs obtaining treatment for SUD and SMI.

B. Benefits

i. Evidence-Based Stimulant Use Disorder Treatment Models

This Demonstration seeks to add contingency management as part of TRUST, a comprehensive outpatient treatment pilot for Medicaid members ages 18 and older with stimulant use disorder (e.g., cocaine, methamphetamine and similar drugs). This pilot will combine evidence-based interventions including contingency management, motivational interviewing, community reinforcement, exercise and cognitive behavioral therapy for Medicaid members with a completed ASAM criteria assessment diagnosed with a qualifying stimulant use disorder.

ii. Tenancy Support Services

This Demonstration proposes to add coverage for a tenancy support services program to assist Medicaid members ages 18 and older with SUD, SMI or SED, who are experiencing chronic homelessness or frequent housing instability and frequently engage with crisis systems and institutional care. Tenancy support services will include pre-tenancy supports and tenancy sustaining services to support an individual's ability to prepare for and transition to housing, as well as assist individuals in maintaining services once housing is secured.

iii. Medicaid Benefits for Inmates in State Prisons in the 30 Days Prior to Release

In the 30 days prior to release from state prisons, eligible Medicaid members will receive limited community-based clinical consultation services provided in-person or via telehealth, in-reach care management services, and a 30-day supply of medication for reentry into the community. Individuals will also receive coverage of certain medications that include long-acting or depot preparations for chronic conditions (e.g., schizophrenia, SUD); acute withdrawal medications; or suppressive, preventive or curative medications, include PrEP and PEP (HIV, HCV, and SUD) that will facilitate maintenance of medical and psychiatric stability upon release. DPHHS is seeking to implement this initiative on January 1, 2023.

C. Eligibility Requirements

All children ages 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan or Medicaid 1115 waivers, as well as children aged 18 eligible for the CHIP program, will be included in this Demonstration. Medicaid members will qualify for services outlined in this Demonstration based upon their medical need for services. Medicaid member eligibility requirements will not differ from the approved Medicaid State Plan, Alternative Benefit Plan and Medicaid 1115 waivers. DPHHS is not proposing changes to Medicaid eligibility standards in this Demonstration application.

D. Health Care Delivery System and Benefits

There are no proposed changes to the Medicaid delivery system as part of this application. Montana plans to continue using a fee-for-service delivery system for all Medicaid services, including behavioral health services.

E. Cost Sharing

Montana currently does not apply cost sharing to any of its Medicaid members and therefore no cost sharing will be imposed under this 1115 Demonstration. All monthly premiums will be consistent with the HELP 1115 Waiver and Cost Sharing State Plan.

II. Goals and Objectives

This proposed Demonstration will allow Montana to better address the behavioral health needs of Montana Medicaid members by:

- Expanding Medicaid's continuum of behavioral health care, including early intervention, crisis intervention treatment, behavioral health treatment and recovery services for individuals with SMI/SED/SUD in support of the state's HEART Initiative;
- Advancing the state's goals for reducing opioid-related deaths and suicides;
- Improving the outcomes and quality of care delivered to individuals with behavioral health needs across outpatient, residential and inpatient levels of care;
- Improving physical and behavioral health outcomes and reducing emergency department visits, hospitalizations and other avoidable services by connecting justice-involved individuals to ongoing community-based physical and behavioral health services; and
- Promoting continuity of medication treatment for justice-involved individuals receiving pharmaceutical treatment

Montana's goals support the broader objectives of the Medicaid program to ensure equitable access to medically necessary services for Medicaid-eligible members. Montana's goals also support the specific goals for SUD and SMI/SED IMD Demonstrations outlined by State Medicaid Director Letter (SMDL) #17-003 and #18-011, including:

- Increased rates of identification, initiation and engagement in behavioral health treatment;
- Increased adherence to and retention in behavioral health treatment;
- Reductions in overdose deaths and suicides, particularly those related to alcohol and illicit drugs;
- Reduced utilization and lengths of stays in emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate for individuals with SUD, SMI and SED, through improved access to treatment and recovery services;
- Fewer preventable readmissions to hospitals and residential settings, where the readmission is preventable or medically inappropriate;
- Improved access to care for physical health conditions among Medicaid members;
- Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services; and 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 treatment and recovery services, including tenancy supports and evidence-based stimulant use disorder treatment models, to

address the behavioral health needs of members with SMI, SED and SUD, including through increased integration of primary and behavioral health care; and

- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals, residential treatment facilities and in the 30 days pre-release from prisons.

III. Enrollment Projections

The state is not proposing any changes to Medicaid eligibility requirements in the Section 1115 Demonstration request. As such, the Demonstration is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes, economic conditions, and, if applicable, continued coverage requirements during the COVID-19 public health emergency.

Table 1. Projected Enrollment by Category of Aid

Category of Aid	***Projected Enrollment***				
	DY 1 ***1/1/22–12/31/22***	**DY 2** ***1/1/23–12/31/23***	**DY 3** ***1/1/24–12/31/24***	**DY 4** ***1/1/25–12/31/25***	**DY 5** ***1/1/26–12/31/26***
Families and Children (not CHIP)	936	962	988	1,015	1,043
CHIP	0	0	0	0	0
Aged, Blind and Disabled	950	974	998	1,022	1,048
ACA Expansion	6,091	6,255	6,425	6,599	6,779
Other (HIFA, Poverty, Transitional MA, Former Foster Care)	321	329	338	347	356
Total	8,298	8,520	8,748	8,983	9,225

IV. Annual Expenditures

Based on the programmatic details described above, Montana has estimated projected spending for the authorization period. For the purposes of public notice and comment, the state has summarized in the table below the projected expenditures for the authorization period, including spending on requested expenditure authorities. The state will include final projections in the Demonstration request submitted to CMS; final numbers may differ as Montana continues to finalize financial data demonstrating the state's historical expenditures and to determine the impact that the COVID-19 public health emergency has had on enrollment and expenditure trends. Montana will establish budget neutrality for these items by building estimates into detailed budget neutrality tables.

Table 2: Projected Expenditures, Montana 1115 SUD/SMI/SED Demonstration

Projected Expenditures (in dollars)					
Expenditure Authorities	**DY 1** ***1/1/22–12/31/22***	**DY 2** ***1/1/23–12/31/23***	**DY 3** ***1/1/24–12/31/24***	**DY 4** ***1/1/25–12/31/25***	**DY 5** ***1/1/26–12/31/26***
IMD Exclusion for SUD[1]	$733,032	$762,573	$793,305	$825,275	$858,534
IMD Exclusion for SMI/SED[2]	$13,750,134	$13,887,636	$14,026,512	$14,166,777	$14,308,445
Tenancy Supports[3]	$11,782,355	$12,257,184	$12,751,149	$13,265,020	$13,799,600
30-Days Pre-Release Coverage[4]	$63,768	$64,406	$65,050	$65,700	$66,357
Evidence-Based Stimulant Use Disorder Treatment Models[5]	$1,686,624	$1,737,223	$1,789,340	$1,843,020	$1,898,310
Total	$28,015,914	$28,709,022	$29,425,355	$30,165,793	$30,931,247

[1] Expenditures are projected using data from Rimrock. Rimrock served 101 patients aged 21-65 in a 40-bed facility in 2020. DPHHS assumed a 3 percent growth rate in the number of individuals served. To calculate cost, DPHHS applied a 1 percent annual growth rate to a proposed rate of $263.12 for 26-day average length of stay.

[2] Expenditures were calculated using data from Montana State Hospital, which had 675 admissions for individuals aged 21-65 in 2020. DPHHS assumed a steady admission rate throughout the five years due to facility limitations. To calculate cost, DPHHS estimated an average per person cost for up to 30 days by taking the average from the various units, their admissions, and an average length of stay for 30 days.

[3] Estimate for homeless patients with SUD or SMI were from the HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations: Montana Report. The report estimated that 347 people with SMI were homeless and 180 with Chronic Substance Abuse were homeless. Estimates for individuals at risk of homelessness are based on the combination of patients served in behavioral health group homes (386), ASAM 3.1 (274), and emergency departments (664). Based on 2017 TEDS data, 38% of all admissions are criminal justice referrals and we expect criminal justice involved individuals are already represented in those our population. DPHHS assumed a 3% growth rate for the population. DPHHS started with $500 PMPM with an assumption of 1% rate increase per year.

[4] DOC estimated that 300 people per year are discharged who have SMI or SUD. It was assumed this population would remain static due to facility limitations. DPHHS assumed a cost estimate for providing care coordination in the last month of a sentence to be $212.56 and applied a 1 percent annual rate increase.

[5] DPHHS applied a population rate increase of 3 percent to the base population estimate for Medicaid members with stimulant disorders in 2020 of 5,047. Contingency management was estimated at $315 annually per member with no rate increases expected.

V. Waiver and Expenditure Authorities

Montana is requesting a waiver of the following sections of the Social Security Act, to the extent necessary, to support implementation of the proposed Demonstration. To the extent that CMS advises the state that additional authorities are necessary to implement the programmatic vision and operational details described above, the state is requesting such waiver or expenditure authority, as applicable. Montana's negotiations with the federal government, as well as state legislative and/or budget changes, could lead to refinements in these lists as the state works with CMS to move these behavioral health initiatives forward.

A. Waiver Authorities

Under the authority of Section 1115(a)(1) of the act, the following waivers shall enable Montana to implement this Section 1115 Demonstration through December 31, 2026.

Table 3: Waiver Requests

Waiver Authority	Use for Waiver
§ 1902(a)(1) Statewideness	To enable the state to provide tenancy supports and stimulant use disorder treatment including contingency management on a geographically limited basis.
§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability	To enable the state to provide tenancy supports, stimulant use disorder treatment including contingency management that are otherwise not available to all members in the same eligibility group.

B. Expenditure Authorities

Under the authority of Section 1115(a)(2) of the act, Montana is requesting expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the act, shall, through December 31, 2026, be regarded as expenditures under the state's Title XIX plan. These expenditure authorities promote the objectives of Title XIX by improving health outcomes for Medicaid populations.

Table 4: Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority
Expenditures related to IMDs	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment or withdrawal management services for SUD or primarily receiving treatment for SMI, who are short-term residents/inpatients in facilities that meet the definition of an IMD.
Expenditures related to state prison inmates	Expenditure authority as necessary under the pre-release Demonstration to receive federal reimbursement for costs not

Expenditure Authority	Use for Expenditure Authority
	otherwise matchable for certain services rendered to individuals who are incarcerated 30 days prior to their release.[6]
Expenditures related to evidence-based stimulant use disorder treatment models	Expenditure authority to provide contingency management small incentives via gift cards to individuals with qualifying psycho-stimulant disorders who are enrolled in a comprehensive outpatient treatment program.
Expenditures related to tenancy supports	Expenditure authority to provide tenancy supports to qualifying individuals with behavioral health needs.

VI. Demonstration Hypotheses and Evaluation Approach

Montana will contract with an independent external evaluator to conduct a critical and thorough assessment of the Demonstration consistent with CMS guidance and the requirements of the special terms and conditions for the Demonstration.

Table 5: Preliminary Evaluation Plan for 1115 SUD and SMI/SED Demonstration

Goal	Hypothesis	Evaluation Approach	Data Sources
Increased rates of identification, initiation and engagement in behavioral health treatment	Earlier identification of and engagement in behavioral health treatment for individuals with behavioral health needs will increase their utilization of community-based behavioral health treatment services.	The state will monitor the number of patients screened using an evidence-based tool, referral and service utilization trends for individuals diagnosed with SUD and/or SMI/SED.	• Claims data • Assessment data (SUD) • Referral information on the number of patients who received specialty SUD or mental health care following referral from an acute care or primary care setting
Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is	Increasing access to community-based treatment and recovery services, including tenancy	The state will monitor the: • Number and percentage of Medicaid	• Claims data

[6] As this Demonstration request is a novel one, the specific additional waivers or expenditure authorities, if any, that would be needed will be identified in collaboration with CMS.

Goal	Hypothesis	Evaluation Approach	Data Sources
preventable or medically inappropriate	supports; evidence-based stimulant use disorder treatment models; and pre-release care management to be provided to inmates in the 30 days pre-release will reduce emergency department utilization and preventable hospital admissions.	members with SUD and/or SMI/SED diagnoses with emergency department visits • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with hospital admissions • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with hospital readmissions • Ratio of emergency department visits to community-based treatment for individuals with SUD and/or SMI/SED • Ratio of hospital admissions to community-based treatment for individuals with SUD and/or SMI/SED	
Improved access to care for physical health	Improved care coordination and	The state will monitor:	• Claims data • Provider data

Goal	Hypothesis	Evaluation Approach	Data Sources
conditions among members with SUD and/or SMI obtaining treatment in IMDs and other behavioral health settings	integration efforts (e.g., physical health assessments and linkages to physical health services) will increase the diagnosis and treatment of co-morbid physical health conditions among members with SUD and/or SMI/SED obtaining treatment in IMDs.	• The number of patients being treated for SUD or mental illness who receive a primary care visit annually over the number of patients being treated for SUD or mental illness (in all specialty SUD and mental health settings) • The number of physical health assessments completed in IMDs and other behavioral health settings	• Assessment data
Improved availability of crisis stabilization services, including through call centers and mobile crisis units, outpatient services, and residential or inpatient services	Member access to crisis stabilization services across different service modalities will increase throughout the course of the Demonstration.	The state will monitor the: • Number and percentage of individuals accessing crisis services (e.g., mobile crisis response teams, outpatient crisis receiving facilities, inpatient crisis stabilization facilities) • Number and percentage of individuals utilizing certified behavioral health	• Crisis Diversion Grant data • Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
		peer support specialists within crisis services • Number and percentage of individuals presenting for behavioral health crises in emergency departments • Number of behavioral health-related responses from emergency medical services	
Improved care coordination and linkages to community-based behavioral health services following discharges from emergency department, prisons, residential or inpatient treatment	Care coordination for members with SUD and/or SMI/SED experiencing care transitions will improve throughout the course of the Demonstration.	The state will monitor: • Follow-ups after emergency department visit for mental illness or SUD • Number and percentage of facilities that documented member contact within 72 hours of discharge	• Claims data • Provider records
Reductions in overdose- and suicide-related deaths in Montana	Earlier identification and engagement in treatment and expanded access to behavioral health services across the continuum of care will contribute to a decline in overdose-	The state will monitor: • Follow-up and initiation of treatment following overdose reversals • Follow-up and initiation of	• Claims data • Death records • Crisis Diversion Grant data

Goal	Hypothesis	Evaluation Approach	Data Sources
	and suicide-related deaths in Montana.	treatment following crisis intervention services • Number of deaths from overdose and suicide	

VII. Public Review and Comment Process

The complete version of the Demonstration application is available for public review at: http://dphhs.mt.gov/heartwaiver. Paper copies are available to be picked up in person at the DPHHS office located at 111 North Sanders Street, Room 301, Helena, Montana 59601.

Two virtual public meetings will be held regarding the Demonstration application:

(1) July 20 from 1:00 to 3:00 pm MT
(2) July 21 from 10:00 am to 12:00 pm MT

To register for one or both meetings, use the following link: http://dphhs.mt.gov/heartwaiver. You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact Mary Eve Kulawik at (406) 444-2584.

Public comments may be submitted until 11:59 PM (Mountain Time) on September 7. Questions or public comments may be addressed care of Medicaid HEART Waiver, Department of Public Health and Human Services, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by telephone to (406) 444-2584, or by electronic mail to dphhscomments@mt.gov. Please note that comments will continue to be accepted after September 7, but the state may not be able to consider those comments prior to the initial submission of the demonstration application to CMS.

After Montana reviews comments submitted during this state public comment period, the state will submit a revised application to CMS. Interested parties will also have an opportunity to officially comment during the federal public comment period; the submitted application will be available for comment on the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.