State of Montana
Department of Public Health and Human Services

Medicaid Section 1115 Demonstration: Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration

DRAFT FOR PUBLIC COMMENT
July 2021

Contents

Section I: Executive Summary

Montana's Department of Public Health and Human Services (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 Healing and Ending Addiction through Recovery (HEART) demonstration request will complement the state's comprehensive strategy to expand access to behavioral health treatment for Medicaid members. Specifically, Montana is requesting approval to authorize federal Medicaid matching funds for the provision of targeted services for Medicaid members with behavioral health needs including tenancy supports, evidence-based stimulant use disorder treatment models including contingency management services, and targeted services provided to inmates in the 30 days prior to release. Additionally, this Section 1115 Demonstration will seek federal authority to reimburse for short-term acute inpatient and residential stays at institutions for mental disease (IMD) for individuals diagnosed with substance use disorders (SUD), serious mental illness (SMI), and serious emotional disturbance (SED).[1] In parallel to this Demonstration request, the state intends to add home visiting services for pregnant and parenting individuals with behavioral health needs; mobile crisis response services; clinically managed, population-specific, high-intensity residential services; and clinically managed residential withdrawal management to its Medicaid State Plan. Approval of this Demonstration will assist Montana in addressing its serious public health crisis in substance use disorders—including alcohol abuse, methamphetamine use, and opioid abuse and overdose—as well as surging mental health needs among state residents.

The state's intent to improve the behavioral health service continuum aligns with the state's commitment to advance health equity. The state is home to approximately 78,000 people of American Indian heritage, which is more than 6 percent of the state's total population; approximately 24,000 American Indian/Alaska Native (AI/AN) residents are Medicaid members. AI/AN populations in Montana have severe health disparities that ultimately result in their having life spans about 20 years shorter than those of White residents. By pursuing this Demonstration, the state can continue to address the disproportionately high rates of mental illness and SUD that Montana's AI/AN Medicaid enrollees experience.

While the implementation of Medicaid expansion in 2016 significantly improved access to Medicaid covered mental health and SUD services, gaps in access to critical behavioral health services still remain. 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 passage of the HEART Initiative, which invests significant state and federal funding in the state's behavioral health continuum.

This Demonstration seeks to expand access to and improve transitions of care across inpatient, residential, and community-based treatment and recovery services for individuals with SUD, SMI and SED by adding services to support successful community living, increasing access to intensive community treatment models and obtaining coverage for short-term stays delivered to individuals residing in IMDs.

[1] Montana uses the term SMI in place of the term severe disabling mental illness (SDMI) for the purposes of this Demonstration application.

This Demonstration will also enable the state to provide additional resources to help the state combat SUD-related overdoses and suicides, and complement its efforts to build out a robust and integrated behavioral health delivery system.

Montana is seeking an effective term of five years for the Demonstration from January 1, 2022, to December 31, 2026, for all provisions, except for Medicaid benefits for inmates in state prisons in the 30 days prior to release, which DPHHS is seeking to implement on January 1, 2023.

Section II: Program Overview

A. Background

System Overview

Montana Medicaid covers a continuum of behavioral health services ranging from early intervention services to crisis intervention, outpatient treatment, residential treatment, inpatient treatment and recovery services for individuals with behavioral health needs as detailed in Table 1.

The Addictive and Mental Disorders Division (AMDD) located within DPHHS manages the delivery of publicly funded—Medicaid, Substance Abuse and Mental Health Services Administration (SAMHSA) block grant, discretionary grant, and state-funded—mental health services for adults and SUD prevention and treatment programs for adolescents and adults. Through Montana Medicaid, DPHHS also contracts with behavioral health providers and agencies statewide to provide community-based and inpatient services for Medicaid members through Medicaid fee-for-service. The state works closely with its tribal partners, Indian Health Service and Urban Indian Centers to ensure that AI/AN Medicaid members have access to behavioral health services.

Table 1. Current Medicaid Continuum of Behavioral Health Services Covered Under the Montana Medicaid State Plan and Home and Community-Based Services (HCBS) Waiver

Mental Health and SUD	Mental Health	SUD

• Targeted case management
• Certified peer support services
• Outpatient services, both clinical and paraprofessional including therapy provided by licensed clinicians
• Inpatient hospital services
• Intensive outpatient program
	• Dialectical behavior therapy (DBT)
	• Illness management and recovery (IMR)
	• Crisis stabilization services
	• Day treatment, which includes:
	  ○ Community-based psychiatric rehabilitation and support services (CBPRS)
	  ○ Group therapy
	• Adult foster care support
	• Behavioral health group homes
		• Screening, brief intervention and referral to treatment (SBIRT)
		• SUD assessment
		• Outpatient services (ASAM 1.0)
		• SUD intensive outpatient treatment services (ASAM 2.1)
		• SUD partial hospitalization (ASAM 2.5)
		• SUD clinically managed high-intensity residential services (ASAM 3.5)

Mental Health and SUD	Mental Health	SUD
	• Program of Assertive Community Treatment (PACT) • Montana Assertive Community Treatment (MACT) • Montana Medicaid Severe and Disabling Mental Illness (SDMI) 1915(c) Waiver	• SUD medically monitored intensive inpatient services (ASAM 3.7) • Medication Assisted Treatment

SUD Crisis in Montana

Similar to all other states in the country, Montana has been working to address a persistent and shifting SUD crisis that impacts individuals, families and communities throughout the state. The state's opioid-related overdose deaths have remained relatively steady over the past few years compared to those of other states throughout the country due to the state's coordinated efforts to address emerging SUD issues. Over the past decade, the state has created and grown strong partnerships between local, tribal, and state health and justice partners. The state has also expanded access to evidence-based treatment and recovery services while promoting harm reduction and appropriate justice system diversion.

Although the state has made progress in addressing SUD, more work is required to expand access to SUD prevention and treatment services and prevent drug overdoses. Alcohol misuse affects a significant number of Montanans, with 21 percent of adult state residents reporting binge drinking in 2019.[2] Montana's current demand for inpatient and residential SUD treatment beds exceeds capacity, with the IMD exclusion exacerbating access shortages.

While opioids still account for the largest percentage of drug overdoses in the state, methamphetamine-related deaths, hospitalizations and emergency department visits in Montana have increased over the last few years.[3] In 2019, the annual methamphetamine-related death rate in Montana was 7.2 per 100,000 people, exceeding the national average of 5.7 per 100,000 people. [4] For example, nationally, the risk of dying from methamphetamine overdose is 12 times higher for AI/ANs than for other groups.[5] While state-specific SUD estimates are less readily available for the AI/AN population, data from the Tribal Epidemiology Centers of the Indian Health Service show that methamphetamine use has more than tripled in Montana's AI/AN populations between 2011 and 2015.[6]

Approximately 12,900 Montanans aged 12 years and older used methamphetamine in the period 2009-2019.[7] Over 65 percent of child and family services division substance-use related placements listed

[2] "Alcohol Use in Montana," MT DPHHS, January 2021. Available at: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/EpiAlcoholUse2021.pdf.
[3] "Summary of Methamphetamine Use in Montana." Public Health in the 406. August 2020. Available at: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/MethamphetamineSummary2020.pdf.
[4] Ibid.
[5] Valentino, Tom. "NIH's HEAL Initiatives Keep Progressing Thanks to Scientists' Ingenuity." April 6, 2021. Available at: https://www.psychcongress.com/article/nihs-heal-initiatives-keep-progressing-thanks-scientists-ingenuity.
[6] Indian Health Service: The Federal Health Program for American Indians and Alaska Natives. Available at: https://www.ihs.gov/epi/tecs/publications-and-resources/.
[7] Ibid.

methamphetamine as the primary drug. The increase in methamphetamine use has also been linked to increases in violent crimes in the state.[8] In Missoula, on the western side of the state, the county attorney's office reported that the amount of methamphetamine seized by task forces nearly doubled in a five-year period. Treatment for methamphetamine use carries with it a unique set of problems. First, unlike opiates and opioids, there is no evidence-based medication assisted treatment for methamphetamine. Treatment can be long, because the drug is neurotoxic, and users may need to be treated for multiple physical ailments as well as brain trauma prior to being able to receive treatment. Finally, the use of methamphetamine is linked to violent crime, which lends an immediacy to the need for effective treatment.[9]

This Demonstration will enable the state to expand evidence-based SUD treatment across the continuum of care for individuals with opioid, stimulant use or alcohol use disorder.

Mental Health Challenges in Montana

Addressing mental health needs that range from mild to severe among adults and children remains a key priority for the state. Consistent with rising national averages, approximately one in five adults in Montana report symptoms of mental illness, and 5 percent of adults, or 42,600 report serious mental illness.[10,11] More troubling, Montana has ranked in the top five states for suicide rates across all age groups for the past 30 years and had the third-highest suicide rate in the country in 2019, with more than 250 deaths.[12] Individuals who commit suicide are often struggling with depression and/or SUD; 42 percent of suicide victims in Montana had alcohol in their systems.[13] Across all age groups, the highest rates of suicide are among AI/AN, highlighting the need to address mental health on a community level.[14]

Gaps in access to behavioral health treatment services and significant shortages of behavioral health professionals contribute to the state's persistently high rates of mental illness and suicide. The state has been diligently working to improve access to mental health prevention and treatment services, and to integrate screening and treatment into primary care settings, expand short-term crisis intervention

[8] "Violent Crime Increasing in Yellowstone County." Department of Justice, U.S. Attorney's Office, District of Montana. September 1, 2020. Available at: https://www.justice.gov/usao-mt/pr/violent-crime-increasing-yellowstone-county#:~:text=Yellowstone%20County%20has%20had%2067,almost%20a%2021%20percent%20increase.

[9] Tooke, Michelle; Shane Darke, Sharlene Kaye, Joanne Ross, and Rebecca McCretin. "Comparative rates of violent crime amongst methamphetamine and opioid users: Victimisation and offending." National Drug and Alcohol Research Centre, University of New South Wales. 2008. Available at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.568.2221&rep=rep1&type=pdf.

[10] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health." SAMHSA. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[11] "2018-2019 National Survey on Drug Use and Health: Model Based Prevalence Estimates (50 States and the District of Columbia)." SAMHSA. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32803/2019NSDUHsaeMaps/2019NSDUHsaeMaps/2019NSDUHsaeMaps.pdf.

[12] "Suicide in Montana: Facts, Figures and Formulas for Prevention." DPHHS. Updated January 2021. Available at: https://dphhs.mt.gov/Portals/85/suicideprevention/SuicideinMontana.pdf.

[13] "2016 Suicide Mortality Review Team Report," DPHHS. Available at: https://dphhs.mt.gov/Portals/85/suicideprevention/2016SuicideMortalityReviewTeamReport.pdf.

[14] Ibid.

services and community-based treatment services for adults with SMI using assertive community treatment, and expand the behavioral health workforce using behavioral health peer support specialists.

Behavioral Health Needs for Justice-Involved Populations

Ensuring continuity of health coverage and care for justice-involved populations is a high priority for Montana. Currently there are 3,700 inmates in state prisons and 1,800 inmates in local jails.[15] Providing behavioral health services to justice-involved populations can help to further decriminalize mental illness and SUD.

Individuals leaving incarceration are particularly vulnerable to poorer health outcomes—justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of violence, overdose and suicide than people who have never been incarcerated.[16] According to the Montana Department of Corrections (DOC), at least 75 percent of the population in the Montana Women's Prison have a mental health diagnosis with almost half of the women in the Montana Women's Prison diagnosed with an SMI. In Montana state prisons, approximately 20 percent of the population have an SMI. In 2016, it was estimated that 40 percent of individuals processed through the DOC were for offenses related to substance use.[17] A 2020 study from DPHHS shows that individuals released from the Montana DOC had an 11.2 times higher risk of death than the general population; this is driven by a 27 times higher rate of drug overdose in this population.[18]

Evidence suggests that improving health outcomes for justice-involved populations requires focused care management in order to connect individuals to the services they need upon release into their communities.[19] Montana's DPHHS and DOC have collaborated to better streamline Medicaid enrollment and coordinate SUD treatment and medical care for the reentry population. Medicaid enrollment is a standard part of the discharge process for individuals in DOC prison custody; DPHHS already has agreements in place to suspend coverage, maintain eligibility for incarcerated individuals, and turn on Medicaid coverage the same day an individual is released from DOC to ensure they can receive SUD treatments and medical care on day one. To further improve the efforts of DPHHS and DOC to ensure justice-involved populations have a stable network of health care services and supports upon discharge, Montana is seeking to provide limited community-based clinical consultation services, in-reach care management, and coverage of certain medications that will facilitate maintenance of medical and psychiatric stability upon release; medication coverage will also include 30-day supply of medication following reentry into the community.

This Demonstration will address the healthcare needs of Montana's justice-involved population and promote the objectives of the Medicaid program by ensuring high-risk, justice-involved individuals

[15] Prison Policy Initiative: Montana Profile. 2018. Available at: https://www.prisonpolicy.org/profiles/MT.html.
[16] Binswanger, Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release from Prison — A High Risk of Death for Former Inmates," New England Journal of Medicine, January 2007.
[17] Substance Use in Montana: A summary of state level initiatives for the Department of Justice. September 2017. Available at: https://dojmt.gov/wp-content/uploads/Substance-Use-in-Montana-DOJ-FINAL-September-19th.pdf.
[18] Improving Substance Use Disorder Treatment in the Montana Justice System. 2020. Available at: http://mbcc.mt.gov/DesktopModules/EasyDNNNews/DocumentDownload.ashx?portalid=130&moduleid=87994&articleid=20595&documentid=3400.
[19] "How Strengthening Health Care at Reentry Can Address Behavioral Health and Public Safety: Ohio's Reentry Program,' available at https://cochs.org/files/medicaid/ohio-reentry.pdf.

receive needed coverage and health care services prior to and post-release into the community. Montana will be able to bridge relationships between community-based Medicaid providers and justice-involved populations prior to release to improve the likelihood that individuals with a history of behavioral health needs receive stable and continuous care.

Assessment of the Availability of Mental Health Services

Montana completed an assessment of the availability of mental health services that will be included in the Appendix to this application using the CMS-provided template to understand the current prevalence of members with SMI and SED, as well as provider participation in Medicaid across psychiatrists, other practitioners licensed to treat mental illness and other specialty mental health providers. According to available claims data, fourteen percent of adults on Medicaid have an SMI and 14 percent of children on Medicaid have an SED. There is a higher percentage of members with SMI/SED in urban counties and their adjacent counties than other counties. Thirty-one percent of all members with SMI/SED reside in the five most populated counties (Cascade, Flathead, Gallatin, Missoula, and Yellowstone), which also have the most services available.

The assessment revealed a shortage of outpatient providers who are specialized to treat members with mental illness. In particular, the assessment found that there is a need for more psychiatrists and providers who specialize in psychiatry. There are 13 counties throughout the state that lack prescribers who can treat members with SMI. Similarly, there is a lack of other practitioners treating mental illness in many counties, particularly practitioners that accept Medicaid. Currently, about 65 percent of licensed mental health practitioners are enrolled in Medicaid. There are 12 counties that do not have licensed mental health practitioners and 13 counties where none are enrolled in Medicaid.

B. Overview of Current Initiatives to Improve Behavioral Health Care

To address the serious behavioral health challenges faced by Montanans detailed above, the state—working across its agencies—has implemented complementary strategies to improve the behavioral health delivery system for adults and children.

Prevention and Early Intervention Strategies

The state has invested in prevention and early intervention strategies that aim to support the development of healthy behaviors and reduce reliance on crisis care, with a particular community-driven focus on children, youth and their families, including:

- **Parenting Montana:** This web-based resource for parents braids together supports grounded in evidence-based practices to help kids and families thrive and cultivates a positive, healthy culture among Montana parents with an emphasis on curbing underage drinking. This resource also provides resources to provide parents or those in a parenting role with tools for everyday parenting challenges from the elementary to post-high school years.
- **Communities That Care (CTC):** CTC promotes healthy youth development and addresses risk and protective factors to help mitigate problem behaviors in communities. Planning for this program began in January 2018, and the project's vision is to engage in a five-phase community change process that helps reduce levels of youth behavioral health problems before they escalate, providing a path to disrupt the cycle of issues encouraging problem behaviors.

- **Suicide Prevention Efforts for Youth:** The state implemented a number of suicide prevention programs focused on school-age children and youth, including Signs of Suicide; Question, Persuade and Refer; and PAX Good Behavior Game (GBG). PAX GBG teaches elementary-age students' self-regulation, self-control and self-management as well as additional social-emotional skills including teamwork and collaboration. PAX GBG is currently in over a hundred schools statewide and growing, with the goal of implementing districtwide in grades K-5 in as many districts as possible, with ongoing supports to ensure fidelity and long-term sustainability.
- **Suicide Prevention and Modernization Initiatives:** The state collaborated with the National Council for Behavioral Health to revamp its State Suicide Prevention Strategic Plan and implement suicide prevention activities. As part of this effort, the State has provided federal grants and direct state funds to Tribes and Urban Indian Health Centers to support local planning and implementation of Zero Suicide, a comprehensive approach to suicide care that aims to reduce the risk of suicide for individuals seen in health care systems, and to seek training for self-care best practices for frontline health and behavioral health staff and community members. The state has also established the use of the Centers for Disease Control and Prevention's National Violent Death Reporting System, which tracks all suicides.

SUD-Specific Strategies

Over the past five years, the state has increased its focus on addressing SUD and has implemented a range of initiatives including the following:

- **SUD Task Force and Strategic Plan:** DPHHS first convened the SUD Taskforce in fall of 2016 to develop an SUD Task Force Strategic Plan covering 2017-2019 with input from 250 individuals representing 135 organizations statewide. Operating under this plan from 2017 to 2019, Montana implemented numerous strategies to improve systems for preventing, treating and tracking SUD statewide. In 2019, DPHHS reconvened the SUD Task Force to update the strategic plan for 2020-2023 to reflect the state's progress in implementing the plan's strategies and the state's current experience.[20]
- **Upgraded Prescription Drug Monitoring Program (PDMP):** The Montana Prescription Drug Registry (MPDR) transitioned to a new system vendor in March 2021 to support expanded prescription drug monitoring services throughout the state. First authorized by the Montana Legislature in 2011, MPDR is an online tool that provides a list of controlled substance prescriptions to health care providers to improve patient care and safety, as well as identify potential misuse or diversion of controlled substances. All state-licensed pharmacies are required to report prescription data, including information identifying the prescriber and patient, and the drug name, strength and dosage, for Schedule II-V controlled substances. Prescribers are also required to review the patient's record in the MPDR prior to prescribing an opioid or benzodiazepine in almost all cases; exceptions include prescriptions for patients receiving hospice care, in chronic pain provided the prescriber reviews the patient's record

[20] "Montana Substance Use Disorder Task Force Strategic Plan 2020 – 2023." DPHHS. Available at: https://dphhs.mt.gov/Portals/85/publichealth/documents/EMSTS/opioids/MontanaSubstanceUseDisordersTaskForceStrategicPlan.pdf?

every three months, or the prescription is being administered to a patient in a health care facility.[21]

- **Family-Centered Standard of Care for Pregnant People:** The Meadowlark Initiative, a partnership that began in 2018 between DPHHS and the Montana Health Care Foundation, utilizes a care team, including an obstetrics provider, a behavioral health provider and a care coordinator, to integrate and coordinate care for pregnant, postpartum and parenting people who suffer from addiction and mental illness. In addition, the Strengthening Families Initiative provides an opportunity to further enhance coordination with specialty SUD treatment and recovery services for pregnant, postpartum and parenting people and their families.
- **Stimulant Use Disorder Monitoring and Treatment Pilot:** DPHHS monitors the prevalence of and issues associated with methamphetamine use in Montana as part of its state Epidemiology Outcome Workgroup. AMDD is also initiating The TReatment of Users with STimulant Use Disorder (TRUST) model to combine evidence-based interventions including motivational interviewing, contingency management, community reinforcement, cognitive behavioral therapy and exercise for individuals with stimulant use disorder.
- **Naloxone Training and Access:** Under the state's State Opioid Response grant, training on how to use and administer Naloxone is available free of charge. Emergency medical services (EMS), law enforcement, school nurses, harm reduction clinics, families and individuals can also access Naloxone through this program.
- **State Epidemiological Outcomes Workgroup (SEOW)**: As part of the state's ongoing analysis of SUD needs and outcomes, Montana established the SEOW for the purpose of identifying, interpreting, and distributing data relevant to substance use and mental health (SUMH). The SEOW aims to inform prevention practices and policies by providing meaningful data about the consequences, related behaviors, and contributing risk and protective factors of SUMH disorders in Montana.

Mental Health and Crisis-Specific Strategies

In recent years, the state has made significant investments to restructure its crisis system, suicide prevention, and behavioral health treatment and recovery support systems for individuals with significant behavioral health needs. First, the state has undertaken a number of steps to overhaul its behavioral health crisis system in order to sustain funding for ongoing needs, foster local innovation, create equity between state general fund programs and the Medicaid model, and ensure all programs are evidence-based and aligned with national best practices. Crisis-specific initiatives include:

- **Distribution of grants to counties and tribal partners:** AMDD distributed grants to fund counties' crisis systems (e.g., crisis intervention teams, community coordinators and mobile crisis response teams) and reflect the impact of COVID-19 on communities' crisis needs. The state also issued grants focused specifically on mobile crisis response. Planning for regional crisis stabilization hubs has begun with a grant from the National Association of State Mental Health Program Directors.
- **Lifeline crisis call centers:** Over the past two years, additional funding was provided to the state's two regional Suicide Prevention Lifeline Centers to improve the infrastructure in order to

[21] Montana Prescription Drug Registry (MPDR)." Montana Department of Labor & Industry. Available at: https://boards.bsd.dli.mt.gov/pharmacy/mpdr/

better manage increases in call volume and to provide in-depth data surveillance. The state also received and is implementing a grant to strategically plan for implementation in Montana.

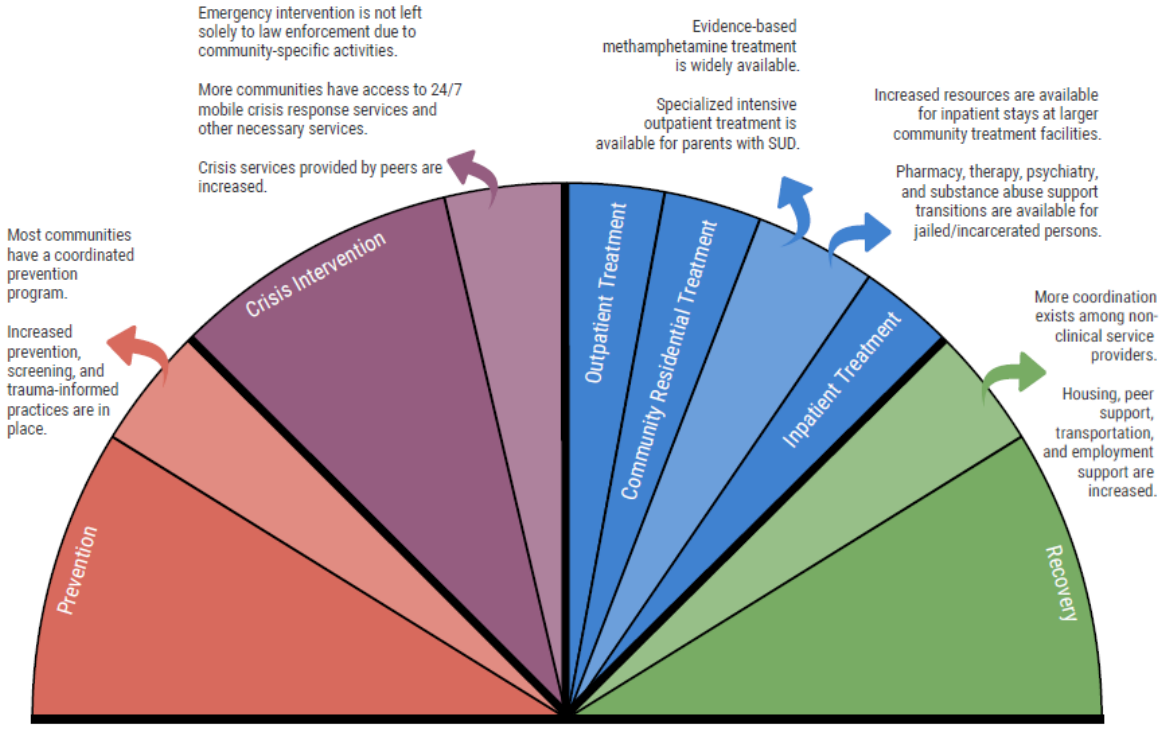
Other mental health treatment and recovery initiatives include:

- **Expanding drop-in centers:** Seven drop-in centers currently operate in Montana to provide a voluntary, safe place for individuals that fits their personal needs or preferences and engages them in socialization, crisis mitigation, and overall quality-of-life improvement. The state also funds a warmline outside of its lifeline and COVID-19 crisis line.
- **Strengthening assertive community treatment:** AMDD worked collaboratively with the Behavioral Health Alliance of Montana on the creation of a tiered program that includes assertive outreach, mental health treatment, health, vocational, integrated dual disorder treatment, family education, wellness skills, care management, tenancy support, and peer support from a mobile, multidisciplinary team in community settings. The program now has a fidelity assessment component that is provided through the Western Interstate Commission on Higher Education (WICHE), which also provides the fidelity reviews for other states.
- **Expansion of home- and community-based waiver program**: Montana Medicaid doubled its number of slots for individuals with a severe and disabling mental illness who also meet the criteria for a nursing home but can live in the community with appropriate services and supports.

C. Montana's Vision for Behavioral Health Reform

Montana intends to use this 1115 Demonstration to support its broader efforts to strengthen its evidence-based behavioral health continuum of care for individuals with SUD and SMI/SED; enable prevention and earlier identification of behavioral health issues, particularly among at-risk children and youth; and improve the quality of care delivered through improved data collection and reporting. In particular, this Demonstration will support the state's implementation of Governor Greg Gianforte's HEART Initiative which seeks to fill gaps across the state's substance use and crisis continuum of care using evidence-based care models and treatment services.

Figure 1. HEART Fund Model of Care



HEART Initiative and Early Intervention Model

Montana's proposed prevention model builds on its current initiatives to implement community-based programs that address suicide, mental health and SUD and includes the following goals:

- Increase the number of counties and Indian reservations in Montana that have prevention specialists;
- Increase the number of evidence-based coalition processes in more Montana communities (e.g., Communities That Care and Collective Impact);
- Increase the number of schools implementing PAX GBG or similar school-based/family-oriented, evidence-based strategies that promote enhanced social-emotional behavioral and self-regulation and long-term resilience;
- Increase the number of evidence-based interventions focusing on community-based prevention;
- Increase access to programs that address suicide and mental health prevention;
- Increase the implementation of SBIRT and other evidence-based primary care interventions; and
- Promote the use of validated screening tools in local schools and primary care to address substance use and suicide ideation.

HEART Initiative Crisis Intervention Model

Montana intends to implement the CRISIS NOW model on a statewide basis that ensures the provision of appropriate services to anyone, anywhere and anytime. The CRISIS NOW model identifies four key elements of a successful crisis system:

- High-tech crisis call centers;
- 24/7 mobile crisis response;

- Crisis stabilization programs; and
- Essential principles and practices including recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

As detailed above, Montana has been building the foundation of this model over the past several years using a combination of grants, state funding and Medicaid funding. This Demonstration will support Montana's efforts to realize its vision of a cohesive crisis system of care that links individuals in need to the appropriate level of care. Montana intends to add mobile crisis response services to its Medicaid State Plan in order to divert individuals from corrections facilities and emergency rooms, and is seeking to support successful transitions from prisons to community-based settings to ensure continuity of care and the provision of adequate supports to reduce recidivism.

HEART Initiative SUD Treatment Model

Montana proposes to enhance the SUD continuum of care and ensure that individuals are linked to the level of care that best meets their treatment need, through the addition of new services using the Medicaid State Plan or 1115 Demonstration authority.

- The state intends to add the following SUD treatment services to its Medicaid State Plan:
  - SUD Clinically Managed Population Specific High Intensity Residential (ASAM 3.3) for adults only; and
  - SUD Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM) for adults only.
- The state is seeking authority through this Demonstration to:
  - Provide evidence-based stimulant use disorder treatment models, including models that include contingency management, as part of a comprehensive treatment model for individuals with stimulant disorder;
  - Authorize federal Medicaid matching funds for the provision of targeted Medicaid services to eligible inmates of state prisons with SUD, SMI or SED in the 30 days prior to their release into the community; and
  - Reimburse for short-term residential and inpatient stays in IMDs.

HEART Initiative Recovery Support Model

The state proposes to enhance recovery supports for individuals with SUD and SMI/SED through an expansion of tenancy support services under this Demonstration to ensure that these individuals have the supports necessary to thrive in their communities. The state also intends to ensure that appropriate care coordination flows through the continuum from treatment through recovery.

D. Demonstration Goals and Objectives

This Demonstration will allow Montana to better address the behavioral health needs of Montana residents 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.

Montana will provide detailed information on its strategy for meeting Demonstration milestones (as identified in SMD #17-003 and SMD #18-011) in its draft Implementation Plans. Montana will finalize and submit its Implementation Plans following submission of this application to CMS within 90 days of approval of this proposed Demonstration.

E. Hypothesis and Evaluation Plan

The Demonstration will test whether the expenditure authority granted increases access to behavioral and physical health services and improves outcomes for Medicaid members with SUD and/or SMI/SED.

Montana will contract with an independent external evaluator to conduct a critical and thorough assessment of the Demonstration. The independent external evaluator will develop a comprehensive evaluation design that is consistent with CMS guidance and the requirements of the special terms and conditions for the Demonstration.

Based on the goals identified above through CMS guidance, the state proposes to test the tentative hypotheses using a high-level evaluation plan summarized in Table 2 below. All components of the preliminary evaluation plan are subject to change as the program is implemented and an evaluator is identified.

Table 2: 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 preventable or medically inappropriate	Increasing access to community-based treatment and recovery services, including tenancy 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	The state will monitor the: • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with emergency department visits • Number and percentage of Medicaid members with SUD and/or	• Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
	emergency department utilization and preventable hospital admissions.	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 conditions among members with SUD and/or SMI obtaining treatment in IMDs and other behavioral health settings	Improved care coordination and 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 state will monitor: • 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	• Claims data • Provider data • Assessment data

Goal	Hypothesis	Evaluation Approach	Data Sources
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 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	• Crisis Diversion Grant data • Claims data
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	• Claims data • Provider records

Goal	Hypothesis	Evaluation Approach	Data Sources
		within 72 hours of discharge	
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- and suicide-related deaths in Montana.	The state will monitor: • Follow-up and initiation of treatment following overdose reversals • Follow-up and initiation of treatment following crisis intervention services • Number of deaths from overdose and suicide	• Claims data • Death records • Crisis Diversion Grant data

Section III: Eligibility and Enrollment

A. Eligibility

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 who are eligible for the CHIP Program, will be included in this Demonstration. Pre-release services will be provided to inmates of state prisons with SUD and/or SMI. This Demonstration will only directly impact members diagnosed with SUD or SMI/SED.

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, and DPHHS is not proposing changes to Medicaid eligibility standards in this Demonstration application.

See Table 3 for more information on Medicaid eligibility groups affected by this Demonstration.

Table 3. Medicaid Eligibility Groups Affected by the Demonstration

Eligibility Group	Federal Citations	Income Federal Poverty Level (FPL)
Medicaid Children Ages 18-20	42 CFR § 435.117	0-143 percent FPL
CHIP Children Aged 18	SSA § 2102	144-261 percent
Adults	42 CFR § 435.119	0–138 percent FPL
Parents/Caretaker Relatives	42 CFR § 435.110	0–24 percent FPL

Eligibility Group	Federal Citations	Income Federal Poverty Level (FPL)
Pregnant Women	42 CFR § 435.116	0–157 percent FPL
Aged/Blind/Disabled	42 CFR §§ 435.120-435.138	SSI benefit rate. May spend down to qualify.

If CMS approves this Demonstration proposal, Montana projects that approximately 300 individuals each year will receive Medicaid coverage 30 days pre-release. This estimate is based on data received from the Department of Corrections and the Board of Pardon and Parole.

B. Enrollment

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 4. 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

Section IV: Benefits and Delivery System

A. Benefits

Montana is seeking to add new Medicaid services under this Demonstration as part of its commitment to ensuring that Medicaid members have access to a full continuum of behavioral health services including:

- Evidence-based stimulant use disorder treatment models, including contingency management;
- Tenancy supports; and
- Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.

These additional services will complement new SUD treatment services and crisis services that the state is planning to add to its Medicaid State Plan:

- Home visiting services for pregnant, post-partum people, and parents/caretakers with behavioral health needs;
- Mobile crisis response services;
- Clinically managed population-specific high-intensity residential services (ASAM 3.3); and
- Clinically managed residential withdrawal management (ASAM 3.2-WM).

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). Contingency management allows individuals in treatment to earn small motivational incentives for meeting treatment goals (e.g., negative urine drug screens). These incentives are in the form of low-denomination gift cards that individuals can exchange for goods and services from a variety of retail stores. Contingency management is the only treatment that has demonstrated robust outcomes for individuals with stimulant disorder, including reduction or cessation of drug use and longer retention in treatment.[22, 23, 24]

This pilot will combine evidence-based interventions including contingency management, motivational interviewing, community reinforcement, exercise and cognitive behavioral therapy. Contingency management will only be available to Medicaid members with a completed ASAM criteria assessment

[22] De Crescenzo, F., Ciabattini, M., D'Alò, G. L., De Giorgi, R., Del Giovane, C., Cipriani, A. "Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis." 2018. PLoS Medicine. 15(12), e1002715. PMCID: PMC6306153. Available at: https://pubmed.ncbi.nlm.nih.gov/30586362/

[23] Farrell, M., Martin, N. K., Stockings, E., Baez, A., Cepeda, J. A., Degenhardt, L., Ali, R., Tran, L. T., Rehm, J., Torrens, M., Shoptaw, S., "Responding to global stimulant use: challenges and opportunities." Lancet. 394, 1652-1667. 2019. doi: 10.1016/S01406736(19)32230-5. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32230-5/fulltext

[24] AshaRani, P. V., Hombali, A., Seow, E., Jie, W. O., Tan, J. H., Subramaniam, M. "Non-pharmacological interventions for methamphetamine use disorder: a systematic review, Drug and Alcohol Dependence". 2020. doi:https://doi.org/10.1016/j.drugalcdep.2020.108060. Available at: https://pubmed.ncbi.nlm.nih.gov/32445927/

who are diagnosed with a qualifying stimulant use disorder and are participating in the TRUST pilot. Incentives will also be subject to an aggregate limit of $390 per twelve-month period.

Tenancy Support Services

This Demonstration proposes to add coverage for a tenancy support services program to assist members ages 18 and older with SMI and/or SUD who are experiencing chronic homelessness or frequent housing instability, who frequently engage with crisis systems and institutional care who will benefit from housing-related pre-tenancy and tenancy sustaining services.

A Medicaid member aged 18 and older is eligible for tenancy supports, if they meet:

- At least one of the following needs-based criteria, and
- At least one risk factor

Needs-based criteria: The member has a behavioral health need, defined below, and is expected to benefit from housing supports:

- Serious mental illness (SMI) diagnostic criteria, and/or
- Substance use disorder (SUD)

Risk Factors: The member has at least one of the following risk factors:

- At risk of homelessness (e.g., an individual who will lose their primary nighttime residence);
- Homelessness (e.g., residing in a place not meant for human habitation, a shelter for homeless persons, a safe haven, fleeing domestic or violence or the streets);
- History of frequent or lengthy stays in an institutional setting, institution-like setting, assisted living facility, or residential setting;
- Frequent ED visits or hospitalizations;
- History of involvement with the criminal justice system; or
- Frequent turnover or loss of housing as a result of behavioral health symptoms.

Tenancy support services will include:

- Pre-tenancy supports: These include activities to support an individual's ability to prepare for and transition to housing, such as:
    - Completion of person-centered screening and assessment to identify housing preferences and barriers related to successful tenancy;
    - Development of an individualized housing support plan based on the assessment;
    - Development of an individualized housing support crisis plan;
    - Housing search services including assisting with rent subsidy, collecting required documentation for housing application, and assistance with searching for housing; and
    - Move-in support services such as assisting individuals in identifying resources to cover expenses related to move-in (e.g., security deposits and move-in costs) and with the move (e.g., ensuring housing unit is safe and ready for move-in).
- Tenancy sustaining services. These include services to assist individuals in maintaining services once housing is secured, such as:

- Relationship building with the property management and neighbors through education and training on the roles, rights and responsibilities of the tenant and landlord and assistance resolving disputes with landlords and/or neighbors;
- Assistance with the housing recertification process;
- Coordinating with the member to review, update and modify their housing support, including the development of a rehousing plan, as appropriate, and crisis plans;
- Advocacy and linkage with community resources to prevent eviction;
- Early identification and intervention for behaviors jeopardizing housing;
- Assistance with credit repair activities and skill building;
- Housing stabilization services; and
- Continued training and tenancy and household management.

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 which 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.

For the care management provided to inmates in the 30 days pre-release, the in-reach care management benefit will be delivered by SUD providers contracted through drug courts and additional contracted community-based providers with particular expertise working with justice-involved individuals with behavioral health needs. The scope of in-reach care management will include but not be limited to the following:

- Conducting a care needs assessment;
- Developing a transition plan for community-based health services;
- Making referrals to physical and behavioral health providers for appointments post release;
- Linking justice-involved populations to other critical supports that address social determinants of health; and
- Development of a medication management plan.

Delivery of services during the 30 days pre-release will require close coordination with the state prisons to both identify/refer members and ensure connections to care once individuals are released from incarceration. Montana is seeking to implement the Medicaid coverage 30 days pre-release by January 1, 2023. Recognizing the need for system and operations changes, the state plans to implement in a phased rollout.

B. Delivery System

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.

C. 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.

Section V: Demonstration Financing

A. Budget Neutrality

Montana is developing the budget neutrality calculation for the five-year Demonstration period. 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 authorities requested in the demonstration renewal do not represent new spending but instead represent spending that would otherwise be expected under the Montana Medicaid State Plan. For example, the inclusion of selected services for justice-involved individuals prior to release is expected to keep total spend at or below current levels by averting the need for significant expenditures on inpatient, emergency department, and other acute services post-release. Montana also proposes to treat spending on tenancy support services as hypothetical because they are comparable to what is available to the state via 1915(i) state plan authority.

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 5: 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[25]	733,032	762,573	793,305	825,275	858,534
IMD Exclusion for SMI/SED[26]	13,750,134	13,887,636	14,026,512	14,166,777	14,308,445
Tenancy Supports[27]	11,782,355	12,257,184	12,751,149	13,265,020	13,799,600

[25] 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.

[26] 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.

[27] 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.

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***
30-Days Pre-Release Coverage[28]	63,768	64,406	65,050	65,700	66,357
Evidence-Based Stimulant Use Disorder Treatment Models[29]	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

B. Maintenance of Effort

Montana has summarized the outpatient community-based mental health expenditures for state fiscal year 2020, distributed by population and stratified according to federal share, state share general funds and state share county-level funding in the table below. 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. Montana is committed to maintaining or improving access to community-based mental health services throughout the course of this Demonstration.

Table 6: Montana SFY 2020 Expenditures on Community-Based Mental Health Services

Total	Federal	State – General Funds (Matchable)	State-County Funds	Total
Medicaid Expansion	$33,426,401	$3,714,045	N/A	$37,140,446
Standard	$34,870,493	$18,776,419	N/A	$53,646,912
Total Montana Medicaid	$68,296,894	$22,490,464	N/A	$90,787,358

[28] 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 a applied a 1 percent annual rate increase.
[29] 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.

Section VI: 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 7: 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, and 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 8: 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 otherwise matchable for certain services rendered to incarcerated individuals 30 days prior to their release.[30]

[30] 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.

Expenditure Authority	Use for Expenditure Authority
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.

Section VII: Public Review and Comment Period

The 60-day public comment period for Montana's Section 1115 demonstration application is from July 9 to September 7. All comments must be received no later than 11:59 PM (Mountain Time) on September 7.

All information regarding Montana's Section 1115 demonstration application can be found on the DPHHS website at https://dphhs.mt.gov/heartwaiver. DPHHS will update this website throughout the public comment and application process.

Two 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 (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.