NOTICE OF PUBLIC COMMENT PERIOD AND PUBLIC HEARINGS
Montana Section 1115 Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration Renewal Request
Full Public Notice – October 27, 2026

The Montana Department of Public Health and Human Services (DPHHS) is providing public notice of its intent to: (1) submit a Section 1115 Demonstration renewal request to the Centers for Medicare and Medicaid Services (CMS), requesting authority to continue and amend the Montana Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration, on or before Dec. 1, 2026; and (2) hold public hearings to receive comments on the HEART Demonstration renewal application. DPHHS is seeking renewal of the HEART Demonstration for an additional five-year period from July 1, 2027, through June 30, 2032. All proposed requests are subject to CMS approval.

Section I – Program Description and Demonstration Goals and Objectives

A. HEART Demonstration Description

The HEART Demonstration was initially approved by CMS on July 1, 2022, with a subsequent amendment approved on Feb. 26, 2024. Since approval, the Demonstration has served as a critical vehicle for advancing Montana's behavioral health priorities, expanding access to evidence-based services, and supporting broader Medicaid program innovations aimed at addressing substance use disorder (SUD), serious mental illness (SMI), and other behavioral health needs. Montana's overarching goal for the HEART Demonstration renewal is to continue to improve the health and well-being of Medicaid members by strengthening access to high-quality behavioral health services and support. The renewal will enable Montana to sustain key Demonstration initiatives, evaluate their long-term impact, and advance additional strategies that improve access, quality, and continuity of care.

DPHHS is requesting renewal of the Montana Section 1115 HEART Demonstration to continue and strengthen access to behavioral health services and supports for individuals with SUD, SMI, and other behavioral health needs. Through this renewal request, Montana seeks to continue existing Demonstration authorities for SUD treatment in institutions for mental diseases (IMDs), contingency management, pre-tenancy and tenancy sustaining support services, and pre-release services for justice-involved individuals. The renewal request would impact current and future Montana Medicaid members with behavioral health needs, including individuals with SUD, individuals with SMI, individuals experiencing or at risk of homelessness, and justice-involved individuals preparing to return to the community.

Montana is seeking through this demonstration to continue and, where applicable, amend existing Demonstration features, including the continuation of:

- SUD IMD expenditure authority;
- Contingency management for stimulant use disorder, with a proposed eligibility criteria refinement to remove the requirement that stimulant use disorder be the

primary diagnosis;
- Pre-tenancy and tenancy sustaining support services;
- Pre-release services for justice-involved individuals, including lowering the minimum eligibility age to 18 years and older, extending the service delivery timeframe from 30 days to 60 days prior to release, and adding peer support services to the targeted set of Medicaid services provided prior to release.

B. Goals and Objectives

This Demonstration renewal will build on the HEART Demonstration and continue strengthening Montana's behavioral health system to better meet the needs of Medicaid members with behavioral health needs. Specifically, the Demonstration will support Montana's efforts to:

1. Expand Medicaid's behavioral health continuum of care, including early intervention, crisis services, outpatient and residential treatment, and recovery supports for individuals with SUD and SMI;
2. Advance efforts to reduce opioid-related overdose deaths and suicides;
3. Improve the quality of care and outcomes across outpatient, residential, and inpatient settings; and
4. Strengthen care transitions and continuity of medication treatment for justice-involved individuals by connecting individuals to ongoing community-based physical and behavioral health services and reducing avoidable emergency department visits, hospitalizations, and other high-cost utilization.

Section II – Summary of Current Demonstration Features to be Continued

The current HEART Demonstration authorizes expenditures for SUD treatment in IMD, as well as expenditure and waiver authorities for Medicaid-eligible adults with SUD and/or SMI to expand access to evidence-based contingency management for stimulant use disorder, housing-related supports, and transitional services for justice-involved individuals returning to the community.

Collectively, these initiatives advance the Demonstration's goals of improving behavioral health outcomes, reducing unmet treatment and support needs, preventing unnecessary institutionalization, and promoting long-term recovery and community integration.

1. ***SUD Treatment in IMDs.*** Effective July 1, 2022, the HEART Demonstration waived the federal IMD exclusion, permitting Medicaid reimbursement for short-term residential SUD treatment in facilities with more than 16 beds. As of SFY 2026, 1,728 Medicaid members received services under the SUD IMD authority.[1]

[1] Montana DPHHS (September 2025), Healing and Ending Addiction Through Recovery and Treatment (HEART). Available at: https://dphhs.mt.gov/assets/StatutorilyRequiredReports/MCA16-12-122HEARTReport9-1-25.pdf.

2. ***Contingency Management.*** Montana launched contingency management services for adults with stimulant use disorder on Jan. 1, 2026. This evidence-based intervention uses positive incentives to promote treatment engagement and stimulant abstinence. To support implementation, provider training and technical assistance were provided by the University of California, Los Angeles (UCLA), beginning in Dec., 2025.[12] As of State Fiscal Year (SFY) 2026, two agencies are delivering contingency management services, with an additional agency awaiting enrollment. Across those agencies, 97 individuals have completed the contingency management overview training course.
3. ***Tenancy Support Services***. Effective June 1, 2025, DPHHS commenced implementation of tenancy support services, providing pre-tenancy and tenancy-sustaining services to Medicaid members with qualifying behavioral health conditions who are experiencing or at risk of homelessness. In SFY 2026, 525 members were assessed for eligibility, and 205 members received tenancy support services, including direct support in housing deposits and application fees. A total of 27 agencies currently provide tenancy support services statewide.
4. ***Reentry Demonstration Initiative.*** On Oct. 15, 2025, DPHHS launched the reentry services for incarcerated individuals with behavioral health needs in Montana's three state correctional facilities under the Department of Corrections (DOC). Covered services include case management, Medication-Assisted Treatment (MAT), medications provided prior to release, and limited clinical consultation services. DOC is in the final stages of implementing its Medicaid billing systems; at this time, no Medicaid claims have been paid.

Section III – Summary of Eligibility, Cost-Sharing, Benefits, and Delivery System

A. Eligibility Requirements

There are no proposed changes to Medicaid eligibility criteria under the HEART Demonstration renewal request.

B. Health Care Delivery System and Benefits

There are no proposed changes to the Medicaid delivery system under the HEART Demonstration renewal request.

C. Cost Sharing

Montana currently does not apply cost sharing to any of its Medicaid members. Montana will implement cost sharing as required under H.R. 1 for expansion adults with income between 100 to 138 percent of the federal poverty level, and beneficiaries who are subject to cost sharing under H.R. 1 will be subject to cost sharing, as applicable, under this Demonstration.[2]

Section IV – Enrollment Projections

[2] Section 71120 of H.R. 1 (P.L. 119-21). Available at https://www.congress.gov/bill/119th-congress/house-bill/1/text

Table 1 below describes historical enrollment for the initial Demonstration period.

Table 1. *Historical Enrollment by Category of Aid*

Category of Aid	Historical 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)	84	150	189	216	42
CHIP	0	0	0	0	0
Aged, Blind and Disabled	60	73	82	90	25
ACA Expansion	719	1,091	1,433	1,574	313
Other (HIFA, Poverty, Transitional MA, Former Foster Care)	32	18	16	16	4
Total	895	1,332	1,720	1,896	384

Table 2 below describes projected enrollment under the HEART Demonstration renewal request by Medicaid eligibility group.

Table 2. *Projected Enrollment by Category of Aid*

Category of Aid	Projected Enrollment				
	DY 6 *7/1/27–6/30/28*	DY 7 *7/1/28–6/30/29*	DY 8 *7/1/29–6/30/30*	DY 9 *7/1/30–6/30/31*	DY 10 *7/1/31–6/30/32*
Families and Children (not CHIP)	470	500	528	549	571
CHIP	1	2	3	4	5
Aged, Blind and Disabled	196	208	220	229	238
ACA Expansion	3,422	3,644	3,848	3,999	4,157
Other (HIFA, Poverty, Transitional MA, Former Foster Care)	34	37	39	40	42

Total	**4,123**	**4,391**	**4,638**	**4,821**	**5,013**

Section V – Annual Expenditures

Montana expects the HEART Demonstration renewal request to remain budget neutral, consistent with Section 1115 requirements and CMS budget neutrality policies. Through this renewal, Montana seeks to continue existing Demonstration authorities that support access to behavioral health services and recovery supports, including inpatient and residential treatment for SUD and mental health, contingency management services, pre-tenancy and tenancy supports, and reentry services for justice-involved individuals. Montana is developing detailed budget neutrality projections for the requested renewal period and will continue to work with CMS throughout the negotiation and approval process to finalize the budget neutrality methodology and expenditure estimates.

Table 3 describes Montana's historical Demonstration expenditures for the initial Demonstration period.

Table 3. *Historical Demonstration Expenditures for the HEART Renewal Period*

Historical Expenditures (in dollars)					
Expenditure Authorities	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*
IMD Exclusion for SUD	$5,714,950	$8,938,524	$9,758,544	$10,274,848	$1,211,878
Tenancy Supports	-	-	$34	$124,000	$26,092
60-Days Pre-Release Coverage	-	-	-	-	-
Evidence-Based Stimulant Use Disorder Treatment Models	-	-	-	$6,276	-
Total	$5,714,950	$8,938,524	$9,758,578	$10,405,124	$1,237,970

Table 4 describes Montana's projected Demonstration expenditures for the requested renewal period.

Table 4. *Projected Demonstration Expenditures for the HEART Renewal Period*

Projected Expenditures (in dollars)

Expenditure Authorities	DY 6 *7/1/27–6/30/28*	DY 7 *7/1/28–6/30/29*	DY 8 *7/1/29–6/30/30*	DY 9 *7/1/30–6/30/31*	DY 10 *7/1/31–6/30/32*
IMD Exclusion for SUD	$11,876,577	$12,446,653	$13,044,092	$13,670,209	$14,326,379
Tenancy Supports	$3,000,000	$3,399,000	$3,851,067	$4,363,259	$4,943,572
60-Days Pre-Release Coverage	$5,777,568	$6,236,538	$6,731,969	$7,266,757	$7,844,028
Evidence-Based Stimulant Use Disorder Treatment Models	$172,725	$271,524	$355,696	$383,953	$414,454
Total	**$20,826,871**	**$22,353,715**	**$23,982,824**	**$25,684,177**	**$27,528,433**

Montana has summarized State Fiscal Year 2025 outpatient, community-based mental health expenditures by population, with funding sources stratified by federal share, State general funds, and State county-level funds in Table 5.

Table 5. *Montana SFY 2025 Expenditures on Community-Based Mental Health Services*

Total	Federal	State – General Funds (Matchable)	State-County Funds	Total
Medicaid Expansion	$71,732,820	$8,018,169	$0	$79,750,989
Standard	$98,023,214	$58,511,956	$0	$156,535,170
Total Montana Medicaid	**$169,756,034**	**$66,530,125**	**$0**	**$236,286,159**

Section VI – Waiver and Expenditure Authorities

A. Waiver Authorities

Under the authority of Section 1115(a)(1) of the Act, Montana requests renewal of the following waiver authorities, which are necessary to implement and operate the HEART Demonstration through June 30, 2032.

Table 6. *Waiver Requests*

Waiver Authority	Use for Waiver
§ 1902(a)(1) State-wideness	To enable the state to provide contingency management services on a less-than-statewide basis to qualifying beneficiaries. To enable the state to cover pre-tenancy and tenancy support services on a geographically limited basis. To enable the state to provide pre-release services, as authorized under this Demonstration, to qualifying beneficiaries on a geographically limited basis.
§ 1902(a)(8) Reasonable Promptness	To the extent necessary, to enable the state to limit enrollment through waiting lists for pre-tenancy and tenancy support services.
§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability	To enable the state to provide contingency management services through approved providers to eligible individuals with stimulant use disorders, that are not otherwise available to other beneficiaries in the same eligibility group. To the extent necessary, to allow the state to offer a varying set of benefits to beneficiaries eligible for pre-tenancy and tenancy support services. To enable the state to provide only a limited set of pre-release services to qualifying beneficiaries that is different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the state plan.
§ 1902(a)(23)(A) Freedom of Choice	To the extent necessary, to enable the state to restrict freedom of choice of provider for beneficiaries who receive contingency management services. To the extent necessary, to enable the state to restrict freedom of choice of provider for beneficiaries who receive pre-tenancy and tenancy support services under the Demonstration. To enable the state to require qualifying beneficiaries to receive pre-release services, as authorized under this Demonstration, through only certain providers.

B. Expenditure Authorities

Under the authority of Section 1115(a)(1) of the Act, Montana requests renewal of the following expenditure authorities, which are necessary to implement and operate the Demonstration through June 30, 2032.

Table 7. *Expenditure Authority Requests*

Expenditure Authority	Use for Expenditure Authority
Expenditures for Residential and Inpatient Treatment for Individuals with SUD	Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.
Expenditures Related to Contingency Management	Expenditures for contingency management services provided to qualifying beneficiaries from a provider that has been approved by DPHHS to pilot the Contingency Management benefit.
Expenditures Related to Pre-Tenancy and Tenancy Support Services	Expenditures for pre-tenancy and tenancy support services provided to qualifying beneficiaries, from a provider that has been approved by DPHHS, and subject to annual enrollment limits and waiting lists.
Expenditures Related to Pre-Release Services	Expenditures for pre-release services provided to qualifying Medicaid beneficiaries for up to 60 days immediately prior to the expected date of release from a participating State prison.

Section VIII – Demonstration Hypotheses and Evaluation Approach

Montana contracted with an independent external evaluator, the University of Montana Rural Institute, to conduct a comprehensive evaluation of the HEART Demonstration. CMS approved the HEART Demonstration Evaluation Design on February 17, 2026. The Interim Evaluation Report is posted on DPHHS' HEART website at: https://dphhs.mt.gov/HEARTWaiver.

Specific measures and data sources are detailed in the following Evaluation Measures and Data Sources Tables (***tables 8-10***). Each outcome measure included in this evaluation plan has been explicitly mapped to one or more evaluation questions and associated hypotheses across the three evaluation domains: process, outcome, and impact. The measures were selected to ensure comprehensive coverage of the Demonstration's goals, including access to care, quality of treatment, health outcomes, and cost containment.

Table 8. *Aim 1 Evaluation Measures and Data Sources*

Aim 1: Promote increased access to care for members with SUD		
Research Question	Measure	Data Source
Primary Driver: Increased rates of identification, initiation, and engagement in treatment for SUD (G1).		
Hypothesis 1.1: The Demonstration will expand access to critical levels of care for OUD and other SUDs (M1), resulting in increased rates of identification, initiation, and engagement in treatment for SUD (G1, G7, G8a).		

Process Research Question 1.1.1: Have critical levels of care been revised and expanded to align with ASAM standards?	Revision of ASAM level 3.1 to create bundled rate. Alignment of new bundled rate for ASAM level 2.1, 2.5, 3.5, 3.7, 3.7- WM, MAT. Implementation of ASAM level 3.3 and 3.2-WM. Expansion of ASAM level 0.5. New MAT provider types.	Stakeholder surveys /interviews, administrative documentation
	ARM adding targeted services for youth, revising provider bundled rate and fee schedule. State licensure rules. Amend Other Rehabilitation SPA.	Stakeholder surveys /interviews, administrative documentation
Process Research Question 1.1.2: did the state implement the Reentry Demonstration Initiative according to its CMS-approved implementation plan and achieve each of the five Reentry Initiative milestones?	#/% Milestones with documentation of full implementation	Administrative documentation provided by DPHHS
	PRISM Implementation and Reach	Organizational survey /interviews of providers and stakeholders
Outcomes Research Question 1.1.3: Have rates of identification, initiation, and engagement in treatment for OUDs and other SUDs increased as measured by utilization?	Medicaid Beneficiaries with Newly Initiated SUD Treatment / Diagnosis (#/%) (CMS #2)	Claims, see MT monitoring protocol for codes
	Any SUD Treatment (#/%) (CMS #6)	Claims, see MT monitoring protocol for codes
	Early Intervention (#/%) (CMS #7)	Claims, see MT monitoring protocol for codes
	Outpatient services (#/%) (CMS #8)	Claims, see MT monitoring protocol for codes
	Intensive Outpatient and Partial Hospitalization Services (#/%) (CMS #9)	Claims, see MT monitoring protocol for codes

	Residential and Inpatient Services (#/%) (CMS #10)	Claims, see MT monitoring protocol for codes
	Withdrawal Management (#/%) (CMS #11)	Claims, see MT monitoring protocol for codes
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) within 14 days (#/%) (CMS #15)	Claims, see MT monitoring protocol for codes
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment within 34 days (IET-AD) (#/%) (CMS #15)	Claims, see MT monitoring protocol for codes
	Average Length of Stay in IMDs (#/mean stay) (CMS #36)	Claims, see MT monitoring protocol for codes

Research Question	Measure	Data Source
Hypothesis 1.2: The Demonstration will increase use of evidence-based SUD-specific patient placement criteria (M2) resulting in increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs (G1, G7, G8b).		
Process Research Question 1.2.1: Has widespread use of ASAM patient placement criteria been implemented?	Standardization of the multi-dimensional assessment tool	Stakeholder surveys / interviews, administrative documentation
	# trainings and % providers trained in assessment tool	Stakeholder surveys / interviews, administrative documentation
	ARM adding provider documentation of trainings, provider manual revisions, adding levels of care to inspector general office	Stakeholder surveys / interviews, administrative documentation
	Environmental scan conducted	Stakeholder surveys / interviews, administrative documentation.

Research Question	Measure	Data Source
Hypothesis 1.3: The Demonstration will achieve sufficient provider capacity at critical levels of care, including for MAT for OUD (M4), resulting in increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs (G1).		
Process Research Question 1.3.1: Is there sufficient provider capacity at each level of care and for MAT and contingency management?	Conducted assessment of availability of Medicaid-enrolled providers	Stakeholder surveys / interviews, administrative documentation
	Expanded access with residential treatment providers to expand to ASAM level 3.2-WM	Provider database
	Expanded access with therapeutic group home providers to integrated ASAM level 3.5 program standards	Provider database
	Expanded providers offering ASAM level 3.3	Provider database
	Medicaid-enrolled providers offering MAT services	Provider database
	Geographic distribution of MAT providers by RUCA code	Provider database, RUCA
	Wait times for MAT (if available, or reported experiences of wait times)	Provider surveys, Claims
	Providers offering CM	Provider database/Claims
	# providers participating in trainings and workgroups	Stakeholder surveys / interviews, administrative documentation

Research Question	Measure	Data Source
Hypothesis 1.3: The Demonstration will achieve sufficient provider capacity at critical levels of care, including for MAT for OUD (M4), resulting in increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs (G1).		
Process Research Question 1.3.2: Has the contingency management benefit been implemented with fidelity to the evidence-based design by qualified providers?	Providers offering CM to fidelity	Stakeholder surveys / interviews, administrative documentation.
Outcomes Research Question 1.3.3: Has the availability of providers in Medicaid accepting new patients, including MAT, improved under the demonstration?	SUD Provider Availability (#) (CMS #13)	Claims/provider database
	SUD Provider Availability - MAT (CMS #14)	Claims/provider database
	#/% beds and beds available	Stakeholder surveys/interviews, administrative documentation
Outcomes Research Question 1.3.4: Are justice-involved individuals who are eligible for Medicaid enrolled in coverage and able to access healthcare immediately upon release from carceral care?	Re-entry reenrollment in Medicaid	Claims
	Time to activation of Medicaid services after reenrollment in Medicaid after release from prison	Claims

Research Question	Measure	Data Source
Primary Driver: Improved access to care for physical health conditions among beneficiaries with SUD (G6).		
Hypothesis 1.4: The Demonstration will improve care coordination and transitions between levels of care (M6) resulting in improved access to care for physical and behavioral health conditions among beneficiaries with SUD (G6, G7, G8b).		
Process Research Question 1.4.1: Are beneficiaries of tenancy supportive services receiving an assessment and housing plan through the standardized process set forth by DPHHS and approved by CMS?	Housing planning	Beneficiary and stakeholder surveys; Document review
Process Research Question 1.4.2: Are housing plans and associated supportive service referrals followed up to verify care linkages and housing stability?	Tenancy referrals and care linkages	Beneficiary and stakeholder surveys; Document review
Outcomes Research Question 1.4.3: Has the demonstration implemented changes that improve care coordination for physical and behavioral care?	ARM revising provider manual to incorporate new discharge planning requirements	Beneficiary and stakeholder surveys; Document review
	Providers able to implement new discharge/transfer planning requirements, including input from patient, family, staff, and referral sources	Beneficiary and stakeholder surveys; Document review
Outcomes Research Question 1.4.4: Have prerelease enrollment and case management services allowed justice-involved individuals to access physical and	Case management and access to care: Reentry	Beneficiary and stakeholder surveys; Document review

Research Question	Measure	Data Source
Primary Driver: Improved access to care for physical health conditions among beneficiaries with SUD (G6).		
Hypothesis 1.4: The Demonstration will improve care coordination and transitions between levels of care (M6) resulting in improved access to care for physical and behavioral health conditions among beneficiaries with SUD (G6, G7, G8b).		
behavioral healthcare services upon reentry to communities?		
Outcomes Research Question 1.4.5: Has improving care coordination resulted in increased utilization of physical health services for members with SUD diagnoses?	Access to Preventative / Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (#/%) (CMS #32)	Claims, see MT monitoring protocol for codes

Table 9. *Aim 2 Evaluation Measures and Data Sources*

Aim 2: Improve the quality of care for members with SUD		
Research Question	Measure	Data Source
Primary Driver: Increased adherence to and retention in treatment for OUD and other SUDs (G2)		
Hypothesis 2.1: The Demonstration will implement nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications (M3), resulting in increased adherence to and retention in treatment for OUD and other SUDs (G2, G7).		
Process Research Question 2.1.1: Have evidence-based SUD program standards been used in evaluating residential treatment provider qualifications?	New OIG licensure rules aligning with ASAM criteria for level 2.5 and 3.3. Revised OIG licensure rules aligning with ASAM criteria for levels 3.1, 3.5, 3.7, 3.2-WM, 3.7-WM.	Stakeholder surveys/interviews, administrative documentation

Aim 2: Improve the quality of care for members with SUD		
Research Question	**Measure**	**Data Source**
Primary Driver: Increased adherence to and retention in treatment for OUD and other SUDs (G2)		
Hypothesis 2.1: The Demonstration will implement nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications (M3), resulting in increased adherence to and retention in treatment for OUD and other SUDs (G2, G7).		
	#/% providers licensed for each ASAM level of care provided	Claims/provider database
	#/% providers reviewed for compliance	Claims/provider database
	#/% residential and inpatient providers who provide onsite or facilitate offsite MAT access	Claims/provider database
Outcomes Research Question 2.1.2: Has increased utilization of SUD program standards for SUD residential Treatment resulted in increased adherence and retention in treatment?	Continuity of Pharmacotherapy for OUD (#/%) (CMS #22)	Claims, see MT monitoring protocol for codes
	Medication-Assisted Treatment (#/%) (CMS #12)	Claims, see MT monitoring protocol for codes
	Perceptions of Outcomes	MT MHSIP Adult Survey
	Perceptions of Treatment Planning	MT MHSIP Adult Survey

Research Question	**Measure**	**Data Source**
Hypothesis 2.2: The Demonstration will improve care coordination and transitions between levels of care qualifications (M6), resulting in increased adherence to and retention in treatment for OUD and other SUDs (G2, G7, G8e).		
Process Research Question 2.2.1: Has the demonstration implemented changes	ARM revising provider manual to incorporate new discharge planning requirements	Stakeholder surveys / interviews, administrative documentation

Research Question	Measure	Data Source
Hypothesis 2.2: The Demonstration will improve care coordination and transitions between levels of care qualifications (M6), resulting in increased adherence to and retention in treatment for OUD and other SUDs (G2, G7, G8e).		
that improve care coordination and transitions between levels of care?	Providers able to implement new discharge/transfer planning requirements, including input from patient, family, staff, and referral sources	Stakeholder surveys/interviews, administrative documentation
Process Research Question 2.2.2: Have demonstration services been designed and implemented using person-centered planning processes and according to the CMS-approved plan for tenancy supports?	Person-centered care	Stakeholder surveys/interviews, administrative documentation
Outcomes Research Question 2.2.3: Has enhanced care coordination across the SUD continuum of care resulted in increased follow up after an ED visit?	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence: Age 18 and Older (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure] (CMS #17-1)	Claims, see MT monitoring protocol for codes
	Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) [NCQA; NQF #3489; Medicaid Adult Core Set; Adjusted HEDIS measure] (CMS #17-2)	Claims, see MT monitoring protocol for codes

Table 10. *Aim 3 Evaluation Measures and Data Sources*

Aim 3: Improve outcomes for members using SUD services and maintain costs		
Research Question	**Measure**	**Data Source**
Primary Driver: Reduction in overdose deaths, particularly those due to opioids. (Goal 3)		
Hypothesis 3.1: The Demonstration will increase SUD and MAT provider capacity (M4) and implement comprehensive treatment and prevention strategies to address prescription drug abuse and OUD (M5), resulting in a reduction in overdose deaths (G7, G8d, G8f, G8h).		
Process Research Question 3.1.1: Has the Demonstration coordinated with related state efforts, and have local implementation partners coordinated with local stakeholders, to expand and improve treatment and prevention strategies to address prescription drug abuse and OUD?	Coordination between Medicaid Demonstration and MT Substance Use Disorder Task Force, alignment of Demonstration with Task Force Strategic Plan	Stakeholder surveys/interviews, administrative documentation
	Coordination with MT Prescription Drug Registry and implementation of HB 86 (2021) to limit opioid prescriptions for opioid-naïve members	Stakeholder surveys/interviews, administrative documentation
	Coordination with HB 333 (2021) implementation expanding providers of naloxone	Stakeholder surveys/interviews, administrative documentation
	Coordination between correctional facilities and medical/behavioral health providers.	Stakeholder surveys/interviews, administrative documentation
	Coordination between housing system and medical/behavioral health providers	Stakeholder surveys/interviews, administrative documentation

Aim 3: Improve outcomes for members using SUD services and maintain costs		
Research Question	**Measure**	**Data Source**
Primary Driver: Reduction in overdose deaths, particularly those due to opioids. (Goal 3)		
Hypothesis 3.1: The Demonstration will increase SUD and MAT provider capacity (M4) and implement comprehensive treatment and prevention strategies to address prescription drug abuse and OUD (M5), resulting in a reduction in overdose deaths (G7, G8d, G8f, G8h).		
	Coordination with State Epidemiological Outcomes Workgroup	Stakeholder surveys/interviews, administrative documentation
Impact Research Question 3.1.2: Have the comprehensive treatment and prevention strategies of the HEART 1115 waiver been effective in addressing prescription drug abuse and OUD?	Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set] (CMS #18)	Claims, see MT monitoring protocol for codes
	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set] (CMS #21)	Claims, see MT monitoring protocol for codes
Impact Research Question 3.1.3: Did comprehensive treatment and prevention strategies of the HEART 1115 waiver correspond to a reduction in overdose deaths?	Overdose deaths count and rate (CMS #26/27)	MT Vital Statistics Death Records
Impact Research Question 3.1.4: Did the Reentry Initiative reduce all-cause deaths among Medicaid enrollees incarcerated or recently released from Montana state prisons?	All-cause deaths among incarcerated/recently released Medicaid enrollees	MT Vital Statistics Death Records, match with Medicaid enrollees justice-involved

Research Question	Measure	Data Source
Primary Driver: Reduced utilization of EDs and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services (Goal 4).		
Hypothesis 3.2: The Demonstration improve care coordination and transitions between levels of care (M6), resulting in reduced utilization of EDs and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate (G4, G8b, G8c, G8g).		
Impact Research Question 3.2.1: Did ED utilization decrease after implementation of improved care coordination?	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries (CMS #23	Claims, see MT monitoring protocol for codes
Impact Research Question 3.2.2: Did inpatient stays decrease after implementation of Improved care coordination?	Inpatient stays for SUD per 1,000 Medicaid Beneficiaries (CMS #24)	Claims, see MT monitoring protocol for codes

Research Question	Measure	Data Source
Primary Driver: Reduced readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD (Goal 5).		
Hypothesis 3.3: The Demonstration will lead to widespread use of evidence-based SUD-specific Patient Placement Criteria (M2), resulting in reduced readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD (G5, G8g).		
Impact Research Question 3.3.1: Did readmissions to the same or higher level of care, where readmission is preventable or medically inappropriate for OUD and other SUD, decrease?	Readmissions Among Beneficiaries with SUD (#/%) (CMS #25)	Claims, see MT monitoring protocol for codes

Research Question	Measure	Data Source
Hypothesis 3.4: Reduced ED utilization and reduced readmissions (G4, G5, G7, G8) will drive cost savings for the Medicaid system.		
Impact Research Question 3.4.2: Does participation in contingency management incentive program result in overall cost savings to Medicaid system? (See Cost Outcome methodology in Evaluation Plan)	Per Capita SUD Spending (CMS #30)	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	Per Capita SUD Spending within IMDs (CMS #31)	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	Total Cost per beneficiary per month (PBPM)	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	SUD Cost Drivers - Total SUD Spending PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	SUD Cost Drivers - IMD SUD Spending PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	SUD Cost Drivers - Non-IMD SUD Spending PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	SUD Cost Drivers - Non-SUD Spending PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	Source of treatment cost drivers for members with SUD - Inpatient services PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	Source of treatment cost drivers for members with SUD -Emergency Department services PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	Source of treatment cost drivers for members with SUD - Non-ED Outpatient services PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.

Research Question	Measure	Data Source
Hypothesis 3.4: Reduced ED utilization and reduced readmissions (G4, G5, G7, G8) will drive cost savings for the Medicaid system.		
	Source of treatment cost drivers for members with SUD - Pharmacy PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
	Source of treatment cost drivers for members with SUD - Long Term Care PBPM	Claims, see MT monitoring protocol for codes. Use provider paid amounts.

Section IX – Public Review and Comment Process

The State is extending the public comment period through Nov. 27, 2026, to align with the federal requirement to post the Interim Evaluation Report for the HEART Demonstration with the renewal application for public comment. The State is required to post this report for 30 days prior to the HEART renewal submission; this report is preliminary and has not yet been approved by CMS. The public comment period for the HEART Demonstration Renewal Application began on Tuesday, Sept. 1, 2026, and will now close on Nov. 27, 2026. All comments must be received by 11:59 p.m. (Mountain Time) on Nov. 27, 2026.

DPHHS will hold two public meetings on the Demonstration renewal application. The public hearing on Oct. 2, 2026, will be a hybrid meeting, and the public may attend in-person or virtually. The public hearing on Oct. 7, 2026, will be held as part of a Montana Health Coalition meeting and will be accessible to the public virtually only due to building security restrictions. Individuals requiring reasonable accommodations should contact DPHHS at 406-444-2584.

(1) First Public Hearing

- Date: Friday, Oct. 2, 2026
- Time: 10 a.m. – 12 p.m. MT
- Location:
  - Cogswell Building, Conference Rooms C205, C207, and C209 (combined)
    1400 E. Broadway St.
    Broadway Entrance, south side of building
    Helena, MT
- Virtual Registration: Register for the Zoom link here.

(2) Second Public Hearing

- Date: Wednesday, Oct. 7, 2026
- Time: 3 p.m. – 4:30 p.m. MT
- Location: *(Virtual only for non-Montana Health Coalition members)*
  - Montana Health Coalition/Medicaid Advisory Committee Meeting

111 North Sanders Street
Room 306
Helena, MT

- Virtual Registration: Register for the Zoom link here.

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

Public comments may be submitted until 11:59 p.m. (Mountain Time) on Nov. 27, 2026. Questions or public comments may be addressed care of Medicaid HEART Waiver, Department of Public Health and Human Services, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by telephone to 406-444-2584, or by electronic mail to dphhscomments@mt.gov. Comments received after Nov. 27, 2026 will continue to be accepted, but DPHHS may not be able to consider those comments prior to initial submission of the renewal application to CMS.

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