State of Montana
Department of Public Health and Human Services

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

Draft for Public Comment
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Contents

Section I: Executive Summary

Montana's Department of Public Health and Human Services (DPHHS) is requesting a Section 1115 Demonstration amendment to build upon the strides made by the state over the past decade to establish a comprehensive continuum of behavioral health—mental health and substance use disorder (SUD)—services for its Medicaid members. This Healing and Ending Addiction through Recovery and Treatment (HEART) demonstration amendment 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, contingency management services and targeted services provided to inmates in the 30 days prior to release. This Section 1115 Demonstration amendment request will also seek federal authority to reimburse for short-term acute inpatient and residential stays at institutions for mental disease (IMDs) for stays by children or youth with serious emotional disturbance (SED) at IMDs that are also qualified residential treatment programs (QRTPs).[1] In parallel with 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 amendment request will assist Montana in addressing its serious public health crisis in Substance Use Disorder (SUD)—including alcohol abuse, methamphetamine use, and opioid abuse and overdose—as well as surging mental health needs among children and youth.

On October 1, 2021, Montana's DPHHS submitted the underlying HEART demonstration request to CMS.[2] The objective of the Section 1115 Demonstration request was to build upon the strides made by the state over the past decade to establish a continuum of behavioral health—mental health and substance use disorder (SUD)—services for its Medicaid members. This HEART 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, as outlined in H.B. 701.

On July 1, 2022, Montana received CMS approval for the SUD IMD component of the HEART Demonstration, with concurrent approval of the required Substance Use Disorder (SUD) Implementation Plan and SUD Health Information Technology (HIT) Plan.[3] The Demonstration approval that was obtained will allow the State to receive federal financial participation (FFP) for state plan services provided to otherwise-eligible Medicaid beneficiaries, ages 18 to 64, who are primarily receiving treatment and withdrawal management services for SUD in residential and inpatient settings that qualify as institutions for mental disease (IMDs). It will also support Montana's efforts to connect individuals with appropriate levels of care, improve availability of Medication Assisted Treatment (MAT), and enhance access to SUD evidence-based services. The Demonstration will give beneficiaries access to a continuum of services in settings that, absent the Demonstration approval, would be ineligible for payment for most Medicaid enrollees, allowing the state to provide more coordinated and comprehensive treatment to SUD beneficiaries.

CMS's Demonstration approval on July 1, 2022 did not include approval for SED services provided in an IMD for youth. By submitting this Demonstration amendment request, Montana DPHHS is seeking Demonstration authority to receive FFP for state plan services provided to otherwise eligible Medicaid beneficiaries, under 21 years old, with SEDs in IMDs that are QRTPs.

Montana DPHHS is not seeking any amendments to the other HEART Demonstration authority requests that are currently pending CMS approval—contingency management, tenancy supports, and reentry services for justice-involved populations.

DPHHS is submitting the amendment request via redline changes to the underlying HEART Demonstration submitted in October 2021. DPHHS is taking this approach in light of the fact that CMS has granted approval for the SUD IMD component of the HEART Demonstration and that DPHHS continues to have HEART Demonstration authority requests pending CMS' approval. By submitting the amendment request using redline changes, DPHHS is seeking to assist CMS and the public in identifying the new requested changes. Any language related to the SUD IMD authority request that were in the underlying HEART Demonstration request have been removed as that component of the HEART Demonstration has already been approved by CMS. 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 and children and youth with 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. 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 amendment to the current Demonstration request, which is effective from July 1, 2022 through June 30, 2027.

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.

[1] Montana uses the term SMI in place of the term severe disabling mental illness (SDMI) for the purposes of this Demonstration application.
[2] State of Montana Department of Public Health and Human Services, "Medicaid Section 1115 Demonstration: Healing and Ending Addiction Through Recovery and Treatment (HEART) Demonstration," October 2021, available at https://www.medicaid.gov/sites/default/files/2021-10/mt-heart-demo-pa.pdf.
[3] "Montana Healing and Ending Addiction Through Recovery and Treatment Demonstration," Project Number 11-W—00395/8, July 1, 2022, available at https://www.medicaid.gov/sites/default/files/2022-07/mt-heart-demo-ca.pdf.

The Behavioral Health and Developmental Disabilities Division (BHDD) 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 the Indian Health Service, Tribes, and Urban Indian Health 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
	• Program of Assertive Community Treatment (PACT)
	• Montana Assertive Community Treatment (MACT)
	• Montana Medicaid Severe and Disabling Mental Illness (SDMI) 1915(c) Waiver
		• 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)
		• SUD medically monitored intensive inpatient services (ASAM 3.7)
		• Medication Assisted Treatment

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 reports symptoms of mental illness, and 5 percent of adults, or 42,600, report serious mental illness.[4,5] 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.[6] Individuals who commit suicide are often struggling with depression and/or SUD; 42 percent of suicide victims in Montana had alcohol in their systems.[7] Across all age groups, the highest rates of suicide are among AI/AN populations, highlighting the need to address mental health on a community level.[8]

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, to integrate screening and treatment into primary care settings, expand short-term crisis intervention 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.

Like many rural states, Montana has a shortage of residential and intensive outpatient treatment for children and youth with SED. This provider shortage disproportionately impacts children and youth involved with child welfare and AI/AN children and youth. While Montana is still working to address provider shortages, this amendment request is an important step in Montana's ongoing effort to expand access to the full continuum of mental health services for children and youth, from prevention/early intervention services to outpatient therapy to intensive outpatient treatment and residential care.[9] 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.[10] Providing behavioral health services to justice-involved populations can help 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.[11] 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

[4] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health." SAMHSA. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.
[5] "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/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.
[6] "Suicide in Montana: Facts, Figures and Formulas for Prevention." DPHHS. Updated January 2021. Available at: https://dphhs.mt.gov/Portals/85/suicideprevention/SuicideinMontana.pdf.
[7] "2016 Suicide Mortality Review Team Report," DPHHS. Available at: https://dphhs.mt.gov/assets/suicideprevention/2016suicidemortalityreviewteamreport.pdf.
[8] Ibid.
[9] For a description of Montana's efforts to build out an extensive continuum of care to identify and meet the needs of youth who are experiencing SED, and its substantial investments in prevention and early intervention to engage youth at risk of SED or SMI in treatment sooner, see the State's response to Milestone 3 and 4 in the attached SMI/SED Implementation Plan (i.e., Increasing Access to a Continuum of Care, and Earlier Identification and Engagement in Treatment, respectively). Available at: https://www.medicaid.gov/sites/default/files/2021-10/mt-heart-demo-pa.pdf
[10] Prison Policy Initiative: Montana Profile. 2018. Available at: https://www.prisonpolicy.org/profiles/MT.html.
[11] Binswanger, I.; Stern, M.; Deyo, R.; Heagerty, P.; Cheadle, A.; Elmore, J.; Koepsell, T. "Release from Prison — A High Risk of Death for Former Inmates," New England Journal of Medicine, January 2007.

through the DOC were convicted of offenses related to substance use.[12] 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.[13]

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.[14] 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 behavioral health treatment and other 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 a 30-day supply of medication following reentry into the community.

This Demonstration will address the health care needs of Montana's justice-involved population and promote the objectives of the Medicaid program by ensuring high-risk, justice-involved individuals 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—included as APPENDIX A 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, 14 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 in other counties. Thirty-one percent of all members with SMI/SED reside in the five most populated counties in the state (Cascade, Flathead, Gallatin, Missoula and Yellowstone), which also have the most services available.

The assessment revealed a shortage of outpatient providers who are licensed 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 those who accept Medicaid. Currently, about 65 percent of licensed mental health practitioners are enrolled in Medicaid. There are 12 counties without 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 includes 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 100 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.

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:** BHDD 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.

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[12] 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.
[13] 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
[14] "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.

- **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 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.

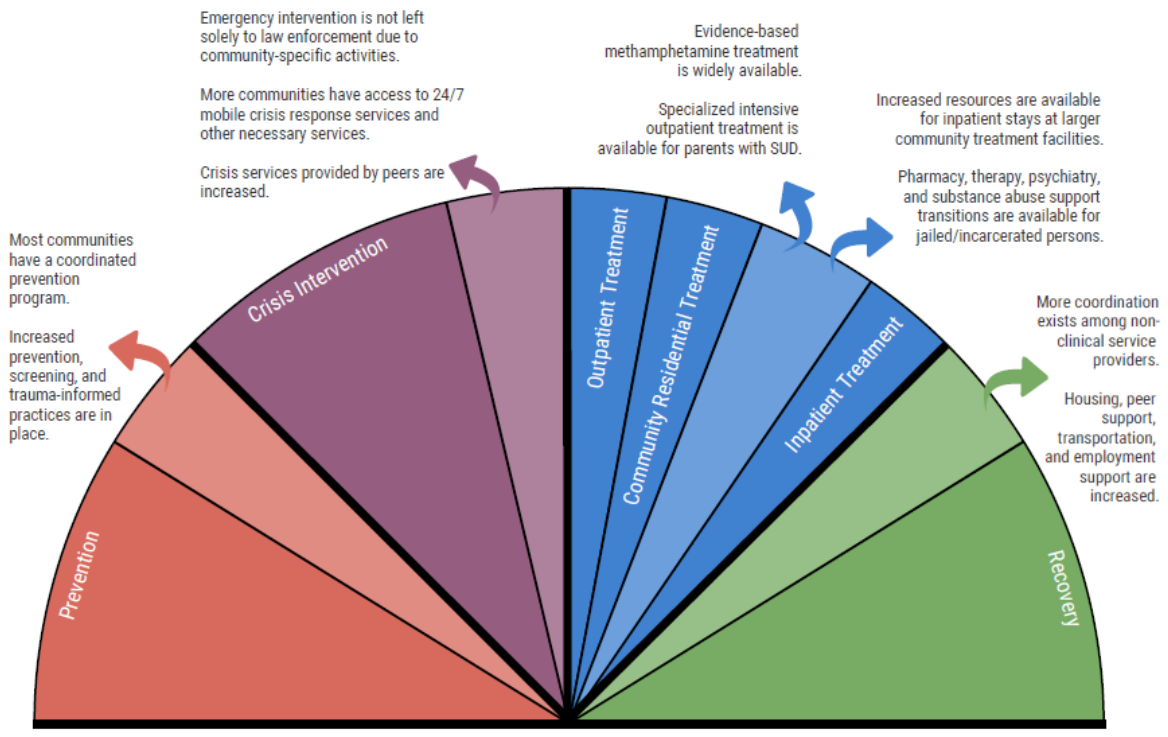
Other mental health treatment and recovery initiatives include:

- **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 ACT:** BHDD worked collaboratively with the Behavioral Health Alliance of Montana on the creation of a tiered program that includes assertive outreach, mental health treatment, health treatment, vocational training, 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 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; 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., CTC 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 prevention and mental health issues;
- 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 amendment request to:
  - Provide contingency management as part of a comprehensive treatment model for individuals with stimulant use disorder;
  - Provide tenancy supports;
  - 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 stays by children or youth with SED at IMDs that are also QRTPs.

On July 1, 2022, MT DPHHS received CMS approval for the SUD IMD component of the underlying Demonstration request, with concurrent approval of the required SUD Implementation Plan and SUD Health Information Technology (HIT) Plan. This approval authorized federal financial participation (FFP) reimbursement for the above mentioned state plan services provided to otherwise-eligible Medicaid beneficiaries, ages 18 to 64, who are primarily receiving treatment and withdrawal management services for SUD in residential and inpatient settings that qualify as 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 proposed Demonstration amendment request will allow Montana to better address the behavioral health needs of Montana Medicaid members by:

- Expanding Medicaid's continuum of behavioral health care through providing behavioral health treatment and recovery services for children and youth with SED in support of the state's HEART Initiative; and
- Improving the outcomes and quality of care delivered to children and youth with behavioral health needs receiving residential and inpatient levels of care.

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 SED IMD Demonstrations outlined by State Medicaid Director Letter (SMDL) #18-011, including:

- Increased rates of identification, initiation and engagement in behavioral health treatment;
- Increased adherence to and retention in behavioral health treatment;
- 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 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 availability of services provided during intensive outpatient services, acute short-term stays in residential crisis stabilization programs, residential treatment settings throughout the state.

Detailed information on Montana's strategy for meeting Demonstration milestones (as identified in SMDL #17-003 and SMD #18-011) will be included in the SED Implementation Plan to be submitted to CMS following Demonstration amendment approval.

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 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 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 children and youth screened using an evidence-based tool, referral and service utilization trends for individuals diagnosed with SED. The state will monitor that the individual's evidence-based assessment aligns with	• Claims data • Assessment data (CASII)

Goal	Hypothesis	Evaluation Approach	Data Sources
		the level of care they are receiving.	
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 for individuals with an SED, including youth and children in QRTPs, will reduce emergency department utilization and preventable hospital admissions.	The state will monitor the: • Number and percentage of Medicaid members with SED diagnoses with emergency department visits • Number and percentage of Medicaid members with SED diagnoses with hospital admissions • Number and percentage of Medicaid members with SED diagnoses with hospital readmissions • Ratio of emergency department visits to community-based treatment for individuals with SED • Ratio of hospital admissions to community-based treatment for individuals with SED	• Claims data
Improved availability of 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 presenting for behavioral health crises in emergency departments • Number of behavioral health-related responses from emergency medical services	• Claims data
Improved care coordination and linkages to community-based behavioral health services following discharges from emergency department and residential or inpatient treatment	Care coordination for members with SED experiencing care transitions will improve throughout the course of the Demonstration.	The state will monitor: • Provider self-assessments of fidelity to program rules with an emphasis on family engagement and natural supports.	• Provider Self Assessments on Fidelity to Family Engagement

Section III: Eligibility and Enrollment

A. Eligibility

All children up to age 21 who are diagnosed with an SED, staying in an IMD that is classified as a QRTP, and are otherwise eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan, or Medicaid 1115 waivers 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, 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 0-17	42 CFR § 435.117	0-143 percent FPL
Medicaid Children Ages 18-20	42 CFR § 435.117	0-143 percent FPL
Adults	42 CFR § 435.119	0-138 percent FPL
Parents/Caretaker Relatives	42 CFR § 435.110	0-24 percent 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.

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 unwind. Table 4 provides the estimated enrollment for the five years of the Demonstration, from DY 1 to DY 5.

Table 4. Projected Enrollment by Category of Aid

Category of Aid	*Projected Enrollment*				
	DY 1 ***7/1/22-6/30/23***	**DY 2** ***7/1/23-6/30/24***	**DY 3** ***7/1/24-6/30/25***	**DY 4** ***7/1/25-6/30/26***	**DY 5** ***7/1/26-6/30/27***
Families and Children (not CHIP)	49	56	61	61	62
Aged, Blind and Disabled	48	55	59	60	61
ACA Expansion	921	1158	1310	1329	1351
Other (HIFA, Poverty, Transitional MA, Former Foster Care)	412	471	556	566	574
Total	**1,430**	**1,740**	**1,986**	**2,016**	**2,048**

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:

- Contingency management;
- Tenancy supports; and
- Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.

On July 1, 2022, MT DPHHS received CMS approval for a SUD IMD Demonstration, with concurrent approval of the required SUD Implementation Plan and SUD Health Information Technology (HIT) Plan. Through this amendment request, Montana is seeking expenditure authority to cover stays in IMDS that are QRTPs for children and youth with SED. Montana requests that for the first two years following the effective date of the demonstration, QRTPs be exempted from the length of stay requirements set forth in SMDL #18-011 (i.e., a statewide average length of stay of 30 days and the limit on federal financial participation to stays of no more than 60 days).[15]

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

- Home visiting services for pregnant and postpartum 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).

Contingency Management

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 use disorder, including reduction or cessation of drug use and longer retention in treatment.[16, 17, 18]

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 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 12-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, and/or 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, as defined below, and is expected to benefit from housing supports:

- SMI diagnostic criteria, and/or
- 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 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;

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[15] *See* Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements, Q & A, Oct. 19, 2021, *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf.

[16] 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/.

[17] 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.

[18] 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/.

  - 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 regarding 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, including long-acting or depot preparations for chronic conditions (e.g., schizophrenia, SUD); acute withdrawal medications; or suppressive, preventive or curative medications, including PrEP and PEP (HIV, Hep C, 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 partnering with 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
- Developing 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 for 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 has estimated projected spending for the five-year Demonstration period based on the programmatic detail described earlier in this application. The authorities requested in the demonstration period 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. Montana developed projections for the demonstration period based on state historical expenditures, as available, as well as anticipated cost and utilization trends.

The state's budget neutrality model is included in APPENDIX C of this application.

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. Montana is committed to maintaining or improving access to community-based mental health services throughout the course of this Demonstration.

Table 5: Montana Medicaid SFY 2020 Expenditures on Community-Based Mental Health Services

Total	Federal	State–General Funds (Matchable)	State-County Funds	Total
Expansion	$34,401,658	$3,822,406	NA	$38,224,064
Standard	$35,137,324	$18,920,098	NA	$54,057,422
Total MT Medicaid	**$69,538,982**	**$22,742,504**	**NA**	**$92,281,486**

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 June 30, 2027.

Table 6: Waiver Requests

Waiver Authority	Use for Waiver
§ 1902(a)(1) Statewideness	To enable the state to provide tenancy supports and 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 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 June 30, 2027, 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 7: 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, who are short-term residents/inpatients in facilities that meet the definition of an IMD, or primarily receiving treatment for SED who are residents of QRTPs who 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 in the 30 days prior to their release.[19]
Expenditures related to contingency management pilot	Expenditure authority to provide contingency management through small incentives via gift cards to individuals with qualifying psycho-stimulant use disorders who are enrolled in a comprehensive outpatient treatment program.
Expenditures related to tenancy supports pilot	Expenditure authority to provide tenancy supports to qualifying individuals with behavioral health needs.

[19] 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.

Section VII: Compliance with Public Notice Process

To be completed after state notice and public comment period concludes.

Section VIII: Public Notice

To be completed after state notice and public comment period concludes.