

Montana HEART Section 1115 Demonstration Renewal Request

**State of Montana
Department of Public Health and Human
Services**



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Section I – Executive Summary

The Montana Department of Public Health and Human Services (DPHHS) is seeking approval to renew its Section 1115 Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration. Since its initial approval, the HEART Demonstration has served a critical role in advancing Montana’s behavioral health priorities by expanding access to services and supports for Medicaid members with substance use disorder (SUD), serious mental illness (SMI), and other behavioral health needs.

The current Demonstration is authorized through June 30, 2027. Through this application, Montana DPHHS requests approval to renew the HEART Demonstration for an additional five-year period, through June 30, 2032. As part of this renewal, Montana seeks to continue the existing waiver and expenditure authorities that have enabled successful implementation of the Demonstration while making targeted refinements informed by operational experience.

Section II – HEART Demonstration Overview

A. Background

The HEART Demonstration was initially approved by the Centers for Medicare & Medicaid Services (CMS) on July 1, 2022, with a subsequent amendment approved on February 26, 2024. Since its 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 SUD, 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.

Montana requests a five-year extension of the HEART Demonstration, including continuation of the waiver and expenditure authorities necessary to maintain and enhance core Demonstration components. The State will work collaboratively with CMS throughout the renewal process and recognizes that ongoing discussions with CMS, as well as future legislative or budgetary actions, may result in refinements to the proposals described in this application.

Key components of the Demonstration include requests for:

- Continued federal waiver and expenditure authority for coverage of targeted services for Medicaid-eligible members with behavioral health needs, including:
 - Contingency management for stimulant use disorder,
 - Pre-tenancy and tenancy sustaining support services; and
 - Pre-release services for justice-involved individuals.¹
- Continued federal expenditure authority for federal matching funds for short-term inpatient and residential treatment in institutions for mental disease (IMDs) for individuals with SUD.

¹ Note that in Montana, “pre-release” may sometimes refer to pre-release treatment centers prior to release; however, in the context of this HEART Demonstration application, the State is using the term to describe the period immediately preceding reentry into the community, as consistent with CMS terminology.

B. Historical Summary of the HEART Demonstration: 2022-2027

Background and System Overview

Montana Medicaid provides a comprehensive continuum of behavioral health services, including early intervention, crisis response, outpatient treatment, residential and inpatient care, and recovery support for individuals with behavioral health needs. The Behavioral Health & Developmental Disabilities (BHDD) Division, within the Department of Public Health and Human Services (DPHHS), administers these services across funding streams, including Medicaid, Substance Abuse and Mental Health Services Administration (SAMHSA) block and discretionary grants, and State funding. Through a fee-for-service (FFS) delivery system, DPHHS contracts with providers statewide and partners closely with Tribal 638 governments, the Indian Health Service (IHS), and Urban Indian Organizations to ensure access to culturally appropriate care for American Indian and Alaska Native (AI/AN) Medicaid members.

While this infrastructure establishes a broad service continuum, significant gaps in access, capacity, and care coordination persist, particularly in rural areas and among individuals with complex behavioral health needs. The HEART Demonstration was designed as a key mechanism to strengthen and more fully integrate this system, addressing longstanding challenges related to SUD, mental health conditions, and the needs of justice-involved populations.

SUD Crisis in Montana

Recent data underscore the continued prevalence of Montana's substance use crisis. According to data estimates from 2024, 22.2 percent of Montanans aged 12 and older experienced a SUD in the past year, substantially exceeding the national rate of 17 percent.² Montana also reported higher rates than the national average for a SUD, illicit drug use, marijuana use, and opioid use.²

The most significant challenges are driven by methamphetamine and alcohol use. In 2024, 2.14 percent of Montanans ages 18 and above reported methamphetamine use in the past year, compared to 0.94 percent nationally. Further, methamphetamine-related overdose mortality disproportionately affects AI/AN populations, with death rates more than four times higher than those of non-indigenous Montanans.³ Methamphetamine-related deaths increased by 193 percent between 2018 and 2023, exceeding the national increase of 175 percent during the same period. Stimulant use disorders also place a substantial burden on Montana's health care system. In 2023, hospitals charged approximately \$53.5 million to

² Substance Abuse and Mental Health Services Administration, (2025) 2023-2024 National Surveys on Drug Use and Health: Model Based Prevalence Estimates (50 States and the District of Columbia). Available at: [2024-nsduh-sae-tables-percent.pdf](#).

³ Montana Department of Health & Human Services, (2026) Summary of Methamphetamine use in Montana. Available at: [Meth Drug Use Summary.pdf](#).

treat nearly 3,800 patients for methamphetamine overdose and other stimulant-related conditions.⁴

Alcohol-related abuse has likewise worsened, with alcohol-related deaths nearly doubling over the past decade, and 23 percent of Montanans experiencing binge alcohol use in the past month, exceeding the national average of 21 percent.⁵

Mental Health Challenges in Montana

Montana continues to face significant mental health needs across the state. In 2024, approximately 25.6 percent of adults reported a mental illness in the past year and 6.9 percent experienced SMI – both exceeding national averages. Among adolescents, 17.5 percent experienced a major depressive episode in the past year, and rates of serious suicidal ideation among both adults and youth remain elevated above the national average.⁶

Behavioral Health Challenges Among Justice-Involved Individuals

Ensuring continuity of coverage and care for justice-involved Montanans remains a key priority for the State. Behavioral health needs among incarcerated individuals are substantial across both state prisons and local detention facilities. Approximately 20 percent of Montana’s prison population has an SMI, and 40 percent of individuals processed through the Department of Corrections (DOC) were convicted of a substance-related offense.⁷ Further, a 2020 study found that individuals released from the DOC faced a 11.2 times higher risk of death than the general population, driven largely by an overdose mortality rate that was 27 times higher than that of the general population.⁸ These findings underscore the continued need for investments in behavioral health treatment, care coordination, and reentry supports to ensure justice-involved Montanans can access services before, during, and following incarceration.

All together, these trends support Montana’s continued need for Demonstration authority to maintain and strengthen access to behavioral health services for Medicaid members with behavioral health needs.

⁴ Montana Department of Public Health & Human Services, (2024) Methamphetamine Use in Montana. Available at: [MethUse2024Final.pdf](#).

⁵ Lani Paulson, (2024) Alcohol Use in Montana. Available at: <https://dphhs.mt.gov/assets/BHDD/PreventionResources/AlcoholUse2024Final.pdf>.

⁶ Substance Abuse and Mental Health Services Administration, (2025) 2023-2024 National Surveys on Drug Use and Health: Model Based Prevalence Estimates (50 States and the District of Columbia). Available at: [2024-nsduh-sae-tables-percent.pdf](#).

⁷ 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>.

⁸ 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>.

C. Summary of Current HEART Demonstration

The HEART Demonstration, currently authorized through June 30, 2027, supports a comprehensive continuum of behavioral health services for Medicaid members with behavioral health needs, while addressing factors that contribute to poor health outcomes, institutionalization, homelessness, and justice-system involvement. Services are delivered through Montana's existing FFS Medicaid delivery system and are available to eligible members who meet the applicable clinical, housing, or justice-involvement criteria. The Demonstration is funded through a combination of HEART State Special Revenue and federal Medicaid matching funds.

Montana does not impose cost sharing under this Demonstration. Montana has not modified Medicaid eligibility requirements under this Demonstration renewal request.

Under the current approval, the 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 State Fiscal Year (SFY) 2026, 1,728 Medicaid members received services under the SUD IMD authority.⁹
2. ***Contingency Management.*** Montana launched contingency management services for adults with stimulant use disorder on January 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 December 2025.¹² As of 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

⁹ 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>.

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 TSS statewide.

4. ***Reentry Demonstration Initiative.*** On October 15, 2025, DPHHS in partnership with DOC launched the reentry services for incarcerated individuals with behavioral health needs in Montana's three state correctional facilities. 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 their Medicaid billing systems; at this time no Medicaid claims have been paid.

D. Goals and Objectives of the HEART Demonstration Renewal

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

- **Expand Medicaid's behavioral health continuum of care**, including early intervention, crisis services, outpatient and residential treatment, and recovery support for individuals with SUD and SMI;
- **Advance efforts to reduce opioid-related overdose deaths and suicides;**
- **Improve the quality of care and outcomes** across outpatient, residential, and inpatient settings; and
- **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.

Findings to date: Interim evaluation findings from the independent evaluation (conducted from July 2022 to June 2025) indicated progress toward several of these objectives, particularly expansion of the behavioral health continuum through the SUD IMD component, where per-beneficiary access increased across all measured access metrics. Findings on overdose mortality are mixed, with the all-drug overdose death rate declining 12.1% and the opioid-specific rate rising 5.6% between the DY1 and DY2 proxy years. Evaluation findings suggest that the strongest evidence to date is associated with the SUD IMD component, where quantitative and qualitative data consistently indicate increased access to residential treatment and other SUD services. The evaluation also found widespread adoption of American Society of Addiction Medicine (ASAM)-aligned treatment practices and increased integration of MAT within residential settings. At the same time, improvements in access were not consistently accompanied by

improvements in continuity of care, treatment retention, or care transitions. Across quantitative and qualitative findings, these limitations were most commonly associated with workforce shortages, limited step-down treatment capacity, housing instability, and disruptions related to Medicaid unwinding rather than deficiencies in clinical care delivery. Additional Demonstration time is needed to determine whether early gains in access translate into sustained improvements in longer-term outcomes. Evidence on care transitions and continuity is limited at this stage, as the tenancy support, contingency management, and reentry components had not yet generated sufficient outcome data within the evaluation window.

The HEART Demonstration advances these objectives through four authorized service areas, each designed to address critical gaps in behavioral health care and support long-term recovery and community integration.

Initiative 1: SUD Treatment (IMD Authority)

- Increase rates of identification, initiation, and engagement in SUD treatment.
- Increase adherence to and retention in treatment.
- Reduce overdose deaths, particularly those due to opioids.
- Reduce preventable utilization of emergency departments and inpatient hospital settings through improved access to continuum of care services.
- Reduce preventable readmissions to the same or higher level of care
- Improve access to care for physical health conditions among members with SUD.

Findings to date: Interim evaluation findings show measurable progress on several of these objectives. Access and engagement in SUD treatment increased across all Milestone 1 metrics between DY1 and DY2, with the largest gains in MAT (+26.2%) and residential/inpatient services (+14.6%). Findings were more mixed for adherence and retention: treatment initiation held steady, while continuity of opioids use disorder (OUD) pharmacotherapy declined, an effect attributed in part to shortened enrollment windows during Medicaid unwinding. SUD-related ED visits and 30-day readmissions rose modestly, though reliability of the readmission trend is limited by a substantial decline in the qualifying-stay denominator.

Initiative 2: Contingency Management

- Expand access to evidence-based stimulant use disorder treatment for Medicaid members for whom no FDA-approved pharmacotherapy exists.
- Evaluate the cost-effectiveness of contingency management and its effects on beneficiary health and recovery outcomes.

Findings to date: Contingency management rules became effective July 2025; with

rollout still in the early stages during the evaluation period the program had not yet reached the maturity needed for outcome analysis. Provider interviews describe contingency management as an effective engagement tool for stimulant use disorder and identify implementation groundwork — including provider training and a purpose-built tracking platform — as supportive of program readiness.

Initiative 3: Tenancy Support Services

- Improve housing stability and housing-related outcomes for Medicaid members with SMI or SUD experiencing homelessness or housing insecurity.
- Assess the impact of tenancy supports on health outcomes, treatment engagement, and recovery for individuals with SMI or SUD.

Findings to date: Tenancy support services rules became effective June 2025; with rollout still in the early stages during the evaluation period the program had not yet reached the maturity needed for outcome analysis. Early-implementation provider interviews describe growth in the provider network, including expansion into rural areas, alongside implementation challenges related to provider enrollment timelines and workforce capacity.

Initiative 4: Reentry Demonstration Initiative

- Increase coverage and continuity of care through pre-release eligibility assessment and enrollment support.
- Improve access to services prior to release and strengthen transitions of care into the community.
- Improve coordination and connections between correctional systems, DPHHS, and community-based physical and behavioral health providers.
- Reduce all-cause mortality in the near-term post-release period
- Reduce emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid members through increased preventive and routine care.
- Reduce overdose and overdose-related death in the near-term post-release through stabilizing medications and medications for addiction treatment.

Findings to date: Reentry initiative rules became effective October 2025; with rollout still in the early stages during the evaluation period the program had not yet reached the maturity needed for outcome analysis. Stakeholder interviews describe collaborative planning between DPHHS and the DOC, including systems for identifying Medicaid-eligible individuals prior to release, alongside implementation challenges related to data sharing and billing infrastructure.

Section III – Eligibility and Enrollment

A. Eligibility

The State is not proposing any changes to the Medicaid eligibility criteria under the HEART Demonstration renewal request.

All children aged 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana Medicaid State Plan well as children aged 18 who are eligible for the CHIP Program, will be included in this Demonstration. This Demonstration will only directly impact members diagnosed with or suspected to have a SUD and/or SMI/serious emotional disturbance (SED).

Medicaid members will qualify for services outlined in this Demonstration based upon their SUD, SMI, or SED behavioral health need for services.

Table 1 provides additional information on Medicaid eligibility groups affected by this Demonstration.

Table 1. Medicaid Eligibility Groups Affected by the Demonstration

Eligibility Group	Federal Citations	Income Federal Poverty Level (FPL)
Medicaid Children Ages 18-20	42 CFR § 435.118-435.119, 435.222	0-132 percent FPL
CHIP Children Aged 18	Title XXI of the Social Security Act, § 2101	143-261 percent FPL
Adults	42 CFR § 435.119	0–132 percent FPL
Parents/Caretaker Relatives	42 CFR § 435.110	0–24 percent FPL
Pregnant and postpartum 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

Table 2 below describes historical enrollment for the initial Demonstration period.

Table 2. Historical Enrollment by Category of Aid

Category of Aid	Historical Enrollment
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	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 3 below describes projected enrollment under the HEART Demonstration renewal request by Medicaid eligibility group.

Table 3. 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

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Category of Aid	<i>Projected Enrollment</i>				
	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
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 IV – Demonstration Renewal Request

A. Continuing Demonstration Features

Montana’s current HEART Demonstration is scheduled to expire on June 30, 2027. Through this renewal request, the State seeks to extend the Demonstration for an additional five-year period to continue advancing comprehensive, evidence-based behavioral health-focused support for Medicaid members. Through this renewal request, Montana seeks to sustain core Demonstration initiatives while advancing targeted enhancements to improve access to behavioral health services and strengthen care transitions.

Specifically, Montana proposes to continue the following existing Demonstration features for individuals with SUD, SMI or SED:

- **SUD IMD Expenditure Authority**, which enables the State to receive federal Medicaid matching funds for short-term residential and inpatient treatment provided in IMDs to Medicaid eligible individuals with a SUD;
- **Contingency Management Services**, an evidence-based intervention that uses structured incentives to promote engagement in treatment and sustained abstinence for individuals with stimulant use disorder;
- **Pre-Tenancy and Tenancy Sustaining Services**, which assist individuals with securing and maintaining stable housing as a foundation for recovery and improved health outcomes; and
- **Pre-Release Services for Justice-Involved Individuals**, including case management, MAT, a supply of medications in hand upon release, and limited clinical consultation in order to support continuity of coverage and care upon release into the community.

i. SUD IMD

Current Authority. Montana’s current SUD IMD Demonstration authority addresses a critical gap in the State’s behavioral health service continuum by allowing Medicaid coverage for short-term residential and inpatient SUD treatment in larger community-based facilities that would otherwise be subject to the federal IMD exclusion. This Demonstration authority supports access to clinically appropriate levels of care for individuals with significant SUD treatment needs and helps reduce delays in placement for residential and withdrawal management treatment.

Through HEART-expanded Medicaid treatment services, Montana Medicaid members have access to all levels of care included in the ASAM Criteria, Third Edition. As of SFY 2026, 1,877 Medicaid members received treatment through these expanded services, including 1,728

members who received ASAM 3.5 SUD IMD services.¹² Continued expenditure authority is necessary to maintain access to residential treatment levels of care in IMDs and sustain the State's progress in strengthening the SUD inpatient and community-based treatment continuum.

Demonstration Renewal Request. Montana is seeking to continue Demonstration authority for short-term residential and inpatient treatment in IMDs for the next five-year Demonstration period.

As part of the continuum of behavioral health care provided under the SUD IMD Demonstration authority, Medicaid beneficiaries have access to a comprehensive suite of SUD treatment services including short-term residential and inpatient services delivered in IMD settings authorized under this Demonstration. These services assist with the transition to, and coordination with community-based treatment and recovery support to ensure continuity of care and promote long-term recovery outcomes. The Demonstration authority enables the State to receive federal financial participation for otherwise covered services provided to short-term IMD residents, supporting access to clinically appropriate levels of care consistent with ASAM standards.

Montana has successfully implemented its SUD Demonstration, including completion of key milestones and State actions identified in the SUD Implementation Plan and Health Information Technology (HIT) Plan outlined in the 2022 HEART Demonstration approval. The State continues to demonstrate progress in delivering evidence-based services and maintaining appropriate lengths of stay in residential treatment settings.

Renewal of the SUD IMD authority will ensure continued access to medically necessary residential treatment services while allowing Montana to build upon implementation progress and further evaluate long-term impacts on treatment engagement, recovery outcomes, and utilization of higher-cost services.

ii. Contingency Management

Current Authority. As described in detail in the Background Section of this Demonstration renewal request, Montana continues to experience significant health and public safety impacts related to stimulant use, particularly methamphetamine. Under the current Demonstration authority, contingency management services are available to Medicaid members who have completed an ASAM assessment and have a qualifying primary stimulant use disorder diagnosis. Services are delivered by DPHHS-approved providers in eligible treatment settings and use evidence-based motivational incentives to reinforce treatment engagement, attendance, and abstinence from stimulant use.

Consistent with federal guidance, motivational incentives provided through Montana's contingency management program qualify for the federal "general welfare exclusion" and are therefore excluded from beneficiaries' modified adjusted gross income (MAGI)-based eligibility determinations, non-MAGI eligibility determinations, and Medicaid share-of-cost

calculations. As a result, participation in the program and receipt of incentives do not adversely affect an individual's Medicaid eligibility or cost-sharing obligations.

Montana commenced implementation of contingency management services statewide beginning January 1, 2026, as part of a broader strategy to address increasing rates of stimulant use disorder. The benefit is targeted to Medicaid members with a primary stimulant use disorder, participating in structured treatment programs.

The State's model integrates contingency management with other evidence-based interventions, including motivational interviewing, cognitive behavioral therapy, and community reinforcement approaches, to support sustained recovery.

Demonstration Renewal Request. Montana is seeking to continue Demonstration authority for contingency management, with one eligibility modification, for the next five-year Demonstration period.

The following describes the qualifying criteria and covered services under this request.

Qualifying Criteria. Individuals with a diagnosed stimulant use disorder—regardless of whether it is the primary diagnosis—would be eligible to receive contingency management services. This would eliminate the current requirement that the stimulant use disorder be the individual's primary diagnosis.

The change is intended to remove a key access barrier by allowing individuals with co-occurring substance use or mental health conditions to receive clinically appropriate, evidence-based contingency management services. Eliminating the primary diagnosis requirement would expand access to treatment for a broader population with stimulant use disorder.

All other eligibility requirements remain unchanged.

Benefits. Montana is not proposing any changes to the current structure of the contingency management benefits under this renewal request. Currently, the contingency management benefit consists of a defined set of modest motivational incentives available to members who meet established treatment goals, such as stimulant-free drug screens or other indicators of treatment adherence.

Incentives are structured and time-limited within a single treatment episode and are subject to programmatic limits to ensure alignment with federal guidance.

iii. Pre-Tenancy and Tenancy Sustaining Support Services

Current Authority. On 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 are at risk of homelessness. Stable housing is a foundational component of recovery for individuals with

behavioral health conditions. Pre-tenancy and tenancy sustaining services provide targeted, supportive assistance to individuals with SUD and/or SMI who are experiencing or at risk of homelessness or housing instability.

Covered services currently include:

- Assessment and Planning (e.g., housing assessments and housing planning)
- Pre-tenancy supports (e.g., search assistance, transition planning, and one time move in supports); and
- Tenancy sustaining services (e.g., landlord engagement, eviction prevention, and ongoing housing stabilization).

By addressing housing instability, these services support improved health outcomes, reduce avoidable utilization of institutional care, and promote successful community integration.

Demonstration Renewal Request. Montana is seeking to continue Demonstration authority for tenancy support services for the next five-year Demonstration period.

Montana is not proposing any changes to the eligibility criteria for tenancy support services nor the scope of covered services.

iv. Reentry Initiative Services

Current Authority. The HEART Demonstration's Reentry Initiative launched on October 15, 2025. Currently, adults age 19 or older with a mental illness and/or SUD who are in the 30 days prior to expected date of release from a state prison will receive pre-release case management, MAT, limited clinical consultation services, and medications provided upon release. Together, these pre-release services support identification of health needs, engagement in treatment, care coordination, and linkage to community-based providers before an individual returns to the community. To date, implementation has occurred within three state-operated correctional facilities: Montana State Prison, Montana Women's Prison, and Riverside Correctional Facility.

Implementation of the Reentry Initiative has required substantial coordination among DPHHS, the Montana DOC, community-based providers, and other stakeholders. Key implementation activities have included establishing processes for Medicaid eligibility determinations and enrollment, coordinating release dates with Medicaid activation, enrolling correctional providers, developing billing and data-sharing systems, and creating workflows to support continuity of care.

To support implementation readiness, Montana utilized approved capacity-building funding to strengthen correctional health infrastructure and operational capacity. Investments included telehealth equipment and privacy booths, billing system enhancements, project management support, workforce capacity, and other operational improvements necessary to deliver Demonstration services effectively.

Renewal of this authority will allow Montana to continue advancing these efforts, expand access to pre-release services, strengthen care transitions, and build upon early implementation lessons to improve health outcomes for justice-involved individuals statewide.

Demonstration Renewal Request. Montana requests to extend authority for reentry initiative services for the next five-year Demonstration period. As part of this renewal request, Montana seeks to: (1) lower the minimum eligibility age to 18 years and older; (2) extend the pre-release service coverage period from 30-days to 60-days prior to release, and (3) add peer support services as a covered reentry service.

Qualifying Criteria. Montana is proposing to revise the age eligibility criteria for the reentry initiative by lowering the minimum age requirement from 19 to 18 years. All other eligibility requirements will remain unchanged. Individuals who meet the approved Demonstration eligibility requirements of a mental illness or SUD will continue to qualify for pre-release services.

The change is intended to better align with Section 5121 of the Consolidated Appropriations Act for reentry services for youth and will ensure consistent communications across reentry services.¹⁰

Pre-Release Time Period. Montana is requesting authority to extend the pre-release coverage period from 30-days to 60-days prior to expected date of release.

This request is informed by implementation experience and reflects both operational and clinical considerations identified during the initial Demonstration period. Specifically, correctional facility partners have indicated that reentry planning often begins well before the current 30-day window, limiting opportunities to fully engage eligible individuals, establish community-based provider relationships, and coordinate post-release services. Extending the coverage period will allow for earlier identification of eligible individuals, more comprehensive person-centered care planning, and stronger connections to community-based providers.

The proposed 60-day coverage period will also provide greater opportunities to address operational challenges associated with release-date changes, provider scheduling, care coordination, and service delivery within correctional settings. Montana anticipates that the expanded timeframe will improve the effectiveness of pre-release interventions and strengthen continuity of care during reentry.

¹⁰ Section 5121 of H.R.2617 - Consolidated Appropriations Act, 2023 (Public Law No: 117-328). Available [here](https://www.congress.gov/bill/117th-congress/house-bill/2617/text): <https://www.congress.gov/bill/117th-congress/house-bill/2617/text>

Covered Services. Montana proposes to maintain the current scope of covered services—case management, MAT, limited clinical consultation, and medications in hand upon release—and add peer support services to the suite of pre-release services.

Consistent with CMS’s guidance on peer supports and Reentry Initiative Section 1115 Demonstrations,¹¹ Montana proposes to incorporate peer support services into its reentry service array to enhance care coordination, facilitate engagement with treatment and recovery resources, and support successful transitions from incarceration to the community.

Peer support services will provide mentorship, engagement, recovery support, and care navigation delivered by trained individuals with lived experience. These services are intended to complement clinical treatment by promoting trust, increasing engagement in care, supporting self-management and recovery goals, and strengthening connections to community-based services and supports.

Peer support services are particularly valuable during the transition from incarceration to the community, when individuals may face barriers to navigating health care systems, maintaining treatment engagement, and accessing recovery-oriented resources. Incorporating peer support services into the service array will enhance Montana’s ability to provide person-centered, trauma-informed reentry services and promote sustained engagement in care following release.

B. Delivery System

There are no proposed changes to the Medicaid delivery system as part of this renewal application. Montana plans to continue using the FFS delivery system for all authorized Medicaid services.

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; beneficiaries who are subject to cost sharing under H.R. 1 will be subject to cost sharing, as applicable, under this Demonstration.¹²

¹¹ Centers for Medicare & Medicaid Services, “Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated,” SMDL #23-003, April 17, 2023. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf>

¹² Section 71120 of H.R. 1 (P.L. 119-21). Available at <https://www.congress.gov/bill/119th-congress/house-bill/1/text>

Section V – Demonstration Renewal Evaluation

A. Background

The HEART Demonstration was designed to improve health outcomes for Medicaid members through the implementation of innovative behavioral health initiatives, including expanded access to SUD treatment, contingency management services, pre-tenancy and tenancy supports, and reentry services. The Demonstration was intended to test whether the expenditure authorities granted under the waiver increased access to behavioral and physical health services and improved outcomes for Medicaid members with SUD and/or SMI.

Consistent with the Special Terms and Conditions (STCs) of the Demonstration, Montana contracted with an independent external evaluator, the University of Montana (UM) Rural Institute, to conduct a comprehensive and rigorous evaluation of the Demonstration. The UM Rural Institute developed an Evaluation Design that was consistent with CMS evaluation guidance and the requirements established in the STCs. The Evaluation Design was approved by CMS on February 17, 2026. Additional information regarding the Demonstration evaluation is available in Attachment E of the HEART Demonstration STCs.

B. Demonstration Evaluation Questions and Hypotheses

i. Overview

The UM Rural Institute developed the HEART Demonstration Evaluation Design around three overarching evaluation aims, each supported by a series of hypotheses and research questions aligned with the Demonstration's goals and objectives. The evaluation employs a mixed-methods approach to assess Demonstration implementation, outcomes, and system impacts. Specifically, the evaluation is designed to:

- Assess the extent to which Demonstration initiatives were implemented as intended (process evaluation);
- Evaluate whether the Demonstration achieved its stated goals related to access to care, service utilization, quality, and health outcomes (outcome evaluation); and
- Examine the Demonstration's impact on health system utilization and Medicaid expenditures, including the extent to which the Demonstration contributed to cost stabilization and improved resource utilization within Montana's Medicaid program (impact evaluation).

The process and outcome evaluations rely primarily on stakeholder and beneficiary surveys and interviews, administrative document review, and implementation monitoring activities. The impact evaluation utilizes secondary analysis of administrative claims data, hospital

discharge data, vital statistics, and other relevant administrative datasets to assess changes in service utilization, health outcomes, and costs over time.

The evaluation framework is informed by the Practical, Robust Implementation and Sustainability Model (PRISM), which provides a structured approach for assessing the multilevel contextual factors that influence implementation, sustainability, and outcomes across Demonstration initiatives.

Evaluation Measures. The Evaluation Design includes a comprehensive set of measures and data sources organized by evaluation aim, research question, and hypothesis. Measures were selected to assess key Demonstration objectives related to access to care, treatment engagement, quality of services, health outcomes, utilization patterns, and program costs.

Specific measures and data sources are detailed in the following Evaluation Measures and Data Sources Tables (*tables 4-6*). Each outcome measure included in the CMS approved 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 4. 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

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	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

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	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	Provider database

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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).		
	providers to expand to ASAM level 3.2-WM	
	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
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,	SUD Provider Availability (#) (CMS #13)	Claims / provider database
	SUD Provider Availability - MAT (CMS #14)	Claims / provider database

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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).		
improved under the demonstration?	#/% 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	ARM revising provider manual to incorporate new discharge planning	Beneficiary and stakeholder surveys; Document review

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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).		
that improve care coordination for physical and behavioral care?	requirements	
	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 behavioral healthcare services upon reentry to communities?	Case management and access to care: Reentry	Beneficiary and stakeholder surveys; Document review
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 5. Aim 2 Evaluation Measures and Data Sources

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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
	#/% 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 that	ARM revising provider manual to incorporate new discharge planning requirements	Stakeholder surveys / interviews, administrative documentation

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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).		
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 6. *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
	Coordination with State Epidemiological Outcomes Workgroup	Stakeholder surveys / interviews, administrative documentation

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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).		
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

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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 3.3.1: Did readmissions to the same or higher level of care, where	SUD Spending (CMS #28)	Claims, see MT monitoring protocol for codes. Use provider paid amounts.

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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.		
readmission is preventable or medically inappropriate for OUD and other SUD, decrease?	SUD Spending within IMDs (CMS #29)	Claims, see MT monitoring protocol for codes. Use provider paid amounts.
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	Claims, see MT monitoring protocol for

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.		
	SUD - Non-ED Outpatient services PBPM	codes. Use provider paid amounts.
	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.

ii. Demonstration Findings to Date

As illustrated in the tables above, the evaluation draws primarily on Medicaid administrative claims and enrollment data for the IMD component — the only component fully operational throughout the evaluation period (July 1, 2022–June 30, 2026) — supplemented by 32 stakeholder and provider interviews, 37 beneficiary interviews, a 93-respondent beneficiary survey, and administrative document review. Because the contingency management, tenancy support, and reentry components were approved by CMS on February 26, 2024, and were not fully implemented within the evaluation period, outcome analysis for these components was not yet feasible; findings related to these components with beneficiary perspectives and claims-based outcomes to follow in the summative evaluation. Because Medicaid enrollment declined by approximately 23% between DY1 and DY2 due to unwinding, all IMD utilization metrics are reported as rates per 1,000 enrolled beneficiary-months rather than raw counts, and quality and transition metrics are reported as proportions of eligible episodes.

Process Evaluation. The IMD component was fully implemented and operational during the evaluation period, generating two full Demonstration years of claims data and serving as the primary focus of the interim evaluation. The three amendment components — contingency management, tenancy support services, and reentry services — were approved in February 2024 amendment and remained in pre-implementation or very early implementation through the close of the interim evaluation period. As a result, evaluation activities for these components focused primarily on implementation progress rather than outcomes. Provider and stakeholder interviews indicate that Montana’s implementation approach included regulatory rulemaking, provider outreach and training, and technical assistance to support program launch. Stakeholders generally viewed these efforts positively while identifying implementation challenges related to provider enrollment, workforce capacity, housing availability, interagency coordination, and operational readiness.

Outcome Evaluation. Access to SUD treatment through the IMD component improved on a per-beneficiary basis across every Milestone 1 metric between DY1 and DY2, despite the enrollment decline associated with unwinding. Rates increased for any SUD treatment (8.75 to 10.09 per 1,000 beneficiary-months, +15.3%), early intervention/SBIRT (0.71 to 0.85, +19.7%), outpatient SUD services (7.37 to 8.44, +14.5%), IOP/partial hospitalization (1.10 to 1.18, +7.3%), residential and inpatient services (1.44 to 1.65, +14.6%), withdrawal management (0.12 to 0.15, +25.0%), and MAT (3.13 to 3.95, +26.2%), the largest gain among access metrics. The rate of beneficiaries treated in IMDs specifically rose 20.1% (1.39 to 1.67 per 1,000 beneficiary-months), and average IMD length of stay increased modestly from 16.80 to 17.50 days, consistent with the Demonstration's stabilization target.

Continuity and care-transition metrics were more variable. Continuity of OUD pharmacotherapy declined substantially, from 22.63% to 16.58% (–26.7%), a change the evaluation attributes largely to shortened continuous-enrollment windows during unwinding that mechanically compress the measurement period rather than to a decline in underlying medication adherence. Initiation of alcohol and other drugs (AOD) treatment held essentially stable overall (12.70% to 12.37%), while engagement improved marginally (52.88% to 53.49%). Follow-up after SUD- and mental-health-related emergency department visits declined modestly across all four measurement windows (range: –1.7% to –4.0%) but remained high in absolute terms, with 30-day follow-up after mental health ED visits still at 79.79% in DY2. SUD readmissions within 30 days rose slightly, from 24.79% to 25.75% (+3.9%); the qualifying inpatient-stay denominator for this measure declined 55% between DY1 and DY2, and the evaluation notes this reliability limitation should inform interpretation of the readmission trend.

Provider capacity metrics presented a more constrained picture on their primary basis. The raw count of unique SUD providers billing Medicaid declined from 2,704 to 2,637 (–2.5%), and the number of MAT-prescribing providers remained flat at 17 across both years — on the count basis, the appropriate measure of network expansion, provider capacity did not grow during the evaluation period, though rates per enrolled beneficiary rose.

Impact Evaluation. Using the DPHHS Injury and Overdose Indicators dataset as the best available proxy for overdose mortality — Montana death certificates do not carry Medicaid payer information, making a Medicaid-linked measure incomputable — the statewide age-adjusted all-drug overdose death rate declined from 19.0 to 16.7 per 100,000 Montana population (–12.1%) between the DY1 (CY2022) and DY2 (CY2023) proxy years, while the opioid-specific rate rose slightly from 10.7 to 11.3 (+5.6%), within the range of expected year-to-year variation. SUD-related emergency department visits rose modestly on a rate basis (5.59 to 5.90 per 1,000 beneficiary-months, +5.5%), which the evaluation attributes in part to improved SUD identification and coding in ED settings rather than solely to increased need. Opioid safety indicators were largely stable: high-dose opioid prescribing rose slightly on a small base (0.70% to 0.76%; DY1 N=80, DY2 N=66 beneficiaries meeting the threshold), and concurrent opioid-benzodiazepine prescribing was essentially unchanged (3.27% to 3.28%).

Across quantitative and qualitative sources, findings converge on a consistent pattern: the IMD component meaningfully expanded per-beneficiary access to SUD treatment and strengthened alignment with evidence-based clinical standards — including widespread ASAM-based placement and normalization of MAT within residential treatment settings — while continuity of care, care transitions, and provider capacity remain constrained by workforce shortages, shortage of step-down placement options, housing instability, and administrative disruption associated with Medicaid unwinding.

iii. New Areas of Demonstration Evaluation

Renewal of the Demonstration will provide additional time to evaluate the longer-term effects of the SUD IMD component and the extent to which early gains in treatment access translate into sustained improvements in treatment engagement, continuity of care, utilization, and health outcomes. Interim findings indicate that access to SUD treatment services increased on a per-beneficiary basis during the evaluation period and that IMD services have become an established component of Montana’s SUD treatment continuum. However, important questions remain regarding longer-term outcomes, including treatment retention, transitions between levels of care, utilization of acute care services, and recovery trajectories as implementation matures.

In addition, renewal would provide sufficient implementation and observation time to evaluate the contingency management, tenancy support services, and reentry components approved in February 2024. These components were in pre-implementation or early implementation during the interim evaluation period, limiting analysis primarily to implementation activities and stakeholder perspectives. A renewed Demonstration period will allow future evaluations to assess beneficiary uptake, service utilization, implementation fidelity, and outcomes associated with these components using administrative and qualitative data.

Collectively, the renewed Demonstration period will strengthen Montana’s ability to evaluate both the longer-term effects of Medicaid-financed residential and inpatient treatment services and the implementation of new behavioral health service models. These findings will contribute to the evidence base regarding the role of residential treatment services within Medicaid and inform future policy decisions related to behavioral health service delivery.

Section VI – Demonstration Financing

A. Budget Neutrality

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, 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.

Consistent with CMS guidance, Montana anticipates evaluating the net financial impact of Demonstration activities and identifying the appropriate budget neutrality treatment for each component of the Demonstration. The State will include detailed budget neutrality analyses and supporting documentation as part of its final renewal submission.

As described in the June 2026 State Medicaid Director Letter, CMS will prospectively assess budget neutrality at the Demonstration level and require certification by the CMS Chief Actuary that the Demonstration is not expected to increase federal Medicaid expenditures relative to what would have occurred absent the Demonstration.¹³ The State's budget neutrality analysis will therefore evaluate both the direct and indirect fiscal impacts associated with the renewal proposal, including impacts on utilization, care delivery, and administrative expenditures, as required by CMS guidance. Montana anticipates that several components of the HEART Demonstration may qualify as Medicaid Authorizable Populations and Services under CMS policy.

Table 7. *Historical Demonstration Expenditures for HEART*

Expenditure Authorities	Historical Expenditures (in dollars)				
	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

¹³ Centers for Medicare & Medicaid Services, (2026, June 11) Budget neutrality and certification by the Chief Actuary of CMS for Section 1115 Medicaid Demonstration projects (SMD #26-003). U.S. Department of Health and Human Services. Accessible at: [smd-26-003.pdf](#).

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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 8. Projected Demonstration Expenditures for the HEART Renewal Period

Expenditure Authorities	Projected Expenditures (in dollars)				
	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

B. Maintenance of Efforts

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 the table below. The State will incorporate final expenditure projections into the Demonstration application submitted to CMS; however, these figures may change as Montana continues to finalize the historical financial

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data used to document baseline spending. Montana remains committed to maintaining – and, where possible, enhancing – access to community-based mental health services throughout the Demonstration renewal period.

Table 9. *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 VII – Waiver and Expenditure Authorities

Pursuant to Section 1115(a) of the Social Security Act (the Act), Montana requests renewal of the waiver and expenditure authorities necessary to continue implementation of the HEART Demonstration for an additional five-year approval period through June 30, 2032. These authorities will support the State’s efforts to improve access to behavioral health services, address SUDs, expand supportive housing interventions, and strengthen care transitions for justice-involved individuals.

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. The State recognizes that ongoing discussions with CMS, future legislative actions, budgetary considerations, and operational refinements may result in modifications to the authorities requested below as Montana continues to advance its behavioral health transformation initiatives.

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 Demonstration through June 30, 2032.

Table 10. Requested 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.

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	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 11. 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 – Public Review and Comment Period

The 60-day public comment period for the HEART Demonstration Renewal Application will begin on Tuesday, September 1, 2026, and close on October 31, 2026. All comments must be received by 11:59 PM (Mountain Time) on October 31, 2026.

DPHHS will hold two public meetings on the Demonstration renewal application. The public hearing on October 2, 2026, will be a hybrid meeting and the public may attend in-person or virtually. The public hearing on October 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, October 2, 2026
- **Time:** 10:00 AM – 12:00 PM 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, October 7, 2026
- **Time:** 3:00 – 4:30 PM 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 PM (Mountain Time) on October 31, 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,

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MT 59604-4210, or by telephone to (406) 444-2584, or by electronic mail to dphhscomments@mt.gov. Comments received after October 31, 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>.