GREG GIANFORTE
GOVERNOR

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

CHARLIE BRERETON
DIRECTOR

February 15, 2024

The Honorable Xavier Becerra, Health and Human Services Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW, Sixth Floor
Washington, DC 20201

Dear Secretary Becerra:

The State of Montana submits to the U.S. Department of Health and Human Services the enclosed Section 1115 Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration Waiver amendment application.

The amendment application seeks approval from Centers for Medicare and Medicaid Services (CMS) to amend the Section 1115 HEART to add stays by children and youth with serious emotional disturbance (SED) at Institutions of Mental Disease (IMDs) that are also Qualified Residential Treatment Programs (QRTPs).

On November 29, 2023, Montana Department of Public Health and Human Services began the state-level, 60-day public noticing process with all Montanans, including healthcare organizations, advocacy groups, and Medicaid members and their families. This included a presentation to the Children, Families, Health and Human Services Interim Committee on January 18, 2024, and a public hearing held on December 15, 2023. DPHHS also informed Tribal Governments, Urban Indian Organizations, and Indian Health Service via a tribal consultation letter mailed on November 24, 2023.

On behalf of all Montanans, I look forward to collaborating with CMS on getting the HEART 1115 Demonstration Waiver amendment adding IMD services for youth with SED approved in a timely manner.

Sincerely,

Mike Randol
Montana Department of Public Health and Human Services
Medicaid and Health Services Executive Director/State Medicaid Director

C: Daniel Tsai, M.D., CMS
Jacey Cooper, CMS
Anne Marie Costello, CMS
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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

November 29, 2023

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.

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[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:
	  o Community-based psychiatric rehabilitation and support services (CBPRS)
	  o 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 through the DOC were convicted of offenses related to substance use.[12] A 2020 study from

[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/assets/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.

[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.

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.

[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.

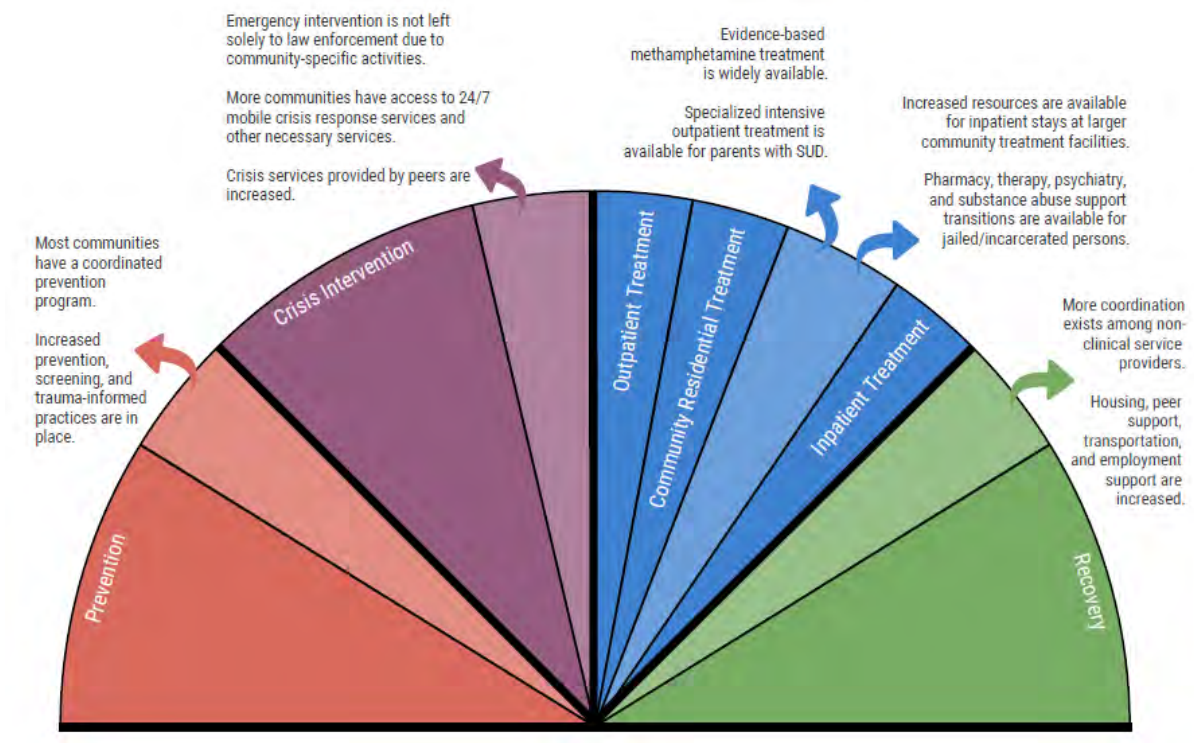
Other mental health treatment and recovery initiatives include:

- **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 the level of care they are receiving.	• Claims data • Assessment data (CASII)

Goal	Hypothesis	Evaluation Approach	Data Sources
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;
    - Housing search services including assisting with rent subsidy, collecting required documentation for housing application and assistance with searching for housing; and

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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/.

    - 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

The state public comment period occurred from November 29, 2023 until January 28, 2024. A hybrid in-person and virtual public hearing was held on December 15, 2023. The state received two verbal comments in support of the HEART Demonstration amendment request at the public hearing. No additional comments were submitted during the public comment period. A summary of the key themes from the two comments received, as well as the state's response is included below. Given the supportive nature of the comments received, no changes were made to this amendment request. The state appreciates the comments it received and is committed to working with stakeholders to continue improving access to behavioral health treatment for children and youth Medicaid members.

Comment: Two commenters expressed strong support for the 1115 HEART Demonstration amendment request and the impact it could have for Montana's children and youth.

Response: The state appreciates the commenters' strong support for the Demonstration amendment request. DPHHS is committed to addressing growing mental health needs among children and youth through this amendment request by expanding access to and improving care transition for children and youth with SED in need of residential treatment. DPHHS looks forward to working with beneficiaries, providers, and other stakeholders in designing and implementing this amendment request.

Appendix

A. Assessment of the Availability of Mental Health Services

Medicaid Section 1115 SMI/SED Demonstrations Availability Assessment - Instructions (Version 2.0)

Instructions for Completing the Assessment of the Availability of Mental Health Services ("Annual Availability Assessment"	
Before you begin:	**The state will submit multiple Availability Assessments. The state will submit an Initial Availability Assessment at the time of application and annual assessments thereafter.**
	In populating its Initial Availability Assessment and each subsequent Annual Availability Assessment, the state should report data as of the same month and day each year. In other words, if the Initial Availability Assessment displays values as of August 1, 2019, subsequent Availability Assessments should display values as of August 1, 2020, August 1, 2021, August 1, 2022, etc. Within each assessment, the state should enter this information into the cell labeled "Time Period Reflected in Assessment (month/day/year)" (found in the "Availability Assessment" tab). **It is also important to use the same data sources to populate the Initial and Annual Availability Assessments. The state should enter information on its data sources into the columns labeled "Brief description of data source(s) used to populate this (sub-)section" (found in the "Availability Assessment" tab).**
	Enter the state name, data entry date(s), and time period reflected in the Availability Assessment in cells C2-4.
	To hide pop-up instructions as you complete the Availability Assessment, hit "escape."
	Please Note: To add rows for additional geographic designations you must use the "Add Row" button in cell F2 (you may need to click "Enable Content" at the top of the tab if it appears). Please do not add rows manually.
Column	**Instructions**
B	In column B, enter each geographic designation starting in cell B10. Add rows using the "Add Row" button as needed to capture all geographic designations. Geographic designation means a state-defined geographic unit for reporting data, such as county, region, or catchment area. The state should consider how it divides its mental health system into smaller units or catchment areas to select geographic designations that will yield meaningful, actionable information.
C	In column C, starting in cell C10, please select whether geographic designation entered in the corresponding cell in column B could be considered urban or rural. If the geographic designation should be categorized as something other than urban or rural, select "Other-please explain" and record an explanation in the notes box in column D. Urban is defined as a Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget (42 CFR § 412.64(b)) Rural is defined as any area outside an urban area as defined in 42 CFR § 412.64(b).
D	In column D, beginning in cell D10, please use this space to explain the state's response if the state selects 'Other-please explain' in column C.
E	In column E, starting in cell E10, enter the total number of adult Medicaid beneficiaries **ages 18-20** in each geographic designation at the selected point in time. Medicaid beneficiary means a person who has been determined to be eligible to receive Medicaid services as defined at 42 CFR §400.200. Note: this age category is separate in order to avoid double counting beneficiaries in the residential treatment category and to facilitate the calculation of certain ratios in the assessment. See the note in the following cell for additional explanation.

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Column	Instructions
F	In column F, starting in cell F8, enter the number of adult Medicaid beneficiaries ages 18-20 with SMI in each geographic designation at the selected point in time. As defined on page 1 of the State Medicaid Directors Letter, serious mental illness means persons age 18 and over who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. Note: in the State Medicaid Directors letter (SMDL #18-011), SMI is defined to include individuals age 18 years and older, and SED includes children younger than 18. However, the residential treatment section of the Availability Assessment requests data on PRTFs, and the federal definition for PRTFs includes facilities that serve individuals under the age of 21. In order to avoid double counting beneficiaries in the residential treatment category, the assessment requests data on beneficiaries age 0-17, 18-20, and 21 and older separately.
G	In column G, starting in cell G8, enter the total number of adult Medicaid beneficiaries **age 21 and older** in each geographic designation at the selected point in time.
H	In column H, starting in cell H10, enter the number of adult Medicaid beneficiaries age 21 and older with SMI in each geographic designation at the selected point in time. Note: in the SMDL, SMI is defined to include individuals age 18 years and older, and SED includes children younger than 18. However, the residential treatment section of the Availability Assessment requests data on PRTFs, and the federal definition for PRTFs includes facilities that serve individuals under the age of 21. In order to avoid double counting beneficiaries in the residential treatment category, the assessment requests data on beneficiaries age 0-17, 18-20, and 21 and older separately.
I	In column I, starting in cell I10, the Availability Assessment will automatically calculate the percent of adult Medicaid beneficiaries who have SMI in each geographic designation. The state should not input any values into this column or modify the formulas in this column.
J	In column J, starting in cell J10, enter the total number of Medicaid beneficiaries **under the age of 18** in each geographic designation at the selected point in time.
K	In column K, starting in cell K10, enter the number of beneficiaries **under the age of 18 with SED** in each geographic designation at the selected point in time. As defined on page 2 of the SMDL, individuals with SED are those from birth up to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment" is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills.
L	In column L starting in cell L10, the Availability Assessment will automatically calculate the percent of beneficiaries under the age of 18 who have SED in each geographic designation. The state should not input any values into this column or modify the formulas in this column.

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Column	Instructions
M	In column M, starting in cell M10, the Availability Assessment will automatically calculate the number of Medicaid beneficiaries (total) in each geographic designation.
N	In column N, starting in cell N10, the Availability Assessment will automatically calculate the percent with Medicaid beneficiaries with SMI or SED (total) in each geographic designation.
O	In column O, starting in cell O10, the Availability Assessment will automatically calculate the percent with SMI or SED (total) in each geographic designation.
P	In column P, beginning in cell P10, please use this space to provide notes about the data source(s) used to populate the section.
Q	In column Q, beginning in cell Q10, please use this space to provide any additional notes regarding the section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
R	In column R, starting in cell R10, enter the number of psychiatrists or other practitioners who are authorized to prescribe psychiatric medications in each geographic designation. A psychiatrist is any psychiatrist licensed to practice in the state under state licensure laws. Other prescribers authorized to prescribe psychiatric medications means the number of mental health practitioners other than psychiatrists who are authorized to prescribe psychiatric medications as defined by state licensure laws.
S	In column S, starting in cell S10, enter the number of Medicaid-enrolled psychiatrists or other practitioners who are authorized to prescribe psychiatric medications in each geographic designation. Medicaid-enrolled means any provider enrolled in Medicaid to obtain Medicaid billing privileges, as defined in 42 CFR §455.410.
T	In column T, starting in cell T10, enter the number of Medicaid-enrolled psychiatrists or other practitioners who are authorized to prescribe psychiatric medications and are accepting new Medicaid patients in each geographic designation. Accepting new Medicaid patients means any provider enrolled in Medicaid to obtain Medicaid billing privileges who will treat new Medicaid-enrolled patients.
U-W	In columns U-W, starting in cell U10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
X	In column X, beginning in cell X10, please use this space to provide details on the specific types of practitioners used to populate this sub-section.
Y	In column Y, beginning in cell Y10, please use this space to provide notes about the data source(s) used to populate the sub-section.
Z	In column Z, beginning in cell Z10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
AA	In column AA, starting in cell AA10, enter the number of other practitioners certified or licensed to independently treat mental illness in each geographic designation. Other types of practitioners certified or licensed to independently treat mental illness means non-psychiatrist mental health providers who are certified or licensed to independently treat mental illness as defined by state licensure laws. This may include, but is not limited to, licensed psychologists, clinical social workers, and professional counselors.
AB	In column AB, starting in cell AB10, enter the number of Medicaid-enrolled other types of practitioners certified and licensed to independently treat mental illness in each geographic designation.

Column	Instructions
AC	In column AC, starting in cell AC10, enter the number of Medicaid-enrolled other types of practitioners certified and licensed to independently treat mental illness accepting new Medicaid patients in each geographic designation.
AD-AF	In columns AD-AF, starting in cell AD10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
AG	In column AG, beginning in cell AG10, please use this space to provide details on the specific types of practitioners used to populate this sub-section.
AH	In column AH, beginning in cell AH10, please use this space to provide notes about the data source(s) used to populate the sub-section.
AI	In column AI, beginning in cell AI10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
AJ	In column AJ, starting in cell AJ10, enter the number of community mental health centers (CMHCs) in each geographic designation. A community mental health center is an entity that provides outpatient mental health services, 24 hour emergency care services, day treatment, screenings, and consultation and educational services, as defined at 42 CFR §410.2.
AK	In column AK, starting in cell AK10, enter the number of Medicaid-enrolled CMHCs in each geographic designation.
AL	In column AL, starting in cell AL10, enter the number of Medicaid-enrolled CMHCs accepting new Medicaid patients in each geographic designation.
AM-AO	In columns AM-AO, starting in cell AM10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
AP	In column AP, beginning in cell AP10, please use this space to provide notes about the data source(s) used to populate the section.
AQ	In column AQ, beginning in cell AQ10, please use this space to provide any additional notes regarding the section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
AR	In column AR, starting in cell AR10, enter the number of providers offering intensive outpatient services in each geographic designation. Intensive outpatient services are designed to meet the needs of individuals who may be at risk for crisis or requiring a higher level of care, or who are in transition from a higher level of care. Intensive outpatient services may include partial hospitalization programs, day treatment, intensive outpatient programs, assertive community treatment, and other services and settings more intensive than regular outpatient and less intensive than inpatient or residential care.
AS	In column AS, starting in cell AS10, enter the number of Medicaid-enrolled providers offering intensive outpatient services providers in each geographic designation.
AT	In column AT, starting in cell AT10, enter the number of Medicaid-enrolled providers offering intensive outpatient services accepting new Medicaid patients in each geographic designation.
AU-AW	In columns AU-AW, starting in cell AU10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
AX	In column AX, beginning in cell AX10, please use this space to provide details on the specific types of services used to populate this section.
AY	In column AY, beginning in cell AY10, please use this space to provide notes about the data source(s) used to populate the section.

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Column	Instructions
AZ	In column AZ, beginning in cell AZ10, please use this space to provide any additional notes regarding the section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
BA	In column BA, starting in cell BA10, enter the number of residential mental health treatment facilities (adult) in each geographic designation. A residential mental health treatment facilities (adult) is a facility not licensed as a psychiatric hospital, whose primary purpose is to provide individually planned programs of mental health treatment services in a residential care setting for adults as defined for SAMHSA's N-MHSS. Please exclude residential SUD treatment facilities.
BB	In column BB, starting in cell BB10, enter the number of Medicaid-enrolled residential mental health treatment facilities (adult) in each geographic designation.
BC	In column BC, starting in cell BC10, enter the number of Medicaid-enrolled residential mental health treatment facilities (adult) accepting new Medicaid patients in each geographic designation.
BD-BF	In columns BD-BF, starting in cell BD10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
BG	In column BG, starting in cell BG10, enter the total number of residential mental health treatment facility beds (adult) in each geographic designation.
BH	In column BH, starting in cell BH10, enter the total number of Medicaid-enrolled residential mental health treatment beds (adult) in each geographic designation.
BI	In column BI, starting in cell BI10, enter the total number of Medicaid-enrolled residential mental health treatment beds available to adult Medicaid patients in each geographic designation. Available to Medicaid adult Medicaid patients means any facility or bed available to serve Medicaid patients over the age of 110.
BJ-BL	In columns BJ-BL, starting in cell BJ10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
BM	In column BM, beginning in cell BM10, please use this space to provide details on the specific types of facilities used to populate this sub-section.
BN	In column BN, beginning in cell BN10, please use this space to provide notes about the data source(s) used to populate the sub-section.
BO	In column BO, beginning in cell BO10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
BP	In column BP, starting in cell BP10, enter the number of psychiatric residential treatment facilities (PRTF) in each geographic designation. A PRTF is a non-hospital facility with a provider agreement with a state Medicaid agency to provide the inpatient psychiatric services to individuals under age 21 benefit (psych under 21 benefit). The facility must be accredited by the Joint Commission, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting organization with comparable standards recognized by the State. PRTFs must also meet the requirements at 42 CFR §441.151 - §441.1102, and 42 CFR §4103.350 – §4103.376.
BQ	In column BQ, starting in cell BQ10, enter the number of Medicaid-enrolled PRTFs in each geographic designation.
BR	In column BR, starting in cell BR10, enter the number of Medicaid-enrolled PRTFs accepting new Medicaid patients in each geographic designation.

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Column	Instructions
BS-BU	In columns BS-BU, starting in cell BS10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
BV	In column BV, starting in cell BV10, enter the total number of PRTF beds in each geographic designation.
BW	In column BW, starting in cell BW10, enter the number of Medicaid-enrolled PRTF beds in each geographic designation.
BX	In column BX, starting in cell BX10, enter the number of Medicaid-enrolled PRTF beds available to Medicaid patients in each geographic designation. Available to Medicaid patients means any facility or bed available to serve Medicaid patients.
BY-CA	In columns BY-CA, starting in cell BY10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
CB	In column CB, beginning in cell CB10, please use this space to provide details on the specific types of facilities used to populate this sub-section.
CC	In column CC, beginning in cell CC10, please use this space to provide notes about the data source(s) used to populate the sub-section.
CD	In column CD, beginning in cell CD10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
CE	In column CE, starting in cell CE10, enter the number of public and private psychiatric hospitals in each geographic designation. A psychiatric hospital is an institution which provides diagnosis and treatment of mentally ill persons, as defined at 42 USC §1395x.
CF	In column CF, starting in cell CF10, enter the number of public and private psychiatric hospitals available to Medicaid patients in each geographic designation.
CG-CH	In columns CG-CH, starting in cell CG10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
CI	In column CI, beginning in cell CI10, please use this space to provide notes about the data source(s) used to populate the sub-section.
CJ	In column CJ, beginning in cell CJ10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
CK	In column CK, starting in cell CK10, enter the number of psychiatric units in acute care hospitals in each geographic designation. A psychiatric unit is a separate inpatient psychiatric unit of a general hospital that provides inpatient mental health services and has specifically allocated staff and space (beds) for the treatment of persons with mental illness, as defined for SAMHSA's N-MHSS.
CL	In column CL, starting in cell CL10, enter the number of psychiatric units in critical access hospitals (CAHs) in each geographic designation. A critical access hospital is a small facility that provides 24-hour emergency care, outpatient services, as well as inpatient services to people in rural areas, as defined in 42 CFR §4105.606.
CM	In column CM, starting in cell CM10, enter the number of Medicaid-enrolled psychiatric units in acute care hospitals in each geographic designation.
CN	In column CN, starting in cell CN10, enter the number of Medicaid-enrolled psychiatric units in CAHs in each geographic designation.
CO	In column CO, starting in cell CO10, enter the number of Medicaid-enrolled psychiatric units in acute care hospitals accepting new Medicaid patients in each geographic designation.

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Column	Instructions
CP	In column CP starting in cell CP10, enter the number of Medicaid-enrolled psychiatric units in CAHs accepting new Medicaid patients in each geographic designation.
CQ-CV	In columns CQ-CV, starting in cell CQ10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
CW	In column CW, beginning in cell CW10, please use this space to provide notes about the data source(s) used to populate the sub-section.
CX	In column CX, beginning in cell CX10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
CY	In column CY, starting in cell CY10, enter the number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) in each geographic designation. Please enter the number of licensed psychiatric hospital beds as defined by state licensure requirements.
CZ	In column CZ, starting in cell CZ10, enter the number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients in each geographic designation.
DA-DB	In columns DA-DB, starting in cell DA10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
DC	In column DC, beginning in cell DC10, please use this space to provide notes about the data source(s) used to populate the sub-section.
DD	In column DD, beginning in cell DD10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
DE	In column DE, starting in cell DE10, enter the number of residential mental health treatment facilities (adult) that qualify as an institution for mental diseases (IMDs) in each geographic designation. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services per section 1905(i) of the Social Security Act. See also 42 CFR §435.1010 and section 4390 of the State Medicaid Manual.
DF	In column DF, starting in cell DF10, enter the number of Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs in each geographic designation.
DG	In column DG, starting in cell DG10, enter the number of Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs accepting Medicaid patients in each geographic designation.
DH-DJ	In columns DH-DJ, starting in cell DH10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
DK	In column DK, beginning in cell DK10, please use this space to provide details on the specific types of facilities used to populate this sub-section.
DL	In column DL, beginning in cell DL10, please use this space to provide notes about the data source(s) used to populate the sub-section.
DM	In column DM, beginning in cell DM10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.

Column	Instructions
DN	In column DN, starting in cell DN10, enter the number of psychiatric hospitals that qualify as IMDs in each geographic designation.
DO	In column DO, starting in cell DO10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
DP	In column DP, beginning in cell DP10, please use this space to provide notes about the data source(s) used to populate the sub-section.
DQ	In column DQ, beginning in cell DQ10, please use this space to provide any additional notes regarding the sub-section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
DR	In column DR, starting in cell DR10, enter the number of crisis call centers in each geographic designation. Please enter the number of crisis call centers as defined by the state.
DS	In column DS, starting in cell DS10, enter the number of mobile crisis units in each geographic designation. A mobile crisis unit is a team that intervenes during mental health crises, as defined by the state.
DT	In column DT, starting in cell DT10, enter the number of crisis observation/ assessment centers in each geographic designation. Please enter the number of observation or assessment centers as defined by the state.
DU	In column DU, starting in cell DU10, enter the number of crisis stabilization units in each geographic designation. Crisis stabilization units offer medically monitored short-term crisis stabilization services, as defined by the state.
DV	In column DV, starting in cell DV10, enter the number of coordinated community crisis response teams in each geographic designation. Coordinated community crisis response means a community-based program or entity that manages crisis response across various community entities or programs, as defined by the state.
DW-EA	In columns DW-EA, starting in cell DW10, the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
EB	In column EB, beginning in cell EB10, please use this space to provide details on the specific types of services used to populate this section.
EC	In column EC, beginning in cell EC10, please use this space to provide notes about the data source(s) used to populate the section.
ED	In column ED, beginning in cell ED10, please use this space to provide any additional notes regarding the section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
EE	In column EE, starting in cell EE10, enter the number FQHCs that offer behavioral health services in each geographic designation. Federally qualified health center (FQHC) means an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR §405.2434 and 42 CFR §405.2401.
EF	In column EF, starting in cell EF10,the Availability Assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
EG	In column EG, beginning in cell EG10, please use this space to provide notes about the data source(s) used to populate the section.
EH	In column EH, beginning in cell EH10, please use this space to provide any additional notes regarding the section, such as notes on data limitations, explanations for specific values, or information that could assist with data interpretation.
EI	Beginning in column EI, add additional counts and ratios for provider and setting types that the state considers important to its mental health system. The state should not modify any of the previous columns.

Definitions of terms used in the Availability Assessment	
Term	**Definition**
Accepting new Medicaid patients	***Accepting new Medicaid patients*** means any provider enrolled in Medicaid to obtain Medicaid billing privileges who will treat new Medicaid-enrolled patients.
Adult	An ***adult*** is a person age 18 and over [SMDL].
Available to Medicaid patients	***Available to Medicaid patients*** means any facility or bed available to serve Medicaid patients.
Community mental health center (CMHC)	A ***community mental health center (CMHC)*** is defined in §410.2 as "an entity that (1) provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and clients of its mental health service area who have been discharged from inpatient treatment at a mental health facility; (2) provides 24-hour-a-day emergency care services; (3) provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services; (4) provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of this admission; (5) meets applicable licensing or certification requirements for CMHCs in the state in which it is located; and (6) provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act.
Coordinated community crisis response	***Coordinated community crisis response*** means a community-based program or entity that manages crisis response across various community entities or programs, as defined by the state.
Crisis call center	***Crisis call centers*** are defined by the state.
Crisis stabilization unit	***Crisis stabilization units*** offer medically monitored short-term crisis stabilization services, as defined by the state.
Critical access hospital	A ***critical access hospital*** is a small facility that provides 24-hour emergency care, outpatient services, as well as inpatient services to people in rural areas, as defined in 42 CFR §485.606.
Federally qualified health center	***Federally qualified health center (FQHC)*** means an entity that meets all the requirements at 1905(l)(2)(B) of the Social Security Act.
Geographic designation	***Geographic designation*** means a state-defined geographic unit for reporting data, such as county, region, or catchment area.
Institution for mental diseases (IMD)	An ***institution for mental diseases*** is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services per section 1905(i) of the Social Security Act. See also 42 CFR §435.1010 and section 4390 of the State Medicaid Manual.

Term	Definition
Intensive outpatient services	***Intensive outpatient services*** are designed to meet the needs of individuals who may be at risk for crisis or requiring a higher level of care, or who are in transition from a higher level of care. Intensive outpatient services may include partial hospitalization programs, day treatment services, intensive outpatient programs, Assertive Community Treatment, intensive case management, intensive peer supports, written standardized protocols for escalating outpatient services when an individual is experiencing a crisis or increased need, and other services and settings more intensive than regular outpatient and less intensive than inpatient or residential care.
Licensed psychiatric hospital bed	***Licensed psychiatric hospital beds*** are defined by state licensure requirements.
Medicaid beneficiary	***Medicaid beneficiary*** means a person who has been determined to be eligible to receive Medicaid services as defined at 42 CFR §400.200.
Medicaid-enrolled	***Medicaid-enrolled*** means any provider enrolled in Medicaid to obtain Medicaid billing privileges, as defined in 42 CFR §455.410.
Mental health practitioners other than psychiatrists who are certified or licensed by the state to independently treat mental illness	***Mental health practitioners other than psychiatrists who are certified or licensed to independently treat mental illness*** are non-psychiatrist mental health providers who are certified or licensed to independently treat mental illness as defined by state licensure laws. This may include, but is not limited to, licensed psychologists, clinical social workers, and professional counselors. Practitioners who are required to work under the supervision of another practitioner and/or who are required to bill Medicaid under another practitioner should be excluded.
Mobile crisis unit	A ***mobile crisis unit*** is a team that intervenes during mental health crises, as defined by the state.
Observation or assessment centers	***Observation or assessment centers*** are defined by the state.
Other practitioners who are authorized to prescribe psychiatric medications	***Other practitioners who are authorized to prescribe psychiatric medications*** are defined by state licensure laws.
Psychiatric hospital	A ***psychiatric hospital*** is an institution which provides diagnosis and treatment of mentally ill person, as defined at 42 USC §1395x. The state should report on both public and private psychiatric hospitals.

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Term	Definition
Psychiatric residential treatment facility (PRTF)	A ***psychiatric residential treatment facility*** is a non-hospital facility with a provider agreement with a state Medicaid agency to provide the inpatient psychiatric services to individuals under age 21 benefit (psych under 21 benefit). The facility must be accredited by the Joint Commission, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting organization with comparable standards recognized by the State. PRTFs must also meet the requirements at 42 CFR §441.151 - §441.182, and 42 CFR §483.350 – §483.376.
Psychiatric unit	A ***psychiatric unit*** is a separate inpatient psychiatric unit of a general hospital that provides inpatient mental health services and has specifically allocated staff and space (beds) for the treatment of persons with mental illness, as defined for SAMHSA's National Mental Health Services Survey (N-MHSS).
Psychiatrist	A ***psychiatrist*** is any psychiatrist licensed to practice in the state under state licensure laws.
Residential mental health treatment facilities (adult)	A ***residential mental health treatment facilities (adult)*** is a facility not licensed as a psychiatric hospital, whose primary purpose is to provide individually planned programs of mental health treatment services in a residential care setting for adults as defined for SAMHSA's N-MHSS. Please exclude residential SUD treatment facilities.
Rural	***Rural*** means any area outside an urban area as defined in 42 CFR § 412.64(b).
Serious emotional disturbance (SED)	Persons with ***serious emotional disturbance*** means individuals from birth up to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment" is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills [SMDL].
Serious mental illness (SMI)	Persons with ***serious mental illness means*** individuals, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. [SMDL] Note: in the SMDL, SMI is defined to include individuals age 18 years and older, and SED includes children younger than 18. However, the residential treatment section of the availability assessment requests data on PRTFs, and the federal definition for PRTFs includes facilities that serve individuals under the age of 21. In order to avoid double counting beneficiaries in the residential treatment category, the assessment requests data on beneficiaries age 0-17, 18-20, and 21 and older separately.

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Term	Definition
Urban	***Urban*** means a Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget (42 CFR § 412.64(b)).

Narrative Description (to be completed at baseline)
1. In the space below, describe the mental health service needs (e.g. prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. [Limit responses to 500 words if possible]
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. Additionally, the state has struggled to promote and sustain evidence-based practices, such as illness, management and recovery (IMR), dialectical behavior therapy (DBT) and community rehabilitation and treatment (CRT). According to available claims data, twelve percent of adults on Medicaid have a SMI and fourteen percent of children on Medicaid have a SED. There is a higher percentage of members with SMI/SED in urban counties and the adjacent counties. Thirty-one percent of all members with SMI/SED reside in the five most populated counties (Cascade, Flathead, Gallatin, Missoula, Yellowstone), which also have most available services available. 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. 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 services and community-based treatment services for adults with SMI using the Assertive Community Treatment (ACT), and expand the behavioral health workforce using certified behavioral health peer support specialists.
2. In the space below, describe the organization of the state's Medicaid behavioral health service delivery system at the beginning of the demonstration. [Limit responses to 500 words if possible]
The Department of Public Health and Human Services (DPHHS) administers program and payment for publicly funded behavioral health services, which include mental health (MH) and substance use disorder (SUD) prevention and treatment programs. These programs include the three healthcare facilities that serve individuals in need of more serious care: Montana State Hospital in Warm Springs and Galen, Mental Health Nursing Care Center in Lewistown, and Montana Chemical Dependency Center in Butte. The Treatment Bureau within Addictive and Mental Disorders Division (AMDD) oversees adult mental health and both adult and youth SUD services, while the Children's Mental Health Bureau (CMHB) within the Developmental Services Division (DSD) oversees youth mental health services. DPHHS contracts with behavioral health providers and agencies statewide to provide community-based and inpatient services, primarily through Medicaid. Services range from prevention and early intervention services to inpatient, residential, home and community-based, and recovery support services. Behavioral health services covered under Montana Medicaid for members that meet medical necessity criteria are described in the AMDD Medicaid Services Provider Manual for SUD and Adult Mental Health found here, https://dphhs.mt.gov/amdd/amddmedicaidservicesprovidermanual, and the Children's Mental Health Bureau Medicaid Services Provider Manual found here, https://dphhs.mt.gov/assets/dsd/CMB/providermanuals/CMHBMedicaidServicesProviderManual01012021.pdf. Montana's Severe and Disabling Mental Illness (SDMI) 1915 (c) Home and Community Based Services (HCBS) waiver is a Medicaid-funded mental health program providing specialized services for Medicaid members who would otherwise require institutional level of care. These services are provided to keep members out of a higher level of care such as the Montana State Hospital, nursing homes, emergency rooms, and avoidable hospitalizations. SDMI HCBS waiver services are provided statewide and services focus on specific specialized needs of members with mental illness, thus giving them the opportunity to remain independent and out of higher levels of care.
3. In the space below, describe the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. At minimum, explain any variations across the state in the availability of the following: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. [Limit responses to 1000 words if possible]

Montana State Hospital (MSH) is the lone psychiatric hospital for adults in the state, located in Deer Lodge county. MSH serves Montana via civil commitments, involuntary commitments, emergency detentions, or court ordered placements. MSH has 228 beds available for individuals needing that level of care. There are two Psychiatric Residential Treatment Facilities for youth in the state, located in Helena (48 beds) and Billings (88 beds). There are five inpatient psychiatric units within hospitals located in the following urban locations: Billings (44 beds), Great Falls (18 beds), Helena (22 beds), Kalispell (41 beds), and Missoula (38 beds). As defined in the assessment, there are 26 community mental health centers (CMHCs) across the state with 56 office locations, again primarily in more populated areas, with some having multiple satellite offices. The definition indicates that a CMHC should be able to provide outpatient and intensive outpatient services. The intensive outpatient services available through those CMHCs includes day treatment programs (seven youth and 17 adult) and Assertive Community Treatment (ACT). Montana has multiple tiers of ACT which have been modified to better serve the urban and rural areas of the state. There are currently teams located in following locations: Conrad, Glasgow, Libby, Kalispell, Miles City, Missoula, Hamilton, Great Falls, Helena (2), Billings (2), Butte, and Bozeman. The has been discussion about an additional team in Dillon, MT. There are 38 counties being covered by these 14 teams. The state has discussed with providers the expansion of teams to increase coverage; however, staffing, and geographic distance are cited as the main barriers to expanding service statewide. The suggestion for additional ACT teams in underserved areas is based on an internal population study focusing on the distribution of members with SMI throughout all 56 counties. Partial hospitalization programs are also included in intensive outpatient services and that service is provided through the following hospitals: Billings Clinic (Billings), Benefits Healthcare (Great Falls), St. Peter's Hospital (Helena), Pathways Treatment Center (Kalispell), and St. Patrick's Hospital (Missoula). Outpatient care via prescribers and other providers is available in 44 of 56 counties. Based on claims data, there are also 30 Federally Qualified Health Centers (FQHC) offering behavioral health services. There is one state-wide crisis line, which relays calls to local CHMCs. There are five Mobile Crisis Units (Great Falls, Kalispell, Bozeman, Helena, and Missoula), six inpatient Crisis Stabilization Units (Kalispell, Polson, Missoula, Hamilton, Butte, Bozeman), and one outpatient Crisis Stabilization Unit (Billings).

4. In the space below, describe any gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment. [Limit responses to 500 words if possible]

There are no identifiers through the Department of Labor that would indicate a prescriber specializes in psychiatry. As a result, we had to rely entirely on claims data looking at prescribers who treated members with mental health issues. Out of 1377 prescribers identified, 58 were psychiatrists. There is a need for more psychiatrists and providers who specialize in psychiatry. There are 10 counties in which there are no prescribers treating those with MH issues, indicating lack of access in those counties. Two of those counties (Blaine and Phillips) encompass the entirety of the Fort Belknap reservation and one county (Daniels) houses a portion of the Fort Peck reservation. Similarly, there is a lack of other practitioners treating mental illness in many counties, particularly those that take Medicaid. Currently, around fifty-one (51) percent of licensed mental health practitioners are enrolled in Medicaid. There are 11 counties that do not have licensed mental health practitioners and 19 counties where none are enrolled in Medicaid. There is also a lack of adult IOP services statewide as there are 27 counties without a CMHC physical location to offer those services, which leaves members in those locations to receive services with limited or no options for in-person services. Many of the counties with satellite offices are not staffed everyday and provide as needed services leaving members to receive services via telehealth or by appointment or look elsewhere.

5. In the space below, describe any gaps in the availability of mental health services or service capacity NOT reflected in the Availability Assessment. [Limit responses to 500 words if possible]

The availability assessment shows licensed practitioners and services provided based on the county of residence. However, it does not reflect the county of employment for licensed professionals or where they delivered services. This shows limitations in the data sources and the ability to pinpoint existing and potentially identify additional gaps. In addition, many of the state's rural counties have CMHC offices, but those offices are not staffed daily which means that individuals may not be able to obtain an appointment as quickly as they need. The increasing prevalence of telehealth services may help address this gap.
Additionally, the assessment did not specifically look at service capacity related to Montana's tribal populations. Montana is home to seven Indian reservations, all of which are in rural, isolated counties which lack access to mental health services. They have very few psychiatric and other mental health providers and are geographically far from major cities that have more intensive services. For example, Big Horn county, which makes up the majority of the Crow Reservation (7,900 residents), only has three Medicaid providers providing psychiatric services and six other Medicaid mental health providers. Montana is currently implementing Tiers 2 and 3 of the Montana Medicaid Tribal Health Improvement Program (T-HIP) to address disparities in those communities.

Lastly, social workers at the Montana State Hospital (MSH) report extreme difficulty in finding placements for discharges of

Montana Department of Public Health and Human Services

SED Assessment

Medicaid Section 1115 SMI/SED Demonstrations Annual Availability Assessment (Version 2.0)

State Name	Montana
Date of Assessment	
Time Period Reflected in Assessment (month/day/year)	July 1, 2019 - June 30, 2020

PLEASE NOTE: Use the same reporting month and day (under "Time Period Reflected in Assessment") and data sources across Availability Assessment submissions. If the state is completing an Annual Availability Assessment, please refer to the initial Availability Assessment to confirm that the reporting month, reporting day, and data sources are the same.

Geographic Designation			Beneficiaries											
			Adult					Children			Total			
	Geographic designation	Is this geographic designation primarily urban or rural?	Additional notes on this sub-section, including data limitations	Number of adult Medicaid beneficiaries (18 - 20)	Number of adult Medicaid beneficiaries with SMI (18 - 20)	Number of adult Medicaid beneficiaries (21+)	Number of adult Medicaid beneficiaries with SMI (21+)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (0-17)	Number of Medicaid beneficiaries with SED (0 - 17)	Percent with SED (0-17)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)
1.	Beaverhead	Rural		114	8	1333	116	9%	765	97	13%	2212	221	10%
2.	Big Horn	Rural		445	12	3475	127	4%	3384	169	5%	7304	308	4%
3.	Blaine	Rural		177	3	1412	25	2%	1242	52	4%	2831	80	3%
4.	Broadwater	Rural		58	5	666	67	10%	437	42	10%	1161	114	10%
5.	Carbon	Other-please explain	imity to Yellows	122	14	1334	138	10%	739	80	11%	2195	232	11%
6.	Carter	Rural		10		92	1	1%	71	7	10%	173	8	5%
7.	Cascade	Urban		1156	142	13412	1704	13%	8568	1390	16%	23136	3236	14%
8.	Chouteau	Rural		71	4	612	32	5%	408	40	10%	1091	76	7%
9.	Custer	Rural		164	35	1694	309	19%	1177	230	20%	3035	574	19%
10.	Daniels	Rural		17		156	10	6%	112	10	9%	285	20	7%
11.	Dawson	Rural		112	10	1029	127	12%	743	93	13%	1884	230	12%
12.	Deer Lodge	Rural		132	22	1646	239	15%	738	159	22%	2516	420	17%
13.	Fallon	Rural		29	0	242	15	6%	244	28	11%	515	43	8%
14.	Fergus	Rural		159	17	1601	176	11%	957	123	13%	2717	316	12%
15.	Flathead	Rural		1512	193	15792	2003	13%	10411	1504	14%	27715	3700	13%
16.	Gallatin	Rural		918	110	10647	998	10%	6132	771	13%	17697	1879	11%
17.	Garfield	Rural		15		154	8	5%	153	7	5%	322	15	5%
18.	Glacier	Rural		484	8	4441	96	2%	3119	221	7%	8044	325	4%
19.	Golden Valley	Rural		16	1	183	6	4%	94	4	4%	293	11	4%
20.	Granite	Rural		29	2	367	18	5%	202	25	12%	598	45	8%
21.	Hill	Rural		394	22	3719	164	5%	2811	194	7%	6924	380	5%
22.	Jefferson	Rural		124	16	1222	126	11%	804	143	18%	2150	285	13%
23.	Judith Basin	Rural		37	3	260	14	6%	153	16	10%	450	33	7%
24.	Lake	Rural		628	72	6253	639	10%	4657	574	12%	11538	1285	11%
25.	Lewis and Clark	Rural		861	149	11673	1462	13%	6003	1081	18%	18537	2692	15%
26.	Liberty	Rural		26	1	371	22	6%	233	14	6%	630	37	6%
27.	Lincoln	Rural		339	28	3950	398	10%	2256	285	13%	6545	709	11%
28.	Madison	Rural		76	3	806	43	5%	465	51	11%	1347	97	7%
29.	McCone	Rural		12	1	142	8	6%	117	9	8%	271	18	7%
30.	Meagher	Rural		42	3	364	16	5%	229	18	8%	635	37	6%
31.	Mineral	Rural		77	9	946	85	9%	598	69	12%	1621	163	10%
32.	Missoula	Urban		1366	287	18762	3294	18%	8766	1541	18%	28894	5122	18%
33.	Musselshell	Rural		90	5	894	95	10%	505	84	17%	1489	184	12%
34.	Park	Rural		177	20	2466	180	8%	1200	197	16%	3843	397	10%
35.	Petroleum	Rural		6	1	52	5	10%	45	4	9%	103	10	10%
36.	Phillips	Rural		67	2	699	18	3%	578	42	7%	1344	62	5%
37.	Pondera	Rural		126	4	1398	91	6%	956	80	8%	2480	175	7%
38.	Powder River	Rural		15		128	9	6%	107	10	9%	250	19	8%
39.	Powell	Rural		74	8	1164	101	9%	509	86	17%	1747	195	11%
40.	Prairie	Rural		13	1	141	13	9%	96	14	15%	250	28	11%
41.	Ravalli	Rural		680	88	6874	844	12%	4009	547	14%	11563	1479	13%
42.	Richland	Rural		104	14	1206	138	12%	863	89	10%	2173	241	11%
43.	Roosevelt	Rural		353	4	3183	69	2%	2706	124	5%	6222	197	3%
44.	Rosebud	Rural		215	3	1861	100	5%	1704	142	8%	3780	245	6%
45.	Sanders	Rural		192	20	2417	214	9%	1386	167	12%	3995	401	10%
46.	Sheridan	Rural		32	1	328	30	9%	246	4	2%	606	35	6%
47.	Silver Bow	Rural		494	85	7309	1079	15%	3591	777	22%	11394	1941	17%
48.	Stillwater	Rural		99	8	911	89	10%	633	93	15%	1643	190	12%

Montana Department of Public Health and Human Services

SED Assessment

Medicaid Section 1115 SMI/SED Demonstrations

State Name
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	Geographic Designation			Providers														
				Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications									Other Practitioners Certified					
	Geographic designation	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications Accepting New Medicaid Patients	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients	Specific type(s) of practitioners used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness
1.	Beaverhead				14		15.78571429	0	-				23	10		22.1
2.	Big Horn				3		102.6666667	0	-				8			-
3.	Blaine				1		80	0	-				3			-
4.	Broadwater				4		28.5	0	-				7	2		57
5.	Carbon				11		21.09090909	0	-				20	4		58
6.	Carter						-	-	-							-
7.	Cascade				149		21.71812081	0	-				208	105		30.81904762
8.	Chouteau				2		38	0	-				11	3		25.33333333
9.	Custer				21		27.33333333	0	-				24	12		47.83333333
10.	Daniels						-	-	-							-
11.	Dawson				6		38.33333333	0	-				11	8		28.75
12.	Deer Lodge				31		13.5483871	0	-				24	11		38.18181818
13.	Fallon				1		43	0	-							-
14.	Fergus				12		26.33333333	0	-				21	3		105.3333333
15.	Flathead				173		21.38728324	0	-				277	147		25.17006803
16.	Gallatin				158		11.89240506	0	-				412	184		10.21195652
17.	Garfield				2		7.5	0	-							-
18.	Glacier				2		162.5	0	-				10	3		108.3333333
19.	Golden Valley						-	-	-							-
20.	Granite				1		45	0	-							-
21.	Hill				3		126.6666667	0	-				33	17		22.35294118
22.	Jefferson				6		47.5	0	-				30	2		142.5
23.	Judith Basin						-	-	-				2	1		33
24.	Lake				22		58.40909091	0	-				54	33		38.93939394
25.	Lewis and Clark				104		25.88461538	0	-				249	130		20.70769231
26.	Liberty				1		37	0	-							-
27.	Lincoln				10		70.9	0	-				37	18		39.38888889
28.	Madison				2		48.5	0	-				9	4		24.25
29.	McCone				1		18	0	-							-
30.	Meagher				2		18.5	0	-				2			-
31.	Mineral				4		40.75	0	-				11	2		81.5
32.	Missoula				209		24.50717703	0	-				557	324		15.80864198
33.	Musselshell				1		184	0	-					2		92
34.	Park				7		56.71428571	0	-				48	25		15.88
35.	Petroleum						-	-	-				8			-
36.	Phillips				1		62	0	-				4			-
37.	Pondera				2		87.5	0	-				8	4		43.75
38.	Powder River				2		9.5	0	-				1			-
39.	Powell				3		65	0	-				2			-
40.	Prairie						-	-	-				6			-
41.	Ravalli				25		59.16	0	-				89	42		35.21428571
42.	Richland				16		15.0625	0	-				10	4		60.25
43.	Roosevelt				3		65.66666667	0	-				6			-
44.	Rosebud				5		49	0	-				9	1		245
45.	Sanders				2		200.5	0	-				28	10		40.1
46.	Sheridan				1		35	0	-				3	1		35
47.	Silver Bow				54		35.94444444	0	-				108	54		35.94444444
48.	Stillwater				8		23.75	0	-				13	2		95
49.	Sweet Grass						-	-	-				10	3		20.66666667

Montana Department of Public Health and Human Services

SED Assessment

Medicaid Section 1115 SMI/SED Demonstrations

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	Geographic Designation	Ed and Licensed to Independently Treat Mental Illness					Community Mental Health Centers									
	Geographic designation	Ratio of Other Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness Accepting New Patients	Specific type(s) of practitioners used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs	Ratio of Total CMHCs to Medicaid-Enrolled CMHCs	Ratio of Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs Accepting New Patients	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number of Providers Offering Intensive Outpatient Services	Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services
1.	Beaverhead	2.3	-							-	-	-				
2.	Big Horn	-	-							-	-	-				
3.	Blaine	-	-				1	1	1	80	1	1			1	1
4.	Broadwater	3.5	-							-	-	-				
5.	Carbon	5	-							-	-	-				
6.	Carter	-	-							-	-	-				
7.	Cascade	1.980952381	-				4	4	4	809	1	1			4	4
8.	Chouteau	3.666666667	-							-	-	-				
9.	Custer	2	-				1	1	1	574	1	1			1	1
10.	Daniels	-	-				1	1	1	20	1	1			1	1
11.	Dawson	1.375	-				2	2	2	115	1	1			3	3
12.	Deer Lodge	2.181818182	-				1	1	1	420	1	1			1	1
13.	Fallon	-	-							-	-	-				
14.	Fergus	7	-							-	-	-				
15.	Flathead	1.884353741	-				4	4	4	925	1	1			3	3
16.	Gallatin	2.239130435	-				2	2	2	939.5	1	1			1	1
17.	Garfield	-	-							-	-	-				
18.	Glacier	3.333333333	-				2	2	2	162.5	1	1			1	1
19.	Golden Valley	-	-							-	-	-				
20.	Granite	-	-							-	-	-				
21.	Hill	1.941176471	-				1	1	1	380	1	1			1	1
22.	Jefferson	15	-				2	2	2	142.5	1	1			1	1
23.	Judith Basin	2	-							-	-	-				
24.	Lake	1.636363636	-				2	2	2	642.5	1	1			1	1
25.	Lewis and Clark	1.915384615	-				3	3	3	897.333333	1	1			3	3
26.	Liberty	-	-							-	-	-				
27.	Lincoln	2.055555556	-				2	2	2	354.5	1	1			2	2
28.	Madison	2.25	-							-	-	-				
29.	McCone	-	-							-	-	-				
30.	Meagher	-	-							-	-	-				
31.	Mineral	5.5	-							-	-	-				
32.	Missoula	1.719135802	-				7	7	7	731.714286	1	1			7	7
33.	Musselshell	0	-							-	-	-				
34.	Park	1.92	-				2	2	2	198.5	1	1			2	2
35.	Petroleum	-	-							-	-	-				
36.	Phillips	-	-				1	1	1	62	1	1			1	1
37.	Pondera	2	-				1	1	1	175	1	1			1	1
38.	Powder River	-	-							-	-	-				
39.	Powell	-	-				1	1	1	195	1	1			1	1
40.	Prairie	-	-							-	-	-				
41.	Ravalli	2.119047619	-				2	2	2	739.5	1	1			2	2
42.	Richland	2.5	-				1	1	1	241	1	1			1	1
43.	Roosevelt	-	-				1	1	1	197	1	1			1	1
44.	Rosebud	9	-				1	1	1	245	1	1			1	1
45.	Sanders	2.8	-				1	1	1	401	1	1			1	1
46.	Sheridan	3	-							-	-	-				
47.	Silver Bow	2	-				3	3	3	647	1	1			3	3
48.	Stillwater	6.5	-							-	-	-				
49.	Sweet Grass	3.333333333	-							-	-	-				

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SED Assessment

Medicaid Section 1115 SMI/SED Demonstrations

State Name
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Geographic Designation	Intensive Outpatient Services							Residential Mental Health Treatme							
Geographic designation	Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Total Facilities/ Programs Offering Intensive Outpatient Services to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Medicaid-Enrolled Providers Offering Intensive Outpatient Services to Medicaid- Enrolled Providers Offering Intensive Outpatient Services Accepting New Medicaid Patients	Specific type(s) of services used to populate this section	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number of Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) Accepting New Patients	Total Number of Residential Mental Health Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)
1. Beaverhead		-	-	-							-	-	-		
2. Big Horn		-	-	-							-	-	-		
3. Blaine	1	80	1	1							-	-	-		
4. Broadwater		-	-	-							-	-	-		
5. Carbon		-	-	-							-	-	-		
6. Carter		-	-	-							-	-	-		
7. Cascade	4	809	1	1				2	2	2	923	1	1	31	31
8. Chouteau		-	-	-							-	-	-		
9. Custer	1	574	1	1				1	1	1	344	1	1	7	7
10. Daniels	1	20	1	1							-	-	-		
11. Dawson	3	76.66666667	1	1				1	1	1	137	1	1	8	8
12. Deer Lodge	1	420	1	1				6	6	6	43.5	1	1	103	103
13. Fallon		-	-	-							-	-	-		
14. Fergus		-	-	-							-	-	-		
15. Flathead	3	1233.333333	1	1				4	4	4	549	1	1	34	34
16. Gallatin	1	1879	1	1							-	-	-		
17. Garfield		-	-	-							-	-	-		
18. Glacier	1	325	1	1							-	-	-		
19. Golden Valley		-	-	-							-	-	-		
20. Granite		-	-	-							-	-	-		
21. Hill	1	380	1	1							-	-	-		
22. Jefferson	1	285	1	1							-	-	-		
23. Judith Basin		-	-	-							-	-	-		
24. Lake	1	1285	1	1							-	-	-		
25. Lewis and Clark	3	897.3333333	1	1				1	1	1	1611	1	1	24	24
26. Liberty		-	-	-							-	-	-		
27. Lincoln	2	354.5	1	1							-	-	-		
28. Madison		-	-	-							-	-	-		
29. McCone		-	-	-							-	-	-		
30. Meagher		-	-	-							-	-	-		
31. Mineral		-	-	-							-	-	-		
32. Missoula	7	731.7142857	1	1				9	9	9	397.8888889	1	1	96	96
33. Musselshell		-	-	-							-	-	-		
34. Park	2	198.5	1	1							-	-	-		
35. Petroleum		-	-	-							-	-	-		
36. Phillips	1	62	1	1							-	-	-		
37. Pondera	1	175	1	1							-	-	-		
38. Powder River		-	-	-							-	-	-		
39. Powell	1	195	1	1							-	-	-		
40. Prairie		-	-	-							-	-	-		
41. Ravalli	2	739.5	1	1				2	2	2	466	1	1	15	15
42. Richland	1	241	1	1							-	-	-		
43. Roosevelt	1	197	1	1							-	-	-		
44. Rosebud	1	245	1	1							-	-	-		
45. Sanders	1	401	1	1							-	-	-		
46. Sheridan		-	-	-							-	-	-		
47. Silver Bow	3	647	1	1				2	2	2	582	1	1	29	29
48. Stillwater		-	-	-							-	-	-		
49. Sweet Grass		-	-	-							-	-	-		
50. Teton	1	149	1	1							-	-	-		
51. Toole	1	91	1	1							-	-	-		
52. Treasure		-	-	-							-	-	-		
53. Valley	1	191	1	1							-	-	-		
54. Wheatland		-	-	-							-	-	-		

SED Assessment

Medicaid Section 1115 SMI/SED Demonstrations

State Name
Date of Assessment
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	Geographic Designation	Residential Mental Health Treatment Facilities																	
		n Facilities (Adult)							Psychiatric Residential Treatm								
	Geographic designation	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Total Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Residential Treatment Facilities (PRTF)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTFs	Ratio of Total PTRFs to Medicaid-Enrolled PRTFs	Ratio of Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds
1.	Beaverhead		-	-	-														
2.	Big Horn		-	-	-														
3.	Blaine		-	-	-														
4.	Broadwater		-	-	-														
5.	Carbon		-	-	-														
6.	Carter		-	-	-														
7.	Cascade	31	59.5483871	1	1														
8.	Chouteau		-	-	-														
9.	Custer	7	49.14285714	1	1														
10.	Daniels		-	-	-														
11.	Dawson	8	17.125	1	1														
12.	Deer Lodge	103	2.533980583	1	1														
13.	Fallon		-	-	-														
14.	Fergus		-	-	-														
15.	Flathead	34	64.58823529	1	1														
16.	Gallatin		-	-	-														
17.	Garfield		-	-	-														
18.	Glacier		-	-	-														
19.	Golden Valley		-	-	-														
20.	Granite		-	-	-														
21.	Hill		-	-	-														
22.	Jefferson		-	-	-														
23.	Judith Basin		-	-	-														
24.	Lake		-	-	-														
25.	Lewis and Clark	24	67.125	1	1				1	1	1	1081	1	1	48	48			
26.	Liberty		-	-	-														
27.	Lincoln		-	-	-														
28.	Madison		-	-	-														
29.	McCone		-	-	-														
30.	Meagher		-	-	-														
31.	Mineral		-	-	-														
32.	Missoula	96	37.30208333	1	1														
33.	Musselshell		-	-	-														
34.	Park		-	-	-														
35.	Petroleum		-	-	-														
36.	Phillips		-	-	-														
37.	Pondera		-	-	-														
38.	Powder River		-	-	-														
39.	Powell		-	-	-														
40.	Prairie		-	-	-														
41.	Ravalli	15	62.13333333	1	1														
42.	Richland		-	-	-														
43.	Roosevelt		-	-	-														
44.	Rosebud		-	-	-														
45.	Sanders		-	-	-														
46.	Sheridan		-	-	-														
47.	Silver Bow	29	40.13793103	1	1														
48.	Stillwater		-	-	-														
49.	Sweet Grass		-	-	-														
50.	Teton		-	-	-														
51.	Toole		-	-	-														

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SED Assessment

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	Geographic Designation	Residential Treatment Facilities							Public and Private Psychiatric Hospitals							
	Geographic designation	Number of Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Total Number of PRTF Beds to Medicaid-Enrolled PRTF Beds	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid-Enrolled PRTFs Available to Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Public and Private Psychiatric Hospitals	Public and Private Psychiatric Hospitals Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMVSED to Public and Private Psychiatric Hospitals Available to Medicaid Patients	Ratio of Public and Private Psychiatric Hospitals to Public and Private Psychiatric Hospitals Available to Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)
1.	Beaverhead		-	-	-						-	-				
2.	Big Horn		-	-	-						-	-				
3.	Blaine		-	-	-						-	-				
4.	Broadwater		-	-	-						-	-				
5.	Carbon		-	-	-						-	-				
6.	Carter		-	-	-						-	-				
7.	Cascade		-	-	-						-	-			1	
8.	Chouteau		-	-	-						-	-				
9.	Custer		-	-	-						-	-				
10.	Daniels		-	-	-						-	-				
11.	Dawson		-	-	-						-	-				
12.	Deer Lodge		-	-	-				1	1	420	1				
13.	Fallon		-	-	-						-	-				
14.	Fergus		-	-	-						-	-				
15.	Flathead		-	-	-						-	-			1	
16.	Gallatin		-	-	-						-	-				
17.	Garfield		-	-	-						-	-				
18.	Glacier		-	-	-						-	-				
19.	Golden Valley		-	-	-						-	-				
20.	Granite		-	-	-						-	-				
21.	Hill		-	-	-						-	-				
22.	Jefferson		-	-	-						-	-				
23.	Judith Basin		-	-	-						-	-				
24.	Lake		-	-	-						-	-				
25.	Lewis and Clark	48	22.52083333	1	1						-	-			1	
26.	Liberty		-	-	-						-	-				
27.	Lincoln		-	-	-						-	-				
28.	Madison		-	-	-						-	-				
29.	McCone		-	-	-						-	-				
30.	Meagher		-	-	-						-	-				
31.	Mineral		-	-	-						-	-				
32.	Missoula		-	-	-						-	-			1	
33.	Musselshell		-	-	-						-	-				
34.	Park		-	-	-						-	-				
35.	Petroleum		-	-	-						-	-				
36.	Phillips		-	-	-						-	-				
37.	Pondera		-	-	-						-	-				
38.	Powder River		-	-	-						-	-				
39.	Powell		-	-	-						-	-				
40.	Prairie		-	-	-						-	-				
41.	Ravalli		-	-	-						-	-				
42.	Richland		-	-	-						-	-				
43.	Roosevelt		-	-	-						-	-				
44.	Rosebud		-	-	-						-	-				
45.	Sanders		-	-	-						-	-				
46.	Sheridan		-	-	-						-	-				
47.	Silver Bow		-	-	-						-	-				
48.	Stillwater		-	-	-						-	-				
49.	Sweet Grass		-	-	-						-	-				
50.	Teton		-	-	-						-	-				
51.	Toole		-	-	-						-	-				

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Geographic Designation	Inpatient												Psychia		
	Psychiatric Units														
Geographic designation	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients
1. Beaverhead					-	-	-	-	-	-					-
2. Big Horn					-	-	-	-	-	-					-
3. Blaine					-	-	-	-	-	-					-
4. Broadwater					-	-	-	-	-	-					-
5. Carbon					-	-	-	-	-	-					-
6. Carter					-	-	-	-	-	-					-
7. Cascade	1		1		3236	-	1	-	1	-			18	18	179.7777778
8. Chouteau					-	-	-	-	-	-					-
9. Custer					-	-	-	-	-	-					-
10. Daniels					-	-	-	-	-	-					-
11. Dawson					-	-	-	-	-	-					-
12. Deer Lodge					-	-	-	-	-	-			228	228	1.842105263
13. Fallon					-	-	-	-	-	-					-
14. Fergus					-	-	-	-	-	-					-
15. Flathead	1		1		3700	-	1	-	1	-			41	41	90.24390244
16. Gallatin					-	-	-	-	-	-					-
17. Garfield					-	-	-	-	-	-					-
18. Glacier					-	-	-	-	-	-					-
19. Golden Valley					-	-	-	-	-	-					-
20. Granite					-	-	-	-	-	-					-
21. Hill					-	-	-	-	-	-					-
22. Jefferson					-	-	-	-	-	-					-
23. Judith Basin					-	-	-	-	-	-					-
24. Lake					-	-	-	-	-	-					-
25. Lewis and Clark	1		1		2692	-	1	-	1	-			22	22	122.3636364
26. Liberty					-	-	-	-	-	-					-
27. Lincoln					-	-	-	-	-	-					-
28. Madison					-	-	-	-	-	-					-
29. McCone					-	-	-	-	-	-					-
30. Meagher					-	-	-	-	-	-					-
31. Mineral					-	-	-	-	-	-					-
32. Missoula	1		1		5122	-	1	-	1	-			38	38	134.7894737
33. Musselshell					-	-	-	-	-	-					-
34. Park					-	-	-	-	-	-					-
35. Petroleum					-	-	-	-	-	-					-
36. Phillips					-	-	-	-	-	-					-
37. Pondera					-	-	-	-	-	-					-
38. Powder River					-	-	-	-	-	-					-
39. Powell					-	-	-	-	-	-					-
40. Prairie					-	-	-	-	-	-					-
41. Ravalli					-	-	-	-	-	-					-
42. Richland					-	-	-	-	-	-					-
43. Roosevelt					-	-	-	-	-	-					-
44. Rosebud					-	-	-	-	-	-					-
45. Sanders					-	-	-	-	-	-					-
46. Sheridan					-	-	-	-	-	-					-
47. Silver Bow					-	-	-	-	-	-					-

Montana Department of Public Health and Human Services

SED Assessment

Medicaid Section 1115 SMI/SED Demonstrations

State Name
Date of Assessment
Time Period Reflected in Assessment (month/day/year)

	Geographic Designation	Institutions for Mental Diseases															
		No Beds		Residential Treatment Facilities That Qualify As IMDs										Psychiatric Hospitals That Qualify As IMDs			
	Geographic designation	Ratio of Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Number of Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	Ratio of Total Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting New Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Hospitals that Qualify as IMDs	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations
1.	Beaverhead	-					-	-	-						-		
2.	Big Horn	-					-	-	-						-		
3.	Blaine	-					-	-	-						-		
4.	Broadwater	-					-	-	-						-		
5.	Carbon	-					-	-	-						-		
6.	Carter	-					-	-	-						-		
7.	Cascade	1					-	-	-						-		
8.	Chouteau	-					-	-	-						-		
9.	Custer	-					-	-	-						-		
10.	Daniels	-					-	-	-						-		
11.	Dawson	-					-	-	-						-		
12.	Deer Lodge	1					-	-	-				1	420			
13.	Fallon	-					-	-	-						-		
14.	Fergus	-					-	-	-						-		
15.	Flathead	1					-	-	-						-		
16.	Gallatin	-					-	-	-						-		
17.	Garfield	-					-	-	-						-		
18.	Glacier	-					-	-	-						-		
19.	Golden Valley	-					-	-	-						-		
20.	Granite	-					-	-	-						-		
21.	Hill	-					-	-	-						-		
22.	Jefferson	-					-	-	-						-		
23.	Judith Basin	-					-	-	-						-		
24.	Lake	-					-	-	-						-		
25.	Lewis and Clark	1					-	-	-						-		
26.	Liberty	-					-	-	-						-		
27.	Lincoln	-					-	-	-						-		
28.	Madison	-					-	-	-						-		
29.	McCone	-					-	-	-						-		
30.	Meagher	-					-	-	-						-		
31.	Mineral	-					-	-	-						-		
32.	Missoula	1					-	-	-						-		
33.	Musselshell	-					-	-	-						-		
34.	Park	-					-	-	-						-		
35.	Petroleum	-					-	-	-						-		
36.	Phillips	-					-	-	-						-		
37.	Pondera	-					-	-	-						-		
38.	Powder River	-					-	-	-						-		
39.	Powell	-					-	-	-						-		
40.	Prairie	-					-	-	-						-		
41.	Ravalli	-					-	-	-						-		
42.	Richland	-					-	-	-						-		
43.	Roosevelt	-					-	-	-						-		
44.	Rosebud	-					-	-	-						-		
45.	Sanders	-					-	-	-						-		
46.	Sheridan	-					-	-	-						-		
47.	Silver Bow	-					-	-	-						-		
48.	Stillwater	-					-	-	-						-		
49.	Sweet Grass	-					-	-	-						-		
50.	Teton	-					-	-	-						-		
51.	Toole	-					-	-	-						-		
52.	Treasure	-					-	-	-						-		
53.	Valley	-					-	-	-						-		
54.	Wheatland	-					-	-	-						-		
55.	Wibaux	-					-	-	-						-		
56.	Yellowstone	1					-	-	-						-		
57.	*Missing County	-	ds in the unit. Mostly track whet				-	-	-	Health Treatment Fac					-	hospital licensur	MSH qualifies as

Montana Department of Public Health and Human Services

SED Assessment

Medicaid Section 1115 SMI/SED Demonstrations

State Name
Date of Assessment
Time Period Reflected in Assessment (month/day/year)

	Geographic Designation	Crisis Stabilization Services												Federally Qualified Health Centers			
	Geographic designation	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Crisis Stabilization Units	Number of Coordinated Community Crisis Response Teams	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams	Specific type(s) of services used to populate this section	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number FQHCs that Offer Behavioral Health Services	Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations
1.	Beaverhead						-	-	-	-	-				1	221		
2.	Big Horn						-	-	-	-	-				1	308		
3.	Blaine						-	-	-	-	-				2	40		
4.	Broadwater						-	-	-	-	-					-		
5.	Carbon						-	-	-	-	-					-		
6.	Carter						-	-	-	-	-					-		
7.	Cascade		1				-	3236	-	-	-				2	1618		
8.	Chouteau						-	-	-	-	-					-		
9.	Custer						-	-	-	-	-				1	574		
10.	Daniels						-	-	-	-	-					-		
11.	Dawson						-	-	-	-	-					-		
12.	Deer Lodge						-	-	-	-	-				1	420		
13.	Fallon						-	-	-	-	-					-		
14.	Fergus						-	-	-	-	-				1	316		
15.	Flathead		1		1		-	3700	-	3700	-				1	3700		
16.	Gallatin		1		1		-	1879	-	1879	-				2	939.5		
17.	Garfield						-	-	-	-	-					-		
18.	Glacier						-	-	-	-	-				1	325		
19.	Golden Valley						-	-	-	-	-					-		
20.	Granite						-	-	-	-	-					-		
21.	Hill						-	-	-	-	-				1	380		
22.	Jefferson						-	-	-	-	-					-		
23.	Judith Basin						-	-	-	-	-					-		
24.	Lake				1		-	-	-	1285	-					-		
25.	Lewis and Clark		1				-	2692	-	-	-				2	1346		
26.	Liberty						-	-	-	-	-					-		
27.	Lincoln						-	-	-	-	-				1	709		
28.	Madison						-	-	-	-	-					-		
29.	McCone						-	-	-	-	-					-		
30.	Meagher						-	-	-	-	-					-		
31.	Mineral						-	-	-	-	-				1	163		
32.	Missoula		1		1		-	5122	-	5122	-				7	731.7142857		
33.	Musselshell						-	-	-	-	-					-		
34.	Park						-	-	-	-	-				1	397		
35.	Petroleum						-	-	-	-	-					-		
36.	Phillips						-	-	-	-	-					-		
37.	Pondera						-	-	-	-	-					-		
38.	Powder River						-	-	-	-	-					-		
39.	Powell						-	-	-	-	-					-		
40.	Prairie						-	-	-	-	-					-		
41.	Ravalli				1		-	-	-	1479	-				1	1479		
42.	Richland						-	-	-	-	-					-		
43.	Roosevelt						-	-	-	-	-					-		
44.	Rosebud						-	-	-	-	-				1	245		
45.	Sanders						-	-	-	-	-					-		
46.	Sheridan						-	-	-	-	-					-		
47.	Silver Bow				1		-	-	-	1941	-				2	970.5		
48.	Stillwater						-	-	-	-	-					-		
49.	Sweet Grass						-	-	-	-	-					-		
50.	Teton						-	-	-	-	-					-		
51.	Toole						-	-	-	-	-				1	91		
52.	Treasure						-	-	-	-	-					-		
53.	Valley						-	-	-	-	-					-		
54.	Wheatland						-	-	-	-	-					-		
55.	Wibaux						-	-	-	-	-					-		

C. Implementation Plan

B. Budget Neutrality

IMD Overview

How To Use This Spreadsheet:

Consult the tables below for a overview of the "IMD Services Limit" and "Non-IMD Services CNOM Limit" in Scenarios 1 and 2. The tables provide basic concepts and frameworks for establishing the budget neutrality limits--and expenditure reporting requirements for monitoring. The notes below the table provide additional information related to allowable IMD medical assistance services, estimation of the various budget neutrality limits, trend rates, "in lieu of" services and other details of estimation and expenditure reporting. For states proposing to include IMD services as a component of their broader 1115 demonstrations, the limits established in this spreadsheet--once approved by CMS--will be included in the comprehensive budget neutrality spreadsheet, STCs and expenditure monitoring tool (see State Medicaid Director Letter #18-009). The limits established may be used as an upper limit for all medical assistance services provided in an IMD--or separately tabulated by, for example, diagnosis-type (see glossary below for definition of abbreviations).

Scenario 1

Situation: Demonstration CNOM is limited to expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD, SMI and/or SED who are residents in facilities that meet the definition of an IMD (i.e., IMD exclusion related MA).	IMD Services Limit	Non-IMD Services CNOM Limit
Without Waiver (i.e., budget neutrality limit)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day BN Expenditure Limit · PMPM cost × IMD MMs	
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs	

Scenario 2

Situation: Demonstration CNOM include both CNOM for IMD exclusion related MA to *and* CNOM for additional hypothetical services that can be provided outside the IMD.	IMD Services Limit	Non-IMD Services CNOM Limit
Without Waiver (i.e., budget neutrality limit)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day	PMPM Cost · Estimate of average CNOM service cost during Non-IMD MMs · Est. total CNOM service cost ÷ est. Non-IMD MMs · CNOM service cost can include capitated cost of IMD services Member Months

	· *Can* exclude months with ≤ 15 IMD inpatient days under managed care BN Expenditure Limit · PMPM cost × IMD MMs	· Non-IMD MM: Any month of Medicaid eligibility in which a person *could* receive a CNOM service that is not an IMD MM BN Expenditure Limit · PMPM cost × Non-IMD MMs
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs	Expenditures Subject to Limit · All CNOM service costs with dates of service during Non-IMD MMs Reporting Requirements State must be able to identify and report: · Non-IMD MMs separate from IMD MMs · IMD CNOM costs separate from other MA costs

Glossary of Abbreviations
CNOM = expenditure authority (cost not otherwise matchable)
Hypo = hypothetical, i.e., optional services that could be included in the state plan but are instead being authorized in the 1115 using CNOM
IMD = institution for mental diseases
MA = medical assistance
MM = member month
SUD = substance abuse disorder
SMI = serious mental illness
SED = serious emotional disturbance

Notes
1. Date of service for capitation payments is the month of coverage for which the capitation is paid.
2. The IMD Services Limit and Non-IMD Services CNOM Limit are intended to be two distinct budget neutrality tests separately and independently enforced.
3. Services provided in an IMD "in lieu of" other allowable settings are excluded from this budget neutrality test (see below).
4. Some specific unallowable costs are detailed below (see STCs for additional exceptions and caveats).

Estimation for the IMD Services Limit

The IMD Services Limit represents the projected cost of medical assistance during months in which Medicaid eligible are patients at the IMD. These are the acceptable ways for the state to determine the PMPMs for the IMD Services Limit.

· States should present their most recent represenative year of historical data on overall MA costs for individuals with a SUD, SMI and/or SED diagnosis (or proxy) who received inpatient treatment those diagnoses (or could have received inpatient treatment if such services were available), to determine projected MA cost per user of SUD, SMI and/or SED inpatient services for each historical year.
· The per user per month cost(s) are then projected forward using the President's Budget PMPM cost trend--and the projected per user per month costs will become the PMPMs for the IMD Services Limit.
· If the state has an existing comprehensive Medicaid demonstration with already calculated without waiver PMPMs, CMS will incorporate the PMPMs established in this workbook.
· States may also "top off" IMD Services Limit PMPMs with an additional estimated amount representing any additional CNOM services that affected individuals may also receive during IMD months.
· State may use Alternate PMPM Development in Historical tab for estimating expenditures (see 'Supplemental Methodology Document' requirement below).

Trends
PMPM trend rates will generally be the smoothed trend from the most recent President's Budget Medicaid trends and will be supplied to states by CMS.
· The President's Budget trends should be for the eligibility groups that are participating in the IMD demonstration; most often, these will be the Current Adults, New Adults, or a blend of Current and New Adults, to determine average MA cost per user of SUD, SMI and/or SED inpatient services for each historical year.
· The per user per month costs are then projected forward using the President's Budget PMPM cost trend.
· The projected per user per month costs will become the PMPMs for the IMD Services Limit.

Multiple MEGs

There should be one set of MEGs for the current Medicaid state plan IMD Services Limit(s) with associated PMPMs and member months, and one for the Non-IMD Services CNOM Limit and/or Non-Hypothetical CNOM Limit, as applicable.

- States may also develop single, or multiple, PMPMs for SUD, SMI and/or SED.

Member Month Non-Duplication

IMD Services Limit member month must be non-duplicative of Non-IMD Services CNOM Limit member months, and must also be non-duplicative of general comprehensive demonstration budget neutrality limit member months.

- This means that month of Medicaid eligibility for an individual cannot appear as both an IMD Services Limit member month and a Non-IMD Services CNOM Limit member month; it has to be one or the other, and likewise for IMD Services Limit member month and general comprehensive demonstration budget neutrality limit member months.
- IMD Services CNOM Limit member months can be duplicative of general comprehensive demonstration budget neutrality limit member months.

State Data Inputs

States must add their data to the yellow highlighted cells for CMS review and discussion - and choose the appropriate drop-downs corresponding to their data inputs.

- CMS will provide template instructions with this spreadsheet.

"In Lieu of" Services

States must not report expenditures for a capitation payment to a risk-based MCO or PIHP for an enrollee with a short-term stay in an IMD for inpatient psychiatric or substance use disorder services of no more than 15 days within the month for which the capitation payment is made is permissible under the regulation at §438.6(e) for MCOs and PIHPs to use the IMD as a medically appropriate and cost effective alternative setting to those covered under the State plan or ABP.

- This flexibility is referred to in the regulations as "in-lieu-of" services or settings and is effectuated through the contract between the state and the MCO or PIHP.
- For more information on "in leu of" servies, see "Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)" (August 2017).

Unallowable Costs

In addition to other unallowable costs and caveats outlined in the STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following :

- Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
- Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
- Costs for services provided to inmates of a public institution, as defined in 42 CFR 435.1010 and clause A after section 1905(a)(29), except if the individual is admitted for at least a 24 hour stay in a medical institution (see SMI/SED SMDL, p. 13).
- Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G .

Supplemental Methodology Document

The 'Historical Spending Data' and/or 'Alternate PMPM Development' in the IMD Historical tab must be accompanied by a supplemental methodology and data sources document that fully describes, for each MEG, a complete break-out of all SUD, SMI and/or SED services--with descriptions of accompanying expenditures and caseloads.

- There should also be sections/headings in the methodology document which describe all other state data inputs (see 'State Data Inputs' above).

IMD Historical

Representative Data Year:	2023
Type of State Years:	State Fiscal

IMD SED MEG 1	2023
TOTAL EXPENDITURES	$1,120,446
EUGIBLE MEMBER MONTHS	185
PMPM COST	$6,056.46

IMD SUD STD MEG 2	
TOTAL EXPENDITURES	
EUGIBLE MEMBER MONTHS	
PMPM COST	

Alternate Development: IMD Services + Non-IMD & Non-Hypo CNOMs	Estimated Total Expenditures for Medical Assistance Provided in an IMD that are:		Managed Care PMPM (Replicate Column, as Necessary)			Choose "Included" from Drop-Down(s) to Link Services with MEG(s)				
						CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
IMD Services	Currently State Plan FFS (e.g. Carved Out) or Not Currently State Plan but Otherwise Approvable (Including Pending SPAs)	Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or "Costs Not Otherwise Matchable" ("Non-IMD" or "Non-Hypo" CNOMs)	Capitated PMPM for Currently Approved, non-IMD, State Plan or Other Title XIX Services	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost for All Services Provided in an IMD	IMD SED MEG 1	IMD SUD STD MEG 2	MEG 3	Non-IMD Services CNOM Limit MEG	Non-Hypothetical Services CNOM MEG
Service 1			$0		#DIV/0!					
Service 2			$0		#DIV/0!					
Service 3			$0		#DIV/0!					
Service 4			$0		#DIV/0!					
Service 5			$0		#DIV/0!					
Service 6			$0		#DIV/0!					
Service 7			$0		#DIV/0!					
Service 8			$0		#DIV/0!					
Service 9			$0		#DIV/0!					
Service 10			$0		#DIV/0!					
Service 11			$0		#DIV/0!					
Service 12			$0		#DIV/0!					
Add additional services, as necessary			$0		#DIV/0!					
Totals						$0.00	$0.00	$0.00	$0.00	$0.00

IMD Without Waiver

PB Trend Rate(s) Used:

IMD SED MEG 1	5.60%

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) DY 1 (7/1/2022-6/30/2023)	DY 2 (7/1/2023-6/30/2024)	DY 3 (7/1/2024-6/30/2025)	DY 4 (7/1/2025-6/30/2026)	DY 5 (7/1/2026-6/30/2027)	TOTAL WOW
IMD SED MEG 1									
Eligible Member Months	n.a.	n.a.	185	0	0	294	324	348	
PMPM Cost	5.6%	24	$ 6,056.46		$ -	$ 6,754	$ 7,132	$ 7,531	
Total Expenditure				$ -	$ -	$ 1,985,614	$ 2,310,768	$ 2,620,924	$ 6,917,306

IMD With Waiver

ELIGIBILITY GROUP	LAST HISTORIC YEAR	PB TREND RATE	DEMONSTRATION YEARS (DY) DY 1 (7/1/2022-6/30/2023)	DY 2 (7/1/2023-6/30/2024)	DY 3 (7/1/2024-6/30/2025)	DY 4 (7/1/2025-6/30/2026)	DY 5 (7/1/2026-6/30/2027)	TOTAL WW
IMD SED MEG 1								
Eligible Member Months			0	0	294	324	348	
PMPM Cost	$ 6,056	5.6%	$ -	$ -	$ 6,754	$ 7,132	$ 7,531	
Total Expenditure			$ -	$ -	$ 1,985,614	$ 2,310,768	$2,620,924	$ 6,917,306

Total $ 6,917,306

IMD Summary

Supplemetal Test #1: IMD Services Cost Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 1 (7/1/2022-6/30/2023)	DY 2 (7/1/2023-6/30/2024)	DY 3 (7/1/2024-6/30/2025)	DY 4 (7/1/2025-6/30/2026)	DY 5 (7/1/2026-6/30/2027)	
IMD SED MEG 1	$0	$0	$1,985,614	$2,310,768	$2,620,924	$6,917,306
TOTAL	$0	$0	$1,985,614	$2,310,768	$2,620,924	$6,917,306

With-Waiver Total Expenditures

	DY 1 (7/1/2022-6/30/2023)	DY 2 (7/1/2023-6/30/2024)	DY 3 (7/1/2024-6/30/2025)	DY 4 (7/1/2025-6/30/2026)	DY 5 (7/1/2026-6/30/2027)	TOTAL
IMD SED MEG 1	$0	$0	$1,985,614	$2,310,768	$2,620,924	$6,917,306
TOTAL	$0	$0	$1,985,614	$2,310,768	$2,620,924	$6,917,306
Net Overspend	$0	$0	$0	$0	$0	$0

Add Trend Rates & PMPMs from Table Below to 'SUD IMD Supplemental Budget Neutrality Test(s)' STC

SED MEG(s)	Trend Rate	DY 1 (7/1/2022-6/30/2023)	DY 2 (7/1/2023-6/30/2024)	DY 3 (7/1/2024-6/30/2025)	DY 4 (7/1/2025-6/30/2026)	DY 5 (7/1/2026- 6/30/2027)
IMD SED MEG 1	5.6%	$0	$0	$6,754	$7,132	$7,531

	DY 1 (7/1/2022-6/30/2023)	DY 2 (7/1/2023-6/30/2024)	DY 3 (7/1/2024-6/30/2025)	DY 4 (7/1/2025-6/30/2026)	DY 5 (7/1/2026-6/30/2027)	TOTAL
IMD SED MEG 1	$0	$0	$1,985,614	$2,310,768	$2,620,924	$6,917,306
TOTAL	$0	$0	$1,985,614	$2,310,768	$2,620,924	$6,917,306

IMD Caseloads

Projected IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	DY 1 (7/1/2022-6/30/2023)	DY 2 (7/1/2023-6/30/2024)	DY 3 (7/1/2024-6/30/2025)	DY 4 (7/1/2025-6/30/2026)	DY 5 (7/1/2026-6/30/2027)
IMD SED MEG 1	10.0%			294	324	348
Non-Hypothetical Services CNOM Meg			0	0	0	0