State of Montana
Department of Public Health and Human Services

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

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Section I: Executive Summary

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

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

While the implementation of Medicaid expansion in 2016 significantly improved access to Medicaid covered mental health and SUD services, gaps in access to critical behavioral health services still remain. This Demonstration is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through passage of the HEART Initiative, which invests significant state and federal funding in the state's behavioral health continuum.

This Demonstration seeks to expand access to and improve transitions of care across inpatient, residential, and community-based treatment and recovery services for individuals with SUD, SMI and SED by adding services to support successful community living, increasing access to intensive community treatment models and obtaining coverage for short-term stays delivered to individuals residing in IMDs. This Demonstration will also enable the state to provide additional resources to help the state combat SUD-related overdoses and suicides, and complement its efforts to build out a robust and integrated behavioral health delivery system.

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

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

Section II: Program Overview

A. Background

System Overview

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

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

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

Mental Health and SUD	Mental Health	SUD

• Targeted case management
• Certified peer support services
• Outpatient services, both clinical and paraprofessional, including therapy provided by licensed clinicians
• Inpatient hospital services
• Intensive outpatient program
	• Dialectical behavior therapy (DBT)
	• Illness management and recovery (IMR)
	• Crisis stabilization services
	• Day treatment, which includes:
	  ○ Community-based psychiatric rehabilitation and support services (CBPRS)
	  ○ Group therapy
	• Adult foster care support
	• Behavioral health group homes
	• Program of Assertive Community Treatment (PACT)
	• Montana Assertive Community Treatment (MACT)
	• Montana Medicaid Severe and Disabling Mental Illness (SDMI) 1915(c) Waiver
		• Screening, brief intervention and referral to treatment (SBIRT)
		• SUD assessment
		• Outpatient services (ASAM 1.0)
		• SUD intensive outpatient treatment services (ASAM 2.1)
		• SUD partial hospitalization (ASAM 2.5)
		• SUD clinically managed high-intensity residential services (ASAM 3.5)
		• SUD medically monitored intensive inpatient services (ASAM 3.7)
		• Medication Assisted Treatment

SUD Crisis in Montana

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

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

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

Rising methamphetamine use has negatively impacted children and families residing in Montana. Approximately 12,900 Montanans aged 12 years and older used methamphetamine in the period from 2009 to 2019.[6] Over 65 percent of Child and Family Services Division substance-use-related placements listed methamphetamine as the primary drug. The increase in methamphetamine use has also been linked to increases in violent crimes in the state.[7] In Missoula, the county attorney's office reported that the amount of methamphetamine seized by task forces nearly doubled in a five-year period. Treatment for methamphetamine use carries with it a unique set of problems. First, unlike opiates and opioids, there is no evidence-based medication-assisted treatment for methamphetamine. Treatment can be long, because the drug is neurotoxic, and users may need to be treated for multiple physical ailments as well as brain trauma prior to being able to receive rehabilitative treatment. Finally, the use of

[2] "Alcohol Use in Montana," MT DPHHS, January 2021. Available at: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/EpiAlcoholUse2021.pdf.
[3] "Summary of Methamphetamine Use in Montana." Public Health in the 406. August 2020. Available at: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/MethamphetamineSummary2020.pdf.
[4] Ibid.
[5] Indian Health Service: The Federal Health Program for American Indians and Alaska Natives. Available at: https://www.ihs.gov/epi/tecs/publications-and-resources/.
[6] Ibid.
[7] "Violent Crime Increasing in Yellowstone County." Department of Justice, U.S. Attorney's Office, District of Montana. September 1, 2020. Available at: https://www.justice.gov/usao-mt/pr/violent-crime-increasing-yellowstone-county#:~:text=Yellowstone%20County%20has%20had%2067,almost%20a%2021%20percent%20increase.

methamphetamine is linked to violent crime, which lends an immediacy to the need for effective treatment.[8]

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

Mental Health Challenges in Montana

Addressing mental health needs that range from mild to severe among adults and children remains a key priority for the state. Consistent with rising national averages, approximately one in five adults in Montana reports symptoms of mental illness, and 5 percent of adults, or 42,600, report serious mental illness.[9,10] More troubling, Montana has ranked in the top five states for suicide rates across all age groups for the past 30 years and had the third-highest suicide rate in the country in 2019, with more than 250 deaths.[11] Individuals who commit suicide are often struggling with depression and/or SUD; 42 percent of suicide victims in Montana had alcohol in their systems.[12] Across all age groups, the highest rates of suicide are among AI/AN populations, highlighting the need to address mental health on a community level.[13]

Gaps in access to behavioral health treatment services and significant shortages of behavioral health professionals contribute to the state's persistently high rates of mental illness and suicide. The state has been diligently working to improve access to mental health prevention and treatment services, to integrate screening and treatment into primary care settings, expand short-term crisis intervention services and community-based treatment services for adults with SMI using assertive community treatment, and expand the behavioral health workforce using behavioral health peer support specialists.

Behavioral Health Needs for Justice-Involved Populations

Ensuring continuity of health coverage and care for justice-involved populations is a high priority for Montana. Currently, there are 3,700 inmates in state prisons and 1,800 inmates in local jails.[14] Providing behavioral health services to justice-involved populations can help further decriminalize mental illness and SUD.

Individuals leaving incarceration are particularly vulnerable to poorer health outcomes—justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of violence, overdose and suicide than people who have

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

[9] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health." SAMHSA. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[10] "2018-2019 National Survey on Drug Use and Health: Model Based Prevalence Estimates (50 States and the District of Columbia)." SAMHSA. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.

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

[12] "2016 Suicide Mortality Review Team Report," DPHHS. Available at: https://dphhs.mt.gov/assets/suicideprevention/2016suicidemortalityreviewteamreport.pdf.

[13] Ibid.

[14] Prison Policy Initiative: Montana Profile. 2018. Available at: https://www.prisonpolicy.org/profiles/MT.html.

never been incarcerated.[15] According to the Montana Department of Corrections (DOC), at least 75 percent of the population in the Montana Women's Prison have a mental health diagnosis, with almost half of the women in the Montana Women's Prison diagnosed with an SMI. In Montana state prisons, approximately 20 percent of the population have an SMI. In 2016, it was estimated that 40 percent of individuals processed through the DOC were convicted of offenses related to substance use.[16] A 2020 study from DPHHS shows that individuals released from the Montana DOC had an 11.2 times higher risk of death than the general population; this is driven by a 27 times higher rate of drug overdose in this population.[17]

Evidence suggests that improving health outcomes for justice-involved populations requires focused care management in order to connect individuals to the services they need upon release into their communities.[18] Montana's DPHHS and DOC have collaborated to better streamline Medicaid enrollment and coordinate SUD treatment and medical care for the reentry population. Medicaid enrollment is a standard part of the discharge process for individuals in DOC prison custody; DPHHS already has agreements in place to suspend coverage, maintain eligibility for incarcerated individuals and turn on Medicaid coverage the same day an individual is released from DOC to ensure they can receive behavioral health treatment and other medical care on day one. To further improve the efforts of DPHHS and DOC to ensure justice-involved populations have a stable network of health care services and supports upon discharge, Montana is seeking to provide limited community-based clinical consultation services, in-reach care management, and coverage of certain medications that will facilitate maintenance of medical and psychiatric stability upon release; medication coverage will also include a 30-day supply of medication following reentry into the community.

This Demonstration will address the health care needs of Montana's justice-involved population and promote the objectives of the Medicaid program by ensuring high-risk, justice-involved individuals receive needed coverage and health care services prior to and post-release into the community. Montana will be able to bridge relationships between community-based Medicaid providers and justice-involved populations prior to release to improve the likelihood that individuals with a history of behavioral health needs receive stable and continuous care.

Assessment of the Availability of Mental Health Services

Montana completed an assessment of the availability of mental health services—included as APPENDIX A to this application, using the CMS-provided template—to understand the current prevalence of members with SMI and SED, as well as provider participation in Medicaid across psychiatrists, other practitioners licensed to treat mental illness and other specialty mental health providers. According to available claims data, 14 percent of adults on Medicaid have an SMI and 14 percent of children on Medicaid have an SED. There is a higher percentage of members with SMI/SED in urban counties and their adjacent counties than in other counties. Thirty-one percent of all members with SMI/SED reside in

[15] Binswanger, I.; Stern, M.; Deyo, R.; Heagerty, P.; Cheadle, A.; Elmore, J.; Koepsell, T. "Release from Prison — A High Risk of Death for Former Inmates," New England Journal of Medicine, January 2007.
[16] 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.
[17] 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
[18] "How Strengthening Health Care at Reentry Can Address Behavioral Health and Public Safety: Ohio's Reentry Program." Available at https://cochs.org/files/medicaid/ohio-reentry.pdf.

the five most populated counties in the state (Cascade, Flathead, Gallatin, Missoula and Yellowstone), which also have the most services available.

The assessment revealed a shortage of outpatient providers who are licensed to treat members with mental illness. In particular, the assessment found that there is a need for more psychiatrists and providers who specialize in psychiatry. There are 13 counties throughout the state that lack prescribers who can treat members with SMI. Similarly, there is a lack of other practitioners treating mental illness in many counties, particularly those who accept Medicaid. Currently, about 65 percent of licensed mental health practitioners are enrolled in Medicaid. There are 12 counties without licensed mental health practitioners and 13 counties where none are enrolled in Medicaid.

B. Overview of Current Initiatives to Improve Behavioral Health Care

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

Prevention and Early Intervention Strategies

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

- **Parenting Montana:** This web-based resource for parents braids together supports grounded in evidence-based practices to help kids and families thrive and cultivates a positive, healthy culture among Montana parents with an emphasis on curbing underage drinking. This resource also includes resources to provide parents or those in a parenting role with tools for everyday parenting challenges from the elementary to post-high school years.
- **Communities That Care (CTC):** CTC promotes healthy youth development and addresses risk and protective factors to help mitigate problem behaviors in communities. Planning for this program began in January 2018, and the project's vision is to engage in a five-phase community change process that helps reduce levels of youth behavioral health problems before they escalate, providing a path to disrupt the cycle of issues encouraging problem behaviors.
- **Suicide Prevention Efforts for Youth:** The state implemented a number of suicide prevention programs focused on school-age children and youth, including Signs of Suicide; Question, Persuade and Refer; and PAX Good Behavior Game (GBG). PAX GBG teaches elementary-age students self-regulation, self-control and self-management as well as additional social-emotional skills, including teamwork and collaboration. PAX GBG is currently in over 100 schools statewide and growing, with the goal of implementing districtwide in grades K-5 in as many districts as possible, with ongoing supports to ensure fidelity and long-term sustainability.
- **Suicide Prevention and Modernization Initiatives:** The state collaborated with the National Council for Behavioral Health to revamp its State Suicide Prevention Strategic Plan and implement suicide prevention activities. As part of this effort, the state has provided federal grants and direct state funds to Tribes and Urban Indian Health Centers to support local planning and implementation of Zero Suicide, a comprehensive approach to suicide care that aims to reduce the risk of suicide for individuals seen in health care systems, and to seek training for self-care best practices for frontline health and behavioral health staff and community members. The state has also established the use of the Centers for Disease Control and Prevention's National Violent Death Reporting System, which tracks all suicides.

SUD-Specific Strategies

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

- **SUD Task Force and Strategic Plan:** DPHHS first convened the SUD Task Force in the fall of 2016 to develop an SUD Task Force Strategic Plan covering 2017-2019 with input from 250 individuals representing 135 organizations statewide. Operating under this plan from 2017 to 2019, Montana implemented numerous strategies to improve systems for preventing, treating and tracking SUD statewide. In 2019, DPHHS reconvened the SUD Task Force to update the strategic plan for 2020-2023 to reflect the state's progress in implementing the plan's strategies and the state's current experience.[19]
- **Upgraded Prescription Drug Monitoring Program (PDMP):** The Montana Prescription Drug Registry (MPDR) transitioned to a new system vendor in March 2021 to support expanded prescription drug monitoring services throughout the state. First authorized by the Montana Legislature in 2011, MPDR is an online tool that provides a list of controlled-substance prescriptions to health care providers to improve patient care and safety, as well as identify potential misuse or diversion of controlled substances. All state-licensed pharmacies are required to report prescription data, including information identifying the prescriber and patient, and the drug name, strength and dosage, for Schedule II-V controlled substances. Prescribers are also required to review the patient's record in the MPDR prior to prescribing an opioid or benzodiazepine in almost all cases. Exceptions include prescriptions for patients receiving hospice care; for patients in chronic pain, provided the prescriber reviews the patient's record every three months; or where the prescription is being administered to a patient in a health care facility.[20]
- **Family-Centered Standard of Care for Pregnant People:** The Meadowlark Initiative, a partnership that began in 2018 between DPHHS and the Montana Health Care Foundation, utilizes a care team including an obstetrics provider, a behavioral health provider and a care coordinator to integrate and coordinate care for pregnant, postpartum and parenting people who suffer from addiction and mental illness. In addition, the Strengthening Families Initiative provides an opportunity to further enhance coordination with specialty SUD treatment and recovery services for pregnant, postpartum and parenting people and their families.
- **Stimulant Use Disorder Monitoring and Treatment Pilot:** DPHHS monitors the prevalence of, and issues associated with, methamphetamine use in Montana as part of its state Epidemiology Outcome Workgroup. AMDD is also initiating the TReatment of Users of STimulant Use Disorder (TRUST) model to combine evidence-based interventions including motivational interviewing, contingency management, community reinforcement, cognitive behavioral therapy and exercise for individuals with stimulant use disorder in six pilot sites with an additional six underway.
- **Naloxone Training and Access:** Under the state's State Opioid Response grant, training on how to use and administer Naloxone is available free of charge. Emergency medical services (EMS), law enforcement, school nurses, harm reduction clinics, families and individuals can also access Naloxone through this program.
- **State Epidemiological Outcomes Workgroup (SEOW):** As part of the state's ongoing analysis of SUD needs and outcomes, Montana established the SEOW for the purpose of identifying,

[19] "Montana Substance Use Disorder Task Force Strategic Plan." DPHHS. Available at: https://dphhs.mt.gov/assets/publichealth/EMSTS/opioids/MontanaSubstanceUseDisordersTaskForceStrategicPlan.pdf.

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

interpreting and distributing data relevant to substance use and mental health (SUMH). The SEOW aims to inform prevention practices and policies by providing meaningful data about the consequences, related behaviors, and contributing risk and protective factors of SUMH disorders in Montana.

Mental Health and Crisis-Specific Strategies

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

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

Other mental health treatment and recovery initiatives include:

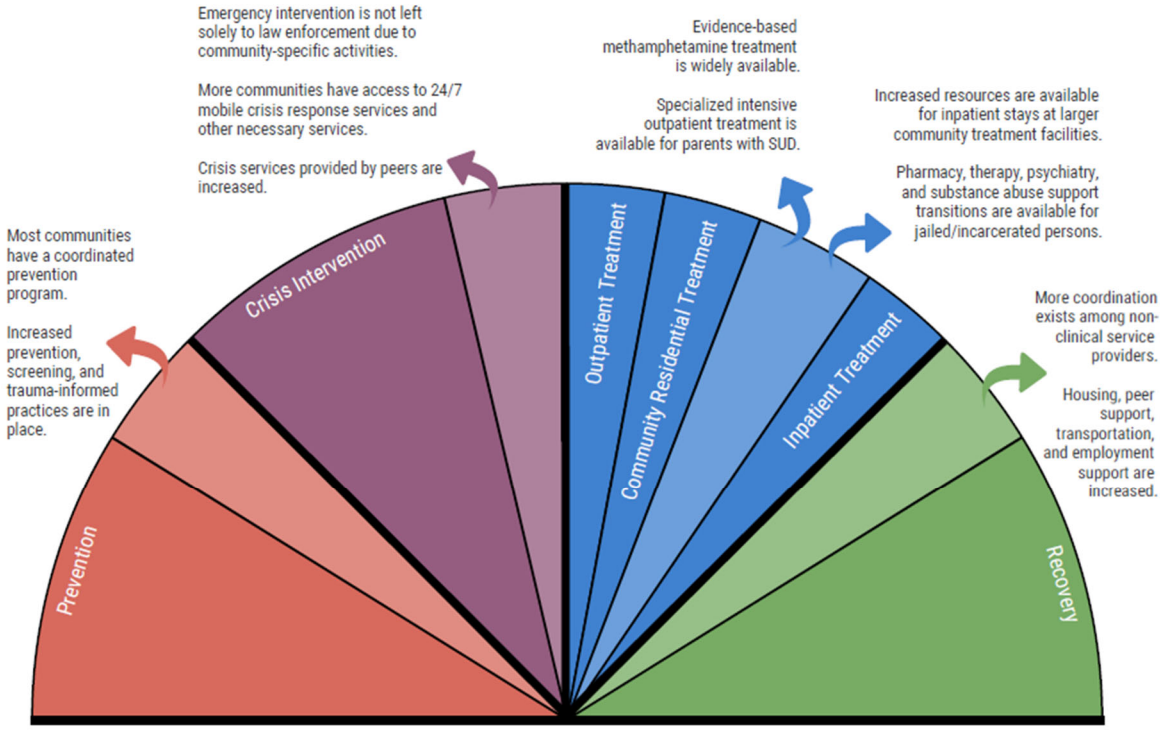
- **Expanding drop-in centers:** Seven drop-in centers currently operate in Montana to provide a voluntary, safe place for individuals that fits their personal needs or preferences and engages them in socialization, crisis mitigation and overall quality-of-life improvement. The state also funds a warmline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

C. Montana's Vision for Behavioral Health Reform

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

the state's substance use and crisis continuum of care using evidence-based care models and treatment services.

Figure 1. HEART Fund Model of Care



HEART Initiative and Early Intervention Model

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

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

HEART Initiative Crisis Intervention Model

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

- High-tech crisis call centers;

- 24/7 mobile crisis response;
- Crisis stabilization programs; and
- Essential principles and practices including recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

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

HEART Initiative SUD Treatment Model

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

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

HEART Initiative Recovery Support Model

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

D. Demonstration Goals and Objectives

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

- Expanding Medicaid's continuum of behavioral health care, including early intervention, crisis intervention treatment, behavioral health treatment and recovery services for individuals with SMI/SED/SUD in support of the state's HEART Initiative;

- Advancing the state's goals for reducing opioid-related deaths, methamphetamine-related deaths and suicides;
- Improving the outcomes and quality of care delivered to individuals with behavioral health needs across outpatient, residential and inpatient levels of care;
- Improving physical and behavioral health outcomes and reducing ED visits, hospitalizations and the use of other avoidable services by connecting justice-involved individuals to ongoing community-based physical and behavioral health services; and
- Promoting continuity of medication treatment for justice-involved individuals receiving pharmaceutical treatment.

Montana's goals support the broader objectives of the Medicaid program to ensure equitable access to medically necessary services for Medicaid-eligible members. Montana's goals also support the specific goals for SUD and SMI/SED IMD Demonstrations outlined by State Medicaid Director Letter (SMDL) #17-003 and SMDL #18-011, including:

- Increased rates of identification, initiation and engagement in behavioral health treatment;
- Increased adherence to and retention in behavioral health treatment;
- Reductions in overdose deaths and suicides, particularly those related to alcohol and illicit drugs;
- Reduced utilization and lengths of stays in ED and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate for individuals with SUD, SMI and SED, through improved access to treatment and recovery services;
- Fewer preventable readmissions to hospitals and residential settings, where the readmission is preventable or medically inappropriate;
- Improved access to care for physical health conditions among Medicaid members;
- Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services; and services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals and residential treatment settings throughout the state;
- Improved access to community-based treatment and recovery services, including tenancy supports and contingency management, to address the behavioral health needs of members with SMI, SED and SUD, including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals, residential treatment facilities and in the 30 days pre-release from prisons.

Detailed information on Montana's strategy for meeting Demonstration milestones (as identified in SMDL #17-003 and SMD #18-011) is included in its draft Implementation Plans submitted as part of this application as APPENDIX E and F.

E. Hypothesis and Evaluation Plan

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

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

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

Table 2: Preliminary Evaluation Plan for 1115 SUD and SMI/SED Demonstration

Goal	Hypothesis	Evaluation Approach	Data Sources
Increased rates of identification, initiation and engagement in behavioral health treatment	Earlier identification of and engagement in behavioral health treatment for individuals with behavioral health needs will increase their utilization of community-based behavioral health treatment services.	The state will monitor the number of patients screened using an evidence-based tool, referral and service utilization trends for individuals diagnosed with SUD and/or SMI/SED.	• Claims data • Assessment data (SUD) • Referral information on the number of patients who received specialty SUD or mental health care following referral from an acute care or primary care setting
Reduced utilization of EDs and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate	Increasing access to community-based treatment and recovery services, including tenancy supports, contingency management, and pre-release care management to be provided to inmates in the 30 days pre-release, will reduce ED utilization and preventable hospital admissions.	The state will monitor the: • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with ED visits • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with hospital admissions • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses	• Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
		with hospital readmissions • Ratio of ED visits to community-based treatment for individuals with SUD and/or SMI/SED • Ratio of hospital admissions to community-based treatment for individuals with SUD and/or SMI/SED	
Improved access to care for physical health conditions among members with SUD and/or SMI obtaining treatment in IMDs and other behavioral health settings	Improved care coordination and integration efforts (e.g., physical health assessments and linkages to physical health services) will increase the diagnosis and treatment of comorbid physical health conditions among members with SUD and/or SMI/SED obtaining treatment in IMDs.	The state will monitor: • The number of patients being treated for SUD or mental illness who receive a primary care visit annually over the number of patients being treated for SUD or mental illness (in all specialty SUD and mental health settings) • The number of physical health assessments completed in IMDs and other behavioral health settings	• Claims data • Provider data • Assessment data
Improved availability of crisis stabilization services, including through call centers and mobile crisis units, outpatient services, and residential or inpatient services	Member access to crisis stabilization services across different service modalities will increase throughout the course of the Demonstration.	The state will monitor the: • Number and percentage of individuals accessing crisis services (e.g., mobile crisis response teams, outpatient crisis receiving facilities, inpatient crisis	• Crisis Diversion grant data • Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
		stabilization facilities) • Number and percentage of individuals utilizing certified behavioral health peer support specialists within crisis services • Number and percentage of individuals presenting for behavioral health crises in EDs • Number of behavioral health-related responses from emergency medical services	
Improved care coordination and linkages to community-based behavioral health services following discharges from EDs, prisons, and residential or inpatient treatment	Care coordination for members with SUD and/or SMI/SED experiencing care transitions will improve throughout the course of the Demonstration.	The state will monitor: • Follow-ups after ED visits for mental illness or SUD • Number and percentage of facilities that documented member contact within 72 hours of discharge	• Claims data • Provider records
Reductions in overdose- and suicide-related deaths in Montana	Earlier identification and engagement in treatment and expanded access to behavioral health services across the continuum of care will contribute to a decline in overdose- and suicide-related deaths in Montana.	The state will monitor: • Follow-up and initiation of treatment following overdose reversals • Follow-up and initiation of treatment following crisis intervention services • Number of deaths from overdose and suicide	• Claims data • Death records • Crisis Diversion grant data

Section III: Eligibility and Enrollment

A. Eligibility

All children ages 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan, or Medicaid 1115 waivers will be included in this Demonstration. Pre-release services will be provided to inmates of state prisons with SUD and/or SMI. This Demonstration will directly impact only members diagnosed with SUD or SMI/SED.

Medicaid members will qualify for services outlined in this Demonstration based upon their medical need for services. Medicaid member eligibility requirements will not differ from the approved Medicaid State Plan, Alternative Benefit Plan and Medicaid 1115 waivers, and DPHHS is not proposing changes to Medicaid eligibility standards in this Demonstration application.

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

Table 3. Medicaid Eligibility Groups Affected by the Demonstration

Eligibility Group	Federal Citations	Income Federal Poverty Level (FPL)
Medicaid Children Ages 18-20	42 CFR § 435.117	0-143 percent FPL
Adults	42 CFR § 435.119	0-138 percent FPL
Parents/Caretaker Relatives	42 CFR § 435.110	0-24 percent FPL
Pregnant Women	42 CFR § 435.116	0-157 percent FPL
Aged/Blind/Disabled	42 CFR §§ 435.120-435.138	SSI benefit rate. May spend down to qualify.

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

B. Enrollment

The State is not proposing any changes to Medicaid eligibility requirements in the Section 1115 Demonstration request. As such, the Demonstration is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes, economic conditions and, if applicable, continued coverage requirements during the COVID-19 public health emergency. Enrollment in the state's Medicaid program was 259,246 in June 2021. Table 4 provides the estimated enrollment impact for the demonstration for the five years of the Demonstration, from DY 1 to DY 5.

Table 4. Projected Enrollment by Category of Aid

Category of Aid	*Projected Enrollment*				
	DY 1 ***1/1/22-12/31/22***	**DY 2** ***1/1/23-12/31/23***	**DY 3** ***1/1/24-12/31/24***	**DY 4** ***1/1/25-12/31/25***	**DY 5** ***1/1/26-12/31/26***
Families and Children (not CHIP)	49	56	61	61	62

Category of Aid	*Projected Enrollment*				
	DY 1 ***1/1/22-12/31/22***	**DY 2** ***1/1/23-12/31/23***	**DY 3** ***1/1/24-12/31/24***	**DY 4** ***1/1/25-12/31/25***	**DY 5** ***1/1/26-12/31/26***
Aged, Blind and Disabled	48	55	59	60	61
ACA Expansion	921	1158	1310	1329	1351
Other (HIFA, Poverty, Transitional MA, Former Foster Care)	412	471	507	512	516
Total	**1,430**	**1,740**	**1,937**	**1,962**	**1,990**

Section IV: Benefits and Delivery System

A. Benefits

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

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

Montana is also seeking expenditure authority to cover short-term stays in IMDs for beneficiaries with SUD and/or SMI/SED.

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

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

Contingency Management

This Demonstration seeks to add contingency management as part of TRUST, a comprehensive outpatient treatment pilot for Medicaid members ages 18 and older with stimulant use disorder (e.g., cocaine, methamphetamine and similar drugs). Contingency management allows individuals in treatment to earn small motivational incentives for meeting treatment goals (e.g., negative urine drug screens). These incentives are in the form of low-denomination gift cards that individuals can exchange for goods and services from a variety of retail stores. Contingency management is the only treatment that has demonstrated robust outcomes for individuals with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment.[21, 22, 23]

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

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

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

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

who are diagnosed with a qualifying stimulant use disorder and are participating in the TRUST pilot. Incentives will also be subject to an aggregate limit of $390 per 12-month period.

Tenancy Support Services

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

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

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

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

- SMI diagnostic criteria, and/or
- SUD

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

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

Tenancy support services will include:

- Pre-tenancy supports. These include activities to support an individual's ability to prepare for and transition to housing, such as:
    - Completion of person-centered screening and assessment to identify housing preferences and barriers related to successful tenancy;
    - Development of an individualized housing support plan based on the assessment;
    - Development of an individualized housing support crisis plan;
    - Housing search services including assisting with rent subsidy, collecting required documentation for housing application and assistance with searching for housing; and
    - Move-in support services such as assisting individuals in identifying resources to cover expenses related to move-in (e.g., security deposits and move-in costs) and with the move (e.g., ensuring housing unit is safe and ready for move-in).
- Tenancy sustaining services. These include services to assist individuals in maintaining services once housing is secured, such as:
    - Relationship building with the property management and neighbors through education and training on the roles, rights and responsibilities of the tenant and landlord and assistance resolving disputes with landlords and/or neighbors;
    - Assistance with the housing recertification process;

- Coordinating with the member to review, update and modify their housing support, including the development of a rehousing plan, as appropriate, and crisis plans;
- Advocacy and linkage with community resources to prevent eviction;
- Early identification and intervention regarding behaviors jeopardizing housing;
- Assistance with credit repair activities and skill building;
- Housing stabilization services; and
- Continued training and tenancy and household management.

Medicaid Benefits for Inmates in State Prisons in the 30 Days Prior to Release

In the 30 days prior to release from state prisons, eligible Medicaid members will receive limited community-based clinical consultation services provided in person or via telehealth, in-reach care management services, and a 30-day supply of medication for reentry into the community. Individuals will also receive coverage of certain medications, including long-acting or depot preparations for chronic conditions (e.g., schizophrenia, SUD); acute withdrawal medications; or suppressive, preventive or curative medications, including PrEP and PEP (HIV, Hep C, and SUD), that will facilitate maintenance of medical and psychiatric stability upon release.

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

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

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

B. Delivery System

There are no proposed changes to the Medicaid delivery system as part of this application. Montana plans to continue using a fee-for-service delivery system for all Medicaid services, including behavioral health services.

C. Cost Sharing

Montana currently does not apply cost sharing to any of its Medicaid members, and therefore no cost sharing will be imposed under this 1115 Demonstration. All monthly premiums will be consistent with the HELP 1115 Waiver and Cost Sharing State Plan.

Section V: Demonstration Financing

A. Budget Neutrality

Montana has estimated projected spending for the five-year Demonstration period based on the programmatic detail described earlier in this application. The authorities requested in the demonstration period do not represent new spending but instead represent spending that would otherwise be expected under the Montana Medicaid State Plan. For example, the inclusion of selected services for justice-involved individuals prior to release is expected to keep total spend at or below current levels by averting the need for significant expenditures on inpatient, emergency department and other acute services post-release. Montana also proposes to treat spending on tenancy support services as hypothetical because they are comparable to what is available to the state via 1915(i) state plan authority. Montana developed projections for the demonstration period based on state historical expenditures, as available, as well as anticipated cost and utilization trends.

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

B. Maintenance of Effort

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

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

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

Section VI: Waiver and Expenditure Authorities

Montana is requesting a waiver of the following sections of the Social Security Act, to the extent necessary, to support implementation of the proposed Demonstration. To the extent that CMS advises the state that additional authorities are necessary to implement the programmatic vision and operational details described above, the state is requesting such waiver or expenditure authority, as applicable. Montana's negotiations with the federal government, as well as state legislative and/or budget changes, could lead to refinements in these lists as the state works with CMS to move these behavioral health initiatives forward.

A. Waiver Authorities

Under the authority of Section 1115(a)(1) of the act, the following waivers shall enable Montana to implement this Section 1115 Demonstration through December 31, 2026.

Table 6: Waiver Requests

Waiver Authority	Use for Waiver
§ 1902(a)(1) Statewideness	To enable the state to provide tenancy supports and contingency management on a geographically limited basis.
§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability	To enable the state to provide tenancy supports and contingency management that are otherwise not available to all members in the same eligibility group.

B. Expenditure Authorities

Under the authority of Section 1115(a)(2) of the act, Montana is requesting expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the act, shall, through December 31, 2026, be regarded as expenditures under the state's Title XIX plan. These expenditure authorities promote the objectives of Title XIX by improving health outcomes for Medicaid populations.

Table 7: Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority
Expenditures related to IMDs	Expenditures for otherwise-covered services furnished to otherwise-eligible individuals who are primarily receiving treatment or withdrawal management services for SUD, or primarily receiving treatment for SMI, who are short-term residents/inpatients in facilities that meet the definition of an IMD.
Expenditures related to state prison inmates	Expenditure authority as necessary under the pre-release Demonstration to receive federal reimbursement for costs not otherwise matchable for certain services rendered to incarcerated individuals in the 30 days prior to their release.[24]
Expenditures related to contingency management pilot	Expenditure authority to provide contingency management through small incentives via gift cards to individuals with qualifying psycho-stimulant use disorders who are enrolled in a comprehensive outpatient treatment program.

[24] As this Demonstration request is a novel one, the specific additional waivers or expenditure authorities, if any, that would be needed will be identified in collaboration with CMS.

Expenditure Authority	Use for Expenditure Authority
Expenditures related to tenancy supports pilot	Expenditure authority to provide tenancy supports to qualifying individuals with behavioral health needs.

Section VII: Compliance with Public Notice Process

Public Notice Process

Montana has undertaken a thorough public notice process in compliance with State and Federal requirements. The State notified the public of its intent to submit the amendment application on July 8, 2021, publishing the waiver application, full public notice and abbreviated public notice on the State's HEART-specific webpage. The HEART webpage included the State's public comment materials, a summary of the dates associated with the period, details about upcoming public hearings (e.g., dates and access information) and information about how stakeholders could submit public comment submissions via email, by U.S. mail, by phone and in public hearings.

Screenshots of the DPHHS webpage updates are available in APPENDIX D. The public notice is available below.

The State also announced dates and Zoom locations for two public hearings and the tribal consultation meeting.

On July 8, 2021, the State published the abbreviated public notice in the state's largest three newspapers:

- Missoulian (Missoula, MT);
- Billings Gazette (Billings, MT); and
- Helena Independent Record (Helena, MT).

The State also emailed an interested parties listserv and the Montana Health Coalition, the State's Medical Care Advisory Committee, to inform them of the application's posting, public comment period, public hearings and process for public comment submission.

Public Hearings

The State certifies that it held two public hearings in accordance with 42 CFR Section 431.408 to present the details of the amendment and to take public comment. Both hearings were held electronically via Zoom to promote social distancing in light of the ongoing COVID-19 public health emergency:

- The first hearing was held on Tuesday, July 20, 2021, from 1 to 3 pm MT via Zoom with approximately 35 attendees joining.
- The second hearing was held on Wednesday, July 21, 2021, from 10 am to 12 pm MT via Zoom with approximately 24 attendees joining.

Telephone, audio and video participation were available for both public hearings. At both hearings, DPHHS presented an overview of the proposed HEART Section 1115 Demonstration application and then accepted public comments from webinar and telephonic participants. The PowerPoint presentation used during the public hearings was posted on the HEART webpage and is accessible here.

In addition to the two public hearings, DPHHS leadership provided an overview of the Demonstration request during the following meetings:

- Children, Families, Health and Human Services Interim Committee on August 10. Materials are available here.
- Montana Health Coalition Meeting on July 29. Materials are available here.
- Montana Medical Association on August 6. Materials are available here.

Please refer to the public notice schedule on the State's website for a full calendar of public notice activities related to the amendment and extension application.

Public Comment Period

The State-required 60-day public comment period ran from July 9, 2021, to September 7, 2021.

The State received 31 comments on the HEART Waiver Application, including 14 comments submitted via email, regular mail, and telephone voicemail, and 17 comments provided orally during the public hearings and tribal consultations.

The State appreciates the public's thoughtful and thorough review of the HEART Waiver request. The state reviewed and considered all public comments. DPHHS is committed to expanding access to and improving the quality of behavioral health services across the continuum of care for Medicaid beneficiaries. DPHHS looks forward to working with beneficiaries, their families, behavioral health providers and other stakeholders in the State's design and implementation planning.

Overall, the majority of comments were largely in support of the 1115 HEART Waiver request. Specifically, commenters were supportive of the inclusion of tenancy supports and contingency management; expanded services and supports for justice-involved populations; and the complementary expansions of the behavioral health continuum that the state is pursuing via Medicaid State Plan. A number of commenters provided policy recommendations to inform the development of these benefits. In addition, commenters were generally positive, and flagged important concerns and questions related to the state's pursuit of waiver of the IMD exclusion for short-term stays for beneficiaries with SUD and SMI/SED.

A summary of the comments and the State's responses are available in APPENDIX B; a copy of written comments is available in APPENDIX C.

Tribal Consultation

Montana is home to eight federally recognized tribal governments. In accordance with the Montana Medicaid State Plan (MT-14-0046) and federal regulations at 42 CFR § 431.408(b), the State conducted tribal consultation for the HEART Waiver through a written notice, as well as a public hearing held virtually in light of the ongoing COVID-19 public health emergency. The state's 60-day tribal public comment period ran from July 9, 2021, to September 7, 2021. On July 8, the State sent tribal consultation letters to tribal governments inviting their input at the public hearings on July 20, 2021, and July 21, 2021. The tribal public notice is included below. On July 28, 2021, the State sent an invitation and on August 4, 2021, the State sent an agenda for the tribal consultation meeting to be held on August 26 to the Indian Health Service, Tribes and Urban Indian Health Centers (ITUs).

On August 26, 2021, Medicaid Director Marie Matthews held the virtual tribal consultation meeting via Zoom to present the HEART Waiver request and discuss with the ITUs the potential impact of the waiver request on Medicaid Program enrollees; 27 individuals attended. The PowerPoint presentation used in the consultation meeting is available here. During the tribal consultation, participants expressed support for the HEART Waiver and raised questions about billing and financing of behavioral health services.

Summary of Changes to Demonstration Request

Following a careful review of the comments received and conversations with sister agencies, DPHHS has decided to not include CHIP in this Demonstration, which is focused on enrollees ages 18 and older, at this time. Based on the experience of this Demonstration, DPHHS will consider adding additional populations including CHIP to this Demonstration.

Section VIII. Public Notice

Full Public Notice

MONTANA SECTION 1115 HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART) DEMONSTRATION APPLICATION

Public Notice – July 9, 2021

The Montana Department of Public Health and Human Services (DPHHS) is providing public notice of its intent to: (1) submit to the Centers for Medicare and Medicaid Services (CMS), on or before September 30, 2021, a written 1115 Demonstration application to request federal authority to test new benefits for Medicaid members with behavioral health needs and to reimburse for acute inpatient and residential stays at institutions for mental disease (IMD) for individuals diagnosed with substance use disorders (SUD) and serious mental illness (SMI) and (2) hold public hearings to receive comments on the 1115 Demonstration application. DPHHS is seeking an effective term of five years for the Demonstration from January 1, 2022, to December 31, 2026. All proposed requests are subject to approval by CMS.

I. Program Description

A. Overview

DPHHS is requesting a Section 1115 Demonstration to build upon the strides made by the state over the last decade to establish a comprehensive continuum of behavioral health—mental health and SUD—services for its Medicaid members. This Demonstration is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through Governor Gianforte's Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative. The HEART Initiative, included in the recently passed H.B. 701, will invest significant state and federal funding to expand the state's behavioral health continuum. The demonstration will support the state's broader efforts to strengthen its evidence-based behavioral health continuum of care for individuals with SUD, SMI and SED; enable prevention and earlier identification of behavioral health issues; and monitor the quality of care delivered to members with behavioral health needs across outpatient, residential and inpatient settings through improved data collection and reporting.

Montana is seeking through this demonstration:

- To add new Medicaid services that are described in greater detail below including:
  - Evidence-based stimulant use disorder treatment models, including contingency management;
  - Tenancy support; and
  - Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.
- Expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs obtaining treatment for SUD and SMI.

B. Benefits

i. Evidence-Based Stimulant Use Disorder Treatment Models

This Demonstration seeks to add contingency management as part of TRUST, a comprehensive outpatient treatment pilot for Medicaid members ages 18 and older with stimulant use disorder (e.g., cocaine, methamphetamine and similar drugs). This pilot will combine evidence-based interventions including contingency management, motivational interviewing, community reinforcement, exercise and cognitive behavioral therapy for Medicaid members with a completed ASAM criteria assessment diagnosed with a qualifying stimulant use disorder.

ii. Tenancy Support Services

This Demonstration proposes to add coverage for a tenancy support services program to assist Medicaid members ages 18 and older with SUD, SMI or SED, who are experiencing chronic homelessness or frequent housing instability and frequently engage with crisis systems and institutional care. Tenancy support services will include pre-tenancy supports and tenancy sustaining services to support an individual's ability to prepare for and transition to housing, as well as assist individuals in maintaining services once housing is secured.

iii. Medicaid Benefits for Inmates in State Prisons in the 30 Days Prior to Release

In the 30 days prior to release from state prisons, eligible Medicaid members will receive limited community-based clinical consultation services provided in-person or via telehealth, in-reach care management services, and a 30-day supply of medication for reentry into the community. Individuals will also receive coverage of certain medications that include long-acting or depot preparations for chronic conditions (e.g., schizophrenia, SUD); acute withdrawal medications; or suppressive, preventive or curative medications, include PrEP and PEP (HIV, HCV, and SUD) that will facilitate maintenance of medical and psychiatric stability upon release. DPHHS is seeking to implement this initiative on January 1, 2023.

C. Eligibility Requirements

All children ages 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan or Medicaid 1115 waivers, as well as children aged 18 eligible for the CHIP program, will be included in this Demonstration. Medicaid members will qualify for services outlined in this Demonstration based upon their medical need for services. Medicaid member eligibility requirements will not differ from the approved Medicaid State Plan, Alternative Benefit Plan and Medicaid 1115 waivers. DPHHS is not proposing changes to Medicaid eligibility standards in this Demonstration application.

D. Health Care Delivery System and Benefits

There are no proposed changes to the Medicaid delivery system as part of this application. Montana plans to continue using a fee-for-service delivery system for all Medicaid services, including behavioral health services.

E. Cost Sharing

Montana currently does not apply cost sharing to any of its Medicaid members and therefore no cost sharing will be imposed under this 1115 Demonstration. All monthly premiums will be consistent with the HELP 1115 Waiver and Cost Sharing State Plan.

II. Goals and Objectives

This proposed Demonstration will allow Montana to better address the behavioral health needs of Montana Medicaid members by:

- Expanding Medicaid's continuum of behavioral health care, including early intervention, crisis intervention treatment, behavioral health treatment and recovery services for individuals with SMI/SED/SUD in support of the state's HEART Initiative;
- Advancing the state's goals for reducing opioid-related deaths and suicides;
- Improving the outcomes and quality of care delivered to individuals with behavioral health needs across outpatient, residential and inpatient levels of care;
- Improving physical and behavioral health outcomes and reducing emergency department visits, hospitalizations and other avoidable services by connecting justice-involved individuals to ongoing community-based physical and behavioral health services; and
- Promoting continuity of medication treatment for justice-involved individuals receiving pharmaceutical treatment

Montana's goals support the broader objectives of the Medicaid program to ensure equitable access to medically necessary services for Medicaid-eligible members. Montana's goals also support the specific goals for SUD and SMI/SED IMD Demonstrations outlined by State Medicaid Director Letter (SMDL) #17-003 and #18-011, including:

- Increased rates of identification, initiation and engagement in behavioral health treatment;
- Increased adherence to and retention in behavioral health treatment;
- Reductions in overdose deaths and suicides, particularly those related to alcohol and illicit drugs;
- Reduced utilization and lengths of stays in emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate for individuals with SUD, SMI and SED, through improved access to treatment and recovery services;
- Fewer preventable readmissions to hospitals and residential settings, where the readmission is preventable or medically inappropriate;
- Improved access to care for physical health conditions among Medicaid members;
- Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services; and services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals and residential treatment settings throughout the state;
- Improved access to community-based treatment and recovery services, including tenancy supports and evidence-based stimulant use disorder treatment models, to address the behavioral health needs of members with SMI, SED and SUD, including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals, residential treatment facilities and in the 30 days pre-release from prisons.

III. Enrollment Projections

The state is not proposing any changes to Medicaid eligibility requirements in the Section 1115 Demonstration request. As such, the Demonstration is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes, economic conditions, and, if applicable, continued coverage requirements during the COVID-19 public health emergency.

Table 1. Projected Enrollment by Category of Aid

Category of Aid	*Projected Enrollment*				
	DY 1 ***1/1/22–12/31/22***	**DY 2** ***1/1/23–12/31/23***	**DY 3** ***1/1/24–12/31/24***	**DY 4** ***1/1/25–12/31/25***	**DY 5** ***1/1/26–12/31/26***
Families and Children (not CHIP)	936	962	988	1,015	1,043
CHIP	0	0	0	0	0
Aged, Blind and Disabled	950	974	998	1,022	1,048
ACA Expansion	6,091	6,255	6,425	6,599	6,779
Other (HIFA, Poverty, Transitional MA, Former Foster Care)	321	329	338	347	356
Total	8,298	8,520	8,748	8,983	9,225

IV. Annual Expenditures

Based on the programmatic details described above, Montana has estimated projected spending for the authorization period. For the purposes of public notice and comment, the state has summarized in the table below the projected expenditures for the authorization period, including spending on requested expenditure authorities. The state will include final projections in the Demonstration request submitted to CMS; final numbers may differ as Montana continues to finalize financial data demonstrating the state's historical expenditures and to determine the impact that the COVID-19 public health emergency has had on enrollment and expenditure trends. Montana will establish budget neutrality for these items by building estimates into detailed budget neutrality tables.

Table 2: Projected Expenditures, Montana 1115 SUD/SMI/SED Demonstration

Projected Expenditures (in dollars)					
Expenditure Authorities	**DY 1** ***1/1/22–12/31/22***	**DY 2** ***1/1/23–12/31/23***	**DY 3** ***1/1/24–12/31/24***	**DY 4** ***1/1/25–12/31/25***	**DY 5** ***1/1/26–12/31/26***
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[25] Expenditures are projected using data from Rimrock. Rimrock served 101 patients aged 21-65 in a 40-bed facility in 2020. DPHHS assumed a 3 percent growth rate in the number of individuals served. To calculate cost, DPHHS applied a 1 percent annual growth rate to a proposed rate of $263.12 for 26-day average length of stay.

[26] Expenditures were calculated using data from Montana State Hospital, which had 675 admissions for individuals aged 21-65 in 2020. DPHHS assumed a steady admission rate throughout the five years due to facility limitations. To calculate cost, DPHHS estimated an average per person cost for up to 30 days by taking the average from the various units, their admissions, and an average length of stay for 30 days.

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Total	$28,015,914	$28,709,022	$29,425,355	$30,165,793	$30,931,247

V. Waiver and Expenditure Authorities

Montana is requesting a waiver of the following sections of the Social Security Act, to the extent necessary, to support implementation of the proposed Demonstration. To the extent that CMS advises the state that additional authorities are necessary to implement the programmatic vision and operational details described above, the state is requesting such waiver or expenditure authority, as applicable. Montana's negotiations with the federal government, as well as state legislative and/or budget changes, could lead to refinements in these lists as the state works with CMS to move these behavioral health initiatives forward.

A. Waiver Authorities

Under the authority of Section 1115(a)(1) of the act, the following waivers shall enable Montana to implement this Section 1115 Demonstration through December 31, 2026.

Table 3: Waiver Requests

Waiver Authority	Use for Waiver
§ 1902(a)(1) Statewideness	To enable the state to provide tenancy supports and stimulant use disorder treatment including contingency management on a geographically limited basis.

[27] Estimate for homeless patients with SUD or SMI were from the HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations: Montana Report. The report estimated that 347 people with SMI were homeless and 180 with Chronic Substance Abuse were homeless. Estimates for individuals at risk of homelessness are based on the combination of patients served in behavioral health group homes (386), ASAM 3.1 (274), and emergency departments (664). Based on 2017 TEDS data, 38% of all admissions are criminal justice referrals and we expect criminal justice involved individuals are already represented in those our population. DPHHS assumed a 3% growth rate for the population. DPHHS started with $500 PMPM with an assumption of 1% rate increase per year.

[28] DOC estimated that 300 people per year are discharged who have SMI or SUD. It was assumed this population would remain static due to facility limitations. DPHHS assumed a cost estimate for providing care coordination in the last month of a sentence to be $212.56 and applied a 1 percent annual rate increase.

[29] DPHHS applied a population rate increase of 3 percent to the base population estimate for Medicaid members with stimulant disorders in 2020 of 5,047. Contingency management was estimated at $315 annually per member with no rate increases expected.

§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability	To enable the state to provide tenancy supports, stimulant use disorder treatment including contingency management that are otherwise not available to all members in the same eligibility group.

B. Expenditure Authorities

Under the authority of Section 1115(a)(2) of the act, Montana is requesting expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the act, shall, through December 31, 2026, be regarded as expenditures under the state's Title XIX plan. These expenditure authorities promote the objectives of Title XIX by improving health outcomes for Medicaid populations.

Table 4: Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority
Expenditures related to IMDs	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment or withdrawal management services for SUD or primarily receiving treatment for SMI, who are short-term residents/inpatients in facilities that meet the definition of an IMD.
Expenditures related to state prison inmates	Expenditure authority as necessary under the pre-release Demonstration to receive federal reimbursement for costs not otherwise matchable for certain services rendered to individuals who are incarcerated 30 days prior to their release.[30]
Expenditures related to evidence-based stimulant use disorder treatment models	Expenditure authority to provide contingency management small incentives via gift cards to individuals with qualifying psycho-stimulant disorders who are enrolled in a comprehensive outpatient treatment program.
Expenditures related to tenancy supports	Expenditure authority to provide tenancy supports to qualifying individuals with behavioral health needs.

VI. Demonstration Hypotheses and Evaluation Approach

Montana will contract with an independent external evaluator to conduct a critical and thorough assessment of the Demonstration consistent with CMS guidance and the requirements of the special terms and conditions for the Demonstration.

Table 5: Preliminary Evaluation Plan for 1115 SUD and SMI/SED Demonstration

Goal	Hypothesis	Evaluation Approach	Data Sources
Increased rates of identification, initiation and engagement in behavioral health treatment	Earlier identification of and engagement in behavioral health treatment for individuals with	The state will monitor the number of patients screened using an evidence-based tool, referral and service	• Claims data • Assessment data (SUD) • Referral information on

[30] As this Demonstration request is a novel one, the specific additional waivers or expenditure authorities, if any, that would be needed will be identified in collaboration with CMS.

Goal	Hypothesis	Evaluation Approach	Data Sources
	behavioral health needs will increase their utilization of community-based behavioral health treatment services.	utilization trends for individuals diagnosed with SUD and/or SMI/SED.	the number of patients who received specialty SUD or mental health care following referral from an acute care or primary care setting
Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate	Increasing access to community-based treatment and recovery services, including tenancy supports; evidence-based stimulant use disorder treatment models; and pre-release care management to be provided to inmates in the 30 days pre-release will reduce emergency department utilization and preventable hospital admissions.	The state will monitor the: • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with emergency department visits • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with hospital admissions • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with hospital readmissions • Ratio of emergency department visits to community-based treatment for individuals with SUD and/or SMI/SED • Ratio of hospital admissions to community-based treatment for individuals with SUD and/or SMI/SED	• Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
Improved access to care for physical health conditions among members with SUD and/or SMI obtaining treatment in IMDs and other behavioral health settings	Improved care coordination and integration efforts (e.g., physical health assessments and linkages to physical health services) will increase the diagnosis and treatment of co-morbid physical health conditions among members with SUD and/or SMI/SED obtaining treatment in IMDs.	The state will monitor: • The number of patients being treated for SUD or mental illness who receive a primary care visit annually over the number of patients being treated for SUD or mental illness (in all specialty SUD and mental health settings) • The number of physical health assessments completed in IMDs and other behavioral health settings	• Claims data • Provider data • Assessment data
Improved availability of crisis stabilization services, including through call centers and mobile crisis units, outpatient services, and residential or inpatient services	Member access to crisis stabilization services across different service modalities will increase throughout the course of the Demonstration.	The state will monitor the: • Number and percentage of individuals accessing crisis services (e.g., mobile crisis response teams, outpatient crisis receiving facilities, inpatient crisis stabilization facilities) • Number and percentage of individuals utilizing certified behavioral health peer support specialists within crisis services • Number and percentage of individuals presenting for behavioral health crises in	• Crisis Diversion Grant data • Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
		emergency departments • Number of behavioral health-related responses from emergency medical services	
Improved care coordination and linkages to community-based behavioral health services following discharges from emergency department, prisons, residential or inpatient treatment	Care coordination for members with SUD and/or SMI/SED experiencing care transitions will improve throughout the course of the Demonstration.	The state will monitor: • Follow-ups after emergency department visit for mental illness or SUD • Number and percentage of facilities that documented member contact within 72 hours of discharge	• Claims data • Provider records
Reductions in overdose- and suicide-related deaths in Montana	Earlier identification and engagement in treatment and expanded access to behavioral health services across the continuum of care will contribute to a decline in overdose- and suicide-related deaths in Montana.	The state will monitor: • Follow-up and initiation of treatment following overdose reversals • Follow-up and initiation of treatment following crisis intervention services • Number of deaths from overdose and suicide	• Claims data • Death records • Crisis Diversion Grant data

VII. Public Review and Comment Process

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 in person at the DPHHS office located at 111 North Sanders Street, Helena, Montana 59601.

Two virtual public meetings will be held regarding the Demonstration application:

(1) July 20 from 1:00 to 3:00 pm MT

(2) July 21 from 10:00 am to 12:00 pm MT

To register for one or both meetings, use the following link: http://dphhs.mt.gov/heartwaiver. You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact (406) 444-2584.

Public comments may be submitted until 11:59 PM (Mountain Time) on September 7. Questions or public comments may be addressed care of Medicaid HEART Waiver, Department of Public Health and Human Services, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by telephone to (406) 444-2584, or by electronic mail to dphhscomments@mt.gov. Please note that comments will continue to be accepted after September 6, but the state may not be able to consider those comments prior to the initial submission of the demonstration application to CMS.

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

Abbreviated Public Notice

MONTANA SECTION 1115 HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART) DEMONSTRATION APPLICATION
Abbreviated Public Notice – July 8, 2021

The Montana Department of Public Health and Human Services (DPHHS) is providing public notice of its intent to: (1) submit to the Centers for Medicare and Medicaid Services (CMS), on or before September 30, a written 1115 Demonstration application to request federal authority to test new benefits for Medicaid members with behavioral health needs including tenancy supports, evidence-based stimulant use disorder treatment models including contingency management services, and targeted services provided to inmates in the 30 days prior to release, and to reimburse for acute inpatient and residential stays at institutions for mental disease (IMD) for individuals diagnosed with substance use disorders (SUD), serious mental illness (SMI) and serious emotional disturbance (SED) and; and (2) hold public hearings to receive comments on the 1115 Demonstration application. DPHHS is seeking an effective term of five years for the Demonstration from January 1, 2022, to December 31, 2026. All proposed requests are subject to approval by CMS.

DPHHS is requesting a Section 1115 Demonstration to build upon the strides made by the state over the last decade to establish a comprehensive continuum of behavioral health—mental health and SUD—services for its Medicaid members. This Demonstration is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through Governor Gianforte's Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative. The HEART Initiative, included in the recently passed H.B. 701, will invest significant state and federal funding to expand the state's behavioral health continuum. The demonstration will support the state's broader efforts to strengthen its evidence-based behavioral health continuum of care for individuals with SUD, SMI and SED; enable prevention and earlier identification of behavioral health issues; and monitor the quality of care delivered to members with behavioral health needs across outpatient, residential and inpatient settings through improved data collection and reporting.

This Demonstration seeks to expand access to and improve transitions of care across inpatient, residential, and community-based treatment and recovery services for individuals with SUD, SMI and SED by adding services to support successful community living, increasing access to intensive community treatment models and obtaining coverage for short-term stays delivered to individuals residing in IMDs. This Demonstration will also enable the state to provide additional resources to help the state combat SUD-related overdoses and suicides, and complement its efforts to build out a robust and integrated behavioral health delivery system.

Approval of this Demonstration will assist Montana in addressing its serious public health crisis in substance use disorders—including alcohol abuse, methamphetamine use, and opioid abuse and overdose—as well as surging mental health needs among state residents. The goals and objectives of the demonstration are described in more detail below.

Summary of Proposed Waiver Features
Montana is seeking:

- To add new Medicaid services under this Demonstration as part of its commitment to ensuring that Medicaid members have access to a full continuum of behavioral health services including:
    - Evidence-based stimulant use disorder treatment models, including contingency management;
    - Tenancy support; and

    - Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.
- Expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs obtaining treatment for SUD, SMI and SED.

All children ages 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan or Medicaid 1115 waivers, as well as children aged 18 eligible for the CHIP program, will be included in this Demonstration.

There are no proposed changes to the Medicaid delivery system as part of this application. Montana plans to continue using a fee-for-service delivery system for all Medicaid services, including behavioral health services.

Public Meetings and Comment Process
The full public notice statement and complete version of the draft of the Demonstration application are available for public review at: http://dphhs.mt.gov/heartwaiver. Paper copies are available to be picked up in person at the DPHHS Director's Office located at 111 North Sanders Street, Room 301, Helena, Montana 59601.

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Tribal Consultation Notice

Department of Public Health and Human Services

Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970♦ www.dphhs.mt.gov

Greg Gianforte, Governor
Adam Meier, Director

July 8, 2021

The Honorable [First Name] [Last Name]
[Title]
[Organization]
[Address]
[City], [State] [Zip]

Re: New Montana Section 1115 Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration Waiver Application

Dear [Title] [Last Name]:

The Montana Department of Public Health and Human Services (DPHHS) is pleased to invite comment from all Tribal Governments, Urban Indian Health Centers, and Indian Health Service (IHS) regarding the department's new 1115 Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration Waiver Application.

The Montana Department of Public Health and Human Services (DPHHS) is providing public notice of its intent to: (1) submit to the Centers for Medicare and Medicaid Services (CMS), on or before September 30, 2021, a written 1115 Demonstration application to request federal authority to test new benefits for Medicaid members with behavioral health needs and to reimburse for acute inpatient and residential stays at institutions for mental disease (IMD) for individuals diagnosed with substance use disorders (SUD) and serious mental illness (SMI) and (2) hold public hearings to receive comments on the 1115 Demonstration application. DPHHS is seeking an effective term of five years for the Demonstration from January 1, 2022, to December 31, 2026. All proposed requests are subject to approval by CMS.

I. Program Description

A. Overview

DPHHS is requesting a Section 1115 Demonstration to build upon the strides made by the state over the last decade to establish a comprehensive continuum of behavioral health—mental health and SUD—services for its Medicaid members. This Demonstration is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through Governor Gianforte's Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative. The HEART Initiative, included in the recently passed H.B. 701, will invest significant state and federal funding to expand the state's behavioral health continuum. The demonstration will

support the state's broader efforts to strengthen its evidence-based behavioral health continuum of care for individuals with SUD, SMI and SED; enable prevention and earlier identification of behavioral health issues; and monitor the quality of care delivered to members with behavioral health needs across outpatient, residential and inpatient settings through improved data collection and reporting.

Montana is seeking through this demonstration:

- To add new Medicaid services that are described in greater detail below including:
    - Evidence-based stimulant use disorder treatment models, including contingency management;
    - Tenancy support; and
    - Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.
- Expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs obtaining treatment for SUD and SMI.

B. Benefits

i. Evidence-Based Stimulant Use Disorder Treatment Models

This Demonstration seeks to add contingency management as part of TRUST, a comprehensive outpatient treatment pilot for Medicaid members ages 18 and older with stimulant use disorder (e.g., cocaine, methamphetamine and similar drugs). This pilot will combine evidence-based interventions including contingency management, motivational interviewing, community reinforcement, exercise and cognitive behavioral therapy for Medicaid members with a completed ASAM criteria assessment diagnosed with a qualifying stimulant use disorder.

ii. Tenancy Support Services

This Demonstration proposes to add coverage for a tenancy support services program to assist Medicaid members ages 18 and older with SUD, SMI or SED, who are experiencing chronic homelessness or frequent housing instability and frequently engage with crisis systems and institutional care. Tenancy support services will include pre-tenancy supports and tenancy sustaining services to support an individual's ability to prepare for and transition to housing, as well as assist individuals in maintaining services once housing is secured.

iii. Medicaid Benefits for Inmates in State Prisons in the 30 Days Prior to Release

In the 30 days prior to release from state prisons, eligible Medicaid members will receive limited community-based clinical consultation services provided in-person or via telehealth, in-reach care management services, and a 30-day supply of medication for reentry into the community. Individuals will also receive coverage of certain medications that include long-acting or depot preparations for chronic conditions (e.g., schizophrenia, SUD); acute withdrawal medications; or suppressive, preventive or curative medications, include PrEP and PEP (HIV, HCV, and SUD) that will facilitate maintenance of medical and psychiatric stability upon release. DPHHS is seeking to implement this initiative on January 1, 2023.

C. Eligibility Requirements

All children ages 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan or Medicaid 1115 waivers, as well as children aged 18 eligible for the CHIP program, will be included in this Demonstration. Medicaid members will qualify for services outlined in this Demonstration based upon their medical need for services. Medicaid member eligibility

requirements will not differ from the approved Medicaid State Plan, Alternative Benefit Plan and Medicaid 1115 waivers. DPHHS is not proposing changes to Medicaid eligibility standards in this Demonstration application.

D. Health Care Delivery System and Benefits

There are no proposed changes to the Medicaid delivery system as part of this application. Montana plans to continue using a fee-for-service delivery system for all Medicaid services, including behavioral health services.

E. Cost Sharing

Montana currently does not apply cost sharing to any of its Medicaid members and therefore no cost sharing will be imposed under this 1115 Demonstration. All monthly premiums will be consistent with the HELP 1115 Waiver and Cost Sharing State Plan.

II. Goals and Objectives

This proposed Demonstration will allow Montana to better address the behavioral health needs of Montana Medicaid members by:

- Expanding Medicaid's continuum of behavioral health care, including early intervention, crisis intervention treatment, behavioral health treatment and recovery services for individuals with SMI/SED/SUD in support of the state's HEART Initiative;
- Advancing the state's goals for reducing opioid-related deaths and suicides;
- Improving the outcomes and quality of care delivered to individuals with behavioral health needs across outpatient, residential and inpatient levels of care;
- Improving physical and behavioral health outcomes and reducing emergency department visits, hospitalizations and other avoidable services by connecting justice-involved individuals to ongoing community-based physical and behavioral health services; and
- Promoting continuity of medication treatment for justice-involved individuals receiving pharmaceutical treatment.

Montana's goals support the broader objectives of the Medicaid program to ensure equitable access to medically necessary services for Medicaid-eligible members. Montana's goals also support the specific goals for SUD and SMI/SED IMD Demonstrations outlined by State Medicaid Director Letter (SMDL) #17-003 and #18-011, including:

- Increased rates of identification, initiation and engagement in behavioral health treatment;
- Increased adherence to and retention in behavioral health treatment;
- Reductions in overdose deaths and suicides, particularly those related to alcohol and illicit drugs;
- Reduced utilization and lengths of stays in emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate for individuals with SUD, SMI and SED, through improved access to treatment and recovery services;
- Fewer preventable readmissions to hospitals and residential settings, where the readmission is preventable or medically inappropriate;
- Improved access to care for physical health conditions among Medicaid members;
- Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services; and services provided during

acute short-term stays in residential crisis stabilization programs, psychiatric hospitals and residential treatment settings throughout the state;

- Improved access to community-based treatment and recovery services, including tenancy supports and evidence-based stimulant use disorder treatment models, to address the behavioral health needs of members with SMI, SED and SUD, including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals, residential treatment facilities and in the 30 days pre-release from prisons.

III. Enrollment Projections

The state is not proposing any changes to Medicaid eligibility requirements in the Section 1115 Demonstration request. As such, the Demonstration is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes, economic conditions, and, if applicable, continued coverage requirements during the COVID-19 public health emergency.

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V. Waiver and Expenditure Authorities

Montana is requesting a waiver of the following sections of the Social Security Act, to the extent necessary, to support implementation of the proposed Demonstration. To the extent that CMS advises the state that additional authorities are necessary to implement the programmatic vision and operational details described above, the state is requesting such waiver or expenditure authority, as applicable. Montana's negotiations with the federal government, as well as state legislative and/or budget changes, could lead to refinements in these lists as the state works with CMS to move these behavioral health initiatives forward.

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[33] Estimate for homeless patients with SUD or SMI were from the HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations: Montana Report. The report estimated that 347 people with SMI were homeless and 180 with Chronic Substance Abuse were homeless. Estimates for individuals at risk of homelessness are based on the combination of patients served in behavioral health group homes (386), ASAM 3.1 (274), and emergency departments (664). Based on 2017 TEDS data, 38% of all admissions are criminal justice referrals and we expect criminal justice involved individuals are already represented in those our population. DPHHS assumed a 3% growth rate for the population. DPHHS started with $500 PMPM with an assumption of 1% rate increase per year.

[34] DOC estimated that 300 people per year are discharged who have SMI or SUD. It was assumed this population would remain static due to facility limitations. DPHHS assumed a cost estimate for providing care coordination in the last month of a sentence to be $212.56 and applied a 1 percent annual rate increase.

[35] DPHHS applied a population rate increase of 3 percent to the base population estimate for Medicaid members with stimulant disorders in 2020 of 5,047. Contingency management was estimated at $315 annually per member with no rate increases expected.

A. Waiver Authorities

Under the authority of Section 1115(a)(1) of the act, the following waivers shall enable Montana to implement this Section 1115 Demonstration through December 31, 2026.

Table 3: Waiver Requests

Waiver Authority	Use for Waiver
§ 1902(a)(1) Statewideness	To enable the state to provide tenancy supports and stimulant use disorder treatment including contingency management on a geographically limited basis.
§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability	To enable the state to provide tenancy supports, stimulant use disorder treatment including contingency management that are otherwise not available to all members in the same eligibility group.

B. Expenditure Authorities

Under the authority of Section 1115(a)(2) of the act, Montana is requesting expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the act, shall, through December 31, 2026, be regarded as expenditures under the state's Title XIX plan. These expenditure authorities promote the objectives of Title XIX by improving health outcomes for Medicaid populations.

Table 4: Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority
Expenditures related to IMDs	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment or withdrawal management services for SUD or primarily receiving treatment for SMI, who are short-term residents/inpatients in facilities that meet the definition of an IMD.
Expenditures related to state prison inmates	Expenditure authority as necessary under the pre-release Demonstration to receive federal reimbursement for costs not otherwise matchable for certain services rendered to individuals who are incarcerated 30 days prior to their release.[36]
Expenditures related to evidence-based stimulant use disorder treatment models	Expenditure authority to provide contingency management small incentives via gift cards to individuals with qualifying psycho-stimulant disorders who are enrolled in a comprehensive outpatient treatment program.
Expenditures related to tenancy supports	Expenditure authority to provide tenancy supports to qualifying individuals with behavioral health needs.

[36] As this Demonstration request is a novel one, the specific additional waivers or expenditure authorities, if any, that would be needed will be identified in collaboration with CMS.

VI. Demonstration Hypotheses and Evaluation Approach

Montana will contract with an independent external evaluator to conduct a critical and thorough assessment of the Demonstration consistent with CMS guidance and the requirements of the special terms and conditions for the Demonstration.

Table 5: Preliminary Evaluation Plan for 1115 SUD and SMI/SED Demonstration

Goal	Hypothesis	Evaluation Approach	Data Sources
Increased rates of identification, initiation and engagement in behavioral health treatment	Earlier identification of and engagement in behavioral health treatment for individuals with behavioral health needs will increase their utilization of community-based behavioral health treatment services.	The state will monitor the number of patients screened using an evidence-based tool, referral and service utilization trends for individuals diagnosed with SUD and/or SMI/SED.	• Claims data • Assessment data (SUD) • Referral information on the number of patients who received specialty SUD or mental health care following referral from an acute care or primary care setting
Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate	Increasing access to community-based treatment and recovery services, including tenancy supports; evidence-based stimulant use disorder treatment models; and pre-release care management to be provided to inmates in the 30 days pre-release will reduce emergency department utilization and preventable hospital admissions.	The state will monitor the: • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with emergency department visits • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with hospital admissions • Number and percentage of Medicaid members with SUD and/or SMI/SED diagnoses with hospital readmissions • Ratio of emergency department visits to community-based treatment	• Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
		for individuals with SUD and/or SMI/SED • Ratio of hospital admissions to community-based treatment for individuals with SUD and/or SMI/SED	
Improved access to care for physical health conditions among members with SUD and/or SMI obtaining treatment in IMDs and other behavioral health settings	Improved care coordination and integration efforts (e.g., physical health assessments and linkages to physical health services) will increase the diagnosis and treatment of co-morbid physical health conditions among members with SUD and/or SMI/SED obtaining treatment in IMDs.	The state will monitor: • The number of patients being treated for SUD or mental illness who receive a primary care visit annually over the number of patients being treated for SUD or mental illness (in all specialty SUD and mental health settings) • The number of physical health assessments completed in IMDs and other behavioral health settings	• Claims data • Provider data • Assessment data
Improved availability of crisis stabilization services, including through call centers and mobile crisis units, outpatient services, and residential or inpatient services	Member access to crisis stabilization services across different service modalities will increase throughout the course of the Demonstration.	The state will monitor the: • Number and percentage of individuals accessing crisis services (e.g., mobile crisis response teams, outpatient crisis receiving facilities, inpatient crisis stabilization facilities) • Number and percentage of individuals utilizing	• Crisis Diversion Grant data • Claims data

Goal	Hypothesis	Evaluation Approach	Data Sources
		certified behavioral health peer support specialists within crisis services • Number and percentage of individuals presenting for behavioral health crises in emergency departments • Number of behavioral health-related responses from emergency medical services	
Improved care coordination and linkages to community-based behavioral health services following discharges from emergency department, prisons, residential or inpatient treatment	Care coordination for members with SUD and/or SMI/SED experiencing care transitions will improve throughout the course of the Demonstration.	The state will monitor: • Follow-ups after emergency department visit for mental illness or SUD • Number and percentage of facilities that documented member contact within 72 hours of discharge	• Claims data • Provider records
Reductions in overdose- and suicide-related deaths in Montana	Earlier identification and engagement in treatment and expanded access to behavioral health services across the continuum of care will contribute to a decline in overdose- and suicide-related deaths in Montana.	The state will monitor: • Follow-up and initiation of treatment following overdose reversals • Follow-up and initiation of treatment following crisis intervention services • Number of deaths from overdose and suicide	• Claims data • Death records • Crisis Diversion Grant data

VII. Public Review and Comment Process

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 in person at the DPHHS office located at 111 North Sanders Street, Room 301, Helena, Montana 59601.

Two virtual public meetings will be held regarding the Demonstration application:

(1) July 20 from 1:00 to 3:00 pm MT

(2) July 21 from 10:00 am to 12:00 pm MT

To register for one or both meetings, use the following link: http://dphhs.mt.gov/heartwaiver. You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact Mary Eve Kulawik at (406) 444-2584.

Public comments may be submitted until 11:59 PM (Mountain Time) on September 7. Questions or public comments may be addressed care of Medicaid HEART Waiver, Department of Public Health and Human Services, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by telephone to (406) 444-2584, or by electronic mail to dphhscomments@mt.gov. Please note that comments will continue to be accepted after September 7, but the state may not be able to consider those comments prior to the initial submission of the demonstration application to CMS.

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

We look forward to engaging with you in this process.

Sincerely,

Marie Matthews
State Medicaid Director

c: Tribal Health Directors
Misty Kuhl, Director, Governor's Office of Indian Affairs
Lesa Evers, Tribal Relations Manager, DPHHS

Appendix

A. Assessment of the Availability of Mental Health Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Narrative Description (to be completed at baseline)
1. In the space below, describe the mental health service needs (e.g. prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. [Limit responses to 500 words if possible]
Addressing mental health needs that range from mild to severe among adults and children remains a key priority for the State. Consistent with rising national averages, approximately one in five adults in Montana report symptoms of mental illness, and 5 percent of adults, or 42,600 report serious mental illness. Additionally, the state has struggled to promote and sustain evidence-based practices, such as illness, management and recovery (IMR), dialectical behavior therapy (DBT) and community rehabilitation and treatment (CRT). According to available claims data, twelve percent of adults on Medicaid have a SMI and fourteen percent of children on Medicaid have a SED. There is a higher percentage of members with SMI/SED in urban counties and the adjacent counties. Thirty-one percent of all members with SMI/SED reside in the five most populated counties (Cascade, Flathead, Gallatin, Missoula, Yellowstone), which also have most available services available. Gaps in access to behavioral health treatment services and significant shortages of behavioral health professionals contribute to the state's persistently high rates of mental illness. The state has been diligently working to improve access to mental health prevention and treatment services, and to integrate screening and treatment into primary care settings, expand short-term crisis intervention services and community-based treatment services for adults with SMI using the Assertive Community Treatment (ACT), and expand the behavioral health workforce using certified behavioral health peer support specialists.
2. In the space below, describe the organization of the state's Medicaid behavioral health service delivery system at the beginning of the demonstration. [Limit responses to 500 words if possible]
The Department of Public Health and Human Services (DPHHS) administers program and payment for publicly funded behavioral health services, which include mental health (MH) and substance use disorder (SUD) prevention and treatment programs. These programs include the three healthcare facilities that serve individuals in need of more serious care: Montana State Hospital in Warm Springs and Galen, Mental Health Nursing Care Center in Lewistown, and Montana Chemical Dependency Center in Butte. The Treatment Bureau within Addictive and Mental Disorders Division (AMDD) oversees adult mental health and both adult and youth SUD services, while the Children's Mental Health Bureau (CMHB) within the Developmental Services Division (DSD) oversees youth mental health services. DPHHS contracts with behavioral health providers and agencies statewide to provide community-based and inpatient services, primarily through Medicaid. Services range from prevention and early intervention services to inpatient, residential, home and community-based, and recovery support services. Behavioral health services covered under Montana Medicaid for members that meet medical necessity criteria are described in the AMDD Medicaid Services Provider Manual for SUD and Adult Mental Health found here, https://dphhs.mt.gov/amdd/amddmedicaidservicesprovidermanual, and the Children's Mental Health Bureau Medicaid Services Provider Manual found here, https://dphhs.mt.gov/assets/dsd/CMB/providermanuals/CMHBMedicaidServicesProviderManual01012021.pdf. Montana's Severe and Disabling Mental Illness (SDMI) 1915 (c) Home and Community Based Services (HCBS) waiver is a Medicaid-funded mental health program providing specialized services for Medicaid members who would otherwise require institutional level of care. These services are provided to keep members out of a higher level of care such as the Montana State Hospital, nursing homes, emergency rooms, and avoidable hospitalizations. SDMI HCBS waiver services are provided statewide and services focus on specific specialized needs of members with mental illness, thus giving them the opportunity to remain independent and out of higher levels of care.
3. In the space below, describe the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. At minimum, explain any variations across the state in the availability of the following: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. [Limit responses to 1000 words if possible]

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

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

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

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

The availability assessment shows licensed practitioners and services provided based on the county of residence. However, it does not reflect the county of employment for licensed professionals or where they delivered services. This shows limitations in the data sources and the ability to pinpoint existing and potentially identify additional gaps. In addition, many of the state's rural counties have CMHC offices, but those offices are not staffed daily which means that individuals may not be able to obtain an appointment as quickly as they need. The increasing prevalence of telehealth services may help address this gap.

Additionally, the assessment did not specifically look at service capacity related to Montana's tribal populations. Montana is home to seven Indian reservations, all of which are in rural, isolated counties which lack access to mental health services. They have very few psychiatric and other mental health providers and are geographically far from major cities that have more intensive services. For example, Big Horn county, which makes up the majority of the Crow Reservation (7,900 residents), only has three Medicaid providers providing psychiatric services and six other Medicaid mental health providers. Montana is currently implementing Tiers 2 and 3 of the Montana Medicaid Tribal Health Improvement Program (T-HIP) to address disparities in those communities.

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

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

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

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

Geographic Designation			Beneficiaries											
			Adult					Children			Total			
	Geographic designation	Is this geographic designation primarily urban or rural?	Additional notes on this sub-section, including data limitations	Number of adult Medicaid beneficiaries (18 - 20)	Number of adult Medicaid beneficiaries with SMI (18 - 20)	Number of adult Medicaid beneficiaries (21+)	Number of adult Medicaid beneficiaries with SMI (21+)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (0 - 17)	Number of Medicaid beneficiaries with SED (0 - 17)	Percent with SED (0-17)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)
1.	Beaverhead	Rural		114	8	1333	116	9%	765	97	13%	2212	221	10%
2.	Big Horn	Rural		445	12	3475	127	4%	3384	169	5%	7304	308	4%
3.	Blaine	Rural		177	3	1412	25	2%	1242	52	4%	2831	80	3%
4.	Broadwater	Rural		58	5	666	67	10%	437	42	10%	1161	114	10%
5.	Carbon	Other-please explain	xmity to Yellows	122	14	1334	138	10%	739	80	11%	2195	232	11%
6.	Carter	Rural		10		92	1	1%	71	7	10%	173	8	5%
7.	Cascade	Urban		1156	142	13412	1704	13%	8568	1390	16%	23136	3236	14%
8.	Chouteau	Rural		71	4	612	32	5%	408	40	10%	1091	76	7%
9.	Custer	Rural		164	35	1694	309	19%	1177	230	20%	3035	574	19%
10.	Daniels	Rural		17		156	10	6%	112	10	9%	285	20	7%
11.	Dawson	Rural		112	10	1029	127	12%	743	93	13%	1884	230	12%
12.	Deer Lodge	Rural		132	22	1646	239	15%	738	159	22%	2516	420	17%
13.	Fallon	Rural		29	0	242	15	6%	244	28	11%	515	43	8%
14.	Fergus	Rural		159	17	1601	176	11%	957	123	13%	2717	316	12%
15.	Flathead	Rural		1512	193	15792	2003	13%	10411	1504	14%	27715	3700	13%
16.	Gallatin	Rural		918	110	10647	998	10%	6132	771	13%	17697	1879	11%
17.	Garfield	Rural		15		154	8	5%	153	7	5%	322	15	5%
18.	Glacier	Rural		484	8	4441	96	2%	3119	221	7%	8044	325	4%
19.	Golden Valley	Rural		16	1	183	6	4%	94	4	4%	293	11	4%
20.	Granite	Rural		29	2	367	18	5%	202	25	12%	598	45	8%
21.	Hill	Rural		394	22	3719	164	5%	2811	194	7%	6924	380	5%
22.	Jefferson	Rural		124	16	1222	126	11%	804	143	18%	2150	285	13%
23.	Judith Basin	Rural		37	3	260	14	6%	153	16	10%	450	33	7%
24.	Lake	Rural		628	72	6253	639	10%	4657	574	12%	11538	1285	11%
25.	Lewis and Clark	Rural		861	149	11673	1462	13%	6003	1081	18%	18537	2692	15%
26.	Liberty	Rural		26	1	371	22	6%	233	14	6%	630	37	6%
27.	Lincoln	Rural		339	28	3950	396	10%	2256	285	13%	6545	709	11%
28.	Madison	Rural		76	3	806	43	5%	465	51	11%	1347	97	7%
29.	McCone	Rural		12	1	142	8	6%	117	9	8%	271	18	7%
30.	Meagher	Rural		42	3	364	16	5%	229	18	8%	635	37	6%
31.	Mineral	Rural		77	9	946	85	9%	598	69	12%	1621	163	10%
32.	Missoula	Urban		1366	287	18762	3294	18%	8766	1541	18%	28894	5122	18%
33.	Musselshell	Rural		90	5	894	95	10%	505	84	17%	1489	184	12%
34.	Park	Rural		177	20	2466	180	8%	1200	197	16%	3843	397	10%
35.	Petroleum	Rural		6	1	52	5	10%	45	4	9%	103	10	10%
36.	Phillips	Rural		67	2	699	18	3%	578	42	7%	1344	62	5%
37.	Pondera	Rural		126	4	1398	91	6%	956	80	8%	2480	175	7%
38.	Powder River	Rural		15		128	9	6%	107	10	9%	250	19	8%
39.	Powell	Rural		74	8	1164	101	9%	509	86	17%	1747	195	11%
40.	Prairie	Rural		13	1	141	13	9%	96	14	15%	250	28	11%
41.	Ravalli	Rural		680	88	6874	844	12%	4009	547	14%	11563	1479	13%
42.	Richland	Rural		104	14	1206	138	12%	863	89	10%	2173	241	11%
43.	Roosevelt	Rural		353	4	3163	69	2%	2706	124	5%	6222	197	3%
44.	Rosebud	Rural		215	3	1861	100	5%	1704	142	8%	3780	245	6%
45.	Sanders	Rural		192	20	2417	214	9%	1386	167	12%	3995	401	10%
46.	Sheridan	Rural		32	1	328	30	9%	246	4	2%	606	35	6%
47.	Silver Bow	Rural		494	85	7309	1079	15%	3591	777	22%	11394	1941	17%
48.	Stillwater	Rural		99	8	911	89	10%	633	93	15%	1643	190	12%
49.	Sweet Grass	Rural		44	3	338	21	6%	245	38	16%	627	62	10%
50.	Teton	Rural		98	10	937	90	10%	708	49	7%	1743	149	9%
51.	Toole	Rural		53	2	853	46	5%	515	43	8%	1421	91	6%
52.	Treasure	Rural		9		84	7	8%	90	11	12%	183	18	10%
53.	Valley	Rural		105	11	1031	102	10%	746	78	10%	1882	191	10%
54.	Wheatland	Rural		32	2	451	36	8%	318	20	6%	801	58	7%
55.	Wibaux	Rural		7		100	4	4%	60	5	8%	167	9	5%
56.	Yellowstone	Urban		2270	379	24969	4235	17%	16465	3067	19%	43704	7681	18%
57.	*Missing County			192	33	3684	444	12%	1835	257	14%	5711	734	13%
Total				15269	1884	172214	20544	12%	106904	15075	14%	294387	37503	13%

Medicaid Section 1115 SMI/SED Demonstrations

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

Geographic Designation			Providers													
			Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications										Other Practitioners Certi			
	Geographic designation	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications Accepting New Medicaid Patients	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients	Specific type(s) of practitioners used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness
1.	Beaverhead				14		15.78571429	0	-				23	10		22.1
2.	Big Horn				3		102.6666667	0	-				8			-
3.	Blaine				1		80	0	-				3			-
4.	Broadwater				4		28.5	0	-				7	2		57
5.	Carbon				11		21.09090909	0	-				20	4		58
6.	Carter						-	-	-							-
7.	Cascade				149		21.71812081	0	-				208	105		30.81904762
8.	Chouteau				2		38	0	-				11	3		25.33333333
9.	Custer				21		27.33333333	0	-				24	12		47.83333333
10.	Daniels						-	-	-							-
11.	Dawson				6		38.33333333	0	-				11	8		28.75
12.	Deer Lodge				31		13.5483871	0	-				24	11		38.18181818
13.	Fallon				1		43	0	-							-
14.	Fergus				12		26.33333333	0	-				21	3		105.3333333
15.	Flathead				173		21.38728324	0	-				277	147		25.17006803
16.	Gallatin				158		11.89240506	0	-				412	184		10.21195652
17.	Garfield				2		7.5	0	-							-
18.	Glacier				2		162.5	0	-				10	3		108.3333333
19.	Golden Valley						-	-	-							-
20.	Granite				1		45	0	-							-
21.	Hill				3		126.6666667	0	-				33	17		22.35294118
22.	Jefferson				6		47.5	0	-				30	2		142.5
23.	Judith Basin						-	-	-				2	1		33
24.	Lake				22		58.40909091	0	-				54	33		38.93939394
25.	Lewis and Clark				104		25.88461538	0	-				249	130		20.70769231
26.	Liberty				1		37	0	-							-
27.	Lincoln				10		70.9	0	-				37	18		39.38888889
28.	Madison				2		48.5	0	-				9	4		24.25
29.	McCone				1		18	0	-							-
30.	Meagher				2		18.5	0	-				2			-
31.	Mineral				4		40.75	0	-				11	2		81.5
32.	Missoula				209		24.50717703	0	-				557	324		15.80864198
33.	Musselshell				1		184	0	-					2		92
34.	Park				7		56.71428571	0	-				48	25		15.88
35.	Petroleum						-	-	-				8			-
36.	Phillips				1		62	0	-				4			-
37.	Pondera				2		87.5	0	-				8	4		43.75
38.	Powder River				2		9.5	0	-				1			-
39.	Powell				3		65	0	-				2			-
40.	Prairie						-	-	-				6			-
41.	Ravalli				25		59.16	0	-				89	42		35.21428571
42.	Richland				16		15.0625	0	-				10	4		60.25
43.	Roosevelt				3		65.66666667	0	-				6			-
44.	Rosebud				5		49	0	-				9	1		245
45.	Sanders				2		200.5	0	-				28	10		40.1
46.	Sheridan				1		35	0	-				3	1		35
47.	Silver Bow				54		35.94444444	0	-				108	54		35.94444444
48.	Stillwater				8		23.75	0	-				13	2		95
49.	Sweet Grass						-	-	-				10	3		20.66666667
50.	Teton				5		29.8	0	-				7	9		16.55555556
51.	Toole				2		45.5	0	-				1	2		45.5
52.	Treasure						-	-	-							-
53.	Valley						-	-	-				4	2		95.5
54.	Wheatland				3		19.33333333	0	-				2	2		29
55.	Wibaux						-	-	-							-
56.	Yellowstone				282		27.23758865	0	-				450	260		29.54230769
57.	*Missing County	mber and Conditions used for					-	-	-	s for a member w	dicaid Claims Dat	cdotal evidence su				-
	Total			**0**	**1377**	**0**	**27.23529412**	**0**	**-**			**i**	**2860**	**1446**	**0**	**25.93568465**

Medicaid Section 1115 SMI/SED Demonstrations

State Name

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

	Geographic Designation	Community Mental Health Centers														
		ed and Licensed to Independently Treat Mental Illness														
	Geographic designation	Ratio of Other Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness Accepting New Patients	Specific type(s) of practitioners used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs	Ratio of Total CMHCs to Medicaid-Enrolled CMHCs	Ratio of Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs Accepting New Patients	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number of Providers Offering Intensive Outpatient Services	Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services
1.	Beaverhead	2.3	-													
2.	Big Horn	-	-							-	-	-				
3.	Blaine	-	-				1	1	1	80	1	1			1	1
4.	Broadwater	3.5	-							-	-	-				
5.	Carbon	5	-							-	-	-				
6.	Carter	-	-							-	-	-				
7.	Cascade	1.980952381	-				4	4	4	809	1	1			4	4
8.	Chouteau	3.666666667	-							-	-	-				
9.	Custer	2	-				1	1	1	574	1	1			1	1
10.	Daniels	-	-				1	1	1	20	1	1			1	1
11.	Dawson	1.375	-				2	2	2	115	1	1			3	3
12.	Deer Lodge	2.181818182	-				1	1	1	420	1	1			1	1
13.	Fallon	-	-							-	-	-				
14.	Fergus	7	-							-	-	-				
15.	Flathead	1.884353741	-				4	4	4	925	1	1			3	3
16.	Gallatin	2.239130435	-				2	2	2	939.5	1	1			1	1
17.	Garfield	-	-							-	-	-				
18.	Glacier	3.333333333	-				2	2	2	162.5	1	1			1	1
19.	Golden Valley	-	-							-	-	-				
20.	Granite	-	-							-	-	-				
21.	Hill	1.941176471	-				1	1	1	380	1	1			1	1
22.	Jefferson	15	-				2	2	2	142.5	1	1			1	1
23.	Judith Basin	2	-							-	-	-				
24.	Lake	1.636363636	-				2	2	2	642.5	1	1			1	1
25.	Lewis and Clark	1.915384615	-				3	3	3	897.333333	1	1			3	3
26.	Liberty	-	-							-	-	-				
27.	Lincoln	2.055555556	-				2	2	2	354.5	1	1			2	2
28.	Madison	2.25	-							-	-	-				
29.	McCone	-	-							-	-	-				
30.	Meagher	-	-							-	-	-				
31.	Mineral	5.5	-							-	-	-				
32.	Missoula	1.719135802	-				7	7	7	731.714286	1	1			7	7
33.	Musselshell	0	-							-	-	-				
34.	Park	1.92	-				2	2	2	198.5	1	1			2	2
35.	Petroleum	-	-							-	-	-				
36.	Phillips	-	-				1	1	1	62	1	1			1	1
37.	Pondera	2	-				1	1	1	175	1	1			1	1
38.	Powder River	-	-							-	-	-				
39.	Powell	-	-				1	1	1	195	1	1			1	1
40.	Prairie	-	-							-	-	-				
41.	Ravalli	2.119047619	-				2	2	2	739.5	1	1			2	2
42.	Richland	2.5	-				1	1	1	241	1	1			1	1
43.	Roosevelt	-	-				1	1	1	197	1	1			1	1
44.	Rosebud	9	-				1	1	1	245	1	1			1	1
45.	Sanders	2.8	-				1	1	1	401	1	1			1	1
46.	Sheridan	3	-							-	-	-				
47.	Silver Bow	2	-				3	3	3	647	1	1			3	3
48.	Stillwater	6.5	-							-	-	-				
49.	Sweet Grass	3.333333333	-							-	-	-				
50.	Teton	0.777777778	-				1	1	1	149	1	1			1	1
51.	Toole	0.5	-				1	1	1	91	1	1			1	1
52.	Treasure	-	-							-	-	-				
53.	Valley	2	-				1	1	1	191	1	1			1	1
54.	Wheatland	1	-							-	-	-				
55.	Wibaux	-	-							-	-	-				
56.	Yellowstone	1.730769231	-				10	10	10	768.1	1	1			6	6
57.	*Missing County	-	-	ogists, Social Workersard records. For Columnmunity mental h						-	-	-	se was used to procu	Cs with 56 locati		
	Total	1.977869986	-				62	62	62	604.887097	1	1			54	54

Medicaid Section 1115 SMI/SED Demonstrations

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

Geographic Designation		Intensive Outpatient Services							Residential Mental Health Treatme							
	Geographic designation	Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Total Facilities/ Programs Offering Intensive Outpatient Services to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Medicaid-Enrolled Providers Offering Intensive Outpatient Services to Medicaid- Enrolled Providers Offering Intensive Outpatient Services Accepting New Medicaid Patients	Specific type(s) of services used to populate this section	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number of Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) Accepting New Patients	Total Number of Residential Mental Health Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)
1.	Beaverhead		-	-	-								-	-	-		
2.	Big Horn		-	-	-								-	-	-		
3.	Blaine	1	80	1	1								-	-	-		
4.	Broadwater		-	-	-								-	-	-		
5.	Carbon		-	-	-								-	-	-		
6.	Carter		-	-	-								-	-	-		
7.	Cascade	4	809	1	1				2	2	2	923	1	1	31	31	
8.	Chouteau		-	-	-								-	-	-		
9.	Custer	1	574	1	1				1	1	1	344	1	1	7	7	
10.	Daniels	1	20	1	1								-	-	-		
11.	Dawson	3	76.66666667	1	1				1	1	1	137	1	1	8	8	
12.	Deer Lodge	1	420	1	1				6	6	6	43.5	1	1	103	103	
13.	Fallon		-	-	-							-	-	-			
14.	Fergus		-	-	-							-	-	-			
15.	Flathead	3	1233.333333	1	1				4	4	4	549	1	1	34	34	
16.	Gallatin	1	1879	1	1							-	-	-			
17.	Garfield		-	-	-							-	-	-			
18.	Glacier	1	325	1	1							-	-	-			
19.	Golden Valley		-	-	-							-	-	-			
20.	Granite		-	-	-							-	-	-			
21.	Hill	1	380	1	1							-	-	-			
22.	Jefferson	1	285	1	1							-	-	-			
23.	Judith Basin		-	-	-							-	-	-			
24.	Lake	1	1285	1	1							-	-	-			
25.	Lewis and Clark	3	897.3333333	1	1				1	1	1	1611	1	1	24	24	
26.	Liberty		-	-	-							-	-	-			
27.	Lincoln	2	354.5	1	1							-	-	-			
28.	Madison		-	-	-							-	-	-			
29.	McCone		-	-	-							-	-	-			
30.	Meagher		-	-	-							-	-	-			
31.	Mineral		-	-	-							-	-	-			
32.	Missoula	7	731.7142857	1	1				9	9	9	397.8888889	1	1	96	96	
33.	Musselshell		-	-	-							-	-	-			
34.	Park	2	198.5	1	1							-	-	-			
35.	Petroleum		-	-	-							-	-	-			
36.	Phillips	1	62	1	1							-	-	-			
37.	Pondera	1	175	1	1							-	-	-			
38.	Powder River		-	-	-							-	-	-			
39.	Powell	1	195	1	1							-	-	-			
40.	Prairie		-	-	-							-	-	-			
41.	Ravalli	2	739.5	1	1				2	2	2	466	1	1	15	15	
42.	Richland	1	241	1	1							-	-	-			
43.	Roosevelt	1	197	1	1							-	-	-			
44.	Rosebud	1	245	1	1							-	-	-			
45.	Sanders	1	401	1	1							-	-	-			
46.	Sheridan		-	-	-							-	-	-			
47.	Silver Bow	3	647	1	1				2	2	2	582	1	1	29	29	
48.	Stillwater		-	-	-							-	-	-			
49.	Sweet Grass		-	-	-							-	-	-			
50.	Teton	1	149	1	1							-	-	-			
51.	Toole	1	91	1	1							-	-	-			
52.	Treasure		-	-	-							-	-	-			
53.	Valley	1	191	1	1							-	-	-			
54.	Wheatland		-	-	-							-	-	-			
55.	Wibaux		-	-	-							-	-	-			
56.	Yellowstone	6	1280.166667	1	1				1	1	1	4614	1	1	8	8	
57.	*Missing County		-	-	-	health centers offere	Licensure data					-	-	-			
	Total	54	694.5	1	1				29	29	29	773.3793103	1	1	355	355	

Medicaid Section 1115 SMI/SED Demonstrations

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

Geographic Designation	Residential Mental Health Treatment Facilities																	
	t Facilities (Adult)							Psychiatric Residential Treatm										
Geographic designation	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Total Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Residential Treatment Facilities (PRTF)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTFs	Ratio of Total PTRFs to Medicaid-Enrolled PRTFs	Ratio of Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds
1. Beaverhead		-	-	-							-	-	-					
2. Big Horn		-	-	-							-	-	-					
3. Blaine		-	-	-							-	-	-					
4. Broadwater		-	-	-							-	-	-					
5. Carbon		-	-	-							-	-	-					
6. Carter		-	-	-							-	-	-					
7. Cascade	31	59.5483871	1	1							-	-	-					
8. Chouteau		-	-	-							-	-	-					
9. Custer	7	49.14285714	1	1							-	-	-					
10. Daniels		-	-	-							-	-	-					
11. Dawson	8	17.125	1	1							-	-	-					
12. Deer Lodge	103	2.53398058	1	1							-	-	-					
13. Fallon		-	-	-							-	-	-					
14. Fergus		-	-	-							-	-	-					
15. Flathead	34	64.58823529	1	1							-	-	-					
16. Gallatin		-	-	-							-	-	-					
17. Garfield		-	-	-							-	-	-					
18. Glacier		-	-	-							-	-	-					
19. Golden Valley		-	-	-							-	-	-					
20. Granite		-	-	-							-	-	-					
21. Hill		-	-	-							-	-	-					
22. Jefferson		-	-	-							-	-	-					
23. Judith Basin		-	-	-							-	-	-					
24. Lake		-	-	-							-	-	-					
25. Lewis and Clark	24	67.125	1	1				1	1	1	1081	1	1	48	48			
26. Liberty		-	-	-							-	-	-					
27. Lincoln		-	-	-							-	-	-					
28. Madison		-	-	-							-	-	-					
29. McCone		-	-	-							-	-	-					
30. Meagher		-	-	-							-	-	-					
31. Mineral		-	-	-							-	-	-					
32. Missoula	96	37.30208333	1	1							-	-	-					
33. Musselshell		-	-	-							-	-	-					
34. Park		-	-	-							-	-	-					
35. Petroleum		-	-	-							-	-	-					
36. Phillips		-	-	-							-	-	-					
37. Pondera		-	-	-							-	-	-					
38. Powder River		-	-	-							-	-	-					
39. Powell		-	-	-							-	-	-					
40. Prairie		-	-	-							-	-	-					
41. Ravalli	15	62.13333333	1	1							-	-	-					
42. Richland		-	-	-							-	-	-					
43. Roosevelt		-	-	-							-	-	-					
44. Rosebud		-	-	-							-	-	-					
45. Sanders		-	-	-							-	-	-					
46. Sheridan		-	-	-							-	-	-					
47. Silver Bow	29	40.13793103	1	1							-	-	-					
48. Stillwater		-	-	-							-	-	-					
49. Sweet Grass		-	-	-							-	-	-					
50. Teton		-	-	-							-	-	-					
51. Toole		-	-	-							-	-	-					
52. Treasure		-	-	-							-	-	-					
53. Valley		-	-	-							-	-	-					
54. Wheatland		-	-	-							-	-	-					
55. Wibaux		-	-	-							-	-	-					
56. Yellowstone	8	576.75	1	1				1	1	1	3067	1	1	88	88			
57. *Missing County		-	-	-	: Deer Lodge Co	Licensure data					-	-	-					
Total	**355**	**63.17746479**	**1**	**1**				**2**	**2**	**2**	**7537.5**	**1**	**1**	**136**	**136**			

Medicaid Section 1115 SMI/SED Demonstrations

State Name

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

Geographic Designation		Inpatient Facilities							Public and Private Psychiatric Hospitals							
	Geographic designation	Number of Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Total Number of PRTF Beds to Medicaid-Enrolled PRTF Beds	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid-Enrolled PRTFs Available to Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Public and Private Psychiatric Hospitals	Public and Private Psychiatric Hospitals Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Public and Private Psychiatric Hospitals Available to Medicaid Patients	Ratio of Public and Private Psychiatric Hospitals to Public and Private Psychiatric Hospitals Available to Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)
1.	Beaverhead		-	-	-						-	-				
2.	Big Horn		-	-	-						-	-				
3.	Blaine		-	-	-						-	-				
4.	Broadwater		-	-	-						-	-				
5.	Carbon		-	-	-						-	-				
6.	Carter		-	-	-						-	-				
7.	Cascade		-	-	-						-	-			1	
8.	Chouteau		-	-	-						-	-				
9.	Custer		-	-	-						-	-				
10.	Daniels		-	-	-						-	-				
11.	Dawson		-	-	-						-	-				
12.	Deer Lodge		-	-	-				1	1	420	1				
13.	Fallon		-	-	-						-	-				
14.	Fergus		-	-	-						-	-				
15.	Flathead		-	-	-						-	-			1	
16.	Gallatin		-	-	-						-	-				
17.	Garfield		-	-	-						-	-				
18.	Glacier		-	-	-						-	-				
19.	Golden Valley		-	-	-						-	-				
20.	Granite		-	-	-						-	-				
21.	Hill		-	-	-						-	-				
22.	Jefferson		-	-	-						-	-				
23.	Judith Basin		-	-	-						-	-				
24.	Lake		-	-	-						-	-				
25.	Lewis and Clark	48	22.52083333	1	1						-	-			1	
26.	Liberty		-	-	-						-	-				
27.	Lincoln		-	-	-						-	-				
28.	Madison		-	-	-						-	-				
29.	McCone		-	-	-						-	-				
30.	Meagher		-	-	-						-	-				
31.	Mineral		-	-	-						-	-				
32.	Missoula		-	-	-						-	-			1	
33.	Musselshell		-	-	-						-	-				
34.	Park		-	-	-						-	-				
35.	Petroleum		-	-	-						-	-				
36.	Phillips		-	-	-						-	-				
37.	Pondera		-	-	-						-	-				
38.	Powder River		-	-	-						-	-				
39.	Powell		-	-	-						-	-				
40.	Prairie		-	-	-						-	-				
41.	Ravalli		-	-	-						-	-				
42.	Richland		-	-	-						-	-				
43.	Roosevelt		-	-	-						-	-				
44.	Rosebud		-	-	-						-	-				
45.	Sanders		-	-	-						-	-				
46.	Sheridan		-	-	-						-	-				
47.	Silver Bow		-	-	-						-	-				
48.	Stillwater		-	-	-						-	-				
49.	Sweet Grass		-	-	-						-	-				
50.	Teton		-	-	-						-	-				
51.	Toole		-	-	-						-	-				
52.	Treasure		-	-	-						-	-				
53.	Valley		-	-	-						-	-				
54.	Wheatland		-	-	-						-	-				
55.	Wibaux		-	-	-						-	-				
56.	Yellowstone	88	34.85227273	1	1						-	-			1	
57.	*Missing County		-	-	-	PRTFs	state licensure da				-	-	hospital licensur	tal in the state, whi		
	Total	**136**	**110.8455882**	**1**	**1**				**1**	**1**	**37503**	**1**			**5**	**0**

Medicaid Section 1115 SMI/SED Demonstrations

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

Geographic Designation	Inpatient														
	Psychiatric Units												Psychiat		
Geographic designation	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients
1. Beaverhead					-	-	-	-	-	-					-
2. Big Horn					-	-	-	-	-	-					-
3. Blaine					-	-	-	-	-	-					-
4. Broadwater					-	-	-	-	-	-					-
5. Carbon					-	-	-	-	-	-					-
6. Carter					-	-	-	-	-	-					-
7. Cascade	1		1		3236	-	1	-	1	-			18	18	179.7777778
8. Chouteau					-	-	-	-	-	-					-
9. Custer					-	-	-	-	-	-					-
10. Daniels					-	-	-	-	-	-					-
11. Dawson					-	-	-	-	-	-					-
12. Deer Lodge					-	-	-	-	-	-			228	228	1.842105263
13. Fallon					-	-	-	-	-	-					-
14. Fergus					-	-	-	-	-	-					-
15. Flathead	1		1		3700	-	1	-	1	-			41	41	90.24390244
16. Gallatin					-	-	-	-	-	-					-
17. Garfield					-	-	-	-	-	-					-
18. Glacier					-	-	-	-	-	-					-
19. Golden Valley					-	-	-	-	-	-					-
20. Granite					-	-	-	-	-	-					-
21. Hill					-	-	-	-	-	-					-
22. Jefferson					-	-	-	-	-	-					-
23. Judith Basin					-	-	-	-	-	-					-
24. Lake					-	-	-	-	-	-					-
25. Lewis and Clark	1		1		2692	-	1	-	1	-			22	22	122.3636364
26. Liberty					-	-	-	-	-	-					-
27. Lincoln					-	-	-	-	-	-					-
28. Madison					-	-	-	-	-	-					-
29. McCone					-	-	-	-	-	-					-
30. Meagher					-	-	-	-	-	-					-
31. Mineral					-	-	-	-	-	-					-
32. Missoula	1		1		5122	-	1	-	1	-			38	38	134.7894737
33. Musselshell					-	-	-	-	-	-					-
34. Park					-	-	-	-	-	-					-
35. Petroleum					-	-	-	-	-	-					-
36. Phillips					-	-	-	-	-	-					-
37. Pondera					-	-	-	-	-	-					-
38. Powder River					-	-	-	-	-	-					-
39. Powell					-	-	-	-	-	-					-
40. Prairie					-	-	-	-	-	-					-
41. Ravalli					-	-	-	-	-	-					-
42. Richland					-	-	-	-	-	-					-
43. Roosevelt					-	-	-	-	-	-					-
44. Rosebud					-	-	-	-	-	-					-
45. Sanders					-	-	-	-	-	-					-
46. Sheridan					-	-	-	-	-	-					-
47. Silver Bow					-	-	-	-	-	-					-
48. Stillwater					-	-	-	-	-	-					-
49. Sweet Grass					-	-	-	-	-	-					-
50. Teton					-	-	-	-	-	-					-
51. Toole					-	-	-	-	-	-					-
52. Treasure					-	-	-	-	-	-					-
53. Valley					-	-	-	-	-	-					-
54. Wheatland					-	-	-	-	-	-					-
55. Wibaux					-	-	-	-	-	-					-
56. Yellowstone	1		1		7681	-	1	-	1	-			44	44	174.5681818
57. *Missing County					-	-	-	-	-	-		ds in the unit. Mdata does not s			-
Total	5	0	5	0	7500.6	-	1	-	1	-			391	391	95.91560102

Medicaid Section 1115 SMI/SED Demonstrations

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

Geographic Designation		Institutions for Mental Diseases															
		ric Beds		Residential Treatment Facilities That Qualify As IMDs									Psychiatric Hospitals That Qualify As IMDs				
	Geographic designation	Ratio of Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	Ratio of Total Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting New Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Hospitals that Qualify as IMDs	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations
1.	Beaverhead	-						-	-	-					-		
2.	Big Horn	-						-	-	-					-		
3.	Blaine	-						-	-	-					-		
4.	Broadwater	-						-	-	-					-		
5.	Carbon	-						-	-	-					-		
6.	Carter	-						-	-	-					-		
7.	Cascade	1						-	-	-					-		
8.	Chouteau	-						-	-	-					-		
9.	Custer	-						-	-	-					-		
10.	Daniels	-						-	-	-					-		
11.	Dawson	-						-	-	-					-		
12.	Deer Lodge	1						-	-	-				1	420		
13.	Fallon	-						-	-	-					-		
14.	Fergus	-						-	-	-					-		
15.	Flathead	1						-	-	-					-		
16.	Gallatin	-						-	-	-					-		
17.	Garfield	-						-	-	-					-		
18.	Glacier	-						-	-	-					-		
19.	Golden Valley	-						-	-	-					-		
20.	Granite	-						-	-	-					-		
21.	Hill	-						-	-	-					-		
22.	Jefferson	-						-	-	-					-		
23.	Judith Basin	-						-	-	-					-		
24.	Lake	-						-	-	-					-		
25.	Lewis and Clark	1						-	-	-					-		
26.	Liberty	-						-	-	-					-		
27.	Lincoln	-						-	-	-					-		
28.	Madison	-						-	-	-					-		
29.	McCone	-						-	-	-					-		
30.	Meagher	-						-	-	-					-		
31.	Mineral	-						-	-	-					-		
32.	Missoula	1						-	-	-					-		
33.	Musselshell	-						-	-	-					-		
34.	Park	-						-	-	-					-		
35.	Petroleum	-						-	-	-					-		
36.	Phillips	-						-	-	-					-		
37.	Pondera	-						-	-	-					-		
38.	Powder River	-						-	-	-					-		
39.	Powell	-						-	-	-					-		
40.	Prairie	-						-	-	-					-		
41.	Ravalli	-						-	-	-					-		
42.	Richland	-						-	-	-					-		
43.	Roosevelt	-						-	-	-					-		
44.	Rosebud	-						-	-	-					-		
45.	Sanders	-						-	-	-					-		
46.	Sheridan	-						-	-	-					-		
47.	Silver Bow	-						-	-	-					-		
48.	Stillwater	-						-	-	-					-		
49.	Sweet Grass	-						-	-	-					-		
50.	Teton	-						-	-	-					-		
51.	Toole	-						-	-	-					-		
52.	Treasure	-						-	-	-					-		
53.	Valley	-						-	-	-					-		
54.	Wheatland	-						-	-	-					-		
55.	Wibaux	-						-	-	-					-		
56.	Yellowstone	1						-	-	-					-		
57.	*Missing County	-	ds in the unit. Ideally track whet					-	-	-	lealth Treatement Fac				-	hospital licensure	MSH qualifies as
	Total	1			0	0	0	-	-	-				1	37503		

Medicaid Section 1115 SMI/SED Demonstrations
State Name
Date of Assessment
Time Period Reflected in Assessment (month/day/year)

	Geographic Designation	Crisis Stabilization Services													Federally Qualified Health Centers			
	Geographic designation	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Crisis Stabilization Units	Number of Coordinated Community Crisis Response Teams	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams	Specific type(s) of services used to populate this section	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number FQHCs that Offer Behavioral Health Services	Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations
1.	Beaverhead						-	-	-	-	-				1	221		
2.	Big Horn						-	-	-	-	-				1	308		
3.	Blaine						-	-	-	-	-				2	40		
4.	Broadwater						-	-	-	-	-					-		
5.	Carbon						-	-	-	-	-					-		
6.	Carter						-	-	-	-	-					-		
7.	Cascade		1				-	3236	-	-	-				2	1618		
8.	Chouteau						-	-	-	-	-					-		
9.	Custer						-	-	-	-	-				1	574		
10.	Daniels						-	-	-	-	-					-		
11.	Dawson						-	-	-	-	-					-		
12.	Deer Lodge						-	-	-	-	-				1	420		
13.	Fallon						-	-	-	-	-					-		
14.	Fergus						-	-	-	-	-				1	316		
15.	Flathead		1		1		-	3700	-	3700	-				1	3700		
16.	Gallatin		1		1		-	1879	-	1879	-				2	939.5		
17.	Garfield						-	-	-	-	-					-		
18.	Glacier						-	-	-	-	-				1	325		
19.	Golden Valley						-	-	-	-	-					-		
20.	Granite						-	-	-	-	-					-		
21.	Hill						-	-	-	-	-				1	380		
22.	Jefferson						-	-	-	-	-					-		
23.	Judith Basin						-	-	-	-	-					-		
24.	Lake				1		-	-	-	1285	-					-		
25.	Lewis and Clark		1				-	2692	-	-	-				2	1346		
26.	Liberty						-	-	-	-	-					-		
27.	Lincoln						-	-	-	-	-				1	709		
28.	Madison						-	-	-	-	-					-		
29.	McCone						-	-	-	-	-					-		
30.	Meagher						-	-	-	-	-					-		
31.	Mineral						-	-	-	-	-				1	163		
32.	Missoula		1		1		-	5122	-	5122	-				7	731.7142857		
33.	Musselshell						-	-	-	-	-					-		
34.	Park						-	-	-	-	-				1	397		
35.	Petroleum						-	-	-	-	-					-		
36.	Phillips						-	-	-	-	-					-		
37.	Pondera						-	-	-	-	-					-		
38.	Powder River						-	-	-	-	-					-		
39.	Powell						-	-	-	-	-					-		
40.	Prairie						-	-	-	-	-					-		
41.	Ravalli				1		-	-	-	1479	-				1	1479		
42.	Richland						-	-	-	-	-					-		
43.	Roosevelt						-	-	-	-	-					-		
44.	Rosebud						-	-	-	-	-				1	245		
45.	Sanders						-	-	-	-	-					-		
46.	Sheridan						-	-	-	-	-					-		
47.	Silver Bow				1		-	-	-	1941	-				2	970.5		
48.	Stillwater						-	-	-	-	-					-		
49.	Sweet Grass						-	-	-	-	-					-		
50.	Teton						-	-	-	-	-					-		
51.	Toole						-	-	-	-	-				1	91		
52.	Treasure						-	-	-	-	-					-		
53.	Valley						-	-	-	-	-					-		
54.	Wheatland						-	-	-	-	-					-		
55.	Wibaux						-	-	-	-	-					-		
56.	Yellowstone				1		-	-	-	7681	-				2	3840.5		
57.	*Missing County						-	-	-	-	-	nd crisis stabiliz	awards. Crisis st	and only available		-	s billed a revenue	
	Total	0	5	0	7	0	-	7500.6	-	5357.571429	-				33	1136.454545		

Availability Assessment

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B. Responses to Public Comments

The State received 31 comments on the HEART Waiver Application, including 14 comments submitted via email, regular mail, and telephone voicemail, and 17 comments provided orally during the public hearings and tribal consultations. This appendix summarizes key themes of the public comments received, as well as comments made during public hearings, and provides the State's responses. The State appreciates the thoughtful comments it received and is committed to working with stakeholders to continue to strengthen Montana's Medicaid program and its delivery of behavioral health services, specifically.

Comment: Many commenters supported the 1115 HEART Waiver request, including the focus on expanding access to and improving the quality of behavioral health services across the continuum of care for Medicaid beneficiaries.
Response: The State appreciates the commenters' overwhelming support for the HEART Waiver initiatives. DPHHS is committed to expanding access to and improving the quality of behavioral health services across the continuum of care for Medicaid beneficiaries. DPHHS looks forward to working with beneficiaries, their families, behavioral health providers and other stakeholders in the State's design and implementation planning.

Comment: Multiple commenters were in support of the HEART Waiver and provided suggestions on how Montana can expand access to crisis services.
Response: The State thanks the commenters for their input on how Montana can expand access to crisis services across the state. Improving coverage and access to behavioral health crisis services is a key component of the HEART Initiative. In particular, Montana is planning to add coverage for mobile crisis intervention services to its Medicaid State Plan to promote sustainability of the current state- and grant-funded mobile crisis service. The State is also actively exploring other opportunities to expand access to crisis services, including ways to better leverage peer specialists in crisis intervention services.

Comment: Multiple commenters expressed support for tenancy supports in the HEART Waiver; one commenter asked for further clarification on which providers will be able to provide tenancy supports, and another commenter asked that DPHHS not limit the types of providers that can provide tenancy supports.
Response: The State thanks the commenters for their support of tenancy supports. DPHHS has not yet defined the eligible provider types for tenancy supports, and looks forward to engaging stakeholders to define eligibility, capacity, and skillsets of health and housing providers that can provide these services in the State's design and implementation planning.

Comment: Multiple commenters expressed support for the pre-release services for incarcerated individuals outlined in the HEART Waiver; three commenters suggested a 90-day supply of medications, instead of a 30-day supply, upon release to allow for stabilizing the individual on medications and assessing the efficacy of the medication.
Response: The State appreciates the commenters' support for this policy initiative. DPHHS believes that providing Medicaid services to prison inmates in the 30 days prior to release will help ensure continuity of health coverage and care for justice-involved populations who experience disproportionately higher rates of physical and behavioral health diagnoses. The State agrees with the commenters regarding the importance of providing supports both pre- and post-release that will support successful transitions

from prisons to community-based settings and ensure continuity of care. Under the proposed HEART Section 1115 Demonstration, DPHHS is seeking to cover a 30-day supply of prescriptions upon release and will work to ensure continuity of care through warm handoffs and discharge planning that will ensure individuals will have access to necessary medications and prescriptions post-release. The objective of this policy initiative is to connect people to community-based services and ensure they will have access to medication management services on a continuous basis, making a 90-day supply of medication unnecessary.

DPHHS recognizes that robust stakeholder engagement is critical to understanding the operational complexity involved with implementing this initiative in the State prison and is committed to engaging stakeholders in the State's design and implementation planning.

Comment: One commenter was in support of the HEART Waiver request, including the request to waive the IMD exclusion for short-term stays, but raised concern about the 30-day length of stay not providing adequate time to properly meet members' individualized needs.
Response: The State appreciates the commenter's support for the HEART Waiver and waiver of the IMD exclusion. The State agrees that some individuals will require lengths of stay that exceed 30 days, and is committed to ensuring that Medicaid beneficiaries who require inpatient or residential treatment in an IMD have lengths of stay that appropriately meet their individualized needs. As a condition of obtaining a waiver of IMD exclusion, DPHHS will be federally required to achieve a statewide average length of stay of 30 days for stays in an IMD across residential and inpatient levels of care. This requirement will not impact an individual's ability to obtain residential or inpatient treatment for as long as is medically required.

Comment: One commenter requested the 30-day pre-release services be provided to people in tribal, federal and BIA correctional facilities.
Response: The State thanks the commenter for this suggestion. DPHHS will include people served by tribal and BIA correctional facilities as target populations for the next phase of this policy initiative. DPHHS is committed to partnering with tribal and BIA facilities to establish enrollment and suspension processes in all facilities in order to build the foundation needed to provide pre-release services.

Comment: Two commenters were opposed to the request of the IMD waiver for SMI/SED and SUD as it relates to the Montana State Hospital. One of the commenters asked the State to limit the IMD waiver request to community-based facilities as opposed to Montana State Hospital.
Response: The State thanks the commenters for raising their concerns regarding the IMD waiver for SMI/SED and SUD. DPHHS is committed to ensuring that Medicaid beneficiaries with SUD and/or SMI/SED are linked to a suitable level of care along a treatment continuum that appropriately meets their needs. Inpatient treatment at state psychiatric hospitals is a vital component of the continuum of care. Individuals with SMI/SED and/or SUD may need less-intensive levels of care as they progress in treatment, and may need more intensive treatment if they suffer a setback, which is why the State is expanding access to the full continuum of care ranging from prevention and early intervention to outpatient treatment, crisis services, residential treatment services and inpatient care through the HEART Program and Waiver. In particular, the State intends to:

- Add mobile crisis intervention services to its Medicaid State Plan
- Implement tenancy supports to enable individuals with SMI, SED and SUD to find and maintain residency in housing

- Implement the TRUST model to provide evidence-based treatment for stimulant use disorder, including contingency management
- Increase the number of evidence-based interventions focusing on community-based prevention
- Increase resources available for inpatient stays at larger community treatment facilities
- Increase the number of counties and Indian reservations in Montana that have prevention specialists
- Increase the number of evidence-based coalition processes in more Montana communities (e.g., Communities That Care and Collective Impact)

Additionally, the State recognizes that there is a shortage of community SUD and mental health treatment beds across the state. The State believes that obtaining a waiver of the IMD exclusion will support its efforts to work with providers to offer and obtain Medicaid reimbursement for community-based residential treatment.

Comment: One commenter asked for the adoptions of the all-inclusive outpatient IHS rate for services provided by Urban Indian Health Centers.

Response: The State thanks the commenter for this idea and will explore ensuring sufficiency of rates through multiple mechanisms.

Comment: One commenter requested the HEART Waiver adopt the most liberal definition of services possible so that all services provided by Urban Indian Health Centers are eligible and to revisit the Montana Medicaid policy that allows reimbursement for one SUD service per day in Urban Indian Health Centers and Federally Qualified Health Centers (FQHCs).

Response: The State thanks the commenter for their suggestion. DPHHS looks forward to engaging its tribal stakeholders to further define service and billing policies in the State's design and implementation planning.

Comment: One commenter expressed support for the development of more treatment facilities operated by Urban Indian Health Centers and/or Tribes.

Response: The State thanks the commenter for their suggestion. The HEART Waiver expands access to treatment facilities operated by Urban Indian Health Centers and/or Tribes in several ways, including:

- Adding services and supports covered by Medicaid
- Paying for short-term stays delivered to individuals residing in IMDs
- Enhancing care coordination
- Expanding provider types

Comment: A few commenters shared their support for the HEART Waiver while raising concern for Montana workforce capacity.
Response: The State thanks commenters for sharing their concerns about behavioral health workforce challenges. The State agrees that expanding the network of behavioral health providers and workforce is critical to ensuring the success of the HEART Waiver and that Medicaid beneficiaries have access to covered services. DPHHS will continue to actively work to expand provider capacity throughout the demonstration. DPHHS efforts to expand capacity include:

- Expanding provider types that can provide behavioral health services

- Ensuring flexibility for services provided via telehealth during and after the COVID-19 public health emergency
- Conducting a review of its Medicaid reimbursement rates for all behavioral health services to determine whether they are sufficient, and exploring bundling or increasing reimbursement
- Working with existing Medicaid providers to gauge their interest and determine what additional supports they require to expand capacity for existing and new services

Since the inception of Medicaid expansion, Montana has seen a dramatic increase in funding and providers. The State acknowledges the current challenges in the behavioral health workforce, but believes workforce capacity will grow as access to and funding for behavioral health services increases.

C. Public Comments

civil rights protection & advocacy system for montana

disability rights montana

July 21, 2021

Department of Public Health and Human Services
Director's Office, Room 301
c/o Mary Eve Kulawik
111 North Sanders Street
PO Box 4210
Helena MT 59604

Received
JUL 26 2021
Director's Office
DPHHS

Re: HEART 1115 demonstration waiver

Thank you for the opportunity to comment on the HEART 1115 demonstration waiver. There are many aspects of the initiative that address long-standing needs for an effective system and we are glad to see them as part of the waiver request. The most notable of these are tenancy support services and support for effective discharge from prison settings. We strongly support those elements of the request.

We are also very glad to learn that the Department plans to submit a state plan amendment to include mobile crisis services as well as support of those who are pregnant and parenting. Both will provide the type of community-based services that are critical to better outcomes and limiting the type of disruption and difficulties that occur when people have to receive services outside of the communities where they live.

However, we have two strong concerns about your proposal. The first is the application of the IMD exclusion to the Montana State Hospital. The second is the current state of the mental health and substance use disorder community system and its capacity to take on the additional services requested in this waiver application.

1. IMD exclusion. As we understand the proposal, the state will be asking for the IMD exclusion to be lifted for ALL IMD's in the state. Practically, we understand from providers in the state that this will cover just one existing private facility - Rimrock in Billings. However, it will also include the state-run psychiatric hospital in Warm Springs - the Montana State Hospital. Although we have no objection to the request to lift the IMD exclusion for Rimrock, as it is situated in a large population center and can provide treatment for people closer to home, we have strong objections to lifting it for the Montana State Hospital.

The plan as we understand it will be for stays of up to 30 days for people with severe mental illness and/or people with substance use disorder. There is no information provided as to whether people will be involuntarily committed for these stays, which is currently how the vast majority of people are admitted to the facility. The Montana State Hospital is not a facility that could be fairly called "community based." It is situated far away from most population centers in Montana and can be quite hard to access for family and friends of patients, which makes it difficult for them to play a part in recovery. It is a large congregate care facility, with all of the limitations that come along with it, including limited access to individual treatment with health care professionals.

1022 Chestnut Street Helena, Montana 59601 | Voice/TDD 406-449-2344 Toll-free 800-245-4743 Fax 406-449-2418
advocate@disabilityrightsmt.org | www.disabilityrightsmt.org

The Montana State Hospital has been in existence for more than 100 years. Reimbursing the state with Medicaid dollars for placing people at the institution as proposed in this demonstration waiver is not a "community based" solution - nor is it a new or innovative proposal. At best, it will send more people away from their homes for treatment in a large, congregate care setting with limited access to health care professionals for therapy. At worst, it will serve as a way to avoid encouraging and funding better treatment alternatives in the community - which is difficult and challenging work. We do not believe it has any place in an innovative demonstration grant and we strongly urge the amendment of the 1115 waiver request to limit the lifting of the IMD exclusion to private, community-based programs only.

Upon review of the materials, it seems that the IMD exclusion is the only initiative in the 1115 waiver request to address the lack of residential bed capacity in the community. Because of this, in addition to the IMD waiver exclusion for truly community-based programs, we would like to see it include other initiatives that directly support and encourage the development of more community-based residential beds, as there are few providers currently in the state that have the capacity to develop this service on their own, given the substantial workforce issues and reimbursement rate that is severely limiting its capacity at this time.

This brings us to our second concern. Although this is not directly about the waiver application, it will profoundly affect its success. It is the current state of the behavioral health and substance use disorder service system in Montana.

2. State of the Current System. The state is in receipt of the letter from the BHAM from early June 2021, which identifies a tremendous need for help from the Department to address the severe lack of staff in these programs. Since that time, BHAM representatives have testified in public forums that programs are having to close down some services and send people with disabilities home because they did not have sufficient staff to serve them.

Given this, all of new proposals in this waiver application - which providers will have to develop and provide once it is approved and Medicaid reimbursement is available - seem somewhat out of touch. This is especially true given that the lack of a sufficient Medicaid rate is a primary issue in the staff shortages being experienced throughout the state. The Department must act now to do what it can with ARPA funds, the "black box" funding included in HB 2, and any other sources to help these programs before the system collapses. This waiver will be irrelevant if the system succumbs to the current pressures.

Sincerely,

Beth Brenneman

Beth Brenneman
Staff Attorney

Mental Health
Advisory Council

DATE: AUGUST 10, 2021

TO: Montana Department of Public Health & Human Services @ dphhscomments@mt.gov

Montana Interim Committee of Children, Family, Health, and Human Services

FROM: Beaverhead County Mental Health Local Advisory Council

RE: Public comment on the Healing and Ending Addiction through Recovery and Treatment (HEART) 1115 Waiver Submission

The Beaverhead County Mental Health Local Advisory Council is a coalition of county-wide members committed to assessing, advocating, planning, and strengthening public mental health services for adults and children in our community. We are stakeholders who advocate for quality mental health for our family, friends, clients, neighbors, patients, and our community/county at large. We take seriously our charge from the 1999 Montana State Legislature that created LACs and directed our representatives to be a critical element in our state's public mental healthcare system.

In that defined representation we appreciate this opportunity to give public comment on the HEART program to the Montana Legislative Interim Committee of Children, Family, Health, and Human Services and the Department of Public Health and Human Services. We generally support this waiver, but offer caveats regarding its statewide implementation.

This expansion of behavioral and addiction-based health services will benefit a great many Montanans who reside in statewide communities. However, we take this opportunity to acknowledge and reinforce the intrinsic hand and glove relationship that exists between mental health challenges, addiction, and physical health. Addiction and mental health are frequently two sides of the same coin: one usually does not exist without the other. Striving for all Montanans' good health must represent both physical AND mental health.

Statewide behavioral health programs are frequently not consistently implemented equitably across our state. Most notable, many rural counties, **and particularly Beaverhead County, has never** recovered from the extensive mental health cuts in

2017. Losing the Western Montana Mental Health Center, and its' accompanying services, remains a significant gap in services for southwest residents.

We ask for your assurance the benefits of the HEART program do not result in this same exclusion of rural counties' services. As you're well aware there are significant issues across the state in regard to the behavioral health workforce and its ability to provide services to all those in need. There are certainly challenges for providers to have a sufficient workforce to provide care in Montana's more populated communities… Missoula, Butte, Helena, Billings, or Great Falls.

But what is "challenging" in more populated communities is essentially **non-existent** in our rural communities of Jackson, Wise River, Wisdom, Lima, and Dillon in Beaverhead County.

While delighted to learn of these services' expansion, we must raise the issue **only some** Montanans will have the opportunity to benefit from these new services. Many more rural residents are effectively locked out from these services.

We ask DPHHS to assure rural residents in need of HEART services and the majority of other mental health services **are not excluded** because they live in a less populated zip code. We understand there are different costs associated with delivering rural services. Regardless, those services are just as important for someone in Dillon or Lima, as it is for someone in Billings or Great Falls.

We submit these comments to encourage the HEART program's implementation is part of a full system of care for physical and mental health services. We request service delivery inequities are resolved so these programs are equitably funded and provided for all Montanans.

Finally, we support any savings from the implementation of the HEART waiver are returned to community-based services in support of behavioral health providers' costs of services.

Thank you for your time and attention to these comments and requests.

Katherine Buckley-Patton

Katherine Buckley-Patton, Executive Director

Beaverhead County Mental Health Local Advisory Council

08/02/2021

Department of Public Health and Human Services
Director's Office, Room 301
111 North Sanders Street
P.O. Box 4210
Helena MT 59604
c/o Mary Eve Kulawik

Ke'lah Savage
Madison County Mental Health
Local Advisory Council
P.O. Box 546
Twin Bridges, MT 59754

Director Meier,

On behalf of the Madison County Mental Health Local Advisory Council, we are writing to support the Montana DPHHS HEART waiver submission. As a rural county with significant demand for additional mental health services, we believe this vital initiative will help increase inpatient and residential treatment options for the most vulnerable in our communities.

The Madison County Mental Health Local Advisory Council is a volunteer-run county board comprised of diverse perspectives focused on increasing awareness and supporting our mental health community.

As a council, we work hard to increase awareness of mental health and substance use services within Madison County and our neighboring counties. As a frontier culture, we continually work to reduce the barriers often identified in rural mental health research. In addition, we work to reduce the stigma of seeking support when one is struggling through education and awareness.

The HEART initiative could increase accessibility and availability of mental health and substance use services by offering services in our community to individuals who may not get services otherwise. Currently, to receive many services, individuals are required to take time off of work, reduce their pay, and find reliable transportation to get too much-needed services. It would be an asset if we, as a state, could increase access to inpatient mental health and substance use services for all and especially for youth. Many individuals wait much too long before receiving services due to not having access either because of our rural location or no beds. The lack of services available to youth is even more complex in our state due to the lack of service available to individuals under the age of 18 years old. Many individuals often give up on seeking support for substance use or behavioral health due to the barriers in place.

Madison County Mental Health Local Advisory Council is in support of the HEART waiver. We believe that if we can increase access to support for individuals seeking behavioral health and/or substance use support, we can create healthier individuals, families, and communities.

Thank you, and please don't hesitate should you have any questions regarding our support,

Sincerely,

Ke'lah Savage

Ke'lah Savage, Chair
on behalf of the Madison County Mental Health Local Advisory Council

Montana Consortium for Urban Indian Health
MCUIH
stronger together

August 6, 2021

Director's Office
Attn: Mary Eve Kulawik, Medicaid State Plan and Waiver Coordinator
Montana Department of Public Health and Human Services
Box 4210
Helena, MT. 59604-4210

RE: Medicaid HEART Waiver

Dear Ms. Kulawik:

Thank you for providing this opportunity to comment on Montana's proposed Healing and Ending Addiction through Recovery and Treatment (HEART) waiver. I write in support of the HEART waiver and the new Medicaid initiatives that are proposed on behalf of All Nations Health Center of Missoula, Billings Urban Indian Health & Wellness Center of Billings, Butte Native Wellness Center of Butte, and Helena Indian Alliance-Leo Pocha Clinic. These four centers are members of the Montana Consortim for Urban Indian Health. Urban Indian Organizations (UIOs) provide essential health services in our communities. UIOs depend on scarce financial resources to provide services to already vulnerable American Indian patients, many of whom are eligible for Montana Medicaid.

This 1115 Demonstration Medicaid waiver will benefit many American Indian people with substance use disorders who live in urban areas. Inclusion of evidence-based stimulant use disorder treatment, tenancy support, and pre-release care management along with a focus on better coordination of behavioral and physical health care will be of great benefit to American Indians. We look forward to the opportunity to provide these new waiver services.

We would also offer the following suggestions that we believe would make this demonstration waiver even better. Please include in your proposal to CMS:

- Adoption of the All-Inclusive Outpatient IHS Rate (AIR) for services provided by Urban Indian Centers. 100% FMAP is currently available for a two-year period starting in April 2021 through the American Rescue Plan Act for services provided by Urban Indian Centers. This windfall to the State could be used to provide the AIR enhanced rate for services for the duration of the waiver. Although we are currently reimbursed for our cost of doing business as an FQHC by Montana Medicaid, there is no "profit" in this kind

Butte Wellness Center| Billings Urban Indian Health and Wellness Center |All Nations Health Center
Helena Indian Alliance
Jason Smith
Executive Director
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of cost-based reimbursement to allow us to expand services. Thus, we struggle to provide new services because of a lack of funding to pay for provider salaries, equipment, and clinical space until a Medicaid cost-based rate can be retroactively applied. This lack of up-front resources stymies us from providing the enhanced SUD services that are needed in our communities.

- Adoption in the HEART waiver of the most liberal definition of "services" possible so that all services provided by an Urban Indian Center are eligible for 100% FMAP or as an alternative adopting the most liberal definition of AI/AN possible to allow 100% FMAP for the greatest number of people we serve. The federal definition of AI/AN for the populations we serve is more liberal than the ACA definition.
- Pre-release case management, medications, and other medical services to be provided 30 days prior to release for people incarcerated in tribal, federal, and BIA correctional facilities. This service is desperately needed for people in these facilities as well as the Montana state prison system.
- Support for development of more treatment facilities operated by Urban Centers and/or Tribes. Facilities that serve the entire family (both parents and children) are especially needed as are culturally sensitive treatment, aftercare, and sober living alternatives. There are few evidence-based treatment models for Indian people. We believe that Montana can become a leader in developing a treatment model that is developed by Indian people for Indian people that honors our resiliency and traditional values while incorporating the best of western models of care. Such a hybrid model will also benefit Indian people outside of Montana.
- Revision of existing Montana Medicaid policy that only allows reimbursement for one substance use treatment per day in Urban Indian Centers and other FQHCs. This policy is outdated in today's treatment world where provision of both group and individual treatment on the same day are the norm. Lack of payment for both group and individual services on the same day unnecessarily slows treatment and negatively affects people in the recovery process. SUD programs at Urban Indian Centers are sometimes forced to offer either individual or group care (only one treatment per client per day) in order to maintain the financial viability of our programs as we are dependent on Medicaid reimbursement. This is a major barrier when people recovering from SUD are trying to work and participate in the community while receiving treatment. This outdated limitation was put in place when Medicaid primarily covered only physical health care in FQHCs to prevent unbundling, but it does not work well for behavioral health services where multiple group and individual services are often provided. This policy should be changed for all affected providers who bill using revenue codes such as Urban Indian Centers and other community based FQHCs as well as tribal and IHS providers. Other non-FQHC community-based SUD and mental health providers do not face a similar reimbursement limitation when providing group and individual services on the same day.

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Helena Indian Alliance
Jason Smith
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Thank you for your consideration. We appreciate the continued partnership and support we receive from the Montana Medicaid program.

Sincerely,

Jason Smith
Executive Director
Montana Consortim for Urban Indian Health

c: Misty Kuhl, Director, Governor's Office of Indian Affairs
Adam Meier, Director, DPHHS
Marie Matthews, Montana State Medicaid Director, DPHHS
Lesa Evers, Tribal Relations Manager, DPHHS
Zoe Barnard, AMDD Administrator, DPHHS

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BEHAVIORAL HEALTH
ALLIANCE OF MONTANA

DATE: July 20, 2021
TO: Montana Department of Public Health and Human Services at dphhscomments@mt.gov
FROM: Behavioral Health Alliance of Montana
RE: Public Comment on the Healing and Ending Addiction through Recovery and Treatment (HEART) 1115 Wavier Submission

The Behavioral Health Alliance of Montana is a membership organization comprised of adult and children's mental health providers, substance use treatment providers, and Tribal behavioral health providers. Our agencies serve the Seriously Mentally Ill (SMI) adults and Seriously Emotionally Disturbed (SED) children's populations and are largely reimbursed by Montana Medicaid.

Thank you for allowing us to give public comment on the HEART Program today. We support the HEART Fund Program and appreciate Governor Gianforte and Montana DPHHS's willingness to submit this waiver.

We will separate our brief comments into two categories: support and suggestions.

SUPPORT:

1. We are supportive of the fact that DPHHS has included mental health in the continuum of services provided by the HEART Program. It is impossible to separate substance use disorder and mental health just as is impossible to separate mental health from physical health.
2. We are supportive of the inclusion of prevention services in the HEART Program. Evidence-based prevention services are the most cost-effective and clinically effective services to keep children and adults from developing a mental illness or substance use disorder. Montana has not traditionally funded prevention programs and we appreciate their inclusion in the HEART Program.
3. We are supportive of the expansion of the continuum of care for behavioral health in the HEART Program. The Alliance has partnered with AMDD to develop a comprehensive continuum of care for adults through the expansion of the Program for Assertive Community Treatment (PACT) and the expansion of both rehabilitation and habilitation residential models.
4. We are supportive of the expanded suicide prevention plan and increased state leadership in implementing evidence-based suicide prevention programs across Montana.
5. We are supportive of the crisis stabilization and mobile crisis models being funded across the state and believe our agencies are integral to the provision of those services.
6. We are supportive of the contingency management pilots currently being conducted throughout the state; some of which are being conducted in the Alliance's member agencies.

PO Box 7635, Missoula, MT 59807 PH: 406-546-4793 info@montanabehavioralhealth.org
www.montanabehavioralhealth.org

BEHAVIORAL HEALTH
ALLIANCE OF MONTANA

7. We are supportive of working with the Department of Corrections to provide seamless care of incarcerated individuals into community-based treatment programs to ensure their success as they integrate back into the communities.
8. We are supportive of the inclusion of tenancy support services as affordable housing remains one of the highest needs in Montana for social determinants of health.
9. We strongly support waiving the IMD exclusion reimbursement for short-term residential and inpatient stays in IMD
10. We strongly support the creation of quality outcomes for SMI, SED and SUD treatment and offer our support in implementing the collection of those outcomes throughout our agencies.

SUGGESTIONS:

1. In the HEART Program 1115 waiver on page 23, DPHHS notes: "a 30-day supply of medication for reentry into the community" will be provided to inmates being released from incarceration. For the purposes of medication assessment, 30 days may not be enough time to assess efficacy of the medication. We would suggest a 90-day supply to allow for stabilizing the individual on medications and assessing the efficacy of the medication.
2. We also suggest DPHHS consider longer term inpatient treatment for SMI co-occurring illness clients using stimulants or opioids. It is difficult to treat these clients in the outpatient setting and ASAM residential facilities cannot typically support these clients.

We will submit this statement in writing as well. Thank you for considering our suggestions.

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MONTANA MEDICAL ASSOCIATION
ADVOCATES FOR ADVANCEMENT

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September 7, 2021

Medicaid HEART Waiver
Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604-4210

Re: New Montana Section 1115 HEART Demonstration Waiver Application

The Montana Medical Association appreciates the opportunity to offer comments on the proposed Section 1115 Healing and Ending Addiction through Recovery and Treatment (HEART) demonstration waiver application. The MMA, as the largest statewide physician organization in Montana, represents practicing physicians, residents and medical students. We also serve as an essential voice for patients.

We have a shared common goal with the Department of building upon the strides made by the state over the last decade to establish a comprehensive continuum of behavior health services for its Medicaid members. By focusing on pilot strategies that will strengthen evidence-based behavioral health continuum of care for individuals with SUD, SMI and SED and enable prevention and earlier identification of behavioral health issues, the quality of care can be enhanced for these patients. In support of this shared goal, the MMA offers its support of the demonstration application with one addition related to care coordination, which is further explained below.

First, we want to express our support for the HEART Initiative. This initiative, through the planned investment of significant state and federal funding, has the potential to expand the state's behavioral health continuum. The Montana Medical Association appreciates the infusion of additional state and federal funds and recognition of the importance of applying additional resources to fortify evidence-based practices in Montana. The Department references the ASAM criteria in the application and we highly emphasize that the ASAM Levels of Care are critical to the strengthening of the behavioral health continuum in Montana with its four broad levels of service and an early intervention level.

Further, the demonstration project pursued should ensure that any provider treating individuals with SUD, SMI and SED has the capacity to provide recovery-oriented addiction services within the five broad levels of care, including Medication-assisted Treatment. Individuals need continuity of care and clinicians should be ready and willing to provide MAT as an evidence-based treatment.

Second, the MMA expresses its support of the Department's interest in designing a comprehensive care coordination approach. We encourage the Department to explore options that do not increase administrative tasks and, prior to any inclusion, to take proper measures to first listen to all providers about the impact of options being considered to their operations and staffing. Options should not disincentivize participation by providers based on their cost structure. The Department should

consider an appropriate reimbursement to create a level playing field for nonprofit and for-profit providers and cover the cost for clinicians to provide base recovery-oriented addiction services at a recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs. Any reimbursement model should also recognize the staffing demands that comes with a care management option that increases regulatory and reporting requirements and provide funding for these staff positions.

In review of the application, it appears to emphasize the higher level of care. The MMA recognizes there is limited bed capacity and appreciates that intensive care is supported in the demonstration. However, lower thresholds of care also need support. Funding of care coordination services is a step in this direction and would impact patients at multiple levels of care.

The MMA requests support for community-based treatment with a care coordination option be added to this application. With worsening social determinants of health and an increasing number of relapses being seen by providers, a demonstration pilot that includes an ability to expend money to pay for a Substance Use Navigator in practices would be impactful. These additional staff members can assist patients in navigating through the complex system. Options could include peer support, care coordination, and case management. Care coordination services can improve the experience of the individual receiving care in this complex system. It also supports the specific goals listed for SUD and SMI/SED IMD Demonstrations outlined by State Medicaid Director Letter (SMDL) #17-003 and #18-011 which includes increased adherence to and retention in behavioral health treatment and improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals, residential treatment facilities and in the 30 days pre-release from prisons.

Additionally, we recognize and support the request of authority for coverage of evidence-based stimulant use disorder treatment models in the application, especially the inclusion of contingency management, which supports community-based treatment. The MMA supports the expansion and the Treatment of Users with Stimulant Use Disorder (TRUST) model through this application. Contingency management has been found to be effective with patients. We request the Department design and pilot the TRUST program in a variety of sites, including both nonprofit and for-profit providers, to collect data on outcomes and the sustainability of the program.

The application includes other proposals to add a tenancy support services program and to provide Medicaid benefits for inmates in state prisons. We also offer our strong support for these added services for coverage. Patients facing chronic homelessness or frequent housing instability can be more challenging to treat. Providing tenancy support services will assist these patients in maintaining a treatment protocol, and the addition of a care coordinator will further assist in their successful recovery.

We appreciate the Department's thoughtful consideration of the points made above and this opportunity to share our insight and perspective.

Sincerely,

Jean Branscum
CEO

Lewis and Clark County
Behavioral Health Local Advisory Council
1930th Ninth Ave., 1st Floor
Helena, MT 59601

August 30, 2021

Medicaid HEART Waiver
Department of Public Health and Human Services
Director's Office
c/o Mary Eve Kulawik
PO Box 4210, Helena, MT 59604-4210

To: Montana DPHHS c/o Mary Eve Kulawik,

RE: Public Statement for Medicaid 1115 Demonstration Waiver for Additional Services and Populations |HEART

The Lewis and Clark County (LCC) Behavioral Health Local Advisory Council consists of more than thirty active community members representing law enforcement, therapist, first responders, teachers, principals, executives, counselors, public health, consumers and more. All are laser focused on our Behavioral Health Crisis System and Continuum of Care and the impacts to services, individuals and families in our county. This council was established with the support of the County Commission in 2011. Additional information and resources can be found on the Lewis and Clark County website under Boards and Councils.

LCC Behavioral Health (BH) Local Advisory Council has four core workgroups to address and define strategies, including the *Legislative and Policy Workgroup*, that is represented in this statement. The LCC BH Local Advisory Council supports and contributes to the Behavioral Health Systems Improvement Leadership Team, who has led the LCC BH Crisis Systems Improvement work, including the recent development of the 2021 LCC BH Crisis Systems Analysis, which is attached for your reference and can also be found on the LCC BH Local Advisory Council Webpage.

After reviewing the information for the *State of MT DPPHS Medicaid Section 1115 Demonstration: Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration, July 2021*, though we support many of these valuable initiatives to improve the treatment, services, funding and outcomes for individuals, families and systems impacted by behavioral and mental health, substance abuse treatment, services and systems, we request that you to consider the following recommendations and insights:

Supported and/or expansion areas:

* **MCRT Medicaid Bundle reimbursement.** We support providing braided revenues beyond county funding for sustainability of this key best practice crisis response service. To assure availability to all county MCRT's, we request no or minimal licensure requirements in billing of MCRT under team member credentials to correlate with available workforce. MCRT responded to 172 individuals in behavioral health crisis in the first 8-months of operation in Lewis and Clark County, and over 50% of those individuals were treated and remained at scene, usually they're homes in the community. This service provides trauma informed care and diverts from hospital emergency department and detention center admissions.

* **30-day re-activation of Medicaid benefits for individuals being released from jail.** We support early activation and request consideration to expand to include county Detention Centers. The loss of Medicaid occurs when

anyone is admitted to Jail or a Detention Center, creating not only immediate loss of coverage for current medications needed to manage MH or SUD diagnosis, which can impact the status and qualification for subsidized housing, adding to homelessness and anxiety levels to perpetuate the crisis cycle.

NOT supported and recommend removal:

Do not support ending the 12-month continuous eligibility proposal for Severely Disabling Mental Illness (SDMI), request this to remain in place. A reduction in length of eligibility and requirement to renew continuously would only add to the staffing and cost requirements for processing in the system for benefits, medication, medical services and stability of housing to add to homeless crisis!

NOT addressed but identified as needed:

* **Provider rates and structure.** An increase in rate structure is one of the most immediate, critical needs for behavioral health providers! The current reimbursement model does not cover operational costs. Improvement of the reimbursement structure is needed for ongoing sustainability of behavioral health providers and services to provide sustainable services.

*** Workforce.** This critical shortage during the COVID19 Pandemic goes beyond the pandemic and is not mentioned in the HEART Fund. Recommendation to address workforce needs with a better wage and benefit compensation to maintain staffing numbers, qualifications and maintain a vital workforce.

In addition, the Help and WASP waivers proposals to end 12-month continuous eligibility will jeopardize access to the supports and services the people with mental illness depend on. Ending 12-month continuous eligibility will interrupt continuous mental health treatment and could result in a failed treatment program. Thousands of Montanans could lose their health insurance, including our family members, friends and neighbors who may experience severely debilitating physical and mental illness who can't navigate these new, overbearing regulations.

In closing, there is concern that the HEART waiver lifting the IMD exclusion may risk needlessly putting more people in institutions away from their communities. That needs close monitoring. The HEART waiver should enhance community-based facilities. That's really where we need to focus our resources, especially addressing our dire workforce shortages. Montana sorely needs workforce support, development and a much better pay and compensation package for direct care providers and other employees throughout the mental health system. The rate system needs improvement.

Thank you for considering our recommendations and viewpoints for this once in a decade opportunity to improve our Behavioral Health Crisis System and Continuum of Care.

Yours in Community,

Lewis and Clark County Behavioral Health Local Advisory Council
Legislative and Policy Workgroup
Matt Furlong, Jolene Jennings, Sean Logan, Mary Ann Dunwell and John Nesbitt

Attachment: Lewis and Clark County Behavioral Health Crisis System Analysis, 2021

Emailed to: dphhscomments@mt.gov

Montana Primary Care Association

Montana Primary Care Association
1805 Euclid Ave
Helena MT 59601

September 7, 2021

Adam Meier
Director
Montana Department of Public Health and Human Services
111 North Sanders Street
PO Box 4210
Helena, MT 59604

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

Submitted via email to dphhscomments@mt.gov

Dear Director Meier:

The Montana Primary Care Association (MPCA) appreciates the opportunity to comment on the DPHHS proposed Medicaid Section 1115 Demonstration: Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration . MPCA is the statewide membership organization for all the state's federally qualified health centers (FQHCs) and the state's five Montana's Urban Indian Organizations (UIOs). Combined, MPCA's members serve as the health home for over 110,000 medically-underserved Montanans, the majority of whom live below the Federal Poverty Level and face multiple social and environmental factors which impact their need for health care and their ability to access care appropriately. With over 80 sites in a frontier state, Montana's FQHCs and UIOs provide affordable, high quality, comprehensive primary care to these individuals, regardless of their insurance status or ability to pay for services and were critical partners with DPHHS during the state's COVID-19 response.

MPCA shares the commitment of DPHHS to "Improving and protecting the health, well-being and self-reliance of all Montanans" and supports the intent of the HEART Demonstration waiver to improve the behavioral health continuum of care in Montana. Expanding access to SUD, SMI and SED services that focus on community-based solutions and implementing innovative strategies that are evidence-based will support the work being done on the ground across the state by primary care providers.

Currently, Montana Medicaid covers a variety of behavioral health services but gaps in care and administrative barriers limit the state's ability to support the full continuum of care. The proposed HEART Demonstration waiver seeks to address several identified areas of concern and, when coupled with the State's intent to amend it's Medicaid State Plan, could result in real improvements to the lives of Montanans living with behavioral health and substance use related issues.

For this 1115 HEART Demonstration waiver application, MPCA offers the following specific comments:

HEART Waiver

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Montana Primary Care Association

1. MPCA strongly supports evidence-based stimulant use disorder treatment models, including contingency management. As an organization committed to improving access to all SUD services, MPCA believes that contingency management is a proven strategy for a very difficult to treat disease;
2. MPCA strongly supports tenancy support services and urges DPHHS to not limit eligible provider types. DPHHS should prioritize those providers and organizations that are community-based and experienced in providing housing support.
3. MPCA supports pre-release care management and Medicaid services provided to justice-involved individuals at least 30 days prior to release. In addition, MPCA supports other public comments related to increasing the 30-day supply of medication to 90-days; and
4. MPCA supports the Demonstration waiver's intent to waive the IMD exclusion. MPCA notes that DPHHS should prioritize community-based residential and inpatient stays.

MPCA requests that DPHHS work closely with a broad range of Montana healthcare providers and patient advocates to best identify community-based strategies that will ensure the success of the Demonstration. MPCA and its members are committed to participating in this Demonstration and looks forward to reviewing the State's implementation plans for this waiver.

Thank you for your consideration of these comments. If you have any questions, please contact Stacey Anderson, MPCA's Policy Director at sanderson@mtpca.org.

Sincerely,

Cindy Stergar, CEO
Montana Primary Care Association

406.442.2750
mtpca.org

1805 Euclid Avenue
Helena, MT 59601

Comment
Expansive efforts should be made to further reduce drug smuggling, trafficking, sales and use. Harsher penalties need to be implemented. Additional male enforcement should be engaged to further reduce and prevent drug related crimes and use. With continuing to reduce drug availability and harsher punishments, less people will require addiction treatments. The rate of relapse after addiction treatment is very high. Since addiction is a very serious disease that leads to many issues, prevention is the best use of resources. Fix the problem, rather than have to provide repeated treatment to those who's lives are ruined by being able to really access drugs to begin with. As far as mental health access and treatment goes, efforts to reduce the negative stigma associated with mental health issues should be increased. Benefits provided by medical insurance companies can be increased to open up access to those who require this kind of medical treatment.
Subject Line: Reject waiver to end continuous eligibility in MT Dear Director Adam Meier, I oppose the waiver to eliminate 12-month continuous Medicaid eligibility. It makes no sense to me that DPHHS' HEART program and waiver support people with severe mental illness, yet this waiver to change eligibility standards would pull the rug out from under them. While the HEART proposal supports Montanans with severe mental illness, DPHHS proposes to give with one hand and take with the other. The Department's waiver proposal to end 12-month continuous eligibility will jeopardize folks' very access to the supports and services described in the HEART proposal. It would interrupt continuous mental health treatment and could result in a failed treatment program. Thank you for your consideration.

Subject Line: Public Comment for the Montana HEART Waiver
August 6, 2021

To whom it may concern:
Thank you for the opportunity to review and provide comment on the draft language of Montana's HEART Waiver Request. I write these comments as a family member attempting to support an extended family member, age 40, navigate a complicated DD diagnosis of mild cognitive impairment/borderline intelligence and in recent years, diagnosed with anxiety, depression, and psychosis. The behavioral health issues developed from being in an abusive relationship with a spouse who not only beat the heck out of her regularly, but forcefully filled her with high potency THC, molly, meth and alcohol. She had never used substances until she entered the abusive relationship in her late 20's. Once out of the marriage, she returned to abstaining from substances but the long-term consequences to her overall health have been devastating.

As a result of the relationship, our family member has a daughter who remains living with the ex-husband, which is a constant worry. Supervised visitation with her daughter is non-existent due to distance and a lack of visitation rights being legally established and enforced. Further ensuring a safe space from the ex-husband is challenging at best. The situation is resulting in an estranged relationship with the daughter and impacts where and the available services our family member can seek services.

In a recent psychological evaluation, our family member's IQ has dropped from borderline to the high 50's. She cannot problem solve without assistance or becoming overwhelmed, and she cannot manage her own affairs, take her medications as prescribed, cannot follow good hygiene and functions far below than what she used to in her early 20's when she had a driver's license, held a job with a job coach, managed her money with some support, and was basically able to live independently. Yes, she was on Medicaid, but she certainly did her part to contribute to society. Once married, all hope was lost.

Our family member has gotten out of the marriage and has returned home to live with her mother, who also has impaired cognition and many health challenges. During this transition, our family member wasn't astute enough to realize her DD services that had remained open were in jeopardy, despite several family members attempting to coach the individual and her mother through the situation. The mother, and quite frankly, the rest of the family is at their wits end. Despite all efforts to educate the mother and brother on mental health, they remain steadfast to their belief that the circumstances are a moral failing on our family member's part.

Since 2016, our family member has been in and out of behavioral health units (BHU) for depression, anxiety, and psychosis. If she takes her medicine as prescribed, she functions at a much higher level, can hold a conversation, and tend to her chores, hygiene, diet, etc. She might even be able to live with some supports and have a job with a job coach. Currently she has a great deal of difficulty taking her medications consistently which results in a downward spiral of despair.

Since May 2021, our family member has been to the behavioral health unit twice. Each time has been for just a few days to get her stabilized on her meds, and then she returns home, and the cycle repeats. The time at the BHU is not enough time to really get our family member stabilized – I call it a drive through stabilization, because it is just a quick fix band aid to a long-term mental health problem. Her psychiatrist is indifferent to this cycle. Medicaid funds these quick fixes only to have the effort not stick and come unraveled.

Due to living 30 minutes away from any structured supports and limited access to transportation, getting to health care, psychiatric, or any public assistance appointments is hit or miss. The family doesn't have cell phones, a computer, or access to the internet to participate in distance counseling, talk with a case manager, etc. One of the recent trips to the BHU required a long-distance ambulance ride to the hospital because there wasn't a crisis response team or support available in her rural community. Medicaid funded that ambulance ride. And, quite honestly, it will be only a few weeks before the next ride via ambulance will happen. Our family member quickly becomes at risk and the only local intervention that seems to have any impact is when law enforcement steps in to try to help, and then an ambulance is called.

Our family member, due to the diligence of her aunts and uncle, she is back on the DD waiting list and we are navigating the current available mental health waiver to hopefully get her into a group home setting where she can get the needed supports for an extended period of time to get her life back on track. Due to the lack of mental health group homes, trained and paid well workers, and funding, we sit and wait. We hope to hell that nothing tragic happens. It is with some hesitation that we think she will do ok in a group home setting, because right now, what she truly needs is 24/7 supervision in a very structured and safe place for a period of time or at least until she can be stable enough to set some goals and begin working toward those goals. Waiting for a slot in a mental health group home appears to be our only available shot to get into services. Remaining at the family home with her mother is no longer a safe and viable option, yet this is the only option for the time being as we wait for a slot.

Clearly our family member, a person with mental health and prior substance use coupled with impaired intelligence, is in great need right now in just about every aspect of her life! Likely, she will continue to need services across her lifetime but if given the right supports now and along the way, perhaps the intensity and cost to Medicaid down the road will be less.

The Montana HEART Waiver for an 1115 demonstration addresses the following challenges:

- Montana lacks community based mental health treatment and support services including crisis services in rural areas.
- Montana lacks an adequate array of inpatient and residential treatment options for someone like our family member who has several co-occurring issues.
- Montana lacks supports for family members like the mother in our situation who is at her wits end.
- Montana lacks rural transportation and means for distance communication when there isn't a cell phone or internet availability.
- Montana lacks home visiting services for families who specifically experience behavioral health problems.
- Montana lacks adequate service slots across the behavioral health continuum.
- Montana lacks the ability to be flexible and creative in serving individuals with mental health issues especially in rural areas because of limited resources, staffing, and slots. A one size fits all does not work.
- Montana lacks a sustained, trained and well paid work force with to work in positions that require high level skills for dealing with someone like our family member, who "burns people out".

Strengthening Montana's continuum of mental health services is absolutely critical, and the HEART waiver addresses many of these long overdue needs. The behavior health field and the individuals they serve need this waiver to plug some of the holes in the leaky dam, and really move the behavioral health system forward and working like it should for Montanans. Thank you again for the opportunity to comment. I wish the state the very best of luck and success in securing the waiver and getting a quick implementation plan going. Montanans are waiting.
As an advocate for preventing the current revolving door of trauma - addiction - arrest - incarceration – release - relapse - re-arrest, I am strongly in favor of Montana's Medicaid HEART Waiver application. Other states have been making good use of this option for year; Montana is just now catching up. Montana's communities can make good and efficient use of these funds. We cannot imprison our way out of mental illness and substance use disorder.
As a representative of an organization that operates four sober living homes in Billings MT, we are in support of the HEART application to expand behavioral health treatment. We emphasize the need to increase peer-support specialists as part of crisis intervention in addition to out-patient treatment that utilizes long-term peer-support specialists.
Subject Line: [redacted] To Whom It May Concern: My name is [redacted] I wish to submit the following comments in regards to the Heart waiver submission. Montana sorely needs substance abuse disorder SUD services and treatment options that involve mental health and our SDMI waiver. I also wonder if housing tenancy options can be expanded though the Heart Waiver to not only those Montanans who experience SUD issues but those Montanans who experience SDMI mental health diagnosis as well. I ask this because it seems that the Money Follows the Person Program has been working with the Montana Healthcare Foundation on housing issues for those Montanans that are transitioning from nursing homes or state hospitals. I know that the HEART Waiver has some tenancy options within its proposal, which I most definitely support. I am hopeful that these could be expanded. In turn, how is the state of Montana working together to expand our universal design visitable housing stock in the HEART and other waiver systems? Also what is happening with Transportation coordination and DPHHS? How are we supporting transportation coordination efforts in all waivers but especially the HEART waiver? Also, is DPHHS working with State Emergency planners to ensure that accessibility for all in Montana's emergency disaster planning is occurring? Are we as a state coordinating how Medicaid, housing, and other services can be ported in and served in the least restrictive environments? Is Montana coordinating with HUD and CMS to ensure that all HUD vouchers and Medicaid programs which are available to eligible Montanans with disabilities are portable and activated that once a person following not only disasters but also nursing home, jail ,state prison ,and or hospital stays?

D. Documentation of Compliance with Public Notice Process

Montana Newspaper Publications

***** Proof of Publication *****

THE MISSOULIAN
500 S. Higgins Ave.
Missoula, MT 59801

Phone: (406) 523-5236 - Fax: (406) 523-5221

Received
JUL 15 2021
Director's Office
DPHHS

MT DPHHS- Medicaid Analyst
Mary Eve Kulawik
PO Box 4210 111 N. Sanders St. Rom 301
Helena, MT 59204

ORDER NUMBER 56026

Chris Arvish, being first duly sworn, deposes and says that he is a Classified Advertising Representative of THE MISSOULIAN, a newspaper of general circulation published daily in the City of Missoula, in the County of Missoula, State of Montana, and has charge of the Advertisements thereof.

That the legal regarding HEART

a true copy of which is hereto annexed, was published in said newspaper on the dates provided below.

Signed: Chris Arvish
Chris Arvish

Section: Legal
Category: 0703 Legals Government MNAXLP
PUBLISHED ON: 07/08/2021

TOTAL AD COST:	135.00
FILED ON:	7/12/2021

STATE OF MONTANA
County of Missoula

Subscribed & Sworn before me this 13th day of July, 2021 by Chris Arvish.

Barbara L Garrison
Notary Public for the State of Montana

BARBARA L GARRISON
NOTARY PUBLIC for the
State of Montana
Residing at Missoula, MT
My Commission Expires
November 02, 2024.

*** Proof of Publication ***

MONTANA SECTION 1115 HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART) DEMONSTRATION APPLICATION
Abbreviated Public Notice – July 8, 2021

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DPHHS is requesting a Section 1115 Demonstration to build upon the strides made by the state over the last decade to establish a comprehensive continuum of behavioral health—mental health and SUD—services for its Medicaid members. This Demonstration is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through Governor Gianforte's Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative. The HEART Initiative, included in the recently passed H.B. 701, will invest significant state and federal funding to expand the state's behavioral health continuum. The demonstration will support the state's broader efforts to strengthen its evidence-based behavioral health continuum of care for individuals with SUD, SMI and SED; enable prevention and earlier identification of behavioral health issues; and monitor the quality of care delivered to members with behavioral health needs across outpatient, residential and inpatient settings through improved data collection and reporting.

This Demonstration seeks to expand access to and improve transitions of care across inpatient, residential, and community-based treatment and recovery services for individuals with SUD, SMI and SED by adding services to support successful community living, increasing access to intensive community treatment models and obtaining coverage for short-term stays delivered to individuals residing in IMDs. This Demonstration will also enable the state to provide additional resources to help the state combat SUD-related overdoses and suicides, and complement its efforts to build out a robust and integrated behavioral health delivery system.

Approval of this Demonstration will assist Montana in addressing its serious public health crisis in substance use disorders—including alcohol abuse, methamphetamine use, and opioid abuse and overdose—as well as surging mental health needs among state residents. The goals and objectives of the demonstration are described in more detail below.

Summary of Proposed Waiver Features
Montana is seeking:
• To add new Medicaid services under this Demonstration as part of its commitment to ensuring that Medicaid members have access to a full continuum of behavioral health services including:
• Evidence-based stimulant use disorder treatment models, including contingency management;
• Tenancy support; and
• Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.
• Expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs obtaining treatment for SUD, SMI and SED.

All children ages 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan or Medicaid 1115 waivers, as well as children aged 18 eligible for the CHIP program, will be included in this Demonstration.

There are no proposed changes to the Medicaid delivery system as part of this application. Montana plans to continue using a fee-for-service delivery system for all Medicaid services, including behavioral health services.

Public Meetings and Comment Process
The full public notice statement and complete version of the draft of the Demonstration application are available for public review at: http://dphhs.mt.gov/heartwaiver. Paper copies are available to be picked up in person at the DPHHS Director's Office located at 111 North Sanders Street, Room 301, Helena, Montana 59601.

Two virtual public meetings will be held regarding the Demonstration application:
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To register for one or both meetings, use the following link: http://dphhs.mt.gov/heartwaiver. You will receive instructions for joining the meeting upon registration. If special accommodations are needed, contact Mary Eve Kulawik at (406) 444-2584.
Public comments may be submitted until 11:59 pm on September 7. Questions or public comments may be addressed care of Medicaid HEART Waiver, Department of Public Health and Human Services, Director's Office, PO Box 4210, Helena, MT 59604-4210, or by

*** Proof of Publication ***

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*** Proof of Publication ***

THE BILLINGS GAZETTE
401 N 28th St
Billings, MT 59101
Ph: (406) 657-1212 Fax: (406) 657-1345

Received
JUL 12 2021
Director's Office
DPHHS

MT DPHHS- Medicaid Analyst
Mary Eve Kulawik
PO Box 4210 111 N. Sanders St. Rom 301
Helena, MT 59204

ORDER NUMBER 56027

The undersigned, being duly sworn, deposes and says. That she is the principal clerk of The Billings Gazette, a newspaper of general circulation published daily in the City of Billings, in the County of Yellowstone, State of Montana, and has charge of the Advertisements thereof.

Mark below if certification for the State of Montana
X I hereby certify that I have read sec. 18-7-204 and 18-7-205, MCA, and subsequent revisions, and declare that the price or rate charged the State of Montana for the publication for which claim is made in printed copy in the amount of $130.00 is not in excess of the minimum rate charged any other advertiser for publication of advertisement, set in the same size type and published for the same number of insertions; further certify that this claim is correct and just in all respects, and that payment or credit has not been received.

Jessica Bledsoe

STATE OF MONTANA
County of Yellowstone

On this day of July 8, 2021 before me, the undersigned, a Notary Public for the State of Montana, personally appeared Jessica Bledsoe known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed same. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal the day and year first above written.

Section: Legal
Category: 0750 LEGAL NOTICES MNAXLP
PUBLISHED ON: 07/08/2021

TOTAL AD COST:	130.00
FILED ON:	7/8/2021

Tammy Ward
NOTARY PUBLIC for the State of Montana
Residing at Billings, MT

My commission expires: June 25, 2023

TAMMY WARD NOTARIAL SEAL STATE OF MONTANA
TAMMY WARD
NOTARY PUBLIC for the
State of Montana
Residing at Billings, Montana
My Commission Expires
June 25, 2023

*** Proof of Publication ***

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*** Proof of Publication ***

continuum of behavioral health services including:
o Evidence-based stimulant use disorder treatment models, including contingency management;
o Tenancy support; and
o Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release.
• Expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs obtaining treatment for SUD, SMI and SED.

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*** Proof of Publication ***

HELENA INDEPENDENT RECORD
2222 Washington St
Helena, MT 59602
Ph: (406) 447-4000

MT DPHHS- Medicaid Analyst
Mary Eve Kulawik
PO Box 4210 111 N. Sanders St. Rom 301
Helena, MT 59204

ORDER NUMBER 56457

The undersigned, being duly sworn, deposes and says. That she is the principal clerk of The HELENA INDEPENDENT RECORD, a newspaper of general circulation published daily in the City of Helena, in the County of Lewis & Clark, State of Montana, and has charge of the advertisements thereof:
That the Public Notice
a true copy of which is printed, was published in said newspaper for the same number of insertions provided below.

July 8, 2021

STATE OF MONTANA
County of Lewis & Clark

Subscribed and sworn to me this 14th day of July, 2021

Section: Legal
Category: 0701 Legals Helena
PUBLISHED ON: 07/08/2021

TOTAL AD COST:	130.00
FILED ON:	7/14/2021

Billie Jo Williams

NOTARY PUBLIC for the State of Montana
Printed Name: Billie Jo Williams
Residing at Clancy, Montana 59634
My commission expires August 31, 2022

(Notary Seal)

BILLIE JO WILLIAMS
NOTARY PUBLIC for the
State of Montana
Residing at Clancy, Montana
My Commission Expires
August 31, 2022

*** Proof of Publication ***

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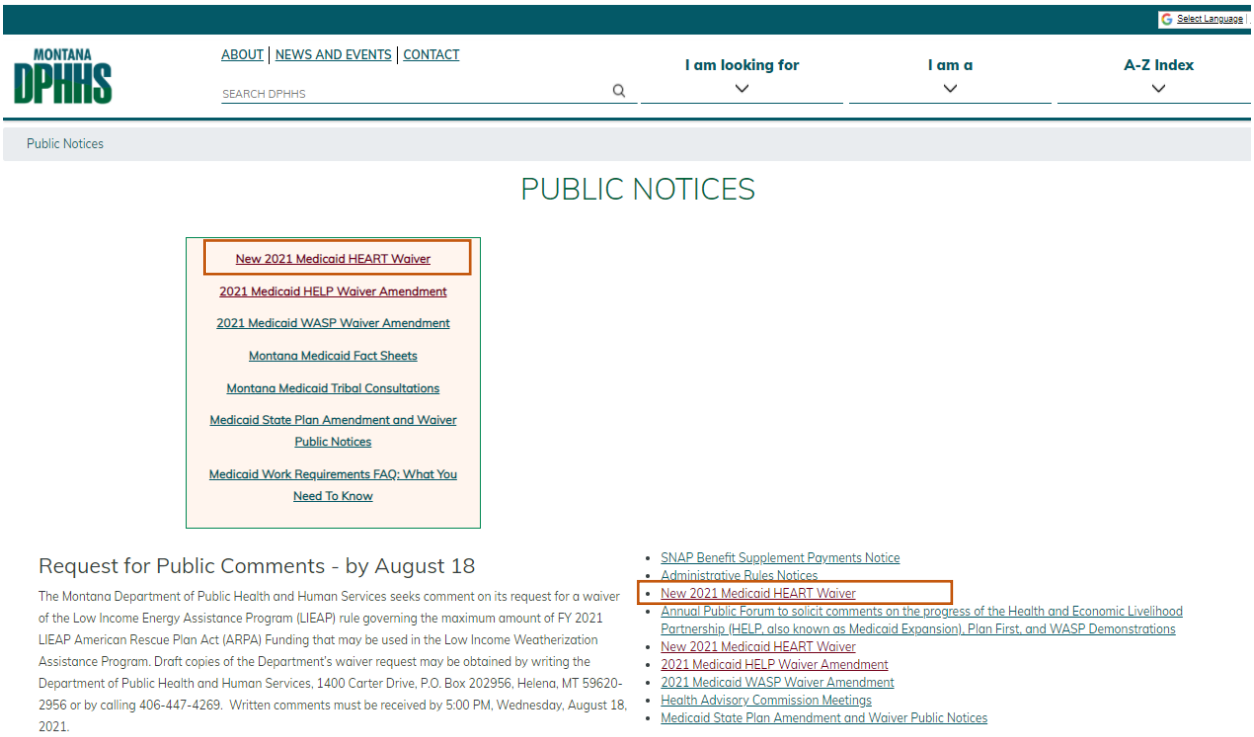
July 8, 2021. **MNAXLP.**

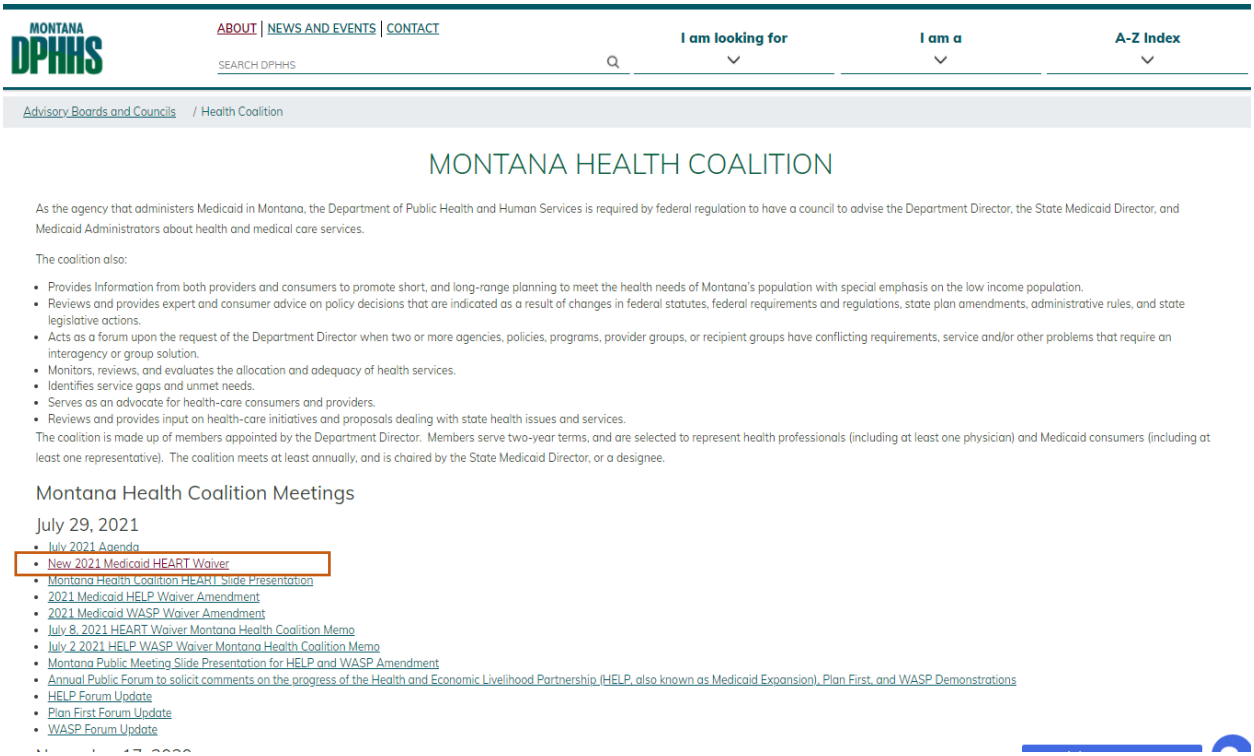
DPHHS Website

LINK: https://dphhs.mt.gov/PublicNotices



Montana Health Coalition Website

LINK: https://dphhs.mt.gov/boardscouncils/healthcoalition



MONTANA DPHHS

ABOUT | NEWS AND EVENTS | CONTACT

SEARCH DPHHS

I am looking for | I am a | A-Z Index

Advisory Boards and Councils / Health Coalition

MONTANA HEALTH COALITION

As the agency that administers Medicaid in Montana, the Department of Public Health and Human Services is required by federal regulation to have a council to advise the Department Director, the State Medicaid Director, and Medicaid Administrators about health and medical care services.

The coalition also:

- Provides Information from both providers and consumers to promote short, and long-range planning to meet the health needs of Montana's population with special emphasis on the low income population.
- Reviews and provides expert and consumer advice on policy decisions that are indicated as a result of changes in federal statutes, federal requirements and regulations, state plan amendments, administrative rules, and state legislative actions.
- Acts as a forum upon the request of the Department Director when two or more agencies, policies, programs, provider groups, or recipient groups have conflicting requirements, service and/or other problems that require an interagency or group solution.
- Monitors, reviews, and evaluates the allocation and adequacy of health services.
- Identifies service gaps and unmet needs.
- Serves as an advocate for health-care consumers and providers.
- Reviews and provides input on health-care initiatives and proposals dealing with state health issues and services.

The coalition is made up of members appointed by the Department Director. Members serve two-year terms, and are selected to represent health professionals (including at least one physician) and Medicaid consumers (including at least one representative). The coalition meets at least annually, and is chaired by the State Medicaid Director, or a designee.

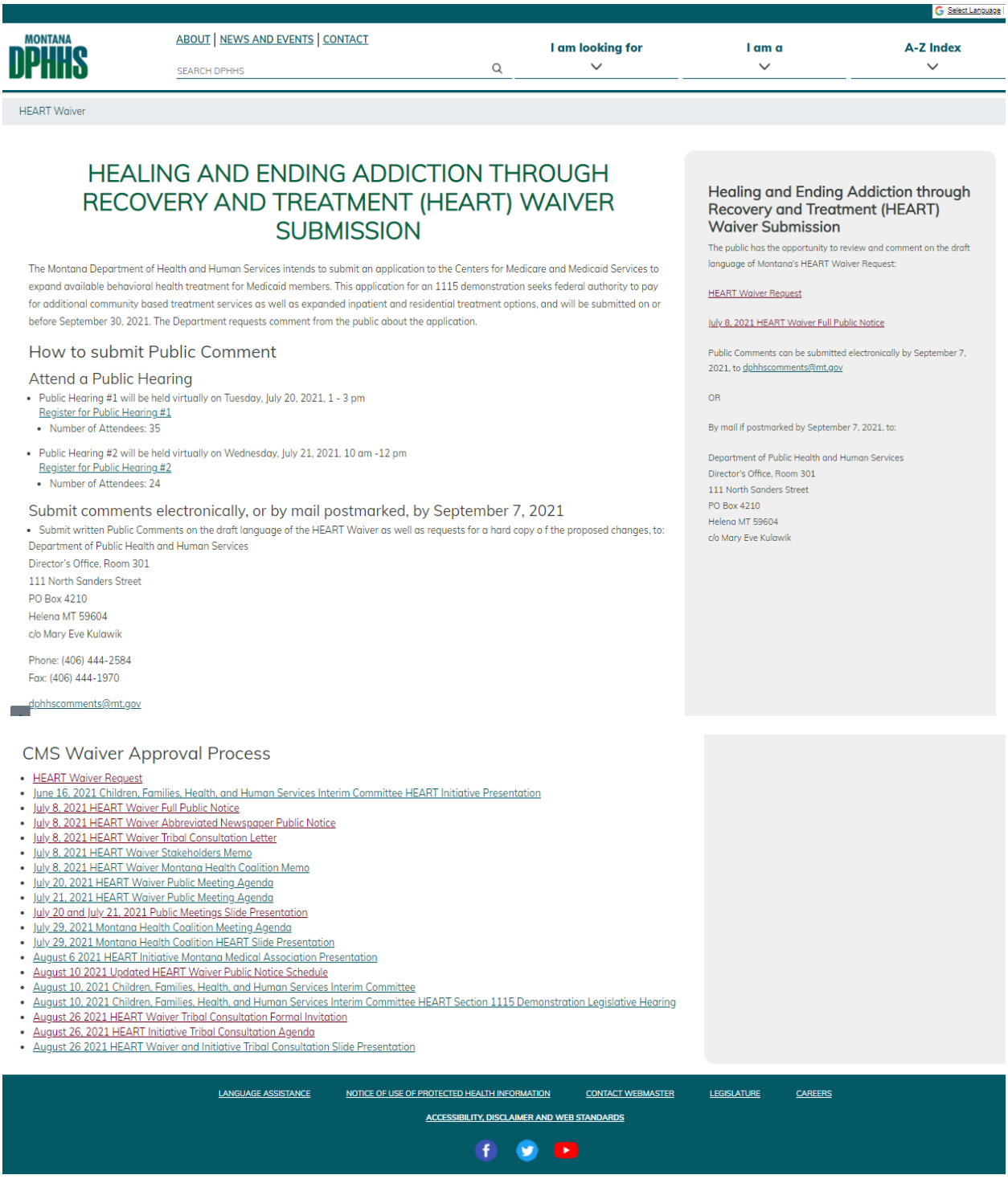
Montana Health Coalition Meetings

July 29, 2021

- July 2021 Agenda
- New 2021 Medicaid HEART Waiver
- Montana Health Coalition HEART Slide Presentation
- 2021 Medicaid HELP Waiver Amendment
- 2021 Medicaid WASP Waiver Amendment
- July 8, 2021 HEART Waiver Montana Health Coalition Memo
- July 2 2021 HELP WASP Waiver Montana Health Coalition Memo
- Montana Public Meeting Slide Presentation for HELP and WASP Amendment
- Annual Public Forum to solicit comments on the progress of the Health and Economic Livelihood Partnership (HELP, also known as Medicaid Expansion), Plan First, and WASP Demonstrations
- HELP Forum Update
- Plan First Forum Update
- WASP Forum Update

1115 HEART Website

LINK: https://dphhs.mt.gov/heartwaiver



Select Language

MONTANA DPHHS

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HEART Waiver

HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART) WAIVER SUBMISSION

The Montana Department of Health and Human Services intends to submit an application to the Centers for Medicare and Medicaid Services to expand available behavioral health treatment for Medicaid members. This application for an 1115 demonstration seeks federal authority to pay for additional community based treatment services as well as expanded inpatient and residential treatment options, and will be submitted on or before September 30, 2021. The Department requests comment from the public about the application.

How to submit Public Comment

Attend a Public Hearing

- Public Hearing #1 will be held virtually on Tuesday, July 20, 2021, 1 - 3 pm
  Register for Public Hearing #1
  - Number of Attendees: 35
- Public Hearing #2 will be held virtually on Wednesday, July 21, 2021, 10 am -12 pm
  Register for Public Hearing #2
  - Number of Attendees: 24

Submit comments electronically, or by mail postmarked, by September 7, 2021

- Submit written Public Comments on the draft language of the HEART Waiver as well as requests for a hard copy o f the proposed changes, to:

Department of Public Health and Human Services
Director's Office, Room 301
111 North Sanders Street
PO Box 4210
Helena MT 59604
c/o Mary Eve Kulawik

Phone: (406) 444-2584
Fax: (406) 444-1970

dphhscomments@mt.gov

Healing and Ending Addiction through Recovery and Treatment (HEART) Waiver Submission

The public has the opportunity to review and comment on the draft language of Montana's HEART Waiver Request:

HEART Waiver Request

July 8, 2021 HEART Waiver Full Public Notice

Public Comments can be submitted electronically by September 7, 2021, to dphhscomments@mt.gov

OR

By mail if postmarked by September 7, 2021, to:

Department of Public Health and Human Services
Director's Office, Room 301
111 North Sanders Street
PO Box 4210
Helena MT 59604
c/o Mary Eve Kulawik

CMS Waiver Approval Process

- HEART Waiver Request
- June 16, 2021 Children, Families, Health, and Human Services Interim Committee HEART Initiative Presentation
- July 8, 2021 HEART Waiver Full Public Notice
- July 8, 2021 HEART Waiver Abbreviated Newspaper Public Notice
- July 8, 2021 HEART Waiver Tribal Consultation Letter
- July 8, 2021 HEART Waiver Stakeholders Memo
- July 8, 2021 HEART Waiver Montana Health Coalition Memo
- July 20, 2021 HEART Waiver Public Meeting Agenda
- July 21, 2021 HEART Waiver Public Meeting Agenda
- July 20 and July 21, 2021 Public Meetings Slide Presentation
- July 29, 2021 Montana Health Coalition Meeting Agenda
- July 29, 2021 Montana Health Coalition HEART Slide Presentation
- August 6 2021 HEART Initiative Montana Medical Association Presentation
- August 10 2021 Updated HEART Waiver Public Notice Schedule
- August 10, 2021 Children, Families, Health, and Human Services Interim Committee
- August 10, 2021 Children, Families, Health, and Human Services Interim Committee HEART Section 1115 Demonstration Legislative Hearing
- August 26 2021 HEART Waiver Tribal Consultation Formal Invitation
- August 26, 2021 HEART Initiative Tribal Consultation Agenda
- August 26 2021 HEART Waiver and Initiative Tribal Consultation Slide Presentation

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E. Montana Substance Use Disorder Plan Protocol

State of Montana

Department of Public Health and Human Services

Montana Substance Use Disorder Plan Protocol

October 2021

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Montana Department of Public Health and Human Services
Substance Use Disorder Plan Protocol

Introduction

Similar to all other states in the country, Montana has been working to address a persistent and shifting substance use disorder (SUD) crisis that impacts individuals and families throughout the state. The state's opioid-related overdose deaths have remained relatively steady over the past few years compared to those of other states due to the state's coordinated efforts to address the SUD crisis. Since 2016, the state has created strong partnerships between local, tribal, and state health and justice partners. The state has also expanded access to evidence-based treatment and recovery services while promoting harm reduction and appropriate justice system diversion.

Montana's Department of Public Health and Human Services (DPHHS) is seeking federal authority to build upon the strides made by the state over the past decade to establish a comprehensive continuum of behavioral health—mental health and SUD—services for its Medicaid-enrolled residents that will complement the state's comprehensive strategy to expand access to behavioral health treatment for Medicaid members. DPHHS is pursuing a joint Section 1115 SUD and serious mental illness (SMI)/serious emotional disturbance (SED) demonstration to strengthen its behavioral health delivery system, specifically, by:

- Expanding its SUD benefits to offer additional residential treatment and withdrawal management services, contingency management as part of a comprehensive treatment model for individuals with stimulant disorder, and tenancy support services;
- Providing targeted Medicaid services to eligible inmates of state prisons with SUD, SMI, or SED in the 30 days prior to their release into the community;
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services;
- Building SUD provider capacity; and
- Strengthening care coordination and care management for individuals with SUD.

The following implementation plan details Montana's approach for meeting the six milestones identified by the Centers for Medicare & Medicaid Services (CMS) as a condition of obtaining a waiver of the IMD exclusion for SUD services.

Milestone 1: Access to Critical Levels of Care for SUD

Montana's Medicaid State Plan covers a wide range of SUD services for Medicaid beneficiaries across outpatient, residential and inpatient care settings. Montana's Medicaid program currently covers many services along the American Society of Addiction Medicine (ASAM) continuum of care, and the state seeks to expand its coverage of the ASAM continuum by adding 3.3 (clinically managed population-specific high-intensity residential programs), 3.2-WM (clinically managed residential withdrawal management), and a bundled rate for 3.1 (clinically managed low-intensity residential) to its State Plan and expanding 0.5 (early intervention). The table below provides an overview of Montana Medicaid coverage for each ASAM level of care, proposed changes, and a summary of actions needed to implement the changes.

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
0.5	Early Intervention	Montana Medicaid covered services include Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT involves the use of a structured screening to determine risk factors related to substance use, a brief intervention and possible referral for treatment. Services can be provided by an LAC or LAC licensure candidate, a physician, or a midlevel provider. *Additional coverage and billing details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 125: Screening, Brief Intervention,*	Currently covered for all.	Will include targeted services for youth who are at risk of developing substance-related problems, or a service for those for whom there is not yet sufficient information to document a diagnosable substance use disorder. Providers will also include physicians and other practitioners, including LAC candidates, LCPCs, LCSWs, LMFTs, and paraprofessionals supervised by	• Promulgate Administrative Rule to revise provider manual to add targeted services for youth and expanded providers. Date: Effective July 1, 2022 • Promulgate ASAM Licensure rules. Date: Effective July 1, 2022 • Amend Other Rehabilitation SPA. Date: Effective July 1, 2022 • Enroll providers to offer new services. Date: Ongoing

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
		and Referral to Treatment (SBIRT), located here.		licensed professionals.	
1	Outpatient Services	Medicaid-funded outpatient SUD therapy services include recovery or motivational enhancement therapies/strategies. Services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided. *Additional coverage and billing details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 520: SUD Outpatient (OP) Therapy (ASAM 1.0) Adult and Adolescent, located here.*	Currently covered for all beneficiaries meeting medical necessity criteria.	No change expected.	N/A
2.1	SUD Intensive Outpatient Services	Montana Medicaid intensive outpatient services are covered as a bundled service package which includes individual, group, and family therapy; educational groups; psychosocial rehabilitation; co-occurring mental health; face-to-face crisis services; and face-to-face care coordination. Intensive	Currently covered for all beneficiaries meeting medical necessity criteria.	No change expected.	N/A

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
		outpatient programs are provided to Medicaid beneficiaries for nine or more hours of structured programming per week (adults) or six or more hours per week (adolescents) to treat multi-dimensional instability. *Additional coverage and billing details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 525: SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1) Adult and Adolescent, located here.*			
2.5	Partial Hospitalization Services	Montana Medicaid partial hospitalization services are covered as a bundled service package that includes individual, group, and family therapy, and psychosocial rehabilitation. Partial hospitalization services include therapeutic and behavioral interventions to address SUD in the structured setting and improve the member's successful functioning in the home, school, and/or community setting. Partial	Currently covered for all beneficiaries meeting medical necessity criteria.	No change expected.	N/A

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
		hospitalization includes a minimum of 20 hours of skilled treatment services per week and is provided in a setting that complies with licensure rule and has direct access to psychiatric, medical, and laboratory services on-site. *Additional coverage and billing details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 530: SUD Partial Hospitalization (ASAM 2.5) Adult and Adolescent, located here.*			
3.1	SUD Clinically Managed Low-Intensity Residential	SUD clinically managed low-intensity residential services are provided in a residential home that functions as a supportive, structured living environment. Members are provided stability and skills building to help prevent or minimize continued substance use. SUD treatment services are provided on-site or off-site. This service includes a minimum of five hours per week of professionally directed treatment services. Montana	Currently covered for all beneficiaries meeting medical necessity criteria but not billed as a bundle.	Creation of a bundled rate to be consistent with other ASAM LOC.	• Promulgate Administrative Rule to revise provider manual. Date: Effective July 1, 2022 • Promulgate ASAM Licensure rules. Date: Effective July 1, 2022 • Promulgate rule to add bundled rate to fee schedule.

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
		Medicaid covered services include individual, group, and family therapy; targeted case management; and certified peer support services. Peer supports will be billable outside of the bundled rate. *Additional coverage and billing details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 535: SUD Clinically Managed Low-Intensity Residential (ASAM 3.1) Adult and Adolescent, located here.*			Date: Effective July 1, 2022 • Amend Other Rehabilitation SPA. Date: Effective July 1, 2022
3.3	Clinically Managed Population-Specific High-Intensity Residential Programs	Clinically managed high-intensity SUD residential services are geared toward adults with cognitive impairments, including developmental delays, and are provided in a structured residential treatment environment with daily clinical services provided at a pace to accommodate cognitive impairments.	No coverage.	Will be covered for all adult enrollees meeting medical necessity criteria.	• Promulgate Administrative Rule to revise provider manual. Date: Effective July 1, 2022 • Promulgate rule to add bundled rate to fee schedule. Date: Effective July 1, 2022 • Promulgate ASAM Licensure rules. Date: Effective July 1, 2022

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
					• Promulgate rule to implement bundled rate. Effective July 1, 2022 • Amend Other Rehabilitation SPA. Date: Effective July 1, 2022
3.5	SUD Clinically Managed High-Intensity Residential Services	Montana Medicaid clinically managed residential treatment programs provide 24-hour structured residential treatment. This service is covered as a bundled service package based on staffing that includes individual, group, and family therapy, and psychosocial rehabilitation. *Additional coverage and billing details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 540: SUD Clinically Managed High-Intensity Residential (ASAM 3.5) Adult and SUD Clinically Managed Medium-Intensity*	Currently covered for all enrollees meeting medical necessity criteria.	Update ASAM Licensure rules to align with ASAM.	• Promulgate Administrative Rule to revise provider manual. Date: Effective July 1, 2022 • Promulgate rule to add bundled rate to fee schedule. Date: Effective July 1, 2022 • Promulgate ASAM Licensure rules. Date: Effective July 1, 2022 • Promulgate rule to implement bundled rate. Date: Effective July 1, 2022 • Amend Other Rehabilitation SPA.

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
		Residential (ASAM 3.5) Adolescent, located here.			Date: Effective July 1, 2022
3.7	SUD Medically Monitored Intensive Inpatient Services	Beneficiaries receiving this level of care are provided a planned regimen of 24-hour professionally directed evaluation, observation, medical management/monitoring, and SUD treatment. This service is covered as a bundled service package based on staffing that includes individual, group, and family therapy; nurse intervention and monitoring; and psychosocial rehabilitation. *Additional coverage and billing details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 545: SUD Medically Monitored Intensive Inpatient (ASAM 3.7) Adult and AUD Medically Monitored High-Intensity Inpatient (ASAM 3.7) Adolescent, located here.*	Currently covered for adult enrollees meeting medical necessity criteria.	Update ASAM Licensure rules to align with ASAM.	• Promulgate Administrative Rule to revise provider manual. Date: Effective July 1, 2022 • Promulgate rule to add bundled rate to fee schedule. Date: Effective July 1, 2022 • Promulgate ASAM Licensure rules. Date: Effective July 1, 2022 • Amend Other Rehabilitation SPA. Date: Effective July 1, 2022
4.0	Medically Managed	DPHHS currently covers medically managed intensive inpatient services with 24-hour	Covered for all enrollees meeting medical	Allow accredited hospitals with verification of	• Promulgate Administrative

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
	Intensive Inpatient Services	nursing care and daily physician care. This level of care is clinically appropriate for individuals presenting with severe, unstable problems in ASAM dimension beyond medical monitoring that require the full resources of the hospital: (1) acute intoxication and/or withdrawal potential; (2) biomedical conditions and complications; or (3) emotional, behavioral, or cognitive conditions and complications.	necessity criteria.	adherence to federal regulations to become state approved for ASAM 4.0 services.	Rule to revise state approval rules. Date: Effective July 1, 2022
MAT	Medication-Assisted Treatment (MAT)	MAT is the use of medications approved by the US Food and Drug Administration (FDA), in combination with behavioral therapies and support services, to provide a whole-patient, patient-centered approach to the treatment of alcohol and opioid use disorders. MAT is currently provided to Montana Medicaid beneficiaries by opioid treatment programs (OTPs) and office-based opioid treatment (OBOT) providers. *Additional coverage and billing details can be found in the*	Currently covered for all enrollees meeting medical necessity criteria.	Consistent with the SUPPORT Act requirements, DPHHS has submitted a MAT SPA to CMS that includes the FDA-approved medications for opioid use disorder, counseling services, and behavioral therapy. To complement these efforts, DPHHS is in the process of creating a new MAT Medicaid provider	• Promulgate rule to add bundled rate to fee schedule. Date: Effective April 1, 2022

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
		Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 550: Medication Assisted Treatment, located here.		type, which will include OBOTs and OTPs. DPHHS is adding care coordination to the MAT bundle.	
3.2-WM	Clinically managed residential withdrawal (residential withdrawal management)	An organized, clinically managed residential withdrawal management service for individuals who are experiencing moderate withdrawal symptoms and who require 24-hour supervision, observation, and support; uses physician-approved protocols to identify individuals who require medical services beyond the capacity of the facility and to transfer these individuals to the appropriate levels of care.	No coverage.	Will be covered for all beneficiaries meeting medical necessity criteria.	• Promulgate Administrative Rule to revise provider manual. Date: Effective July 1, 2022 • Promulgate rule to add bundled rate to fee schedule. Date: Effective July 1, 2022 • Promulgate ASAM Licensure rules. Date: Effective July 1, 2022 • Promulgate rule to implement bundled rate. Effective July 1, 2022 • Amend Other Rehabilitation SPA. Date: Effective July 1, 2022

ASAM Level of Care	Service Title	Description	Current Coverage	Future Coverage	Summary of Action Items Needed
3.7-WM	Medically monitored inpatient withdrawal management	An organized, medically monitored inpatient withdrawal management service under the supervision of a physician that provides 24-hour observation, monitoring, and treatment for individuals who are experiencing severe withdrawal symptoms and require 24-hour nursing care.	Provided by licensed ASAM level 3.7 residential treatment providers.	No change.	N/A
4-WM	Medically managed intensive inpatient withdrawal (hospital-based behavioral health services)	An organized, medically managed inpatient service under the supervision of a physician that provides 24-hour, medically directed evaluation and withdrawal management for individuals who are experiencing severe, unstable withdrawal and require an acute care setting.	Covered for all Medicaid beneficiaries meeting medical necessity criteria by inpatient hospitals.	No change.	• Promulgate Administrative Rule to revise state approval rules. Date: Effective July 1, 2022

Summary of Actions Needed Across Milestone

Action	Timeline
Promulgate Administrative Rule to revise provider manual and state approval rules	Effective July 1, 2022
Amend Other Rehabilitation SPA	Effective July 1, 2022
Promulgate ASAM Licensure rules	Effective July 1, 2022

Milestone 2: Use of Evidence-Based SUD-Specific Patient Placement Criteria

Montana has robust, evidence-based policies in place to ensure that enrollees have access to appropriate SUD services according to their diagnosis and ASAM level-of-care determination. Over the course of the 1115 demonstration, Montana will strengthen its assessment policy, which is a prerequisite for obtaining most SUD services, by working to secure access to ASAM CONTINUUM, the ASAM Criteria decision engine support tool and providing additional training on the ASAM Criteria for its SUD providers.

Provider/Patient Assessments

Current State
Montana Medicaid requires each Medicaid member receiving SUD treatment to have a current comprehensive assessment. The comprehensive assessment must be conducted by an appropriately licensed clinical mental health professional or licensed addictions counselor trained in clinical assessments and operating within the scope of practice of their respective license and be organized according to the six dimensions of the ASAM Criteria.

The assessment must include the following information in order to substantiate the member's diagnosis and provide sufficient detail to individualize the member's treatment plan goals and objectives:

- Presenting problem and history of problems;
- Family history *(including substance use, medical, psychiatric, religious/spiritual, and social history);*
- Developmental history *(including pregnancy, developmental milestones, and temperament)*;
- Substance use and addictive behavior history;
- Personal/social history *(including school, work, peers, leisure activities, sexual activity, abuse, disruption of relationships, military service, financial resources, living arrangements, and religious/spiritual beliefs)*;
- Legal history relevant to history of mental illness, substance use, and addictive behaviors *(including guardianships, civil commitments, criminal mental health commitments, current criminal justice involvement, and prior criminal background)*;
- Psychiatric history *(including psychological symptoms, cognitive issues, and behavioral complications)*;
- Medical history *(including current and past problems, treatment, and medications)*;

- Mental status examination *(including memory and risk factors such as suicidal or homicidal ideation)*;
- Physical examination *(specifically focused on physical manifestations of withdrawal symptoms or chronic illnesses)*;
- Diagnosis *(diagnostic interview and impressions)*;
- Survey of strengths, skills, and resources; and
- Treatment recommendations.

Future State
To further strengthen use of the ASAM multi-dimensional patient assessment, Montana is in the process of taking necessary steps to select and procure a multi-dimensional assessment tool for patient placement for its SUD providers. Use of the tool will help standardize assessments and better support providers throughout the assessment process. Montana will also provide and require all providers administering SUD assessments to obtain training in the ASAM Criteria.

Summary of Actions Needed
- Revise assessment policy and administrative rules to require that licensed providers providing SUD services or assessments document their training with respect to the ASAM Criteria: July 2022
- Conduct ASAM trainings through vendor(s) and other partnering entities: Ongoing
- Montana will continue to work with the vendor and complete an analysis of the current environment; identify necessary stakeholders, determinate requirements, and specifications toward implementation; and take steps for implementation of a standardized assessment: July 2022

Utilization Management

Current State
Montana Medicaid providers must use the Mountain-Pacific Quality Health Utilization Management Portal, Telligen, to request prior and continuing stay authorization for SUD services when authorization is required. Prior authorization may be issued for as many days as deemed medically necessary up to the maximum number of days allowed for the service. Additional prior authorization procedure requirement details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 205: Requesting Prior Authorization – Non-Acute Services, located here. Additional continued stay details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 210: Requesting a Continued Stay Review – Non-Acute Services, located here.

In addition, Montana Medicaid providers may implement an auto-authorization process for acute psychiatric hospitalizations (out of state), SUD medically monitored intensive inpatient (ASAM 3.7), and the crisis stabilization program. Additional auto-authorization details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 206: Requesting Auto-Authorization – Acute Services, located here.

Medicaid clinical coverage policies:

- **ASAM Level 1: SUD Outpatient Therapy.** Prior authorization and continued stay review are not required. The provider must document the medical necessity criteria the member meets in their file.
- **ASAM Level 2.1: SUD Intensive Outpatient Therapy (IOP).** Prior authorization is not required. Continued stay review is required for the IOP bundle after the first 60 billable days for up to 15 billable days. Continued stay review is not required if the provider is not billing the IOP bundled rate. Member must continue to meet the SUD criteria as described in this manual and meet the ASAM Criteria diagnostic and dimensional admission criteria for SUD IOP Services (ASAM 2.1) Adult and Adolescent level of care.
- **ASAM Level 2.5: Partial Hospitalization.** Prior authorization and continued stay review are not required. Member must continue to meet the SUD criteria as described in this manual and meet the ASAM Criteria diagnostic and dimensional admission criteria for SUD Partial Hospitalization (ASAM 2.5) Adult and Adolescent level of care.
- **ASAM Level 3.1: SUD Clinically Managed Low-Intensity Residential.** Prior authorization is required and may be issued for as many days as deemed medically necessary up to 90 days. Continued stay review is required for up to 30 days. Member must continue to meet the SUD criteria as described in this manual with a severity specifier of moderate or severe and meet the ASAM Criteria diagnostic and dimensional admission criteria for SUD Clinically Managed Low-Intensity Residential (ASAM 3.1) level of care.
- **ASAM Level 3.5: SUD Clinically Managed High-Intensity Residential.** Prior authorization is required and may be issued for as many days as deemed medically necessary up to 21 days. Continued stay review is required for up to five days. Member must continue to meet the SUD criteria as described in this manual with a severity specifier of moderate or severe and meet the ASAM Criteria diagnostic and dimensional admission criteria for SUD Clinically Managed High-Intensity Residential (ASAM 3.5) level of care.
- **ASAM Level 3.7: Medically Monitored Intensive Inpatient.** Prior authorization is required and may be submitted via auto-authorization. The initial three days are automatically authorized. The ASAM 3.7 prior authorization form must be submitted within three calendar days of admission. Continued stay review is required after the first three days of service. Member must continue to meet the SUD criteria as described in this manual with a severity specifier of moderate or severe and meet the ASAM Criteria diagnostic and dimensional admission criteria for ASAM 3.7 level of care.

Future State

For newly added SUD services—ASAM 3.3: Clinically managed population-specific high-intensity residential services, and ASAM 3.2-WM: Clinically managed residential withdrawal—the Department will establish prior authorization and utilization management requirements consistent with ASAM standards of care to ensure the appropriateness of patient placement. The clinical coverage policies for these new services will include these prior authorization and utilization management requirements.

Summary of Actions Needed

- Promulgate Administrative Rule to revise provider manual: Effective July 1, 2022
- Promulgate Administrative Rules to add levels of care to Quality Assurance Division (QAD) licensure rules: Effective July 1, 2022
- Amend Other Rehabilitation SPA: Effective July 1, 2022

Summary of Actions Needed Across Milestone

Action	Timeline
Promulgate Administrative Rules to add levels of care to QAD licensure rules and require licensed providers providing SUD services or assessments to document their training with respect to the ASAM Criteria	Effective July 1, 2022
Promulgate Administrative Rule to revise provider manual	Effective July 1, 2022
Amend Other Rehabilitation SPA	Effective July 1, 2022
Conduct ASAM trainings through vendor(s) and other partnering entities	Ongoing
Work with the vendor and complete an analysis of the current environment; identify necessary stakeholders, determinate requirements, and specifications toward implementation; and take steps for implementation of a standardized assessment	Effective July 1, 2022

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

DPHHS' QAD licenses SUD residential facilities. DPHHS monitors outpatient SUD providers using a state-approved list that is separate from licensure requirements. The current licensure rules for SUD residential providers include standards regarding the services that must be offered, program hours, and staff credentials. Today, the degree of alignment between licensure rules for SUD providers and the ASAM Criteria varies across provider types. DPHHS, through cross-division collaboration, is in the process of updating its licensure rules for SUD providers to align with the ASAM Criteria. DPHHS is also working to ensure that residential treatment providers either provide medication-assisted treatment (MAT) on-site or facilitate access to off-site MAT providers within a specified distance, and do not deny admission to individuals obtaining MAT. The Department will also conduct more robust monitoring of SUD treatment providers to ensure compliance with the ASAM Criteria.

Provider Licensure

Current State
Today, QAD's Licensing Bureau licenses and regulates non-acute residential facilities pursuant to Title 50. Chapter 5. Hospital and Related Facilities of the Montana Code. Requirements are codified in Administrative Rules of Montana, Title 37, Chapter 106, subchapter 14. The licensure rules for SUD residential treatment providers were based in part on the ASAM Criteria, but have not been updated to align with the most current edition of the criteria.

The licensing standards for covered residential services are located here.

Future State

QAD in collaboration with Montana Medicaid is in the process of updating its licensure rules for SUD residential treatment providers to align its provider qualifications with the ASAM Criteria. QAD is also preparing to expand the SUD provider types it licenses to include intensive outpatient providers and align those requirements with the ASAM Criteria. DPHHS will continue to monitor SUD outpatient providers through the state approval process rather than licensure rules. When developing licensure rules for new services or new populations that will be able to access a service (e.g., adolescents), QAD will ensure that they reflect ASAM's specifications regarding service definitions, hours of clinical care provided, and program staff credentialing.

Specifically, QAD is proposing new licensure rules that align with the ASAM Criteria for the following services:

- ASAM 2.1 – Intensive Substance Use Disorder Facility;
- ASAM 2.5 – Partial Hospitalization Substance Use Disorder Facility; and
- ASAM 3.3 – Clinically Managed Population-Specific High-Intensity Residential (Adult Only) Substance Use Disorder Facility

In addition, QAD is revising its current licensure rules to align with the ASAM Criteria for the following services:

- ASAM 3.1 – Clinically Managed Low-Intensity Residential (Adult or Adolescent) Substance Use Disorder Facility;
- ASAM 3.5 – Clinically Managed High-Intensity Residential (Adult)/Medium-Intensity Residential (Adolescent) Substance Use Disorder Facility Requirements;
- ASAM 3.7 – Medically Monitored Intensive Inpatient Services;
- ASAM 3.2 WM – Clinically Managed Residential Withdrawal Management Services; and
- ASAM 3.7 WM – Medically Monitored Withdrawal Management Services.

Summary of Actions Needed

- Promulgate ASAM Licensure rules: Effective July 1, 2022
- Promulgate updated/revised state approval rules: Effective July 1, 2022

Monitoring of SUD Treatment Providers

Current State

To ensure that high-quality SUD treatment services are delivered in accordance with state licensure rules, QAD regularly monitors SUD residential treatment providers. QAD's monitoring of residential providers includes surveys every one to three years, complaint investigations, and follow-up surveys to determine compliance with the program rules regarding services offered, hours of clinical care, and program staffing.

Future State

QAD will incorporate questions assessing compliance with the non-clinical components of the ASAM Criteria, as memorialized in the state's updated licensure rules, into its surveys of licensed SUD

treatment providers. QAD, in collaboration with Montana Medicaid, will train its inspectors to ensure they are equipped to monitor providers for compliance with the non-clinical components of the ASAM standards. Montana Medicaid or its designee will conduct clinical reviews of the ASAM standards.

Summary of Actions Needed

- Revise QAD's survey process to provide the ability to assess compliance with ASAM standards: Effective July 1, 2022

Requirement That Residential Treatment Providers Offer MAT On-Site or Facilitate Access to Off-Site Providers

Current State

DPHHS does not currently require residential providers to provide MAT for all Food and Drug Administration-approved types of medication on-site or coordinate care with a licensed OTP or OBOT provider.

Future State

DPHHS will require residential treatment providers that do not provide MAT on-site to have the ability to facilitate off-site access by linking individuals to a licensed OBOT or OTP. As part of this requirement, DPHHS will issue updated rulemaking, policies, and/or care agreements as needed. To ensure provider compliance with this requirement, DPHHS will conduct provider training and provide technical assistance to residential treatment providers.

Summary of Actions Needed

- Promulgate ASAM Licensure rules: Effective July 1, 2022
- Promulgate Administrative Rule to revise provider manual: Effective July 1, 2022

Summary of Actions Needed Across Milestone

Action	Timeline
Promulgate ASAM Licensure rules	Effective July 1, 2022
Revise QAD survey process to provide the ability to assess compliance with ASAM standards	Effective July 1, 2022
Promulgate Administrative Rule to revise provider manual	Effective July 1, 2022
Promulgate Administrative Rule to revise state approval process	Effective July 1, 2022

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care, Including for Medication-Assisted Treatment for Opioid Use Disorder (OUD)

As Montana is a fee-for-service state, DPHHS enrolls SUD providers into Montana Medicaid and manages networks of providers directly. Rural and frontier areas, in particular, face gaps in access to treatment services at critical levels of SUD care, driven by staffing shortages, particularly with respect to residential treatment services. DPHHS has employed a number of strategies to expand its network of providers, including using telemedicine and streamlining state provider requirements to expand the network of state-approved SUD providers at critical levels of care. To ensure that Medicaid members have access to SUD treatment providers at critical levels of care, DPHHS will conduct an assessment of all Medicaid-enrolled providers. As part of this assessment, DPHHS will identify providers that are accepting new patients. DPHHS will use the results of the assessment to target network development efforts.

Current State

DPHHS is actively committed to monitoring and expanding provider access and capacity at all critical levels of care. DPHHS is responsible for the enrollment, disenrollment, credentialing, and assessment of qualifications and competencies of state-approved SUD providers and health care facilities, in accordance with applicable state and federal regulations. To ensure that enrollees have sufficient access to services, DPHHS enrolls any willing qualified and licensed provider, reviews the adequacy of its network on a service-level basis, and collaborates with stakeholders to expand its network for services where shortages exist.

The state faces gaps in access in rural and frontier counties across multiple levels of care with the majority of providers concentrated in the six largest towns—Bozeman, Kalispell, Helena, Missoula, Billings, and Great Falls. DPHHS plans to assess the use of telehealth whenever possible as a key tool to increase access.

Montana has expanded telehealth access during COVID-19 by allowing services to be furnished via audio-only capabilities and by providing payment parity for all telehealth. Even prior to COVID-19, the state had progressive telehealth policies to maximize care access and services. For example:

- **Practice Standards and Licensure:** Montana providers, including state-approved SUD providers, do not need to establish a relationship with a patient prior to engaging with them via telemedicine with the exception of MAT; a telepresenter or health care provider does not need to be present with a patient during a telemedicine encounter.
- **Medicaid Coverage and Reimbursement:** Montana state law requires Medicaid reimbursement for telehealth services at the same rate as for services delivered in person.
- **Medicaid-Eligible Patient Settings:** Montana Medicaid has historically allowed the following patient settings for telehealth encounters, including for SUD treatment: Outpatient Hospital; Federally Qualified Health Center; Rural Health Center; Indian Health Service; Mental Health Center; Chemical Dependency Clinic; Group/Clinic; Public Health Clinic; Family Planning Clinic; or Home.

In an effort to expand access to SUD treatment providers throughout the state, the state eliminated a historic geographic restriction of the number of state-approved SUD providers per

county in 2017, which resulted in a significant expansion of SUD treatment providers across the state, particularly at outpatient levels of care. As a result of the changes, the state went from 32 providers with 92 locations to 69 providers with 163 locations. State law requires SUD treatment providers to obtain state approval in order to bill Medicaid for services.[37]

As described above, Montana faces particular gaps in residential treatment levels of care and medications for opioid use disorder (MOUD) providers, largely due to staffing shortages where providers have difficulty finding staff that can provide continuous coverage. Currently, ASAM residential levels 3.1, 3.5, and 3.7 all have waiting lists for beds. In addition, the state has had difficulty standing up adolescent ASAM residential levels of care and is working with existing mental health group homes for adolescents to offer ASAM level 3.5 for adolescents. DPHHS plans to undertake a comprehensive rate review of all Medicaid covered services, including SUD, to ensure that reimbursement is sufficient and can allow SUD providers to attract and retain staff.

Future State
Within 12 months of the demonstration approval, the Department will complete its statewide assessment of the availability of enrolled Medicaid providers, which will include identifying those that are accepting new patients at the critical levels of care. In order to expand access to SUD treatment across critical levels of care, DPHHS plans to continue leveraging telehealth and engaging current SUD treatment providers to expand service locations and offerings across levels of care.

Building Capacity for New and Expanded Services

The state intends to build network capacity for new or expanded services.

- **Expand service offerings to include ASAM level 3.2-WM and 3.5.** DPHHS plans to work with its residential treatment providers to expand their service offerings to include ASAM level 3.2-WM. To build capacity for adolescent ASAM 3.5, DPHHS will continue to work with its therapeutic group home providers to integrate appropriate ASAM program standards into their treatment programs.
- **Engage with stakeholders** and providers **for ASAM level 3.3.** To build sufficient networks for ASAM level 3.3 (clinically managed population-specific high-intensity residential programs), the state will work to identify providers that may be interested in offering this service.
- **Streamline state approval process for ASAM level 4.0.** Currently, Montana requires hospitals to obtain state approval to bill Medicaid to serve members with primary SUD diagnoses, which is administratively burdensome. DPHHS intends to streamline the process for approval of state-licensed hospitals to provide Medicaid SUD services.
- **Provide training for new Medicaid SUD providers.** DPHHS will educate and require training for new Medicaid SUD providers, to orient them to Medicaid, including topics such as utilization management, credentialing, and billing.

Expanding Access to MAT

Montana relies on OTP and OBOT providers to provide MAT to state residents, including Medicaid members. Currently, the state has one OTP provider with five locations operating within the state. The

[37] https://leg.mt.gov/bills/mca/title_0530/chapter_0240/part_0020/section_0080/0530-0240-0020-0080.html

number of providers waivered to prescribe buprenorphine in Montana increased by over 700%, from 22 in 2017 to over 180 in 2021. Sixty-eight percent of those waivered providers are located in the six most-populated counties. DPHHS is working to identify the number of active buprenorphine providers that serve Medicaid members, and is creating a new MAT Medicaid provider type that will include OTPs and OBOTs and be reimbursed using a bundled rate that includes the dispensing, administering, or prescribing of the MOUD and care coordination.

Summary of Actions Needed

Action	Implementation Timeline
Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care	January 2022 – January 2023
Work to build Medicaid provider networks for new Medicaid levels of care	January 2022 – January 2024

Milestone 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

Like all other states in the country, Montana has been working to comprehensively address a persistent and shifting SUD crisis that impacts individuals and families throughout the state. Beginning in 2016, the state has created strong partnerships between local, tribal, and state health and justice partners to address emerging SUD issues. The state has also worked to improve its opioid prescribing guidelines, increase prevention efforts, and expand access to evidence-based treatment and recovery services while promoting harm reduction and appropriate justice system diversion. As a result of the state's coordinated efforts, the state's opioid-related overdose deaths have remained relatively steady over the past few years compared to those of other states throughout the country that have seen a rise. However, even with these efforts, opioids still account for the largest percentage of drug overdoses in the state.[38]

Montana Substance Use Disorder Task Force

In order to develop more robust, evidence-based systems to prevent, treat, and manage SUD, the state created the Montana Substance Use Disorder Task Force in 2017; in 2020, the task force issued its updated strategic plan for 2020 – 2023. This plan outlines how the state will reduce drug-related mortality, hospitalizations, and emergency department visits related to drug misuse across all populations in Montana. Please see the 2020 – 2023 Montana Substance Use Disorder Task Force Strategic Plan, available here, for more information.

Opioid Prescriptions

[38] "Summary of Methamphetamine Use in Montana." Public Health in the 406. August 2020. https://dphhs.mt.gov/assets/publichealth/Epidemiology/MethamphetamineSummary2020.pdf

Montana is working with its health care providers and health systems to balance the appropriate prescribing of opioid medications, while ensuring that patients, particularly those with chronic pain, receive the care they need.

Prescribing Limits: The 2019 Montana Legislature passed House Bill 86 to limit prescriptions for opioid-naïve members to seven days with the exception of cancer and palliative care patients. Montana's Medicaid Drug Utilization Board limits prescriptions to 90 morphine milligram equivalents (MME) without prior authorization. The goals of this law are to:

- Prevent new cases of opioid dependence;
- Prevent opioid-related overdose; and
- Ensure that members are using the lowest possible dose for the shortest amount of time.

Prescribers can exercise their medical judgment to prescribe more than a seven-day prescription to treat chronic pain, pain associated with cancer, or pain experienced while the patient is in palliative care.

Montana Prescription Drug Registry (MPDR): The Montana Board of Pharmacy manages MPDR, which became functional in 2012. All pharmacies with an active Montana license are required to report to the MPDR. Pharmacies must submit detailed information on all controlled substances—Schedules II, III, IV, and V drugs—dispensed to Montana patients by the next business day after the date the prescription was dispensed. Prescribers are also required to review the patient's record in the MPDR prior to prescribing an opioid or benzodiazepine in almost all cases; exceptions include prescriptions for patients receiving hospice care, for patients in chronic pain provided the prescriber reviews the patient's record every three months, or where the prescription is being administered to patient in a health care facility.

Naloxone

The 2017 Montana Legislature passed House Bill 333, the Help Save Lives from Overdose Act (Act), authorizing the broadest possible access to naloxone, the lifesaving opioid antagonist medication used to reverse an opioid-related drug overdose. The law made amendments to Title 50 of the Montana Code Annotated (MCA) to implement increased access to naloxone.[39] The law requires DPHHS to issue a statewide standing order that authorizes pharmacists who maintain a current active license practicing in a pharmacy located in Montana to initiate a prescription and dispense a naloxone opioid antagonist formulation to eligible recipients. Additionally, the law addresses professional immunity and Good Samaritan laws by allowing medical practitioners to dispense naloxone and protecting eligible recipients from arrest, charge, or prosecution who, acting in good faith, seek medical assistance for an individual experiencing an actual or reasonably perceived drug-related overdose. For more information on DPHHS' implementation of naloxone, see the Montana Implementation Guide for Access to Naloxone Opioid Antagonist available here and the Standing Order for Naloxone Opioid Antagonists available here.

Under the State Opioid Response (SOR) grant, contractor Best Practice Medicine offers master training sessions and master trainers then train authorized users on how to administer naloxone, free of charge. Most of the master trainers are law enforcement officers and EMS personnel, and 47 out of the 56 counties in Montana have master trainers. The state contracted with Ridgeway Pharmacy to distribute naloxone to all those trained to use the medication and to organizations under a Memorandum of

[39] https://leg.mt.gov/bills/mca/title_0500/chapter_0320/part_0060/sections_index.html

Understanding (MOU) with DPHHS. The MOU gives organizations access to distribute naloxone directly to eligible recipients. With the addition of MOUs from some groups—the Department of Corrections, harm reduction organizations, and tribes—Montana has distributed more than twice the amount of naloxone as planned.

MAT

In 2017, Montana expanded the use of MAT, which involves the use of medications and can be supported using behavioral health services, peer support services, and team-coordinated care to effectively treat opioid use disorders and prevent opioid overdose. Since the start of the State Targeted Response Program in 2017, a total of 1,426 patients received MOUD, behavioral health counseling, and recovering support services; most of these patients were between the ages of 25 and 44. Of these patients, 38% were American Indian and 28% were patients with criminal justice involvement.

To bolster the statewide effort to increase the number of practitioners who deliver MOUD, the Montana Primary Care Association (MTPCA) has provided training throughout the state to help practitioners obtain federal buprenorphine waivers. The number of providers waivered to prescribe buprenorphine in Montana increased by over 700%, from 22 in 2017 to over 180 in 2021. In addition to the buprenorphine waiver training, MTPCA has delivered more advanced education about MOUD service provision at all levels, and intensive technical assistance to providers to support the effective integration of care coordination, medications, and behavioral health services into clinic settings to ensure sustainability and quality of services. In FY 2020, 2,194 participants attended 192 educational events delivered by MTPCA, including community meetings, buprenorphine waiver trainings, substance use disorder trainings, American Society of Addiction Medicine (ASAM) trainings, advanced skill trainings, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) trainings.

State Epidemiological Outcomes Workgroup (SEOW)

As part of the state's ongoing analysis of substance use disorder needs and outcomes, Montana established the SEOW for the purpose of identifying, interpreting, and distributing data relevant to substance use and mental health (SUMH). The SEOW aims to inform prevention practices and policies by providing meaningful data about the consequences, related behaviors, and contributing risk and protective factors of SUMH disorders in Montana.

Summary of Actions Needed

None needed.

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Care Coordination and Transitions of Care

Current State
DPHHS is responsible for reimbursing care coordination for Medicaid enrollees. Montana has multiple pathways for the provision of case management and care coordination for Medicaid members, including members with SUD. First, nearly all Medicaid members participate in Passport to Health, the Medicaid

program's primary care case management (PCCM) program where primary care providers serve as the member's medical home and help address the member's medical and social determinants of health needs, though referrals are not needed for MH and SUD services. The PCCM helps coordinate and refer members, including those with SUD, to specialty services and to more intensive and specialized care coordination services, as needed.

Adult and youth Medicaid members with SUD and SMI are also eligible to receive targeted case management (TCM), which helps link these members to medical, social, educational, and other services to mitigate SUD symptoms. TCM provides a comprehensive assessment and reassessment; development of a care plan, referrals, and other coordination-related activities; and monitoring and follow-up activities such as scheduling appointments for the member, to help members obtain needed services to address identified needs and achieve goals specified in the care plan. Members with SUD/SMI may also receive care coordination through the high-risk pregnant women TCM program.

In addition to the care coordination programs listed above, care coordination is provided as part of select Medicaid SUD services, including intensive outpatient (IOP) services (ASAM 2.1) currently and MAT effective April 1, 2022.

Select SUD treatment providers, including IOP and inpatient providers, are required to provide and document discharge planning in each patient's individualized treatment plan. Licensed SUD facility providers, including residential treatment providers, are required as a condition of licensure to develop and share a continuing care plan with the member or the member's legal guardian, parent, or representative at the time of discharge or transfer to another level of care, which must include a discharge summary in the clinical record within one month of the date of the member's formal discharge from services or within three months of the date of the member's last services when no formal discharge occurs. For cases left open when a member has not received services for over 30 days, documentation must be entered into the record indicating the reason for leaving the case open. The discharge summary must include:

- The reason for discharge;
- A summary of the services provided by the provider, including recommendations for aftercare services and referrals to other services, if applicable;
- An evaluation of the member's progress as measured by the treatment plan and the impact of the services provided; and
- The signature of the staff person who prepared the summary and the date of preparation.

Future State
DPHHS plans to update its Medicaid provider manuals to require residential treatment providers to coordinate and monitor services provided to enrollees during transitions of care for members moving from one clinical setting to another. These updates will require the following information in the discharge summary:

- A written summary of services provided, including the patient's participation and progress;
- Community substance use treatment provider's contact name, contact number, and time and date of an initial appointment;
- Health care follow-up including provider's contact name, contact number, and initial appointment (if necessary);

- Current medications, dosage taken, number of times per day, and name of prescribing licensed health care professional;
- Name and contact number of the recovery supports identified in the treatment plan;
- Housing and employment plan; and
- Medical, dental, and psychiatric care received during placement.

DPHHS will require discharge/transfer planning when entering any level of care; this requirement will not duplicate transitional care coordination requirements already in place. Discharge/transfer planning will involve input from the patient, family, staff members, and referral sources. SUD providers will be required to:

- Conduct outreach to the member's primary care provider;
- Facilitate clinical handoffs, including those to behavioral health providers;
- Ensure that a follow-up visit is scheduled within a clinically appropriate time window; and
- Develop relationships with local hospitals, nursing homes, external BH providers and facilities (inpatient, residential, outpatient), and inpatient psychiatric facilities to promote smooth care transitions.

Summary of Actions Needed

Action	Timeline
Promulgate Administrative Rule to revise provider manual to incorporate discharge planning requirements.	Effective July 1, 2022

SUD HIT Plan: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
1. Enhanced interstate data sharing in order to better track patient-specific prescription data.	▪ Montana Prescription Drug Registry (MPDR) is connected to 28 other states, including all border states, via PMPinterconnect to enable two-way data sharing. ▪ As of May 2021, MPDR is connected with military health systems (MHS).	▪ MPDR is currently in the process of connecting with RxCheck to allow states to share interstate data either through PMPinterconnect or RxCheck.	▪ Appriss, Montana's PMP vendor, is setting up the required hardware to connect to RxCheck: January 2022
2. Enhanced "ease of use" for prescribers and other state and federal stakeholders.	▪ MPDR recently changed software vendors to increase ease of use, including auto-license verification for easier registration for Montana licensed health care providers. ▪ MPDR allows delegates to query for an authorized prescriber or pharmacist. ▪ Law enforcement must submit subpoenas and board investigators must submit requests to access information from the MPDR.	▪ MPDR is partnering with Department of Public Health and Human Services (DPHHS) to fund statewide integration for providers and pharmacists. ▪ This will allow access to MPDR data directly from the registered user's electronic health record (EHR), pharmacy management system (PMS), or health	▪ DPHHS completion of contract with Appriss to fund the Statewide Integration Project: October 2021 ▪ Appriss and MPDR State Administrator to kick off Statewide Integration Project with statewide marketing targeting eligible health care facilities and pharmacies: October 2021 ▪ Completion of Statewide Integration Project: August 2022

	Current State	Future State	Summary of Actions Needed
		information exchange (HIE). ▪ Out-of-state direct integration will be evaluated on a case-by-case basis after statewide integration is completed, with a higher priority given to border states. The MPDR also plans to integrate directly with the VHA system.	
3. Enhanced connectivity between the state's PDMP and any statewide, regional, or local health information exchange.	▪ The MPDR does not currently connect with Big Sky Care Connect (BSCC), Montana's HIE.	▪ MPDR integration with the BSCC will occur during the Statewide Integration Project operated with Appriss. ▪ Appriss has the ability to integrate with Dr. First and Collective Medical, vendors for BSCC.	▪ DPHHS completion of contract with Appriss to fund the Statewide Integration Project: October 2021 ▪ Appriss and MPDR State Administrator to kick off Statewide Integration Project with statewide marketing which will include BSCC: October 2021 ▪ Completion of Statewide Integration Project: August 2022

	Current State	Future State	Summary of Actions Needed
4. Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also "Use of PDMP" #6, below).	▪ DPHHS receives annual de-identified data to evaluate Montana opioid prescribing habits. The Board of Pharmacy has created administrative rules for factors that are suggestive of potential misuse or diversion. ▪ Law enforcement must submit subpoenas and board investigators must submit requests to access information from the MPDR.	▪ MPDR will continue to partner with DPHHS to monitor Montana opioid prescribing trends. ▪ MPDR will include new analytic tools to identify trends or thresholds to update clinical alerts and administrative rules to guide prescribing habits.	▪ MPDR State Administrator review of data in Tableau. (January 2022 – January 2023.) ▪ Solicit clinical feedback from the Montana Prescription Drug Registry Advisory Group on clinical alert thresholds and increasing linked resources. (January 2022 – June 2022.)
Current and Future PDMP Query Capabilities			
5. Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e., the state's master patient index (MPI) strategy with regard to PDMP query).	▪ While DPHHS does not currently have an MPI strategy, Medicaid does have several proDUR edits in place to prevent inappropriate payment for opioids. These include, but are not limited to, morphine milligram equivalent (MME) limits, quantity limits, therapeutic duplication controls, and denial of opioid claims for members with a history of opioid use disorder treatment.	▪ DPHHS will work to properly match patients receiving opioid prescriptions with patients in the PDMP.	▪ DPHHS will complete an analysis of the current environment; identify necessary stakeholders, determinate requirements, and specifications toward implementation; and take steps for implementation of an MPI. (January 2022 – June 2022.)
Use of PDMP – Supporting Clinicians With Changing Office Workflows			
6. Develop enhanced provider workflow/business processes to	▪ MPDR allows delegates to query for an authorized prescriber or pharmacist. ▪ Practitioners use the MPDR separately from	▪ DPHHS is working with Appriss Health to integrate MPDR into the	▪ DPHHS completion of contract with Appriss to fund the Statewide Integration

	Current State	Future State	Summary of Actions Needed
better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance, to address the issues that follow.	their EHR to acquire patient controlled substance prescription history. ▪ Prescriber mandatory use of the MPDR legislation went into effect on July 1, 2021.	user's EHR or PMS. The integrated solution will allow users to access the same information that is available in the MT PDMP within their clinical workflows, including patient prescription history, summary information, and clinical risk indicators.	Project: October 2021 ▪ Appriss and MPDR State Administrator to kick off Statewide Integration Project with statewide marketing targeting eligible health care facilities and pharmacies: October 2021 ▪ Completion of Statewide Integration Project: August 2022 ▪ Increase knowledge of mandatory use regulations through Integration Project communications, board meetings, and other outreach opportunities. (Timeframe: ongoing.)
7. Develop enhanced supports for clinician review of the patient's history of controlled substance prescriptions provided	▪ NarxCare and clinical alert tools are available in the MPDR software. These give clinicians a quick summary of their patients' controlled substance history in the form of NarxScore and overdose risk score and alert the provider when	▪ Review of current Board of Pharmacy Administrative Rules on what is considered suggestive of misuse or diversion. ▪ Solicit feedback from registered	▪ MPDR State Administrator review of data in Tableau. (January 2022 – January 2023.) ▪ Solicit clinical feedback from the Montana Prescription Drug Registry Advisory

	Current State	Future State	Summary of Actions Needed
through the PDMP—prior to the issuance of an opioid prescription.	its patients reach certain thresholds. ▪ Resources are available in the format of patient handouts from the CDC and links to the state's naloxone and opioid information provided by DPHHS.	users on increasing linked resources.	Group on clinical alert thresholds and increasing linked resources. (January 2022 – June 2022.)
Master Patient Index/Identity Management			
8. Enhance patient and prescriber profiles by leveraging other state databases in support of SUD care delivery.	▪ While DPHHS does not currently have an MPI strategy, Medicaid does have several proDUR edits in place to prevent inappropriate payment for opioids. These include, but are not limited to, morphine milligram equivalent (MME) limits, quantity limits, therapeutic duplication controls, and denial of opioid claims for members with a history of opioid use disorder treatment. ▪ DPHHS does not currently prevent members from paying cash for medications that are not covered by Medicaid.	▪ DPHHS will work to properly match patients receiving opioid prescriptions with patients in the PDMP.	▪ DPHHS will complete an analysis of the current environment; identify necessary stakeholders, determinate requirements, and specifications toward implementation; and take steps for implementation of an MPI. (January 2022 – June 2022.)
Overall Objective for Enhancing PDMP Functionality and Interoperability			
9. Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, technical assistance, or workflow effort)	▪ The Montana Board of Pharmacy located within the Montana Department of Industry and Labor maintains the Montana Prescription Drug Registry (MPDR), which is tightly governed by state law and regulation. The scope of data sharing from the	▪ DPHHS will continue to use its proDUR edits to prevent inappropriate payments for opioids.	N/A

	Current State	Future State	Summary of Actions Needed
to implement effective controls to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids.	MPDR to DPHHS is generally limited by a memorandum of understanding (MOU) between the two parties to "line-level" MPDR data, including the identities of the patient, prescribing health care provider, dispensing pharmacy, and prescription information, for public health surveillance and epidemiologic analysis conducted by the DPHHS' Public Health and Safety Division. ▪ While DPHHS does not currently have an MPI strategy, Medicaid does have several proDUR edits in place to prevent inappropriate payment for opioids. These include, but are not limited to, morphine milligram equivalent (MME) limits, quantity limits, therapeutic duplication controls, and denial of opioid claims for members with a history of opioid use disorder treatment. ▪ DPHHS does not currently prevent members from paying cash for medications that are not covered by Medicaid.		

Section II. Implementation Administration

Montana's point of contact for the SUD Health IT Plan is:
Name and Title: Rebecca de Camara, Division Administrator, Developmental Services Division
Telephone Number: (406) 444-6925
Email Address: rdecamara@mt.gov

F. Montana Section 1115 SMI/SED Demonstration Implementation Plan

Section 1115 SMI/SED Demonstration Implementation Plan
September 30, 2021

Overview: The implementation plan documents the State's approach to implementing SMI/SED demonstrations. It also helps establish what information the State will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
Financing Plan
Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the State already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the State to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the State will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The State may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The State Medicaid agency should enter into a Memorandum of

Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the State's point of contact for the implementation plan.

Name and Title:	Rebecca de Camara Division Administrator, Developmental Services Division
Telephone Number:	(406) 444-6951
Email Address:	rdecamara@mt.gov

1. Title page for the State's SMI/SED demonstration or SMI/SED components of the broader demonstration

The State should complete this transmittal title page as a cover page when submitting its implementation plan.

State	Montana
Demonstration name	Healing and Ending Addiction through Recovery and Treatment Demonstration
Approval date	*Enter approval date of the demonstration as listed in the demonstration approval letter.*
Approval period	*Enter the entire approval period for the demonstration, including a start date and an end date.*
Implementation date	*Enter implementation date(s) for the demonstration.*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the State's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the State's demonstration. Answers are meant to provide details beyond the information provided in the State's special terms and conditions.

Answers should be concise, but provide enough information to fully answer the question. This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the State primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	***Current Status:*** Montana State Hospital (MSH), the State's only institution for mental disease (IMD) for mental health that is expected to participate in this demonstration, is federally certified.
	Future Status: The State will ensure that all hospitals and residential treatment providers participating in the demonstration are certified, licensed, and/or accredited by a nationally recognized accreditation body to provide mental health treatment.
	Summary of Actions Needed: None needed.
1.b Oversight process (including	***Current Status:*** Montana State Hospital is federally certified. Federal validation surveys are performed

Prompts	Summary
unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	upon request from CMS to assess the compliance with CMS' health and safety standards. To ensure that high-quality SMI/SED treatment services are delivered in accordance with state licensure rules, the Department of Public Health and Human Services (DPHHS) regularly monitors residential treatment providers. DPHHS monitoring of residential providers includes surveys everyone to three years, complaint investigations, and follow-up surveys to determine compliance with the program rules regarding services offered, hours of clinical care, and program staffing.
	Future Status: DPHHS will continue its current oversight of participating hospitals and residential settings to ensure they meet either federal certification criteria or the State's licensure and/or accreditation requirements.
	Summary of Actions Needed: None needed.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	***Current Status:*** The full continuum of mental health care, ranging from outpatient to inpatient care, is currently provided through Montana Medicaid fee-for-service. Most of these services are authorized by Mountain-Pacific Quality Health, which conducts utilization reviews to ensure that beneficiaries have access to the appropriate level of care for as long as medically necessary. Montana Medicaid providers must use Mountain-Pacific Quality Health's Qualitrac Utilization Management Portal to request prior and continued stay authorization for mental health services that are subject to utilization review. Prior authorization may be issued for as many days as deemed medically necessary up to the maximum number of days allowed for the service. Additional prior authorization procedure requirement details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 205: Requesting Prior Authorization – Non-Acute Services, located here, and Policy Number 206, Requesting Prior Authorization-Acute Services, located here. Additional continued stay details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 210: Requesting a Continued Stay Review – Non-Acute Services, located here. In addition, Montana Medicaid providers may implement an auto-authorization process for out-of-state acute psychiatric hospitalizations and crisis stabilization programs. Additional auto-authorization details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 206: Requesting Auto-Authorization – Acute Services, located here.
	Future Status: DPHHS will continue operation of its current review process.

Prompts	Summary
	Summary of Actions Needed: None needed.
1.d Compliance with program integrity requirements and state compliance assurance process	***Current Status:*** DPHHS' Program Compliance Bureau is part of the Office of Inspector General of the Montana DPHHS. Its Surveillance and Utilization Review (SURS) unit is responsible for protecting the integrity of the Montana Medicaid Program from provider fraud, waste, and abuse. Providers are selected for review using a computer detection process that screens all provider billing services to flag unusual practices or refer them for investigation.
	Future Status: DPHHS will continue its program integrity processes.
	Summary of Actions Needed: None needed.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	***Current Status:*** All Medicaid members receiving behavioral health treatment must have a current comprehensive assessment that is updated annually. The comprehensive assessment includes an assessment of a range of psychosocial factors including substance use and addictive behavior history, a medical history, and a mental health examination that incorporates memory and risk factors including suicidal or homicidal ideation. Additional assessment requirement details can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 115: Assessments, located here. For example, MSH requires a comprehensive medical and physical assessment to be completed at admission and incorporates significant findings from the assessment in the treatment plan. The *Admission Psychiatric Evaluation* is performed and completed by a licensed independent practitioner within 24 hours of the patient's admission to MSH; this screening includes assessments on co-morbid physical health conditions, SUDs, and suicide/self-injury risk. Reassessments occur on an annual basis and when there are major changes in the patient's condition.
	Future Status: DPHHS will continue operation of its current screening policies.
	Summary of Actions Needed: None needed.
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	***Current Status:*** DPHHS staff conducts chart audits of patients at MSH to inform provider education and training in order to ensure that quality care is delivered to patients. In addition, the State Mental Disabilities Board of Visitors and Disability Rights Montana conduct site reviews of MSH to monitor the quality of care delivered to its patients.
	Future Status: N/A

Prompts	Summary
	Summary of Actions Needed: N/A
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-Based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	***Current Status:*** MSH develops an individualized aftercare plan specifying services and referrals needed upon discharge for individuals immediately upon admission. MSH staff will work closely with the patient, the patient's family/significant others, and appropriate community agencies to ensure continuity of care is addressed and Montana state statute requirements are met. Medicaid mental health services providers must also include the criteria for discharge in the individualized treatment plan.
	Future Status: MSH will continue to develop an individualized aftercare plan specifying services and referrals needed upon discharge for individuals upon admission, and will include community-based providers in care transitions.
	Summary of Actions Needed: N/A
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	***Current Status:*** There is no requirement in place to ensure that MSH, other psychiatric hospitals, and residential settings assess beneficiaries' housing situation and coordinate with housing services providers when needed and available. Mental health centers (MHCs) or group homes must assist with housing. This demonstration proposes to add tenancy support services.
	Future Status: *By* July 1, 2022, IMDs participating in the demonstration will be required to assess beneficiary housing situations and coordinate with tenancy support services providers. DPHHS plans to update its Medicaid provider manuals to require the coordination and monitoring of services provided to enrollees during transitions of care for members moving from one clinical setting to another, and this update will include requiring information on housing in the discharge summary.
	Summary of Actions Needed: Promulgate Administrative Rule to revise provider manual to incorporate discharge planning requirements by July 1, 2022.
2.c State requirement to ensure psychiatric hospitals and residential settings contact	***Current Status:*** There is no requirement in place to ensure that MSH, other psychiatric hospitals, and residential settings contact beneficiaries and community-based providers through the most effective means possible, e.g., email, text, or phone call within 72 hours post-discharge.

Prompts	Summary
beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post-discharge	***Future Status:*** DPHHS plans to update its Medicaid provider manuals to require providers and community-based providers to contact beneficiaries through the most effective means possible, e.g., email, text, or phone call within 72 hours post-discharge.
	Summary of Actions Needed: Promulgate Administrative Rule to revise provider manual to incorporate the most effective means possible requirements by July 1, 2022.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	***Current Status:*** Information on DPHHS' current and planned investment in crisis services is included below in topic 3.
	Future Status: Information on DPHHS' current and planned investment in crisis services is included below in topic 3.
	Summary of Actions Needed: Information on DPHHS' current and planned investment in crisis services is included below in topic 3.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	***Current Status:*** Adult and youth Medicaid members with SUD and SMI are also eligible to receive targeted case management (TCM), which helps link these members to medical, social, educational, and other services to mitigate SUD symptoms. TCM provides a comprehensive assessment and reassessment, development of a care plan, referrals and other coordination-related activities, and monitoring and follow-up activities such as scheduling appointments for the member, in order to help members obtain needed services and to address identified needs and achieve goals specified in the care plan. Members with SUD/SMI may also be receiving care coordination through the high-risk pregnant women TCM program.
	Future Status: The State complies with this milestone.
	Summary of Actions Needed: N/A
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	

Prompts	Summary
Access to Continuum of Care Including Crisis Stabilization	
3.a The State's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the State, updating the initial assessment of the availability of mental health services submitted with the State's demonstration application. The content of annual assessments should be reported in the State's annual demonstration monitoring reports.	***Current Status:*** DPHHS has conducted an assessment of the availability of mental health services for the Healing and Ending Addiction through Recovery and Treatment Waiver. The assessment is included in Attachment X of this application and reveals a shortage of outpatient providers who are specialized in treating members with mental illness. The assessment found that there is a need for more psychiatrists and providers who specialize in psychiatry and that there is a lack of other practitioners treating mental illness in many rural counties, particularly practitioners that accept Medicaid. There are also widespread shortages of other mental health services in rural counties.
	Future Status: The State intends to conduct and report the required assessment over the course of the demonstration.
	Summary of Actions Needed: The State will complete and submit the assessment each year of the demonstration period.
3.b Financing plan	***Current Status:*** See topic 5 below.
	Future Status: See topic 5 below.
	Summary of Actions Needed: See topic 5 below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	***Current Status:*** The State regularly tracks and updates the availability of both mental health and substance use treatment providers through a manual process. The State recently adjusted its contract with crisis stabilization facilities to increase reporting requirements, which will enable a more thorough accounting of crisis stabilization bed utilization throughout the State. The State recruited an AmeriCorps VISTA program

Prompts	Summary
	member to assess the potential implementation of a behavioral health bed board within Montana. The VISTA member and other state employees conducted extensive outreach with all crisis system providers and conducted site visits to every crisis stabilization facility, as well as several detention centers, hospitals, and other community providers. The State utilized this information to map the existing crisis system infrastructure, identify the typical routing of individuals in crisis, and pinpoint gaps in the system that could be improved upon. To address these issues, DPHHS developed a Behavioral Health Crisis System Strategic Plan, which seeks to overhaul the State's behavioral health crisis system to align with the Crisis Now model, including the development of a statewide bed board. As part of its Strategic Plan, DPHHS is exploring several options that would standardize electronic assessment tools, service utilization reporting, and program outcome measures, all of which would contribute to a statewide behavioral health dashboard. These efforts align with several concurrent initiatives, including a 988 hotline planning grant, which is bringing together stakeholders to facilitate active tracking and coordination of services across the State, and the State's participation in a National Association of State Health Policy Academy on Rural Mental Health Crisis Services.
	Future Status: DPHHS will establish a statewide, electronic platform that will enable both the State and providers to utilize standardized assessment tools and report on the availability of services, including inpatient treatment beds, by early 2024. DPHHS will be engaging an AmeriCorps VISTA member throughout the next year to initiate the research needed to implement this platform. The VISTA member will research ways in which other states have successfully implemented a bed board, what technology infrastructure is currently utilized within Montana, and what entities the State must partner with to strategically develop a bed board. Additionally, the State will be identifying ways in which contract language, reimbursement methodologies, and program policies can be utilized to ensure that providers are consistently required to participate in the use of the tool to ensure it remains relevant and useful.

Prompts	Summary
	Summary of Actions Needed: • Convene a group of stakeholders that represent the various entities that will utilize a statewide bed board: February 1, 2022 • Utilize the work group to review the research conducted by the VISTA member: April 1, 2022 • Develop a decision document that outlines the benefits and challenges of each available option and includes a recommendation from the work group: April 1, 2022 • Utilize state IT or contracted IT resources to develop a prototype, and develop an annual operating budget for the technology platform: July 1, 2022 • Develop a scope of work required to facilitate the maintenance of the bed board: September 1, 2022 • Review all available funding sources, including SAMHSA block grants, state general fund, and Medicaid administrative dollars, that could be utilized to fund the maintenance of the bed board: September 1, 2022 • Identify specific scope to pilot the bed board: September 1, 2022 • Pilot the bed board: October 1, 2022 – March 31, 2023 • Identify and resolve any critical issues that occurred during the pilot: June 1, 2023 • Develop training resources for individuals who will operate the bed board, and publish those training resources on the State website: September 1, 2023 • Conduct presentations and trainings for statewide stakeholders and future utilizers of the bed board: January 1, 2024
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	***Current Status:*** Each Medicaid member receiving behavioral health treatment must have a current comprehensive assessment, updated annually; requirements for the assessment can be found in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy Number 115, available here. DPHHS does not require use of a specific assessment for adults. DPHHS is implementing the Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII) in many programs; these are standardized assessment tools that provide a determination of the appropriate level of service intensity needed by a child or adolescent and their family. The tools are unique in their capacity to determine a service intensity need, guide treatment planning, and monitor treatment outcomes in all clinical and community-based settings. The CASII and

Prompts	Summary
	ECSII are also being used by the Child and Family Services Division as it implements the Family First Prevention Services Act.
	Future Status: DPHHS will continue to implement the CASII and ECSII for patient assessment across its programs and services for children. DPHHS will explore which patient assessment tool to use for adults.
	Summary of Actions Needed: • Conduct research on patient assessment tools for adults for mental health treatment (e.g., LOCUS): March 1, 2023 • Develop a decision document that outlines the benefits and challenges of each available option and includes a recommendation for an assessment tool: April 1, 2023 • Promulgate Administrative Rule to revise provider manual to incorporate use of the assessment tool: July 1, 2023
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	***Current Status:*** DPHHS has been working to improve access for beneficiaries to a full continuum of care including crisis stabilization services. First, the State's Medicaid program covers crisis stabilization services, which include the following: • Outpatient crisis response services, which include evaluation, intervention, and referral for adults experiencing a crisis due to mental illness or a mental illness with a co-occurring substance use disorder, for no more than 23 hours and 59 minutes • Residential crisis stabilization, which includes 24-hour supervised, short-term residential crisis intervention services The State operates multiple state general fund programs that facilitate inpatient crisis stabilization services for non-Medicaid populations and incentivize availability of community-based crisis beds. The State has implemented several grants that support crisis services, including mobile crisis response teams and crisis stabilization programs. The State has recently restructured its largest crisis diversion grant to align grant requirements with national best practices in crisis care and has braided multiple funding sources, including both federal and state dollars, into the grant in order to maximize available funding.

Prompts	Summary
	The State is currently working on 988 hotline implementation to ensure the entire crisis continuum of care is integrated into a statewide crisis line that can actively triage individuals in crisis throughout the State. For children, DPHHS requires MHCs to provide 24-hour telephone crisis response, and also requires crisis planning to take place in each 90-day treatment plan review. Acute hospitalization services are also part of the continuum of care for youth in crisis, which includes crisis stabilization.

	Future Status: As part of the State's HEART Initiative, the State intends to add mobile crisis intervention services to its Medicaid program. The State also intends to strengthen its Medicaid coverage of crisis stabilization services through the following actions:
	• Increase the number of eligible providers and streamline licensing for crisis services through
	  ○ targeted outreach to providers (e.g., hospitals, MHCs, and federally qualified health centers) to promote the development of regional crisis stabilization facilities, and
	  ○ adjustments to licensure and policy requirements to facilitate both crisis receiving and stabilization services in various configurations (either as stand-alone or in combination) that will meet the needs of the State's urban, rural, and frontier communities;
	• Adjust service components and reimbursement rates of inpatient crisis stabilization services for both Medicaid and non-Medicaid populations; and
	• Implement a behavioral health mobile crisis response bundled service for both Medicaid and non-Medicaid populations.
	
	For children specifically, DPHHS is continuing its reviews of program service requirements, with an increased emphasis on individualized crisis planning, response, and staff training.

Prompts	Summary
	Summary of Actions Needed: • Targeted outreach to providers: January 1, 2022 • Submit amended rule: July 1, 2022 • Submit Medicaid state plan amendments for crisis stabilization units and mobile crisis intervention services: July 1, 2022
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	***Current Status:*** The State has invested in prevention and early intervention strategies that aim to support the development of healthy behaviors by, and to identify and engage, beneficiaries with or at risk of SMI or SED in treatment sooner. • **Parenting Montana:** This web-based resource for parents braids together supports grounded in evidence-based practices to help kids and families thrive, and cultivates a positive, healthy culture among Montana parents with an emphasis on curbing underage drinking. This resource also provides parents or those in a parenting role with tools for everyday parenting challenges from the elementary to post-high school years. • **Communities That Care (CTC):** CTC promotes healthy youth development and addresses risk and protective factors to help mitigate problem behaviors in communities. Planning for this program began in January 2018, and the project's vision is to engage in a five-phase community change process that helps reduce levels of youth behavioral health problems before they escalate, providing a path to disrupt the cycle of issues encouraging problem behaviors. • **First Episode Psychosis (FEP):** Currently covered by Montana Medicaid, this evidence-based program identifies an initial psychosis episode in youth and young adults, and ensures early treatment services and support services for the individual and family. FEP programs have been shown to be highly effective in reducing or ameliorating adult psychosis.

Prompts	Summary
	• **Suicide Prevention Efforts for Youth:** The State implemented a number of suicide prevention programs focused on school-age children and youth, including Signs of Suicide; Question, Persuade, and Refer; and PAX Good Behavior Game (GBG). PAX GBG teaches elementary-age students self-regulation, self-control, and self-management as well as additional social-emotional skills including teamwork and collaboration. PAX GBG is currently in over 100 schools statewide and growing, with the goal of implementing districtwide in grades K-5 in as many districts as possible, with ongoing supports to ensure fidelity and long-term sustainability. • **Suicide Prevention and Modernization Initiatives:** The State collaborated with the National Council for Behavioral Health to revamp its State Suicide Prevention Strategic Plan and implement suicide prevention activities. As part of this effort, the State has provided federal grants and direct state funds to Tribal and Urban Indian Health Centers to support local planning and implementation of Zero Suicide, a comprehensive approach to suicide care that aims to reduce the risk of suicide for individuals seen in health care systems, and to seek training for self-care best practices for frontline health and behavioral health staff and community members. The State has also established the use of the Centers for Disease Control and Prevention's National Violent Death Reporting System, which tracks all suicides. • **Innovation Grants:** DPHHS collaborated with the Center for Children, Families and Workforce Development at the University of Montana to fund innovative projects focused on enhancing family engagement and supporting strong transitions to adulthood for children aging out of the Children's Medicaid mental health system. Additionally, Montana Medicaid's Program for Assertive Community Treatment (PACT) includes supported employment for qualifying individuals with SMI.
	Future Status: Montana's proposed prevention model, the HEART Initiative, builds on its current initiatives to implement community-based prevention programs focused on early identification and treatment of individuals at risk of or with SMI. Through the HEART Initiative, DPHHS will

Prompts	Summary
	• Increase the number of counties and Indian reservations in Montana that have prevention specialists; • Increase the number of evidence-based coalition processes in more Montana communities (e.g., CTC and Collective Impact); • Increase the number of schools implementing PAX GBG or similar school-based/family-oriented, evidence-based strategies that promote enhanced social-emotional behavioral and self-regulation and long-term resilience; • Increase the number of evidence-based interventions focusing on community-based prevention; • Increase access to programs that address suicide and mental health prevention; • Increase the implementation of SBIRT (Screening, Brief Intervention, and Referral to Treatment)and other evidence-based primary care interventions; and • Promote the use of validated screening tools in local schools and primary care to address substance use and suicide ideation.
	Summary of Actions Needed: DPHHS will continue to build on its prevention and early intervention services as outlined above throughout the course of the HEART Initiative.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	***Current Status:*** Montana DPHHS employs a number of strategies to integrate behavioral health care in non-specialty settings, including: • **Integrated Behavioral Health Model:** Under this model, primary care clinics are equipped to screen patients for behavioral health concerns and facilitate connections to needed treatment and support. Over half of adult Medicaid patients (59%) are assigned to primary care clinics that also provide behavioral health services, or "integrated behavioral health." By integrating behavioral health services into primary care, providers work together to identify and treat behavioral health conditions. Patients are screened for depression, anxiety, and substance misuse during primary care appointments and, if needed, receive behavioral health care as part of the same visit. Patients who require more intensive behavioral health care are referred to specialty behavioral health providers. • **Patient-Centered Medical Home (PCMH) Model:** PCMH provides primary care, preventive care,

Prompts	Summary
	health maintenance, treatment of illness and injury, and coordination of members' access to medically necessary specialty care, including behavioral health services, by providing referrals and follow-up, team-based ongoing patient care, and care coordination services. There are 23 Federally Qualified Health Centers throughout the State enrolled as PCMH providers; the care management team usually consists of the primary care provider, a nurse, a social worker, and in some cases a behavioral health specialist. Individuals who require more intensive behavioral health services than are provided by the PCMH are referred to specialty behavioral health providers for follow-up. • **Comprehensive Primary Care Plus (CPC+) Model.** Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices. There are currently 49 providers participating in the Montana Medicaid's CPC+ program. Providers participating in the CPC+ model are required to build primary care capabilities to support Behavioral health integrations. • **Montana Project AWARE:** This project is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a collaboration between the Office of Public Assistance, the Children's Mental Health Bureau, and three Local Education Agencies (LEAs): Dillon, Billings, and Rocky Boy. Its primary goal is to support Montana school districts in developing Multi-Tiered Systems of Support for mental health promotion (prevention/education) and response (crisis/treatment). This grant will fund three LEAs to implement evidence-based school mental health practices in order to achieve the following: ▪ Increase awareness of mental health issues and the school district's capacity to prevent and respond to mental health issues ▪ Provide training in mental health prevention and promotion ▪ Foster local policy changes to improve systems for responding to mental health issues in schools ▪ Increase capacity of local school districts to connect youth who have behavioral health

Prompts	Summary
	issues to services ▪ Increase the number of youth referred to Tier 2 or Tier 3 services ▪ Increase the number of youth receiving Tier 1 services (to 100%) ▪ Measure outcomes for youth receiving Tier 2 and Tier 3 services
	Future Status: DPHHS meets the requirements of this milestone, and will continue operating its programs focused on behavioral integration listed immediately above.
	Summary of Actions Needed: N/A
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	**Current Status*:*** DPHHS has invested in an extensive continuum of care to identify and meet the needs of youth who are experiencing SED. This range of services includes the following: • **Acute Hospitalization:** Acute care psychiatric hospitals are psychiatric facilities that are devoted to the provision of inpatient psychiatric care for persons under the age of 21. Inpatient hospitalization is the placement of youth in a hospital for observation, evaluation, and/or treatment. Services are medically oriented and include 24-hour supervision; services may be used for short-term treatment and crisis stabilization. A youth might be admitted to an acute hospital if they are considered dangerous to the self or others. • **Psychiatric Rehabilitation Treatment Facilities (PRTF):** A PRTF is a 24-hour, non-acute, secure residential facility setting for active interventions directed at addressing and reducing the specific impairments that led to the admission and at providing a degree of stabilization that permits safe return to the home environment and/or community-based services. A PRTF typically serves 10 or more children and youth and provides 24-hour staff and psychiatrist supervision, and may include individual therapy, group therapy, family therapy, behavior modification, skills development, education, and recreational services. Lengths of stay tend to be longer in residential treatment centers than in hospitals. • **Partial Hospitalization Program:** A partial hospitalization program (PHP) is provided by a licensed hospital under the direction of a physician, with frequent nursing and medical supervision. Treatment is intensive and is provided in a supervised environment by a multidisciplinary team of qualified and credentialed professionals that may include board-eligible or -certified psychiatrists, clinicians, registered nurses, licensed mental health professionals, and other ancillary staff. This service does not include 24-hour supervision.

Prompts	Summary
	• **Mental Health Therapeutic Group Home (TGH):** A TGH is a community-based treatment alternative provided in a structured group home environment, and is appropriate for youth requiring a higher intensity of specific therapeutic treatment services and social supports than is available through traditional outpatient services and requiring services that exceed the capabilities of support systems for youth. This level of therapeutic treatment intervention includes a consideration of the safety and security needs of the youth, the degree of self-care skills demonstrated by the youth, and the likelihood that the youth will benefit from a community integrated program. • **Extraordinary Needs Aide (ENA):** ENA services are prior-authorized, additional one-to-one, face-to-face, intensive short-term behavior management and stabilization services provided in the TGH by TGH staff, for youth with SED. "Short-term" generally means 90 days or less. ENA services are provided for youth in a TGH who exhibit extreme behaviors that cannot be managed by TGH staffing, including harming the self or others, destruction of property, or a pattern of frequent extreme physical outbursts. • **Targeted Youth Case Management:** TCM services are furnished to assist Medicaid-eligible youth with SED in gaining access to needed medical, social, educational, and other services. Services are provided by a licensed MHC with a license endorsement permitting the center to provide case management services. Case management services include assessment, determination of need, development and periodic revision of a specific care plan, referral and related activities, and monitoring and follow-up activities. • **Youth Day Treatment:** Youth day treatment services are a set of mental health services provided in a specialized classroom setting (not a regular classroom or school setting) and integrated with educational services provided through full collaboration with a school district. The services are focused on building skills for adaptive school and community functioning and on reducing symptoms and behaviors that interfere with a youth's ability to participate in their education at a public school; on minimizing the need for more restrictive levels of care; and on supporting return to a public school setting as soon as possible. Day treatment includes individual, family, and group therapy skill building and integration. • **Home Support Services:** Home support services are in-home therapeutic and family support services for youth living in biological, adoptive, or kinship families who require more intensive therapeutic interventions than are available through other outpatient services. Services are focused on the reduction of symptoms and behaviors that interfere with the youth's ability to function in

Prompts	Summary
	the family and on facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care. The provider is available by phone or in person to assist the youth and family during crises. Home support services include skill building and integration and crisis response, and may include individual and family therapy. • **Therapeutic Foster Care:** Therapeutic foster care services are in-home therapeutic and family support services for youth living in a therapeutic foster home environment, including youth unable to live with their biological or adoptive parents, in kinship care, or in regular foster care. These youth require more intensive therapeutic interventions than are available through other outpatient services. Services focus on skill building and integration for adaptive functioning to minimize the need for more restrictive levels of care and to support permanency or return to the legal guardian. The provider is available by phone or in person to assist the youth and family during crises. Medicaid pays the provider agency for the provision of therapeutic services and supports for the youth and foster family. The Child and Family Services Division of the Montana DPHHS contracts with the provider agency for completion of the foster home licensing study, preparation, training, and foster care reimbursement for the foster family. Foster parents participate in treatment team meetings. Therapeutic foster care services include skill building and integration and crisis response, and may include individual and family therapy. • **Comprehensive School and Community Treatment:** Comprehensive school and community treatment is a comprehensive planned course of community mental health outpatient treatment that includes therapeutic interventions and supportive services provided in a public school-based environment in office and treatment space provided by the school. Services are focused on improving the youth's functional level by facilitating the development of skills related to exhibiting appropriate behaviors in the school and community settings. These youth typically require support through cueing or modeling of appropriate behavioral and life skills to utilize and apply learned skills in normalized school and community settings. Comprehensive school and community treatment includes individual, group, and family therapy; skill building; and integration. • **Outpatient Therapy:** Outpatient therapy services include individual, family, and group therapy in which psychotherapy and related services are provided by a licensed mental health professional acting within the scope of the professional's license or by an MHC in-training mental health professional as defined in ARM 37.87.702(3). Outpatient therapy services represent community-based treatment that incorporates Current Procedural Terminology (CPT) codes. Outpatient

Prompts	Summary
	therapy services may be provided only by individuals licensed by the State of Montana or by an MHC in-training mental health professional. To be reimbursed for outpatient therapy services, the provider must be enrolled in Montana Medicaid. • **Psychiatric Services and Medication Management:** Medication treatment and monitoring services typically include the prescription of psychoactive medications by a physician (e.g., psychiatrist) that are designed to alleviate symptoms and promote psychological growth. Treatment includes periodic assessment and monitoring of the child's reaction(s) to the drugs(s). • **Community-Based Psychiatric Rehab and Support (CBPRS):** CBPRS services are adaptive skill-building and integration services provided in person for youth in home, school, or community settings in order to help these individuals maintain their participation in those settings. CBPRS services may be provided only for youth at risk of out-of-home or residential placement or for youth under age 6 at risk of removal from their current setting. CBPRS services are provided under the supervision of a licensed mental health professional and according to the youth's rehabilitation goals. The focus of the services is to improve or restore the youth's functioning in identified areas of impairment in order to prevent or minimize the need for more restrictive levels of care. Face-to-face consultation with family members, teachers, or other key individuals may be included. CBPRS services may be provided only if a youth also receives other mental health services. They are not provided at the same time as other mental health services. In addition, as detailed above, DPHHS collaborated with the Center for Children, Families and Workforce Development at the University of Montana to fund innovative projects through grants focused on enhancing family engagement and supporting strong transitions to adulthood for children aging out of the Children's Medicaid mental health system.
	Future Status: DPHHS meets the requirements of this milestone and will continue to increase supports for children and families with behavioral health needs. DPHHS will continue to work in collaboration with providers and Montana constituents in order to increase early identification and engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED. DPHHS will utilize data and initiatives created as a result of the Innovation Grants as described above, to improve services to youth and families.
	Summary of Actions Needed:

Prompts	Summary
	• Complete Innovation Grants: September 1, 2021 • Review summary data from Innovation Grants: December 1, 2021 • Create program recommendations: February 28, 2022
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	**Current Status:** The State has recently implemented the CASII and ECSII as described above as a program requirement for Targeted Youth Case Management. One intention of this service requirement is to gather and utilize data produced by providers as a means to understand the severity of need demonstrated by youth in Montana.
	Future Status: The State will collect and review data and processes involved in the administration of the CASII and ECSII within the Targeted Youth Case Management program to potentially expand the use of these assessment tools across other programs administered through Medicaid for youth experiencing SED. The State will utilize its current collaboration with the Center for Children, Families and Workforce Development.
	Summary of Actions Needed: • Implement program recommendations created through Innovation Grant process: June 1, 2022
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the State, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the State's assessment of current availability of mental health services included in the State's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with	***Current Status:*** DPHHS has been working to improve access for beneficiaries to a full continuum of care including crisis stabilization services. First, the State's Medicaid program covers crisis stabilization services, which include the following: • Outpatient crisis response services, which include evaluation, intervention, and referral for adults experiencing a crisis due to mental illness or a mental illness with a co-occurring substance use disorder, for no more than 23 hours and 59 minutes • Short-term residential crisis stabilization, which includes 24-hour supervised, short-term residential crisis intervention services

Prompts	Summary
trained law enforcement and other first responders	The State has also issued state-funded and federal SAMHSA grants to a number of counties and tribal governments to implement mobile crisis pilots. For children, DPHHS requires MHCs to provide 24-hour telephone crisis response, and also requires crisis planning to take place in each 90-day treatment plan review. Acute hospitalization services are also part of the continuum of care for youth in crisis, which includes crisis stabilization.
	Future Status: DPHHS is working to align its crisis system with national best practice standards and to expand access to crisis services for Medicaid beneficiaries in need. • **Crisis Call Center:** DPHHS intends to create a crisis call center that is integrated with the 988 hotline and is able to dispatch mobile crisis teams and track real-time availability of crisis beds, effective July 1, 2022. • **Mobile Crisis Services:** DPHHS is adding coverage for mobile crisis services to its Medicaid State Plan, effective July 1, 2022. The service will have a bundled rate for both Medicaid and non-Medicaid populations. In building the service design, DPHHS is considering models for rural and frontier communities (e.g., tele-response, community paramedicine, community health workers) where traditional mobile crisis teams may be difficult to sustain. • **Crisis Stabilization Units:** DPHHS is implementing a 23-hour-and-59-minute outpatient crisis receiving service and bundled reimbursement rate for both Medicaid and non-Medicaid populations. DPHHS also intends to strengthen its Medicaid coverage of crisis stabilization services through the following actions: • Increase the number of eligible providers and streamline licensing for crisis services through o targeted outreach to providers (e.g., hospitals, MHCs, and federally qualified health centers) to promote the development of regional crisis stabilization facilities, and o adjustments to licensure to facilitate both crisis receiving and stabilization services in one location.

Prompts	Summary
	• Adjust service components and reimbursement rates of inpatient crisis stabilization services for both Medicaid and non-Medicaid populations. DPHHS is also working to increase access to behavioral health services in emergency department settings through partnership with the Health Resources Division and the Montana Hospital Association.
	Summary of Actions Needed: • Conduct targeted outreach to providers: January 1, 2022 • Submit amended licensure rule: July 1, 2022 • Submit Medicaid state plan amendments for crisis stabilization units and mobile crisis intervention services: July 1, 2022
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model	***Current Status:*** Montana Medicaid currently covers a comprehensive continuum of community-based services for mental health. Covered services include TCM; certified peer support services; outpatient services, both clinical and paraprofessional, including therapy provided by licensed clinicians; intensive outpatient treatment services; dialectical behavior therapy; illness management and recovery; day treatment, which includes community-based psychiatric rehabilitation and support services and group therapy; PACT; Montana Assertive Community Treatment (MACT); and Montana Medicaid Severe and Disabling Mental Illness (SDMI) 1915(c) Waiver. See topic 4.b for DPHHS initiatives targeted at expanding access to integrated care settings in the State's Medicaid program.
	Future Status: DPHHS continues to assess the availability of its community-based mental health services in order to ensure that beneficiaries have access to needed services.
	Summary of Actions Needed: N/A
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates that are seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the State's ability to leverage health IT, advance health information exchange(s),	

Prompts	Summary
and ensure health IT interoperability in support of the demonstration's goals."[40] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the State has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	Montana has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e., state, delivery system, and individual provider) to achieve the goals of the demonstration. As outlined in Montana's State Medicaid Health Information Technology Plan (SMHP), DPHHS is collaborating with a broad range of stakeholders to support health information technology (HIT) and health information exchange (HIE) objectives for internal department efforts and statewide efforts. There has been widespread adoption of various electronic health records (EHRs) by providers, including practices, specialty providers, and hospitals in Montana, and progress on multiple HIE fronts. Montana's SMHP indicated that by 2024, DPHHS and external stakeholders expect EHR adoption by providers and hospitals to be close to 100%. The focus on statewide HIE efforts and integration of EHRs with public registries should promote further adoption across the State. In 2016, DPHHS began modernizing the Medicaid enterprise known as Montana's Program for Automating and Transforming Healthcare (MPATH). As part of this modernization, Montana's Medicaid Management Information System (MMIS) is being replaced with multiple components. For example, population health management is one of the Medicaid enterprise components that aggregates patient data across multiple

[40] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
	HIT solutions. The establishment of direct connections with EHRs aims to promote bidirectional data exchanges between Montana DPHHS and providers and ultimately to support the calculation of quality measures and risk scores and the identification of gaps in care. The MPATH HealtheRegistries component is used to manage various care programs through the presentation of comprehensive program-specific registries with unique quality measures supported by comprehensive claims and clinical data that is updated daily. The quality measures and compressive clinical overview for each member are available to assigned provider staff. In addition to the State's effort, the Montana Medical Association (MMA) is leading a multi-stakeholder effort to establish a new statewide HIE for Montana: Big Sky Care Connect (BSCC). The Health Information Exchange of Montana, Inc. (HIEM), is also leading an effort to support interoperability. HIEM is a nonprofit organization that includes hospitals, clinics, and federally funded community health centers in northwest and north-central Montana. DPHHS has already established a secure connection with BSCC to transmit Medicaid claims data to the HIEM, and by the end of 2021 will be receiving admission, discharge, and transfer (ADT) messages from participating BSCC providers for Montana Medicaid members that will be sent via notification to case managers. In early 2022, DPHHS will begin receiving clinical data from participating providers for Montana Medicaid members. Montana's SMHP indicates four objectives to be met by the end of 2024: 1. Implement modular systems and services to modernize the Medicaid enterprise. 2. Develop a sustainable statewide HIE solution for use by multiple stakeholders across the State. 3. Utilize data analytics to inform treatment, payment, and outcomes for health care. 4. Leverage HIE to encourage meaningful use of EHRs. Additional tasks to support this include the following: • Continue to conduct provider outreach, including website updates and communications. • Encourage providers to participate in current HIE planning efforts. • Support the creation of a governance structure, a business plan, and a communication plan for statewide HIE.

Prompts	Summary
	• Provide technical assistance to assist Medicaid providers seeking to create interoperable connections.
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the State's broader State Medicaid Health IT Plan and, if applicable, the State's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Montana's SMI/SED Health IT Plan is aligned with the State's approved Medicaid HIT plan.
Statement 3: Please confirm that the State intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[41] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the State's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following	Montana intends to assess the applicability of the Interoperability Standards Advisory and 45 CFR 170 Part B and to incorporate the relevant standards where applicable. Montana does not have any managed care entities.

[41] Available at https://www.healthit.gov/isa/.

Prompts	Summary
areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact.[42] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[43]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	***Current Status:*** Based on a brief survey of licensed MHCs conducted in the summer of 2021, around 84% have adopted "certified" EHRs (CEHRT, Certified EHR Technologies), though none of those agencies utilize it for e-referrals or closed-loop referrals to outside primary care providers. Several agencies utilize their EHRs for internal referrals. Some agencies are part of the CONNECT referral system. CONNECT is an electronic referral system developed through grant funding and a partnership that includes Montana DPHHS. It is HIPAA, FERPA, 42

[42] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.
[43] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

Prompts	Summary
	CFR, and IDEA compliant. It is available statewide, but not all providers have chosen to be part of the CONNECT network. Currently, nine behavioral health—mental health and SUD—providers and nine SUD providers are part of the CONNECT network.
	Future Status: DPHHS will work with stakeholders to conduct a survey of providers utilizing closed loop referrals and e-referrals, in order to identify the baseline of current activity and identify options for increasing provider implementation. Based on the findings of the survey, DPHHS will work to increase the use of closed-loop referrals and e-referrals among providers.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	***Current Status:*** Based on a brief survey of MHCs, none of those agencies indicated receiving e-referrals or closed loop referrals from outside primary care providers. Several agencies indicated they are still receiving referrals via fax.
	Future Status: DPHHS will conduct a survey of providers utilizing closed loop referrals and e-referrals, in order to identify the baseline of current activity and identify options for increasing provider implementation. Based on the findings of the survey, DPHHS will work to increase the use of closed loop referrals and e-

Prompts	Summary
	referrals among providers.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	***Current Status:*** There is widespread adoption of EHRs across providers; however, the extent of closed loop referrals and e-referrals to community-based supports is unknown.
	Future Status: DPHHS will conduct a survey of providers utilizing closed loop referrals and e-referrals, in order to identify the baseline of current activity and identify options for increasing provider implementation. Based on the findings of the survey, DPHHS will work to increase the use of closed loop referrals and e-referrals among providers.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The State and its providers can create and use an electronic care plan	***Current Status:*** The State is in the process of rolling out tailored care management modules in MPATH to its Medicaid providers. The SMI-specific module is scheduled for the next care management release, which will be in the design phase later this fall, targeting implementation in mid- to late 2022.

Prompts	Summary
	Future Status: The State will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider implementation of electronic care plans. The care management module in MPATH will provide comprehensive case management and workflow to track a member's care from inception to conclusion, with the tracking of key events being triggered based on the member's condition or type of services required. Provider staff, case managers, and state staff are able to complete assessments, plans of care, and cost plans, and to authorize specific services available for a member. Once a care program is onboarded into the MPATH care management solution, the associated providers that serve that care program population are required to use the care management module for case management activities. Medicaid-enrolled providers for specific care programs will be able to access the care management module, which is scheduled to be accessible by December 2022.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022. The State intends to roll out the SMI care management module by December 2022.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	***Current Status:*** As described above, there is widespread adoption of EHRs among providers, and treatment plans are accessible to the care teams within each agency. However, there may be rural providers that have not fully adopted EHRs. Also, there may barriers for members employed by providers with EHRs in certain geographic regions, due to limited broadband connectivity or the mobile nature of some services.

Prompts	Summary
	Future Status: The care management module in MPATH will provide comprehensive case management and workflow to track a member's care from inception to conclusion, with the tracking of key events being triggered based on the member's condition or the type of services required. Once a care program is onboarded into the MPATH care management solution, the associated providers that serve that care program population are required to use the care management module for case management activities. Medicaid-enrolled providers for specific care programs will be able to access the care management module, which is scheduled to be accessible by December 2022. Additionally, DPHHS will survey IMDs and providers of other services outlined in the waiver to identify the baseline of current activities and identify options for any needed increases in implementation.
	Summary of Actions Needed: *N/A*
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	***Current Status:*** MPATH includes an enterprise data warehouse (EDW) that serves as a central repository for all Montana Healthcare Programs enterprise data. This, combined with the care management services and data analytics services modules, will permit the State to track medical records as a youth transitions to adulthood. The MPATH HealtheRegistries component already compiles all available claims and clinical data for every Medicaid member, including transition-aged youth. This is currently available to providers for the individuals they serve in our care programs such as CPC+, PCMH, and T-HIP.
	Future Status: The State will continue working on rolling out updates to the MPATH care management module, which will enhance electronic communications.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022. The SMI-specific module will be rolled out by December 2022.

Prompts	Summary
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	***Current Status:*** Due to widespread adoption of EHRs across providers and the State's development of a care management module in MPATH, which will be available to all Montana Healthcare Programs providers (youth and adult), there are solutions for the creation of electronic care plans. However, there may be rural providers that have not fully adopted EHRs.
	Future Status: The State will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider implementation.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	***Current Status:*** There is widespread adoption of EHRs across providers; however, the extent of coordination of care through electronic communications is unknown.
	Future Status: The State will work toward compliance with CMS requirements. By early 2022, ADT messages for all Medicaid members will be received from the Statewide HIE administered by BSCC. These messages will be posted on the members' home page and sent to the assigned case managers in the care management solution. In addition, these messages will be available to view via an EDW report available to assigned users.
	Summary of Actions Needed: Complete ADT and HIE connectivity by March 2022.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is	***Current Status:*** Due to widespread adoption of EHRs, providers have the capacity exists to electronically

Prompts	Summary
electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	capture individual consent, and that consent is available in those EHRs. However, there may be rural providers that have not fully adopted EHRs.
	Future Status: The State will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider implementation.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	***Current Status:*** Clinical documentation components are included in providers' EHRs. MPATH's care management module will support the development and monitoring of both assessments and screenings. Montana's SMHP goals include ensuring availability of patient data across multiple HIT solutions.
	Future Status: The State will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider implementation by July 1, 2022. MPATH's functionality for SMI providers will go live by December 2022.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022. MPATH's functionality for SMI providers will be live by December 2022.
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of	***Current Status:*** Montana Medicaid allows telehealth as a method of service delivery. Numerous behavioral health and primary care providers are currently utilizing telehealth to provide services. Quite often collaboration occurs between the provider's own internal resources. It is unclear to what extent

Prompts	Summary
integrated mental health care and primary care	providers are leveraging telehealth to support collaborative care across providers and settings.
	Future Status: The State will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider implementation.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022.
Alerting/Analytics (Section 6)	
6.1 The State can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[44])	***Current State:*** Behavioral health agencies are required to perform utilization reviews to ensure that their services are effective and address member needs. Residential and intensive community-based services have staffing and service requirements that ensure frequent contact with and outreach to patients that support the identification of patients at risk.
	Future State: Milestone met.
	Summary of Actions Needed: Milestone met.
6.2 Health IT is being used to advance the care coordination	***Current State:*** Montana's FEP program, EPIC Montana, is part of the SAMHSA's early intervention strategies for treating individuals experiencing the first signs of psychosis. Montana's program utilizes an

[44] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf.

Prompts	Summary
workflow for patients experiencing their first episode of psychosis	evidence-based model called Specialized Treatment Early in Psychosis (STEP). STEP is an interdisciplinary team approach to providing comprehensive care for individuals early in the onset of a psychotic illness, which starts with thorough assessment. Treatment may include medication management, community coaching (e.g., support in getting back to school or work), individual and group therapy, and support and education for family members and friends. However, the service is not available statewide, and most patients rely on support from their local provider.
	Future State: The State will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider implementation. By the end of 2022, MPATH will establish a bidirectional integration with the BSCC statewide HIE. This will involve sending claims and clinical data to the HIE and receiving clinical and ADT messages from the HIE.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022. MPATH will establish a bidirectional integration with the BSCC statewide HIE by December 2022.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	***Current Status:*** The ability to link parent-child records is a feature of some EHRs and could be achieved through MPATH. Montana currently has care coordination as a component of several bundled rates for both SMI and SED. However, the ability to link records is not a current feature, as existing EDW data does not indicate the parent-child relationship on Medicaid claims.
	Future Status: Montana intends to expand coordinated care through a state plan amendment. This shows an interest and need for potential linkage of parent-child medical records. The state will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider

Prompts	Summary
	implementation.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022. Discussion between the State and stakeholders will drive the timeline for a state plan amendment.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	***Current Status:*** In 2018, as part of the updated SMHP, the MMA surveyed primary care providers (PCPs) and non-primary care providers (non-PCPs) to determine adoption of EHRs. The survey showed that 91% of PCPs and 93% of non-PCPs had EHRs. Recent outreach to MHCs indicated that 100% have adopted EHRs. Additionally, MPATH includes an EDW that serves as a central repository for all Montana Healthcare Programs enterprise data.
	Future Status: MPATH's modular approach is aligned with CMS standards and conditions. Additionally, the state will conduct a survey of providers to identify the baseline of current activity and identify options for increasing provider implementation.
	Summary of Actions Needed: The provider survey will be conducted by DPHHS or its designee by July 1, 2022. The dates for the survey and MPATH's modular solutions will be based on the status of objectives outlined in the updated SMHP.

Section 3: Relevant documents

Please provide any additional documentation or information that the State deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

G. Budget Neutrality

IMD Overview

How To Use This Spreadsheet:

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

Scenario 1

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

Scenario 2

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

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

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

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

Estimation for the IMD Services Limit

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

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

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

Multiple MEGs

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

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

Member Month Non-Duplication

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

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

State Data Inputs

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

- CMS will provide template instructions with this spreadsheet.

"In Lieu of" Services

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

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

Unallowable Costs

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

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

Supplemental Methodology Document

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

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

IMD Historical

Representative Data Year:	2020
Type of State Years:	Calendar

IMD SUD EXP MEG 1	2020
TOTAL EXPENDITURES	$502,027
ELIGIBLE MEMBER MONTHS	71
PMPM COST	$7,070.80

IMD SUD STD MEG 2	
TOTAL EXPENDITURES	$212,124
ELIGIBLE MEMBER MONTHS	30
PMPM COST	$7,070.80

IMD MSH EXP MEG 3	
TOTAL EXPENDITURES	$7,817,937
ELIGIBLE MEMBER MONTHS	392
PMPM COST	$19,943.72

IMD MSH STD MEG 4	
TOTAL EXPENDITURES	$5,661,265
ELIGIBLE MEMBER MONTHS	284
PMPM COST	$19,934.03

Continue MEGs from Above, As Needed

Alternate Development: IMD Services + Non-IMD & Non-Hypo CNOMs	Estimated Total Expenditures for Medical Assistance Provided in an IMD that are:		Managed Care PMPM (Replicate Column, as Necessary)			2020 Choose "Included" from Drop-Down(s) to Link Services with MEG(s)				
						CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
IMD Services	Currently State Plan FFS (e.g. Carved Out) or Not Currently State Plan but Otherwise Approvable (Including Pending SPAs)	Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or "Costs Not Otherwise Matchable" ("Non-IMD" or "Non-Hypo" CNOMs)	Capitated PMPM for Currently Approved, non-IMD, State Plan or Other Title XIX Services	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost for All Services Provided in an IMD	IMD SUD EXP MEG 1	IMD SUD STD MEG 2	IMD MSH EXP MEG 3	Non-IMD Services CNOM Limit MEG	Non-Hypothetical Services CNOM MEG
Service 1			$0		#DIV/0!					
Service 2			$0		#DIV/0!					
Service 3			$0		#DIV/0!					
Service 4			$0		#DIV/0!					
Service 5			$0		#DIV/0!					
Service 6			$0		#DIV/0!					
Service 7			$0		#DIV/0!					
Service 8			$0		#DIV/0!					
Service 9			$0		#DIV/0!					
Service 10			$0		#DIV/0!					
Service 11			$0		#DIV/0!					
Service 12			$0		#DIV/0!					
Add additional services, as necessary			$0		#DIV/0!					
Totals						$0.00	$0.00	$0.00	$0.00	$0.00

IMD Without Waiver

PB Trend Rate(s) Used:

IMD SUD EXP MEG 1	1.00%
IMD SUD STD MEG 2	1.00%
IMD MSH EXP MEG 3	1.00%
Eligible Member Months	1.00%

Start DY

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) 2022	2023	2024	2025	2026	TOTAL WOW
IMD SUD EXP MEG 1									
Eligible Member Months	n.a.	n.a.	71	140	175	179	182	186	
PMPM Cost	1.0%	24	$ 7,071	$ 7,213	$ 7,285	$ 7,358	$ 7,431	$ 7,506	
Total Expenditure				$ 1,009,810	$ 1,274,886	$ 1,313,387	$ 1,353,051	$ 1,393,913	$ 6,345,047
IMD SUD STD MEG 2									
Eligible Member Months	n.a.	n.a.	30	60	75	77	78	80	
PMPM Cost	1.0%	24	$ 7,071	$ 7,213	$ 7,285	$ 7,358	$ 7,431	$ 7,506	
Total Expenditure				$ 432,775	$ 546,379	$ 562,879	$ 579,878	$ 597,390	$ 2,719,302
IMD MSH EXP MEG 3									
Eligible Member Months	n.a.	n.a.	392	392	392	392	392	392	
PMPM Cost	1.0%	24	$ 23,382	$ 23,852	$ 24,091	$ 24,332	$ 24,575	$ 24,821	
Total Expenditure				$ 9,350,090	$ 9,443,590	$ 9,538,026	$ 9,633,408	$ 9,729,742	$ 47,694,856

Continue MEGs from Above, As Needed

IMD MSH STD MEG 4									
Eligible Member Months	n.a.	n.a.	284	284	284	284	284	284	
PMPM Cost	1.0%	24	$ 23,382	$ 23,852	$ 24,091	$ 24,332	$ 24,575	$ 24,821	
Total Expenditure				$ 6,774,045	$ 6,841,784	$ 6,910,203	$ 6,979,306	$ 7,049,099	$ 34,554,436

IMD With Waiver

ELIGIBILITY GROUP	LAST HISTORIC YEAR	PB TREND RATE	DEMONSTRATION YEARS (DY) 2022	2023	2024	2025	2026	TOTAL WW
IMD SUD EXP MEG 1								
Eligible Member Months			140	175	179	182	186	
PMPM Cost	$ 7,071	1.0%	$ 7,213	$ 7,285	$ 7,358	$ 7,431	$ 7,506	
Total Expenditure			$ 1,009,810	$ 1,274,886	$ 1,313,387	$ 1,353,051	$ 1,393,913	$ 6,345,047
IMD SUD STD MEG 2								
Eligible Member Months			60	75	77	78	80	
PMPM Cost	$ 7,071	1.0%	$ 7,213	$ 7,285	$ 7,358	$ 7,431	$ 7,506	
Total Expenditure			$ 432,775	$ 546,379	$ 562,879	$ 579,878	$ 597,390	$ 2,719,302
IMD MSH EXP MEG 3								
Eligible Member Months			392	392	392	392	392	
PMPM Cost	$ 23,382	1.0%	$ 23,852	$ 24,091	$ 24,332	$ 24,575	$ 24,821	
Total Expenditure			$ 9,350,090	$ 9,443,590	$ 9,538,026	$ 9,633,408	$ 9,729,742	$ 47,694,856
Continue MEGs from Above, As Needed								
IMD MSH STD MEG 4								
Eligible Member Months	284		284	284	284	284	284	
PMPM Cost	$ 23,382	1.0%	$ 23,852	$ 24,091	$ 24,332	$ 24,575	$ 24,821	
Total Expenditure			$ 6,774,045	$ 6,841,784	$ 6,910,203	$ 6,979,306	$ 7,049,099	$ 34,554,436

Main Budget Neutrality Test (i.e. NOT Hypothetical)
Non-Hypothetical Services CNOM MEG

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Eligible Member Months	n.a.	n.a.	n.a.	284	284	284	284	284	
PMPM Cost	1.0%		$ -	$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

IMD Summary

Supplemetal Test #1: IMD Services Cost Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2022	2023	2024	2025	2026	
IMD SUD EXP MEG 1	$1,009,810	$1,274,886	$1,313,387	$1,353,051	$1,393,913	$6,345,047
IMD SUD STD MEG 2	$432,775	$546,379	$562,879	$579,878	$597,390	$2,719,302
IMD MSH EXP MEG 3	$9,350,090	$9,443,590	$9,538,026	$9,633,408	$9,729,742	$47,694,856
Continue MEGs from Above, As Needed						
TOTAL	$10,792,675	$11,264,854	$11,414,293	$11,566,338	$11,721,045	$56,759,204

With-Waiver Total Expenditures

	2022	2023	2024	2025	2026	TOTAL
IMD SUD EXP MEG 1	$1,009,810	$1,274,886	$1,313,387	$1,353,051	$1,393,913	$6,345,047
IMD SUD STD MEG 2	$432,775	$546,379	$562,879	$579,878	$597,390	$2,719,302
IMD MSH EXP MEG 3	$9,350,090	$9,443,590	$9,538,026	$9,633,408	$9,729,742	$47,694,856
Continue MEGs from Above, As Needed						
TOTAL	$10,792,675	$11,264,854	$11,414,293	$11,566,338	$11,721,045	$56,759,204
Net Overspend	$0	$0	$0	$0	$0	$0

Supplemental Test #2: Non-IMD Services CNOM Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2022	2023	2024	2025	2026	
IMD MSH STD MEG 4	$6,774,045	$6,841,784	$6,910,203	$6,979,306	$7,049,099	$34,554,436
TOTAL	$6,774,045	$6,841,784	$6,910,203	$6,979,306	$7,049,099	$34,554,436

With-Waiver Total Expenditures

	2022	2023	2024	2025	2026	TOTAL
IMD MSH STD MEG 4	$6,774,045	$6,841,784	$6,910,203	$6,979,306	$7,049,099	$34,554,436
TOTAL	$6,774,045	$6,841,784	$6,910,203	$6,979,306	$7,049,099	$34,554,436
Net Overspend	$0	$0	$0	$0	$0	$0

Main Budget Neutrality Test (i.e. NOT Hypothetical)

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2022	2023	2024	2025	2026	
Non-Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0

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

SUD MEG(s)	Trend Rate	2022	2023	2024	2025	2026
IMD SUD EXP MEG 1	1.0%	$7,213	$7,285	$7,358	$7,431	$7,506
IMD SUD STD MEG 2	1.0%	$7,213	$7,285	$7,358	$7,431	$7,506
IMD MSH EXP MEG 3	1.0%	$23,852	$24,091	$24,332	$24,575	$24,821
Continue MEGs from Above, As Needed						
IMD MSH STD MEG 4	1.0%	$23,852	$24,091	$24,332	$24,575	$24,821
Main Test: With Waiver "Coster(s)" (Amendments Only)						
Non-Hypothetical Services CNOM MEG	1.0%	$0	$0	$0	$0	$0

IMD Caseloads

Projected IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	2022	2023	2024	2025	2026
IMD SUD EXP MEG 1	2.0%	140	175	179	182	186
IMD SUD STD MEG 2	2.0%	60	75	77	78	80
IMD MSH EXP MEG 3	0.0%	392	392	392	392	392
IMD MSH STD MEG 4	0.0%	284	284	284	284	284
Non-Hypothetical Services CNOM MEG			0	0	0	0

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Total										
Tenancy										
Pop Type:	Hypothetical									
Eligible Member Months					165	336	346	356	367	
PMPM Cost					$ 2,691.84	$ 2,718.76	$ 2,745.95	$ 2,773.41	$ 2,801.14	
Total Expenditure					$ 444,154	$ 913,503	$ 950,318	$ 988,616	$ 1,028,456	$ 4,325,048
Prison										
Pop Type:	Hypothetical									
Eligible Member Months					150	300	300	300	300	
PMPM Cost					$ 294.32	$ 297.26	$ 300.24	$ 303.24	$ 306.27	
Total Expenditure					$ 44,148	$ 89,179	$ 90,071	$ 90,971	$ 91,881	$ 406,250
TRUST										
Pop Type:	Hypothetical									
Eligible Member Months					90	180	360	371	382	
PMPM Cost					$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	
Total Expenditure					$ 268,294	$ 536,587	$ 1,073,174	$ 1,105,370	$ 1,138,531	$ 4,121,956
PlaceHolder										
Pop Type:	Hypothetical									
Eligible Member Months					-	-	-	-	-	
PMPM Cost					$ -	$ -	$ -	$ -	$ -	
Total Expenditure					$ -	$ -	$ -	$ -	$ -	$ -

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Medicaid										
Tenancy										
Pop Type:	Hypothetical									
Eligible Member Months					38	77	80	82	84	
PMPM Cost					$ 2,691.84	$ 2,718.76	$ 2,745.95	$ 2,773.41	$ 2,801.14	
Total Expenditure					$ 102,155	$ 210,106	$ 218,573	$ 227,392	$ 236,545	$ 994,761
Prison										
Pop Type:	Hypothetical									
Eligible Member Months					54	108	108	108	108	
PMPM Cost					$ 294.32	$ 297.26	$ 300.24	$ 303.24	$ 306.27	
Total Expenditure					$ 15,893	$ 32,104	$ 32,425	$ 32,750	$ 33,077	$ 146,250
TRUST										
Pop Type:	Hypothetical									
Eligible Member Months					20	40	79	82	84	
PMPM Cost					$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	
Total Expenditure					$ 59,025	$ 118,049	$ 236,099	$ 243,181	$ 250,477	$ 906,830
PlaceHolder										
Pop Type:	Hypothetical									
Eligible Member Months					-	-	-	-	-	
PMPM Cost					$ -	$ -	$ -	$ -	$ -	
Total Expenditure					$ -	$ -	$ -	$ -	$ -	$ -

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Expansion										
Tenancy										
Pop Type:	Hypothetical									
Eligible Member Months					127	259	266	274	283	
PMPM Cost					$ 2,691.84	$ 2,718.76	$ 2,745.95	$ 2,773.41	$ 2,801.14	
Total Expenditure					$ 341,998	$ 703,398	$ 731,745	$ 761,235	$ 791,911	$ 3,330,287
Prison										
Pop Type:	Hypothetical									
Eligible Member Months					96	192	192	192	192	
PMPM Cost					$ 294.32	$ 297.26	$ 300.24	$ 303.24	$ 306.27	
Total Expenditure					$ 28,255	$ 57,075	$ 57,645	$ 58,222	$ 58,804	$ 260,000
TRUST										
Pop Type:	Hypothetical									
Eligible Member Months					70	140	281	289	298	
PMPM Cost					$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	
Total Expenditure					$ 209,369	$ 418,536	$ 837,076	$ 862,188	$ 888,054	$ 3,215,125
PlaceHolder										
Pop Type:	Hypothetical									
Eligible Member Months					-	-	-	-	-	
PMPM Cost					$ -	$ -	$ -	$ -	$ -	
Total Expenditure					$ -	$ -	$ -	$ -	$ -	$ -

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

Total

ELIGIBILITY GROUP		DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Tenancy									
Pop Type:	Hypothetical								
Eligible Member Months				165	336	346	356	367	
PMPM Cost				$ 2,691.84	$ 2,718.76	$ 2,745.95	$ 2,773.41	$ 2,801.14	
Total Expenditure				$ 444,154	$ 913,503	$ 950,318	$ 988,616	$ 1,028,456	$ 4,325,048
Prison									
Pop Type:	Hypothetical								
Eligible Member Months				150	300	300	300	300	
PMPM Cost				$ 294.32	$ 297.26	$ 300.24	$ 303.24	$ 306.27	
Total Expenditure				$ 44,148	$ 89,179	$ 90,071	$ 90,971	$ 91,881	$ 406,250
TRUST									
Pop Type:	Hypothetical								
Eligible Member Months				90	180	360	371	382	
PMPM Cost				$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	
Total Expenditure				$ 268,294	$ 536,587	$ 1,073,174	$ 1,105,370	$ 1,138,531	$ 4,121,956
PlaceHolder									
Pop Type:	Hypothetical								
Eligible Member Months				-	-	-	-	-	
PMPM Cost				$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. TI

Medicaid

ELIGIBILITY GROUP		DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Tenancy									
Pop Type:	Hypothetical								
Eligible Member Months				38	77	80	82	84	
PMPM Cost				$ 2,691.84	$ 2,718.76	$ 2,745.95	$ 2,773.41	$ 2,801.14	
Total Expenditure				$ 102,155	$ 210,106	$ 218,573	$ 227,382	$ 236,545	$ 994,761
Prison									
Pop Type:	Hypothetical								
Eligible Member Months				54	108	108	108	108	
PMPM Cost				$ 294.32	$ 297.26	$ 300.24	$ 303.24	$ 306.27	
Total Expenditure				$ 15,893	$ 32,104	$ 32,425	$ 32,750	$ 33,077	$ 146,250
TRUST									
Pop Type:	Expansion								
Eligible Member Months				20	40	79	82	84	
PMPM Cost				$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	
Total Expenditure				$ 59,025	$ 118,049	$ 236,098	$ 243,181	$ 250,477	$ 906,830
PlaceHolder									
Pop Type:	Expansion								
Eligible Member Months				-	-	-	-	-	
PMPM Cost				$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. T

Expansion

ELIGIBILITY GROUP		DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Tenancy									
Pop Type:	Hypothetical								
Eligible Member Months				127	259	266	274	283	
PMPM Cost				$ 2,691.84	$ 2,718.76	$ 2,745.95	$ 2,773.41	$ 2,801.14	
Total Expenditure				$ 341,998	$ 703,398	$ 731,745	$ 761,235	$ 791,911	$ 3,330,287
Prison									
Pop Type:	Hypothetical								
Eligible Member Months				96	192	192	192	192	
PMPM Cost				$ 294.32	$ 297.26	$ 300.24	$ 303.24	$ 306.27	
Total Expenditure				$ 28,255	$ 57,075	$ 57,645	$ 58,222	$ 58,804	$ 260,000
TRUST									
Pop Type:	Expansion								
Eligible Member Months				70	140	281	289	298	
PMPM Cost				$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	$ 2,981.04	
Total Expenditure				$ 209,269	$ 418,538	$ 837,076	$ 862,188	$ 888,054	$ 3,215,125
PlaceHolder									
Pop Type:	Expansion								
Eligible Member Months				-	-	-	-	-	
PMPM Cost				$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1	**Budget Neutrality Summary**																						
2																							
45	**HYPOTHETICALS ANALYSIS**																						
46																							
47	**Without-Waiver Total Expenditures**								**Without-Waiver Total Expenditures**								**Without-Waiver Total Expenditures**						
48		**DEMONSTRATION YEARS (DY)**					**TOTAL**			**DEMONSTRATION YEARS (DY)**					**TOTAL**			**DEMONSTRATION YEARS (DY)**					**TOTAL**
49		**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**				**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**				**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	
50	**Tenancy**	$ 444,154	$ 913,503	$ 950,318	$ 988,616	$ 1,028,456	$ 4,325,048		**Tenancy**	$ 102,155	$ 210,106	$ 218,573	$ 227,382	$ 236,545	$ 994,761		**Tenancy**	$ 341,998	$ 703,398	$ 731,745	$ 761,235	$ 791,911	$ 3,330,287
51	**Prison**	$ 44,148	$ 89,179	$ 90,071	$ 90,971	$ 91,881	$ 406,250		**Prison**	$ 15,893	$ 32,104	$ 32,425	$ 32,750	$ 33,077	$ 146,250		**Prison**	$ 28,255	$ 57,075	$ 57,645	$ 58,222	$ 58,804	$ 260,000
52	**TRUST**	$ 268,294	$ 536,587	$ 1,073,174	$ 1,105,370	$ 1,138,531	$ 4,121,956		**TRUST**	$ 59,025	$ 118,049	$ 236,098	$ 243,181	$ 250,477	$ 906,830		**TRUST**	$ 209,269	$ 418,538	$ 837,076	$ 862,188	$ 888,054	$ 3,215,125
53	**PlaceHolder**	$ -	$ -	$ -	$ -	$ -	$ -		**PlaceHolder**	$ -	$ -	$ -	$ -	$ -	$ -		**PlaceHolder**	$ -	$ -	$ -	$ -	$ -	$ -
54																							
55																							
56	**TOTAL**	$ 756,595	$ 1,539,270	$ 2,113,564	$ 2,184,957	$ 2,258,868	$ 8,853,254		**TOTAL**	$ 177,073	$ 360,259	$ 487,097	$ 503,313	$ 520,099	$ 2,047,841		**TOTAL**	$ 579,522	$ 1,179,010	$ 1,626,466	$ 1,681,645	$ 1,738,769	$ 6,805,412
57																							
58	**With-Waiver Total Expenditures**								**With-Waiver Total Expenditures**								**With-Waiver Total Expenditures**						
59		**DEMONSTRATION YEARS (DY)**					**TOTAL**			**DEMONSTRATION YEARS (DY)**					**TOTAL**			**DEMONSTRATION YEARS (DY)**					**TOTAL**
60		**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**				**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**				**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	
61	**Tenancy**	$ 444,154	$ 913,503	$ 950,318	$ 988,616	$ 1,028,456	$ 4,325,048		**Tenancy**	$ 102,155	$ 210,106	$ 218,573	$ 227,382	$ 236,545	$ 994,761		**Tenancy**	$ 341,998	$ 703,398	$ 731,745	$ 761,235	$ 791,911	$ 3,330,287
62	**Prison**	$ 44,148	$ 89,179	$ 90,071	$ 90,971	$ 91,881	$ 406,250		**Prison**	$ 15,893	$ 32,104	$ 32,425	$ 32,750	$ 33,077	$ 146,250		**Prison**	$ 28,255	$ 57,075	$ 57,645	$ 58,222	$ 58,804	$ 260,000
63	**TRUST**	$ 268,294	$ 536,587	$ 1,073,174	$ 1,105,370	$ 1,138,531	$ 4,121,956		**TRUST**	$ 59,025	$ 118,049	$ 236,098	$ 243,181	$ 250,477	$ 906,830		**TRUST**	$ 209,269	$ 418,538	$ 837,076	$ 862,188	$ 888,054	$ 3,215,125
64	**PlaceHolder**	$ -	$ -	$ -	$ -	$ -	$ -		**PlaceHolder**	$ -	$ -	$ -	$ -	$ -	$ -		**PlaceHolder**	$ -	$ -	$ -	$ -	$ -	$ -
65																							
66																							
67	**TOTAL**	$ 756,595	$ 1,539,270	$ 2,113,564	$ 2,184,957	$ 2,258,868	$ 8,853,254		**TOTAL**	$ 177,073	$ 360,259	$ 487,097	$ 503,313	$ 520,099	$ 2,047,841		**TOTAL**	$ 579,522	$ 1,179,010	$ 1,626,466	$ 1,681,645	$ 1,738,769	$ 6,805,412
68																							
69	**HYPOTHETICALS VARIANCE**	$ -	$ -	$ -	$ -	$ -	$ -		**HYPOTHETICALS VARIANCE**	$ -	$ -	$ -	$ -	$ -	$ -		**HYPOTHETICALS VARIANCE**	$ -	$ -	$ -	$ -	$ -	$ -