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Interim Evaluation Report

Montana HEART 1115(a)
Waiver Demonstration Project

June 30, 2026

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A. Executive Summary

The Healing and Ending Addiction through Recovery and Treatment (HEART) Section 1115(a) Medicaid demonstration, approved July 1, 2022, expands access to evidence-based substance use disorder (SUD) treatment in Montana. This interim evaluation assesses implementation and outcomes from July 1, 2022, through June 30, 2025, with a primary focus on the IMD component, which was the only fully operational component during the evaluation period. Newly approved components—contingency management, tenancy supports, and reentry services—were approved during the evaluation period but were not implemented until after or near the end of its close. As such, they are not included in outcome analysis. Findings related to these components reflect pre-implementation provider and stakeholder perspectives only.

Across all major service categories, rates of SUD treatment increased from DY1 to DY2, including outpatient care, residential and inpatient services, withdrawal management, and medication-assisted treatment (MAT). The largest gains were observed in MAT and residential/inpatient services. These increases occurred despite a substantial decline in Medicaid enrollment during the unwinding period, indicating increases in access on a per-beneficiary basis. Qualitative findings are consistent with these trends, with beneficiaries and providers reporting faster access to treatment, clearer referral pathways, and expanded availability of residential care.

At the same time, improvements in access were not consistently matched by improvements in continuity of care or care transitions. Pharmacotherapy continuity declined, follow-up after emergency department visits decreased modestly, and readmission rates increased slightly. Qualitative findings attribute these patterns to structural factors, including workforce shortages, limited step-down placement options, housing instability, and coverage disruptions during Medicaid redetermination, rather than deficiencies in clinical care.

Implementation of the IMD component is also associated with measurable system-level changes. Providers report increased alignment with evidence-based practices, including widespread use of ASAM criteria and normalization of MAT within residential settings. State-led training and technical assistance have strengthened provider engagement and implementation consistency.

Findings should be interpreted in the context of external disruptions, including the COVID-19 Public Health Emergency and Medicaid unwinding, and the absence of a comparison group. However, results are consistent across quantitative and qualitative data sources and demonstrate a clear pattern: the demonstration has expanded access to SUD treatment but remains constrained in its ability to sustain continuity and coordination due to structural system limitations.

Based on the totality of evidence, the HEART demonstration is on a positive trajectory and demonstrates progress toward expanding access and development of newly approved components. The findings provide strong support for continuation and renewal of the waiver to sustain demonstrated gains in access, support the maturation of newly implemented components, and address the structural barriers identified in this evaluation that currently limit continuity, coordination, and long-term outcomes.

B. General Background Information about the Demonstration

1. Demonstration Overview, Approval, and Reporting

The Healing and Ending Addiction through Recovery and Treatment (HEART) Section 1115(a) Medicaid demonstration was approved by the Centers for Medicare & Medicaid Services (CMS) on July 1, 2022, for a five-year period through June 30, 2027.

Program Description and Objectives

The goal of this demonstration is for the state to enhance access to mental health services, opioid use disorder (OUD), and other substance use disorder (SUD) services and to provide a comprehensive continuum of behavioral health services and SUD treatment to Medicaid beneficiaries with SUD. This demonstration provides the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). It also supports state efforts to link individuals with the appropriate level of care, improve the availability of Medication Assisted Treatment (MAT), and improve access to a continuum of SUD evidence-based services at varied levels of intensity, including withdrawal management services.

The demonstration also supports access to contingency management services for qualifying individuals with a stimulant use disorder and covers pre-tenancy and tenancy support services for qualifying individuals who are experiencing housing insecurity. Finally, the demonstration allows the state to provide a targeted set of pre-release services to individuals who are Medicaid eligible and who are incarcerated in state prisons. This set of services is covered for up to 30 days immediately prior to the expected date of release to improve transitions (in particular, transitions of health coverage and care) back to the community.

During the demonstration period, the state seeks to achieve the following goals:

1. Increased rates of identification, initiation, and engagement in treatment for SUD;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate;
6. Improved access to care for physical health conditions among beneficiaries with SUD;
7. Improved access to community-based treatments and recovery supports, such as tenancy supports and contingency management, to address the behavioral health needs of individuals with serious mental illness (SMI) or SUD.

For the reentry demonstration initiative, the state has the following goals:

1. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings prior to release;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release;
3. Improve coordination and communication between correctional systems, the Montana state Medicaid agency, and community-based providers;

4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings, and in the community to maximize successful reentry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs (HRSN);
6. Reduce all-cause deaths in the near-term post-release;
7. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventative and routine physical and behavioral health care; and
8. Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing overdose, and overdose-related death in the near-term post-release.

The initial waiver approval included the IMD component. On February 26, 2024, CMS approved an amendment to the demonstration to provide the expenditure authority for contingency management services to individuals who have been diagnosed with a stimulant use disorder, pre-tenancy and tenancy support services to qualifying individuals, and pre-release services for qualifying incarcerated beneficiaries. These components are designed to further promote Medicaid objectives by expanding coverage of health care services that would otherwise not be available and increasing access to an array of services that are expected to allow beneficiaries to more effectively access healthcare.

Populations Impacted

Under the demonstration, there is no change to Medicaid eligibility, and the standards and methodologies for eligibility remain set forth under the state plan. All enrollees ages 18-64 that are eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan, or other section 1115 demonstrations are eligible to receive benefits under this demonstration. Medicaid beneficiaries qualify for services in this demonstration based on their diagnosis of an SUD. Additional eligibility criteria apply for the amendment components (contingency management, tenancy supports, and pre-release services) as detailed in the Special Terms and Conditions.

Focus of the Interim Evaluation

As of mid-2026, the HEART Section 1115(a) Medicaid demonstration is in its fourth year of a five-year demonstration period, which extends from July 1, 2022, through June 30, 2027. This interim evaluation report covers the evaluation period from July 1, 2022, through June 30, 2025, as required by CMS for interim reporting.

During the evaluation period covered by this report, the demonstration's primary activities and measurable outcomes have centered on the IMD component, which authorizes federal financial participation for short-term residential SUD treatment in IMDs for Medicaid beneficiaries aged 18-64. Since the components approved by the 2024 amendments were scheduled for implementation beginning in calendar year 2025 and beyond, the rollout of these new authorities falls largely outside the scope of this interim evaluation period. At the time of this report, these services were not implemented during the evaluation period and therefore fall outside the scope of this interim evaluation.

Accordingly, this interim evaluation report focuses on the implementation processes, service delivery, and outcomes associated with the IMD component during the evaluation period (July 1, 2022-June 30, 2025). For the amendment components, this report provides only a preliminary description of their scope, status, and planned evaluation approach and evidence of their implementation as provided through qualitative interviews and document analysis. Outcome analyses for Contingency Management, Tenancy Supports, and Pre-Release Services will be addressed in the summative evaluation report, once sufficient implementation experience and claims data are available to support robust evaluation.

C. Research Questions and Hypotheses

1. Targets for Improvement

The HEART demonstration was designed to address longstanding gaps in access to evidence-based SUD treatment for Medicaid beneficiaries in Montana. The primary targets for improvement during the interim evaluation period are:

- Increased rates of identification, initiation, and engagement in treatment for SUD.
- Increased adherence to and retention in treatment.
- Reductions in overdose deaths, particularly those due to opioids.
- Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate.
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
- Improved access to care for physical health conditions among beneficiaries with SUD.

2. Hypotheses, Research Questions, and Intended Outcomes

The evaluation of the IMD component is guided by a set of hypotheses and research questions that operationalize the demonstration's goals. The following hypotheses and research questions are summarized from the CMS-approved evaluation plan and are the primary focus of this interim evaluation:

Hypotheses

- The demonstration will expand access to critical levels of care for opioid use disorder (OUD) and other SUDs, resulting in increased rates of identification, initiation, and engagement in treatment for SUD.
- The demonstration will increase adherence to and retention in treatment for OUD and other SUDs.
- The demonstration will reduce overdose deaths, particularly those due to opioids.
- The demonstration will reduce utilization of emergency departments and inpatient hospital settings for SUD treatment where the utilization is preventable or medically inappropriate.
- The demonstration will reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
- The demonstration will improve access to care for physical health conditions among beneficiaries with SUD.

Research Questions

- Has the implementation of the IMD component increased the rates of identification, initiation, and engagement in SUD treatment among Medicaid beneficiaries?
- Has the demonstration led to increased adherence to and retention in SUD treatment?
- Has the demonstration contributed to reductions in overdose deaths among Medicaid beneficiaries?
- Has the demonstration resulted in reduced utilization of emergency departments and inpatient hospital settings for SUD treatment?
- Has the demonstration reduced preventable readmissions to the same or higher level of care?
- Has access to care for physical health conditions among beneficiaries with SUD improved during the demonstration period?

Intended Outcomes

- Increases in SUD treatment initiation and engagement rates.
- Improved treatment retention and adherence metrics.
- Decreases in overdose mortality rates among Medicaid beneficiaries.
- Reductions in emergency department visits and inpatient admissions for SUD-related care.
- Fewer preventable readmissions to acute or residential care settings.
- Enhanced access to primary and preventive health services for individuals with SUD.

D. Methodology

1. Evaluation Design

The interim evaluation employs a mixed-methods design, consistent with CMS guidance and the approved evaluation plan. The evaluation is structured to assess both the implementation and outcomes of the IMD component of the HEART demonstration during the period from July 1, 2022, through June 30, 2025. Quantitative analyses of Medicaid administrative data are complemented by qualitative data from stakeholder, provider, and beneficiary interviews, beneficiary surveys, and document review. The primary quantitative analytic approach for this interim evaluation is descriptive and trend analysis, examining changes in key measures over time before and after demonstration implementation.

Conceptual Framework

The evaluation is guided by the Driver Diagram presented in the CMS-approved Evaluation Plan, which specifies the hypothesized pathways linking HEART waiver activities and milestones (M1-M6) to improvements in access, quality, and outcomes for beneficiaries with SUD. The diagram illustrates how demonstration activities are expected to increase treatment initiation and engagement, improve retention and care coordination, and ultimately reduce overdose, acute care utilization, and readmissions.

Although the original evaluation design proposed the use of interrupted time series (ITS) analysis to estimate demonstration effects, ITS was not conducted for this interim evaluation. Two primary factors preclude valid ITS at this stage: (1) insufficient post-implementation data, and (2) the presence of significant external confounders during the early demonstration period. Specifically, the overlap of the COVID-19 Public Health Emergency (PHE) with the initial years of the demonstration, as well as the Medicaid eligibility redetermination process (“unwinding”) that began

in 2023, introduced substantial volatility in enrollment and service utilization patterns. The resulting stabilized post-unwinding post-implementation period comprises only approximately five months of claims data — far fewer than required for reliable ITS estimation. Formal ITS and other quasi-experimental analyses are deferred to the summative evaluation, when a longer and more stable post-implementation period will support robust modeling. The primary analytic approach for this interim evaluation is descriptive rate-based trend analysis, comparing DY1 and DY2 rates per 1,000 beneficiary-months across demonstration metrics; the rationale for the rate-based approach is described in Section E.

2. Demonstration and Comparison Populations

Demonstration Population

The primary population for this evaluation consists of Montana Medicaid beneficiaries aged 18–64 who are eligible for full Medicaid benefits and have a diagnosis of SUD, and who received services under the IMD/SUD component during the evaluation period.

Comparison Population

Given the statewide implementation of the demonstration, no true comparison group is available, and the interim evaluation relies on trend analysis within the demonstration population across DY1 and DY2. For overdose mortality outcomes (Metrics 26 and 27), contextual reference is made to statewide age-adjusted overdose death rates from the Montana Department of Health and Human Services (DPHHS) Injury and Overdose Indicators dataset, which provides annual rates per 100,000 Montana population from the Office of Vital Statistics. These statewide rates serve as the principal population-level benchmark for overdose-related outcomes and are the principal external comparison data for this interim evaluation. All external comparisons are descriptive and contextual in nature; the absence of a matched comparison group limits the ability to attribute observed changes in Montana Medicaid outcomes directly to the HEART demonstration in this interim evaluation.

3. Evaluation Period

The evaluation period for this interim report is July 1, 2022, through June 30, 2025, corresponding to the first three years of the demonstration. Baseline data from prior years (2017–2022) are used to establish pre-demonstration trends for key measures. The demonstration period extends through June 30, 2027; however, this interim evaluation is limited to outcomes and activities through June 30, 2025.

This evaluation period overlaps with several major system-level disruptions that are critical for interpreting implementation and early outcomes. The COVID-19 Public Health Emergency (PHE) was declared effective January 1, 2020, and remained in effect through May 11, 2023. During the PHE, Medicaid continuous enrollment requirements were in place, substantially limiting disenrollment and altering coverage dynamics for the demonstration population. Following the end of the PHE, Medicaid eligibility redeterminations (“unwinding”) began April 1, 2023, with states resuming renewals and disenrollments throughout 2023 and 2024. This period of unwinding occurred during the HEART demonstration and had significant implications for coverage continuity, service utilization, provider reimbursement, and discharge planning—particularly for justice-involved, unstably housed, and high-acuity populations.

The demonstration period extends through June 30, 2027; however, this interim evaluation is limited to outcomes, implementation activities, and contextual factors observed through June 30, 2025.

Later phases of implementation—particularly for newer waiver components and post-unwinding stabilization—will be addressed in the summative evaluation.

4. Evaluation Measures

The evaluation measures are mapped to the demonstration's aims and CMS core sets. A full crosswalk of measures, data sources, and analytic methods is provided in the evaluation plan (see Tables 5–7). Key measures include:

- Rates of identification, initiation, and engagement in SUD treatment (e.g., CMS #2, #6, #7, #8, #9, #10, #11, #15)
- Adherence to and retention in treatment (e.g., continuity of pharmacotherapy, MAT utilization)
- Overdose deaths (e.g., CMS #26/27)
- Utilization of emergency departments and inpatient hospital settings for SUD (e.g., CMS #23, #24)
- Readmissions to the same or higher level of care (e.g., CMS #25)
- Access to care for physical health conditions (e.g., CMS #32)
- Provider capacity and availability (e.g., CMS #13, #14)
- Qualitative measures of access, satisfaction, and care coordination from surveys and interviews.

5. Data Sources

This interim evaluation draws on a diverse set of quantitative and qualitative data sources to provide a comprehensive assessment of the HEART demonstration's implementation and outcomes. The primary quantitative data source was Medicaid administrative claims and enrollment data, which enabled calculation of all CMS-defined SUD demonstration metrics, including service utilization, initiation and engagement rates, and trends in access to specific modalities such as IMD, MAT, and withdrawal management. These data also provided detailed information on beneficiary demographics, service dates, provider types, and geographic distribution, and were used to identify beneficiaries eligible for and receiving HEART waiver services since July 1, 2022.

To supplement Medicaid claims data for overdose mortality outcomes, the evaluation drew on the Montana Department of Public Health and Human Services (DPHHS) Injury and Overdose Indicators dataset, which provides statewide age-adjusted overdose death rates per 100,000 Montana population from the Office of Vital Statistics. This dataset serves as the primary external reference for Metrics 26 and 27, for which Medicaid-linked mortality data are not computable due to the absence of payer information in Montana death certificates. Provider capacity metrics (Metrics 13 and 14) were derived directly from Medicaid administrative claims, with unique provider counts identified from active billing records within the claims data rather than from a separate provider enrollment database. Qualitative data collection included semi-structured key informant interviews with DPHHS staff, providers implementing waiver components, Department of Corrections representatives, and external stakeholders such as advocacy organizations and technical assistance providers. These interviews provided rich insights into implementation activities, system changes, and contextual factors influencing progress. In addition, Medicaid beneficiaries who received HEART waiver services were identified via claims data and invited to participate in a REDCap survey and follow-up interviews. The survey captured demographic

information and service experiences, while interviews offered in-depth perspectives on access to care, service navigation, and care transitions.

Finally, administrative document review—including provider manuals, policy documents, and program implementation materials—was conducted to contextualize both quantitative and qualitative findings. All data collection and management procedures adhered to IRB and data use agreement requirements. By triangulating claims, survey, interview, and document data, the evaluation team was able to provide a nuanced and robust analysis of the demonstration’s early impacts.

6. Analytic Methods

Quantitative Claims Analysis

Medicaid administrative claims and enrollment data were used to calculate all CMS-defined SUD demonstration metrics, including service utilization, initiation and engagement rates, and trends in access to specific modalities (e.g., IMD, MAT, withdrawal management). For each metric, the numerator and denominator were constructed according to CMS Adult Core Set and SUD Monitoring Protocol specifications, with the primary outcome reported as the monthly or annual proportion of eligible beneficiaries with a qualifying claim. Trends were assessed over time, with particular attention to changes before and after demonstration implementation and during the Medicaid redetermination (“unwinding”) period. Where appropriate, subgroup analyses were conducted by age, gender, race/ethnicity, and geography. Descriptive statistics were supplemented by visual trend analysis, and all data management and analysis were performed using R and SAS.

Primary Data Methods

Key Informant Interviews

Semi-structured interviews were conducted between March and May 2026 with three groups: (1) DPHHS staff involved with waiver implementation, (2) providers implementing waiver components (IMD, Tenancy Support Services, Contingency Management, and Reentry), and (3) external stakeholders, including advocacy organizations and technical assistance providers. Participants were recruited via email and phone outreach, with scheduling managed through Calendly. Interview guides were developed using the PRISM (Practical, Robust Implementation and Sustainability Model) framework and focused on implementation activities, system changes, and contextual factors influencing progress. All interviews were conducted via Microsoft Teams, recorded, and transcribed verbatim by REV AI. REV AI is a commercial, cloud-based transcription service that uses advanced automatic speech recognition (ASR) technology to convert audio and video recordings into verbatim text transcripts. REV AI is widely used in research, healthcare, and legal settings due to its high accuracy, security features, and rapid turnaround. All interviews transcribed using REV AI’s automated platform were subsequently reviewed for accuracy and completeness by the evaluation team. This process ensures a reliable and auditable record of qualitative data, supporting transparency and rigor in subsequent analysis.

A total of 32 stakeholder and provider interviews were completed, including 3 IMD providers, 11 tenancy support service providers, 4 reentry service providers, 6 contingency management providers, 3 DPHHS HEART program staff, 5 Department of Corrections representatives, 3 external stakeholders, and 1 behavioral health system stakeholder. Several organizations participated in more than one waiver component, and provider and stakeholder service areas spanned both rural and urban regions across Montana.

Beneficiary Survey and Interviews

Medicaid beneficiaries who received any HEART waiver services since July 1, 2022, were identified using claims data and invited to participate in a REDCap survey via recruitment letters mailed by Montana Medicaid. The survey included demographic questions, modules for each waiver component, and items assessing participants' experiences. Respondents could enter a drawing for a \$100 Amazon gift card. Of 93 survey respondents, 83.9% received IMD/SUD services, 11.8% received both IMD/SUD and TSS, and 4.3% received TSS only¹; 52.7% identified as female, 47.3% as male, 63.4% as White, and 37.6% as American Indian/Alaska Native.

Survey respondents could opt in for a follow-up interview. After providing consent and authorization, a member of the evaluation team contacted the beneficiary to schedule an interview, which was conducted via Microsoft Teams (phone or video). The interview guide focused on access to care, service navigation, and care transitions. All interviews were recorded, transcribed verbatim by REV AI, and de-identified prior to analysis. Participants received a \$40 Amazon gift card. In total, 37 beneficiary interviews were completed.

Qualitative Analysis

All stakeholder, provider, and beneficiary interviews were summarized using MAXQDA AI Assist. MAXQDA AI Assist is an integrated artificial intelligence tool within the MAXQDA qualitative data analysis software suite. AI Assist leverages large language models to generate structured summaries, identify key themes, and support coding of qualitative data, based on user-defined prompts and analytic frameworks. In this evaluation, MAXQDA AI Assist was used to generate initial analytic summaries of interview transcripts, guided by structured prompts aligned with the waiver milestones and PRISM framework. All AI-generated outputs were systematically reviewed and validated by qualitative researchers on the evaluation team to ensure fidelity to the source data, accuracy of theme identification, and alignment with analytic objectives. This hybrid approach enhances analytic efficiency while maintaining methodological rigor and transparency. Thematic findings were triangulated with quantitative results to provide a comprehensive assessment of demonstration implementation and outcomes.

7. Other Additions

Human Subjects Protection and Privacy

All primary data collection activities, including beneficiary surveys and interviews as well as key informant interviews, were reviewed and approved by the University of Montana Institutional Review Board (IRB). All participants provided informed consent, and all data collection, storage, and analysis procedures were conducted in accordance with IRB-approved protocols and HIPAA requirements to ensure the protection of participant privacy and confidentiality.

A Business Associate Agreement (BAA) was established between the University of Montana and the Montana Department of Public Health and Human Services (DPHHS) to govern the secure handling and sharing of protected health information (PHI). All PHI and sensitive data were stored and

¹ Survey data were collected in Spring 2026, after the close of the interim evaluation period (June 30, 2025). Tenancy support services were implemented late in the evaluation period (June 6, 2025), and exposure during the evaluation window was minimal. As such, responses indicating receipt of housing-related support may reflect services received after the evaluation period or other housing-related supports and should not be interpreted as representative of tenancy support service delivery during the evaluation period.

analyzed on secure, access-controlled servers managed by the University of Montana, with strict protocols for data encryption, user authentication, and audit logging.

All tools used for data collection and management—including Microsoft Teams for interviews and REV AI for transcription—were reviewed and approved by the University of Montana IRB as part of the evaluation protocol. Only authorized evaluation team members had access to PHI, and all data were de-identified prior to analysis and reporting. These measures collectively ensure rigorous protection of participant data and compliance with all applicable federal and institutional standards.

Evaluation Independence and Agency Review

The HEART interim evaluation was conducted independently by the University of Montana Rural Institute Evaluation Team, in accordance with best practices for external program evaluation. The evaluation team maintained full autonomy over the design, data collection, analysis, and interpretation of findings. Draft findings and analytic summaries were presented to DPHHS leadership and program staff for review, with the purpose of verifying factual accuracy and providing contextual explanations regarding program operations and policy environment. DPHHS staff were invited to offer their own interpretations and to clarify any programmatic details that could inform quality improvement efforts. However, DPHHS did not influence the analytic approach, the interpretation of results, or the conclusions presented in this report. All final findings and recommendations reflect the independent judgment of the evaluation team, ensuring objectivity and methodological rigor throughout the evaluation process.

E. Methodological Limitations

This interim evaluation is subject to several important limitations that should be considered when interpreting the findings. First, the analysis relies heavily on Medicaid administrative claims data, which, while comprehensive for service utilization, may be subject to coding errors, delays in claims submission, and incomplete capture of services provided outside the Medicaid system.

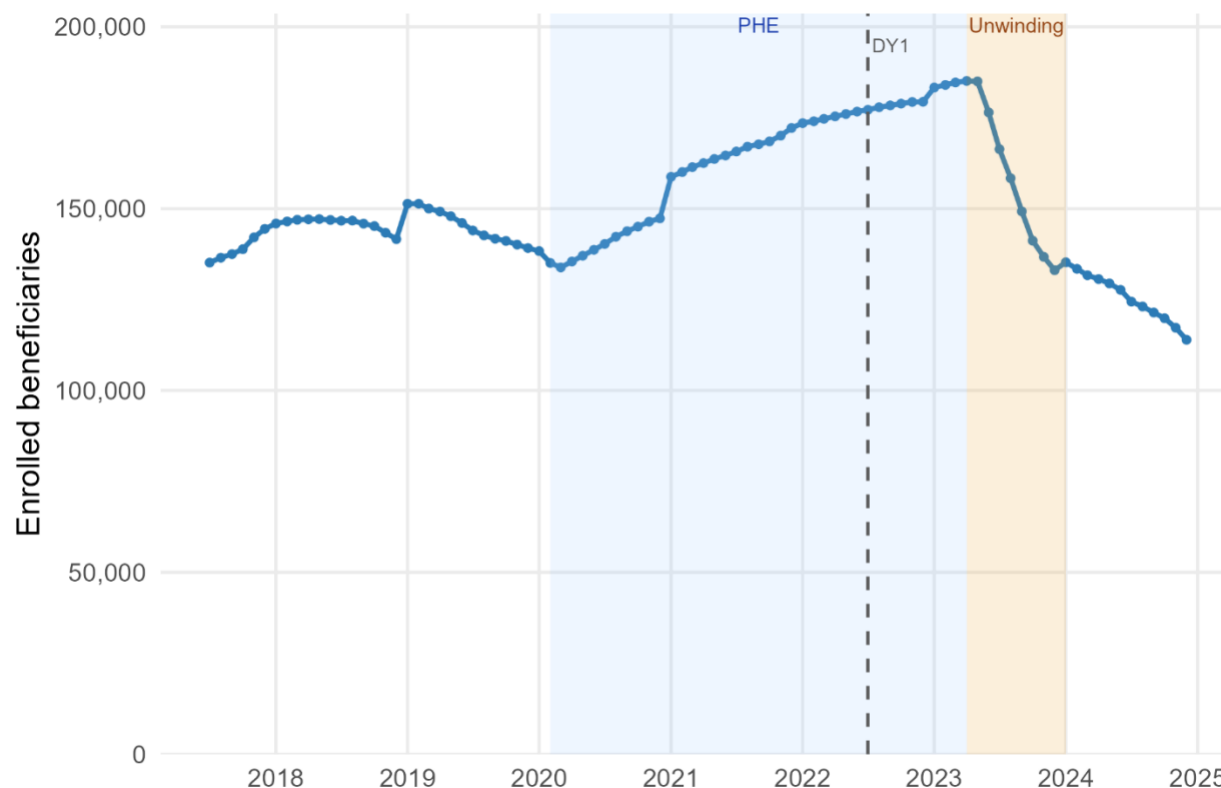
A central analytic limitation is the inability to conduct interrupted time series (ITS) or other quasi-experimental analyses for this interim report. ITS modeling requires enough pre-intervention observations to establish a stable counterfactual trend and enough post-intervention observations to estimate a reliable level change or slope shift. Both requirements are unmet here. For the pre-intervention period, the COVID-19 PHE was declared effective January 27, 2020, and the continuous enrollment requirement took effect February 18, 2020, remaining in force through March 31, 2023. This more than three-year period fundamentally altered Medicaid enrollment dynamics — substantially inflating the enrolled population and suppressing normal disenrollment — making pre-2020 and post-PHE trends non-continuous and inappropriate to pool as a single baseline series. A valid pre-period would require either restricting to pre-COVID data (2017–2019, yielding fewer than 30 quarterly observations), accepting a PHE-specific baseline with its own confounding, or formally segmenting the pre-period — each of which substantially reduces statistical power or introduces new analytic complexity.

For the post-intervention period, the HEART demonstration began July 1, 2022, and Medicaid claims data are available through June 30, 2024, yielding 24 months of nominal post-implementation data. However, the Medicaid unwinding process — during which Montana resumed eligibility redeterminations following the end of the PHE continuous enrollment requirement — began April 1, 2023, and continued through approximately January 2024. This nine-month period of

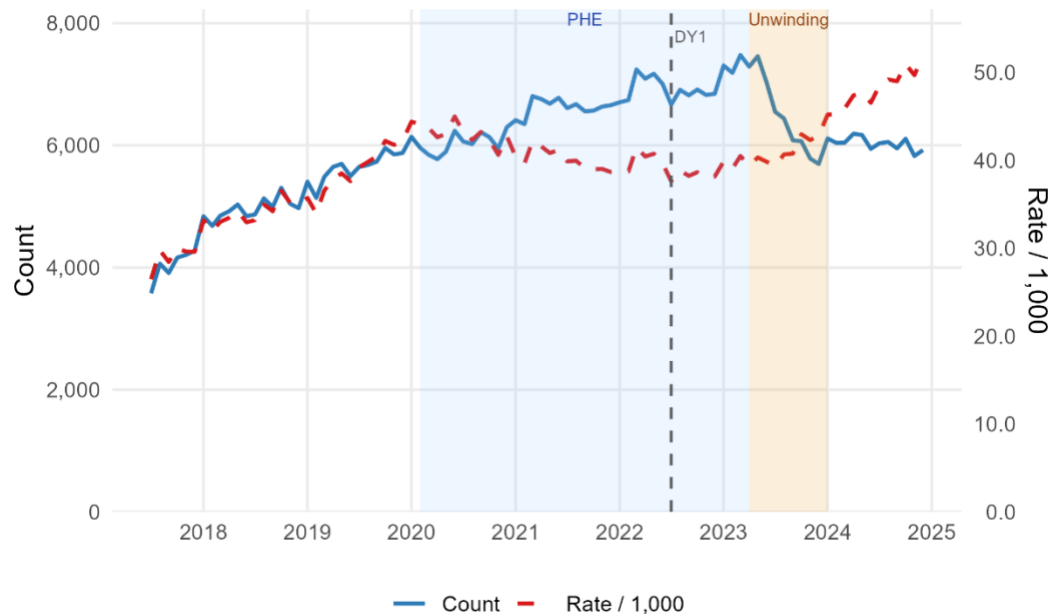
substantial enrollment volatility falls squarely within the early post-implementation window, effectively splitting DY2 into a disrupted phase (April 2023–January 2024) and a stabilized phase (February–June 2024). The clean post-unwinding post-implementation window therefore comprises only approximately five months of data — far fewer than the minimum typically required for reliable ITS estimation.

ITS validity also requires that no concurrent interventions substantially affect the outcome during the post-period. This assumption is violated here. The Medicaid unwinding resulted in an approximately 23% reduction in average monthly enrolled beneficiaries between DY1 (180,792 average monthly enrolled beneficiaries; 2,169,502 total beneficiary-months) and DY2 (139,418 average monthly enrolled beneficiaries; 1,673,019 total beneficiary-months). This enrollment shock independently altered service utilization rates, provider behavior, and denominator composition in ways that cannot be separated from any demonstration effect. Additionally, the February 2024 amendment adding Contingency Management, Tenancy Support Services, and Reentry components introduced new programmatic activity during the post-period, further complicating causal attribution.

For these reasons, formal ITS and other quasi-experimental analyses are deferred to the summative evaluation, when a longer and more stable post-implementation period will be available, the post-unwinding enrollment base will have restabilized, and the full five-year demonstration arc will be observable. The primary analytic approach for this interim evaluation is descriptive rate-based trend analysis, comparing DY1 and DY2 values across all CMS-defined monitoring metrics. Because raw utilization counts are directly proportional to the enrolled population, comparing counts across demonstration years would systematically understate utilization in DY2 relative to DY1 and could produce misleading conclusions about access. Accordingly, all utilization metrics are reported as rates per 1,000 enrolled beneficiary-months, quality and transition metrics are reported as proportions of eligible episodes, and overdose mortality metrics are reported as age-adjusted rates per 100,000 Montana population. Raw counts and denominators are reported in the narrative for transparency. This rate-based approach provides a more valid basis for cross-DY comparison under conditions of enrollment instability and is used consistently throughout the quantitative findings. Figure 1a illustrates the full enrollment trend from July 2017 through December 2024; Figure 1b demonstrates the divergence between raw SUD treatment counts and rate-based utilization that motivates the analytic approach used throughout this report.

Figure 1a: Montana Medicaid enrollment, July 2017-December 2024

Monthly count of distinct enrolled Montana Medicaid beneficiaries, July 2017 through December 2024. The figure illustrates pre-demonstration enrollment trends, the substantial inflation in enrollment during the COVID-19 Public Health Emergency continuous enrollment period (February 2020–March 2023), and the sharp decline during Medicaid eligibility redetermination ("unwinding") beginning April 2023. Average monthly enrollment declined approximately 23% between DY1 (180,792 average monthly enrolled beneficiaries; 2,169,502 total beneficiary-months) and DY2 (139,418; 1,673,019 total beneficiary-months). The dashed vertical line marks the start of DY1 on July 1, 2022; the light-blue band marks the PHE continuous enrollment period; the amber band marks the unwinding period.

Figure 1b: Any SUD treatment: beneficiary count and rate per 1,000 beneficiary-months, July 2017–December 2024

Dual-axis comparison of Medicaid beneficiaries receiving any qualifying SUD treatment service (Metric 6). Solid line: raw monthly count of unique beneficiaries (left axis). Dashed line: rate per 1,000 enrolled beneficiary-months (right axis). The figure illustrates the divergence between raw counts — which declined due to enrollment contraction during Medicaid unwinding — and rate-based utilization, which increased 15.3% from DY1 (8.75 per 1,000) to DY2 (10.09 per 1,000). The dashed vertical line marks the start of DY1 on July 1, 2022; the amber band marks the Medicaid unwinding period (April 2023–January 2024).

Additionally, the denominator for proportion-based metrics fluctuated considerably due to eligibility changes during the PHE and unwinding, complicating the interpretation of trends in service access and engagement. The lack of a true control or comparison group further constrains causal inference, as concurrent policy initiatives and broader system changes may have influenced outcomes independently of the demonstration.

Qualitative findings are limited by the scope and representativeness of interview and survey participants. While efforts were made to recruit a diverse sample of stakeholders, providers, and beneficiaries across regions and service types, participation was voluntary and may not fully reflect the experiences of all groups affected by the waiver. Furthermore, qualitative data are subject to recall bias and the influence of social desirability in participant responses.

Finally, the interim nature of this evaluation means that several demonstration components (e.g., Tenancy Support Services, Contingency Management, and Reentry Services) were in early stages of implementation or had not yet launched during the evaluation period, precluding robust outcome analysis for these elements. As a result, findings presented here primarily reflect the IMD component and should be interpreted as preliminary, pending further analysis in the summative evaluation.

F. Results

1. Overall Demonstration Results

Across all six milestone domains, quantitative analysis of Medicaid claims data for DY1 (July 2022–June 2023) and DY2 (July 2023–June 2024) presents a mixed but generally positive picture of the HEART demonstration’s early impact on access to SUD services in Montana. All results are reported as rates per 1,000 enrolled beneficiaries or proportions of eligible episodes (see Section E for full description of enrollment changes during Medicaid unwinding).

Access to SUD services improved meaningfully on a rate basis across all modalities monitored under Milestones 1 and 2. Rates of any SUD treatment (M6), outpatient services (M8), IOP/partial hospitalization (M9), residential/inpatient care (M10), withdrawal management (M11), and medication-assisted treatment (M12) each increased from DY1 to DY2, with gains ranging from +7.3% (M9) to +26.2% (M12). MAT showed the largest access improvement, increasing from 3.13 to 3.95 per 1,000 beneficiary-months. The rate of beneficiaries treated in IMDs (M5) increased 20.1% (1.39 to 1.67 per 1,000 beneficiary-months), and average IMD length of stay (M36) increased modestly from 16.80 to 17.50 days (+4.2%), consistent with the stabilization target and suggestive of incremental improvement in treatment duration.

Provider capacity metrics (Milestone 4) present a more nuanced picture. The raw count of SUD providers billing Medicaid declined slightly (M13: 2,704 to 2,637, –2.5%), and the number of MAT prescribers remained unchanged at 17 (M14; 14 mapped to a Montana county in Figure 4b) — the primary basis for assessing progress on provider capacity. Supplemental rates per 1,000 average monthly enrolled beneficiaries increased for both metrics (M13: 14.96 to 18.91/1k, +26.4%; M14: 0.09 to 0.12/1k, +33.3%), but these rate gains reflect the smaller enrolled population rather than actual network expansion. On the count basis, provider capacity did not expand during the evaluation period. Qualitative findings confirm that provider capacity remains constrained by workforce shortages, low reimbursement rates, and geographic concentration — particularly in rural and tribal areas.

Care quality and transition metrics (Milestones 5 and 6) were more variable. OUD pharmacotherapy continuity (M22) declined substantially (22.63% to 16.58%, –26.7%), likely driven by shorter continuous enrollment windows during unwinding that compress the PDC calculation period. AOD treatment initiation rates (M15) were essentially stable overall (12.70% to 12.37%, –2.6%), with the alcohol cohort essentially unchanged, and the opioid cohort declining more noticeably (16.90% to 15.43%, –8.7%). AOD treatment engagement rates improved slightly overall (52.88% to 53.49%), with the opioid cohort maintaining the highest engagement by a substantial margin (81.12% to 80.00%). Follow-up after SUD and mental health ED visits (M17) declined modestly across all four windows (range: –1.7% to –4.0%) but remained high in absolute terms. SUD readmissions within 30 days (M25) increased slightly (24.79% to 25.75%, +3.9%), with the denominator of qualifying inpatient stays declining sharply due to unwinding.

Opioid prescribing and overdose risk metrics (Milestone 5) present a largely stable picture with some encouraging signals. The all-drug overdose death rate declined meaningfully (19.0 to 16.7 per 100,000 MT population, –12.1%), while the opioid-specific rate increased slightly (10.7 to 11.3, +5.6%), within expected year-to-year variation for statewide mortality data. SUD emergency department visits increased modestly on a rate basis (5.59 to 5.90 per 1,000 beneficiary-months, +5.5%), possibly reflecting improved SUD coding in ED settings. High-dose opioid prescribing (M18)

increased slightly (0.70% to 0.76%) on a very small absolute base (DY1 N=80 / DY2 N=66 beneficiaries meeting threshold out of DY1 N=11,359 / DY2 N=8,666 qualifying fills), warranting monitoring but not alarm. Concurrent opioid and benzodiazepine prescribing (M21) were essentially unchanged (3.27% to 3.28%, +0.3% — negligible).

In summary, the weight of evidence at mid-demonstration suggests that the HEART waiver has been associated with per-beneficiary improvements in access to SUD treatment across all service modalities, supporting the demonstration's core goal of expanding coverage and utilization of evidence-based care. The clearest gains are in MAT access, residential/inpatient utilization, and overall SUD treatment engagement — all areas directly targeted by the IMD component. Continuity and transition metrics present areas for continued attention, particularly M22 pharmacotherapy continuity and M25 readmissions. The amendment components (Contingency Management, Tenancy Support Services, and Reentry) were in pre-implementation during DY2; claims data from these components will be incorporated in the summative evaluation.

2. IMD Component Results

To provide a comprehensive and policy-relevant assessment of the HEART demonstration's impact on access to IMD care, outcomes for each milestone are presented using a mixed-methods approach. For each milestone, we begin by summarizing key themes from qualitative data sources—including beneficiary, provider, and stakeholder interviews—which offer critical insights into the lived experiences, perceived barriers and facilitators, and contextual nuances that shape access to and delivery of IMD services. These qualitative findings are then complemented by quantitative analysis of Medicaid claims-based metrics, which provide objective, population-level evidence of service utilization and trends over time. By integrating both qualitative and quantitative perspectives for each milestone, we aim to present a balanced and nuanced understanding of the demonstration's effects, highlight areas of convergence and divergence between data sources, and identify both progress and persistent gaps in access to care. This structure ensures that the voices of those most affected by the waiver are foregrounded, while also grounding conclusions in robust, empirical evidence.

a) *IMD Outcomes*

Milestone 1: Access to Critical Levels of Care

Across both beneficiary and stakeholder/provider interviews, the HEART waiver's expansion of Medicaid coverage to IMD facilities has been a significant facilitator of access to residential SUD treatment in Montana. Many beneficiaries described rapid admission experiences, often within days or a week, and consistently reported that Medicaid coverage enabled access to a range of services, including inpatient, outpatient, therapy, and medications. Quick access was sometimes attributed to being known at the facility or having Medicaid approval, and referrals from counselors, legal professionals, or hospital staff were common pathways into care. Providers and DPHHS staff echoed these findings, noting that increased provider education and collaboration among facilities have reduced administrative denials and improved referral pathways. Some facilities have implemented supportive practices, such as assisting patients with Medicaid applications and providing peer support for transportation and logistics.

However, both groups also identified persistent barriers. Some beneficiaries and providers reported delays in admission, particularly for those who were incarcerated, affected by COVID-19, or seeking detoxification. Waitlists and limited bed availability—especially for step-down care like sober living and mental health group homes—were frequently cited as challenges, often resulting in premature

discharges and undermining continuity of care. Strict Medicaid length-of-stay requirements (30-day average) were highlighted as a bottleneck, sometimes forcing clients to leave treatment before securing stable housing or transitioning to lower levels of care, increasing the risk of relapse. Administrative burdens, including complex eligibility processes, Medicaid redetermination, and documentation requirements, disrupted care and created hurdles for both patients and providers. Geographic disparities and workforce shortages, particularly in rural and tribal areas, further limited access, with some clients facing significant travel burdens or a lack of local provider options. These access barriers were often described as highly time-sensitive; as one beneficiary explained, “when a person’s ready, they got to go somewhere... or they’re going to die or give up.”

Overall, while the waiver has expanded access and fostered greater provider collaboration, both beneficiaries and providers emphasized that administrative complexity, continuity of care gaps, and geographic disparities continue to limit comprehensive access to IMD residential treatment services in Montana. These findings suggest that, although the HEART demonstration has made meaningful progress in improving access, ongoing system-level challenges must be addressed to achieve truly comprehensive and equitable access statewide.

Quantitative claims analysis supports and extends these qualitative findings. As described in Section E, all metrics are assessed using rates per 1,000 enrolled beneficiary-months rather than raw counts. On this basis, every access metric under Milestone 1 improved from DY1 to DY2 as shown in Figure 2. The rate of beneficiaries receiving any SUD treatment (M6) increased from 8.75 to 10.09 per 1,000 beneficiary-months (+15.3%). Residential and inpatient SUD care (M10) — which includes IMD services — increased from 1.44 to 1.65 per 1,000 beneficiary-months (+14.6%), continuing the sustained upward trend observed since demonstration start. Medication-assisted treatment (M12) showed the largest rate gain, increasing from 3.13 to 3.95 per 1,000 beneficiary-months (+26.2%). These findings indicate that the demonstration has been associated with meaningful per-beneficiary improvements in access to the full continuum of SUD services, even as the enrolled population contracted. Detailed metric-level findings are presented below.

In summary, the combined evidence suggests that the HEART demonstration has achieved substantial progress toward Milestone 1 by expanding access to IMD and other residential SUD treatment services. At the same time, persistent administrative, geographic, and system-level barriers continue to limit comprehensive and equitable access, underscoring the need for ongoing quality improvement and policy attention to continuity of care, step-down services, and administrative simplification.

Milestone 1 Critical Metrics

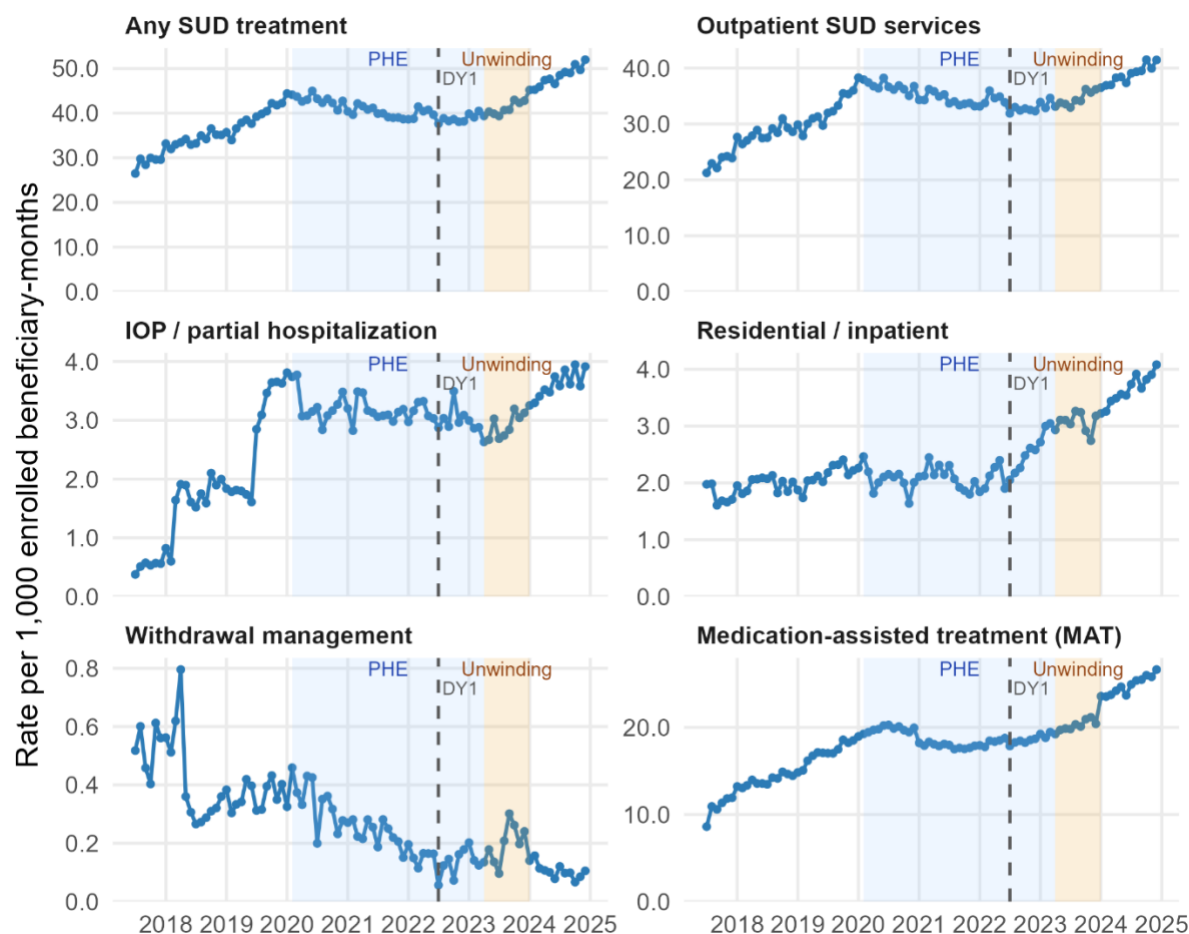
Table 1: Milestone 1 Critical Monitoring Metrics								
Metric #	Metric name	Monitoring metric rate or count ¹²				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		DY1 (Jul 2022–Jun 2023)	DY2 (Jul 2023–Jun 2024)	Absolute change	Percent change			
6	Any SUD Treatment	8.75	10.09	+1.34	+15.3%	Increase	Increase	Yes
7	Early Intervention / SBIRT	0.71	0.85	+0.14	+19.7%	Increase	Increase	Yes
8	Outpatient SUD Services	7.37	8.44	+1.07	+14.5%	Increase	Increase	Yes

9	IOP / Partial Hospitalization Services	1.10	1.18	+0.08	+7.3%	Increase	Increase	Yes
10	Residential and Inpatient Services	1.44	1.65	+0.21	+14.6%	Increase	Increase	Yes
11	Withdrawal Management	0.12	0.15	+0.03	+25.0%	Increase	Increase	Yes
12	Medication-Assisted Treatment	3.13	3.95	+0.82	+26.2%	Increase	Increase	Yes
22†	Continuity of OUD Pharmacotherapy [NQF #3175] (%)	22.63%	16.58%	-6.05 pp	-26.7%	Increase	Decrease	No

¹ M6–M12: rates per 1,000 enrolled beneficiary-months. DY1 denominator: 2,169,502 beneficiary-months. DY2 denominator: 1,673,019 beneficiary-months. Raw counts — M6: 18,991/16,886; M7: 1,531/1,418; M8: 15,980/14,124; M9: 2,395/1,981; M10: 3,123/2,759; M11: 261/249; M12: 6,800/6,613.

† M22: percentage of beneficiaries with ≥2 OUD pharmacotherapy fills achieving PDC ≥80% over full measurement period (DY1 N=1,094/4,834; DY2 N=740/4,462). Decline likely reflects shorter continuous enrollment windows during Medicaid unwinding reducing PDC calculation periods.

² Claims data available for DY1 and DY2 only. DY3 (Jul 2024–Jun 2025) data not yet available.

Figure 2: SUD service-use rates by service setting, July 2017–December 2024

Monthly rates per 1,000 enrolled Medicaid beneficiary-months for six Milestone 1 access metrics (M6–M12): any SUD treatment, outpatient SUD services, intensive outpatient/partial hospitalization, residential/inpatient services, withdrawal management, and medication-assisted treatment. Each panel displays a separate metric on its own vertical scale; panels should not be compared numerically across one another. All six rates increased from DY1 to DY2, with MAT showing the largest gain (+26.2%) and IOP/partial hospitalization the smallest (+7.3%). OUD pharmacotherapy continuity (M22) is a percentage-based metric with an incompatible scale and is not displayed in this figure; see Metric 22 narrative. The light-blue band marks the PHE continuous enrollment period; the amber band marks the Medicaid unwinding period; the dashed vertical line marks the start of DY1 on July 1, 2022.

Metric 6

In DY1, 18,991 unique Medicaid beneficiaries received any qualifying SUD treatment service, representing a rate of 8.75 per 1,000 enrolled beneficiary-months (denominator: 2,169,502 beneficiary-months). In DY2, 16,886 beneficiaries received any SUD treatment, representing a rate of 10.09 per 1,000 beneficiary-months (denominator: 1,673,019 beneficiary-months). Although raw counts declined by 2,105 (–11.1%), the rate increased by 1.34 per 1,000 beneficiary-months (+15.3%), indicating that access to any SUD treatment improved on a per-beneficiary basis. As described in Section E, raw count declines reflect enrollment contraction during Medicaid unwinding and should not be interpreted as reduced access. This metric reflects the broadest measure of SUD service engagement and serves as the aggregate indicator for Milestone 1 access. The rate-based improvement is consistent with the demonstration’s goal of increasing SUD

treatment utilization and aligns with qualitative findings of expanded access and improved referral pathways.

Metric 7

In DY1, 1,531 unique Medicaid beneficiaries received early intervention or SBIRT services, representing a rate of 0.71 per 1,000 enrolled beneficiary-months. In DY2, 1,418 beneficiaries received these services, for a rate of 0.85 per 1,000 beneficiary-months — an increase of 0.14 per 1,000 beneficiary-months (+19.7%) on a rate basis, despite a raw count decline, consistent with enrollment contraction (see Section E), of 113 (–7.4%). The rate-based improvement indicates that Montana’s system for delivering early intervention and SBIRT services has remained robust throughout the demonstration period and has expanded per-beneficiary reach. Early intervention is a leading indicator of system performance on secondary prevention; the sustained and improving rate suggests that the HEART demonstration has supported continued investment in upstream identification and brief treatment for SUD.

Metric 8

In DY1, 15,980 unique Medicaid beneficiaries received outpatient SUD services, a rate of 7.37 per 1,000 enrolled beneficiary-months. In DY2, 14,124 beneficiaries received outpatient SUD services, for a rate of 8.44 per 1,000 beneficiary-months — an increase of 1.07 per 1,000 beneficiary-months (+14.5%) on a rate basis, despite a raw count decline, consistent with enrollment changes (see Section E) of 1,856 (–11.6%). Outpatient SUD care is the most widely utilized service modality in the claims data, and the rate-based improvement indicates that access to this foundational level of care strengthened during the demonstration. This finding aligns with qualitative reports of improved referral pathways, increased provider engagement, and expanded telehealth reach, particularly for beneficiaries in rural and frontier areas.

Metric 9

In DY1, 2,395 unique Medicaid beneficiaries received intensive outpatient or partial hospitalization SUD services, a rate of 1.10 per 1,000 enrolled beneficiary-months. In DY2, 1,981 beneficiaries received these services, for a rate of 1.18 per 1,000 beneficiary-months — an increase of 0.08 per 1,000 beneficiary-months (+7.3%), the smallest rate gain among the access metrics but nonetheless a positive directional trend. As noted previously, IOP and partial hospitalization services are structured, high-intensity outpatient programs that do not involve overnight stays and are distinct from IMD services, which refer to 24-hour residential treatment. The modest rate gain in this modality, combined with larger gains in residential and outpatient levels, is broadly consistent with a system in which beneficiaries are accessing the full continuum of care at improved rates.

Metric 10

In DY1, 3,123 unique Medicaid beneficiaries received residential or inpatient SUD services, a rate of 1.44 per 1,000 enrolled beneficiary-months. In DY2, 2,759 beneficiaries received these services, for a rate of 1.65 per 1,000 beneficiary-months — an increase of 0.21 per 1,000 beneficiary-months (+14.6%). Residential and inpatient services, as captured in this metric, include IMD services (short-term, 24-hour residential or inpatient SUD treatment in specialized facilities) as well as other qualifying hospital-based or residential SUD care. This rate-based improvement — sustained across both demonstration years and persisting through the unwinding period — is among the clearest quantitative signals that the HEART demonstration has been associated with meaningful improvement in access to higher-level SUD care. This finding directly aligns with the demonstration’s core intent: expanding Medicaid coverage of IMD residential services to fill longstanding gaps in the Montana SUD treatment continuum.

Metric 11

In DY1, 261 unique Medicaid beneficiaries received withdrawal management (detoxification) services, a rate of 0.12 per 1,000 enrolled beneficiary-months. In DY2, 249 beneficiaries received these services, for a rate of 0.15 per 1,000 beneficiary-months — an increase of 0.03 per 1,000 beneficiary-months (+25.0%). Although raw counts declined marginally (–4.6%), rate-based analysis indicates that per-beneficiary access to withdrawal management improved during the demonstration period. As described in Section E, this divergence reflects enrollment contraction during Medicaid unwinding. On a rate basis, withdrawal management utilization increased meaningfully, consistent with improved access to this clinically specialized service. This finding also aligns with qualitative reports that the demonstration has supported clearer referral pathways into medically supervised withdrawal services.

Metric 12

In DY1, 6,800 unique Medicaid beneficiaries received MAT for SUD, a rate of 3.13 per 1,000 enrolled beneficiary-months. In DY2, 6,613 beneficiaries received MAT, for a rate of 3.95 per 1,000 beneficiary-months — an increase of 0.82 per 1,000 beneficiary-months (+26.2%), the largest rate gain among all access metrics under Milestone 1. Although raw counts declined (see Section E) by 187 (–2.7%), the rate-based improvement demonstrates that the per-beneficiary reach of MAT expanded substantially during the demonstration. MAT is an evidence-based intervention for opioid use disorder and other SUDs with strong evidence of reducing mortality, relapse, and emergency service utilization. The continued expansion of MAT access under the HEART demonstration is among the most clinically significant findings of this interim evaluation and aligns directly with the demonstration’s goals of improving access to evidence-based pharmacotherapy.

Metric 22

In DY1, 1,094 of 4,834 beneficiaries with qualifying OUD pharmacotherapy fills achieved a Proportion of Days Covered (PDC) of $\geq 80\%$ over the full measurement period, representing a continuity rate of 22.63%. In DY2, 740 of 4,462 qualifying beneficiaries achieved PDC $\geq 80\%$, for a continuity rate of 16.58% — a decline of 6.05 percentage points (–26.7% relative change). This substantial decrease in OUD pharmacotherapy continuity is the most notable adverse trend in the Milestone 1 metric set and warrants careful interpretation. The most likely explanation is structural rather than clinical: Medicaid unwinding disrupted coverage and shortened continuous enrollment windows during DY2. Because PDC is calculated over the full measurement period, beneficiaries who lost Medicaid coverage mid-year and re-enrolled later in DY2 would have a shorter effective observation window and more gaps in days covered, mechanically reducing their PDC below the 80% threshold even if their actual medication adherence during covered periods was unchanged. The denominator itself also contracted (4,834 to 4,462), reflecting fewer beneficiaries with two or more qualifying OUD pharmacotherapy fills in DY2 — likely driven by the same coverage disruptions. Qualitative findings corroborate this interpretation, with providers describing Medicaid coverage lapses as a primary threat to medication continuity, particularly during the critical post-discharge period. This finding underscores the importance of targeted interventions to maintain OUD pharmacotherapy continuity during periods of enrollment instability.

Milestone 2: Use of evidence-based SUD-specific patient placement criteria

From the beneficiary perspective, many individuals reported that their IMD placement was clinically appropriate and well-matched to their needs, describing programs as a “good fit,” “really helpful,” or “exactly what I needed.” Beneficiaries frequently emphasized the value of individualized and holistic approaches, including mental health counseling, group therapy, peer support, and staff

responsiveness to changing needs. These experiences suggest that, at the point of entry, placement decisions often aligned with clinical severity and treatment needs consistent with ASAM criteria.

At the same time, beneficiary experiences also revealed important mismatches that reflect limits in placement options rather than misapplication of criteria. Some beneficiaries described facilities that felt unsuitable due to environmental intensity, pace, or structure—for example, programs that were “too fast-paced” for older adults or individuals with physical limitations. Others described settings that felt punitive or chaotic, which they perceived as misaligned with therapeutic needs. These accounts suggest that while placement may have met minimum clinical eligibility, the range of available settings did not always allow for nuanced matching based on age, cognitive status, or functional limitations, which are core ASAM considerations.

Across beneficiary interviews, a consistent theme was that 30-day treatment durations were often insufficient, particularly for individuals with complex substance use disorders or co-occurring conditions. Many beneficiaries stated that longer stays—such as 60 or 90 days—would have been more appropriate to address root causes, stabilize recovery, and reduce relapse risk. This aligns closely with provider and stakeholder concerns that Medicaid’s 30-day average length-of-stay requirement frequently overrides ASAM-based clinical recommendations, resulting in premature discharge even when continued residential care or structured step-down would be clinically indicated. Beneficiaries articulated this limitation clearly, noting that “30 days just really isn’t enough to dig into why people use substances.”

Providers and DPHHS staff confirmed that ASAM criteria are routinely used to guide placement decisions and reassessment. Facilities described ASAM as a shared framework for determining level of care and for planning step-down transitions. Regular ASAM trainings provided by DPHHS were widely viewed as a facilitator, improving documentation quality and alignment with prior authorization requirements. However, respondents emphasized that the effective application of ASAM criteria beyond admission is constrained by structural factors, rather than lack of clinical knowledge. Chief among these constraints is the shortage of step-down options, including ASAM 3.1 and 3.3 services, sober living environments, and mental health group homes. Providers described repeated situations in which ASAM reassessment identified a clear need for lower-intensity residential or structured housing, but no placement was available within the treatment timeframe. Application processes for some settings can take weeks, often consuming the entirety of a residential stay. As a result, individuals were discharged to outpatient care or unstable housing, despite ASAM-concordant recommendations for continued residential support.

The phase-out of ASAM 3.3 emerged as a particular concern. Providers and DPHHS staff noted uncertainty about how to appropriately place individuals with cognitive impairments or functional limitations who previously would have qualified for 3.3. Without clear alternatives, respondents warned that this population risks being inadequately served, undermining consistent adherence to ASAM placement principles.

Staff training and clinical culture also shaped placement experiences. While ASAM training is broadly available, some facilities described internal tension between abstinence-based philosophies and evidence-based practices such as medication-assisted treatment (MAT). In a small number of cases, resistance to MAT affected how comprehensively ASAM dimensions were applied, though facilities reported addressing these issues through retraining or staff turnover.

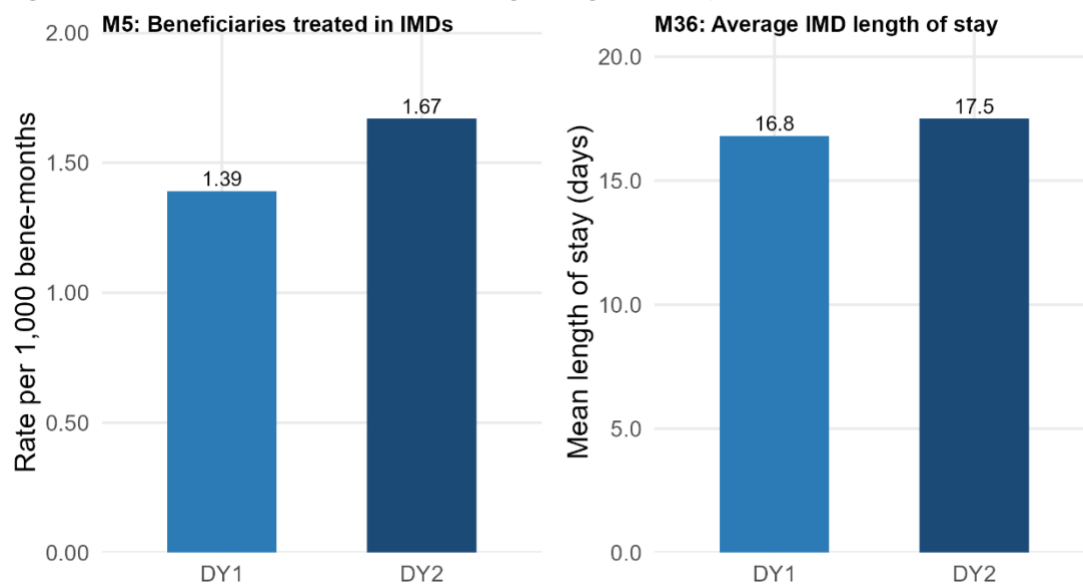
Finally, administrative pressures—including Medicaid redetermination, coverage lapses, low reimbursement rates, and billing system limitations—were described as further disrupting ASAM-aligned placement. Providers reported ethical dilemmas when coverage was lost mid-treatment and facilities lacked the financial capacity to continue care, even when ASAM criteria supported ongoing residential treatment.

In summary, qualitative findings suggest that Montana has made meaningful progress toward Milestone 2 by institutionalizing ASAM-based placement at admission and strengthening provider alignment through training and technical assistance. Beneficiary experiences largely confirm that initial IMD placement is often appropriate and responsive to clinical need. However, system-level constraints—particularly fixed length-of-stay expectations, loss of step-down services, limited placement options, and administrative instability—frequently prevent ASAM criteria from being fully operationalized across the full course of treatment and transition, limiting the demonstration's ability to achieve the intent of evidence-based patient placement statewide.

Quantitative metrics for Milestone 2 provide direct evidence of IMD utilization and treatment duration under the HEART demonstration. Both metrics improved on a rate basis from DY1 to DY2 as illustrated in Figure 3. The rate of beneficiaries treated in IMDs (M5) increased 20.1% (from 1.39 to 1.67 per 1,000 beneficiary-months), indicating that IMD treatment reached a greater share of the enrolled population during DY2 despite enrollment contraction. Average length of IMD stay (M36) increased modestly from 16.80 to 17.50 days (+4.2%), consistent with the stabilization target and suggestive of incremental improvement in treatment duration. These findings are discussed in detail below.

Milestone 2 Critical Metrics

Table 2: Milestone 2 Critical Monitoring Metrics								
Metric #	Metric name	Monitoring metric rate or count ¹²				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		DY1 (Jul 2022–Jun 2023)	DY2 (Jul 2023–Jun 2024)	Absolute change	Percent change			
5	Medicaid Beneficiaries Treated in an IMD for SUD (rate per 1,000 beneficiary-months)	1.39	1.67	+0.28	+20.1%	Increase	Increase	Yes
36†	Average Length of Stay in IMDs (mean days)	16.80	17.50	+0.70	+4.2%	Stabilize	Increase	Yes
¹ M5: rate per 1,000 enrolled beneficiary-months. DY1: N=3,007 unique benes / 2,169,502 beneficiary-months. DY2: N=2,789 / 1,673,019 beneficiary-months.								
† M36: mean days per qualifying IMD stay, not a rate per population. Qualifying stays: DY1 N=3,030; DY2 N=2,902. Slight increase interpreted as gradual positive movement consistent with stabilization target.								
² Claims data available for DY1 and DY2 only. DY3 data not yet available.								

Figure 3: IMD utilization rate and average length of stay, DY1 versus DY2

Two-panel bar chart comparing Milestone 2 metrics across DY1 (July 2022–June 2023) and DY2 (July 2023–June 2024). Left panel: rate of unique Medicaid beneficiaries receiving treatment in an IMD for SUD per 1,000 enrolled beneficiary-months (M5); DY1 = 1.39, DY2 = 1.67 (+20.1%). Right panel: mean length of stay in qualifying IMD facilities in days (M36); DY1 = 16.80 days, DY2 = 17.50 days (+4.2%). Each panel carries its own y-axis label and scale; the two panels use different units and should not be compared numerically. The IMD utilization rate increase provides the clearest quantitative evidence that the HEART demonstration expanded per-beneficiary access to residential SUD treatment. The modest increase in average length of stay is consistent with the demonstration's stabilization target.

Metric 5

In DY1, 3,007 unique Medicaid beneficiaries received treatment in an IMD for SUD, representing a rate of 1.39 per 1,000 enrolled beneficiary-months (denominator: 2,169,502 beneficiary-months). In DY2, 2,789 beneficiaries received IMD treatment, for a rate of 1.67 per 1,000 beneficiary-months (denominator: 1,673,019 beneficiary-months) — an increase of 0.28 per 1,000 beneficiary-months (+20.1%). Although the raw count declined by 218 (–7.3%), reflecting enrollment contraction during Medicaid unwinding, the rate-based improvement indicates that the demonstration was associated with expanded per-beneficiary access to IMD services. This metric is the most direct quantitative measure of the waiver's IMD component, and the 20.1% rate increase provides the clearest evidence that the expansion of Medicaid authority for IMD residential SUD treatment translated into measurable increases in service utilization for eligible beneficiaries.

Metric 36

In DY1, the mean length of stay in qualifying IMD facilities was 16.80 days across 3,030 qualifying stays. In DY2, mean length of stay increased to 17.50 days across 2,902 qualifying stays — an increase of 0.70 days (+4.2%). This modest improvement is consistent with the demonstration's stabilization target for this metric and may reflect incremental progress in aligning residential treatment duration with clinical need. Qualitative findings from providers and beneficiaries describe strong demand for longer residential stays — many reported that 30-day stays were insufficient for individuals with complex disorders or co-occurring conditions. In this context, the slight increase in average stay duration is an encouraging early signal, suggesting that the demonstration may be supporting marginally more adequate treatment exposure over time, even as

structural constraints around length-of-stay authorization remain a persistent challenge. This metric will be monitored in subsequent evaluation periods to assess whether this trend continues.

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications

Qualitative findings from provider, stakeholder, DPHHS, and beneficiary interviews indicate that Montana has made substantial progress toward Milestone 3 by establishing and operationalizing nationally recognized, SUD-specific program standards—particularly ASAM alignment, evidence-based treatment modalities, and medication-assisted treatment (MAT)—as the foundation for IMD provider qualifications. At the same time, findings highlight system level constraints that challenge providers’ ability to consistently maintain these standards in practice, despite strong clinical commitment.

From the provider and state perspective, IMD facilities consistently described their programs as structured around ASAM-aligned models of care, with defined staffing roles, interdisciplinary treatment teams, and standardized clinical processes. Facilities reported maintaining qualified clinical staff, including licensed clinicians, prescribers, and peer support specialists, and emphasized the importance of ongoing staff training to meet evidence-based expectations. DPHHS staff described regular ASAM and clinical trainings, technical assistance, and communication with providers as central mechanisms for reinforcing expectations around provider qualifications and program standards.

A core component of provider standards under the HEART demonstration is the availability and normalization of MAT. IMD facilities consistently described offering MAT as a standard of care, supported by qualified prescribers and clinical protocols. Providers emphasized that access to MAT is not optional but embedded in their program requirements, and several facilities described deliberate actions to align staffing with this standard—including retraining staff, addressing internal resistance, and, where necessary, terminating staff whose practice philosophies conflicted with evidence-based treatment. These actions reflect active enforcement of nationally recognized standards rather than passive adoption.

Providers also described incorporating trauma-informed and person-centered care practices into program design, consistent with national SUD treatment standards. These practices included interdisciplinary treatment planning, peer support integration, and attention to co-occurring mental health needs. While framed primarily as clinical practice, these approaches were described as expectations for staff competence and professional conduct, reinforcing their role as provider standards rather than optional enhancements.

Beneficiary experiences largely corroborate provider reports that nationally recognized standards are being implemented within IMD settings. Many beneficiaries described treatment environments characterized by respectful, non-judgmental care, supportive staff interactions, and access to counseling, group therapy, and skill-building activities. These experiences suggest that provider standards related to trauma-informed care, professional conduct, and evidence-based modalities are translating into practice in many facilities. However, beneficiary reports also revealed variation in experience across facilities, indicating that while standards are set, their implementation is not uniform.

Several beneficiaries described encounters with staff or environments that felt punitive, dismissive, or inadequately supervised, as well as concerns about medication management or basic clinical oversight. While not representative of all settings, these accounts highlight gaps in consistent

application of provider standards, suggesting variability in staff training, supervision, or enforcement. Importantly, these negative experiences appear tied to implementation challenges rather than absence of standards themselves.

Across interviews, providers emphasized that the primary threats to maintaining provider standards are structural rather than clinical. Workforce shortages, particularly in rural and tribal areas, make it difficult to recruit and retain staff who meet qualification requirements. Low Medicaid reimbursement rates limit providers' ability to offer competitive wages, increasing turnover and threatening continuity of skilled staffing. Administrative burdens—such as billing system inefficiencies and coverage disruptions during Medicaid redetermination—divert staff time away from clinical oversight and supervision, further straining providers' ability to uphold standards consistently.

In summary, qualitative findings suggest that Montana has made meaningful progress toward Milestone 3 by adopting nationally recognized SUD-specific standards and embedding them into IMD provider qualifications, clinical expectations, and program design. Providers demonstrate strong alignment with ASAM-based care, MAT, and trauma-informed practices, supported by state-led training and technical assistance. Beneficiary experiences largely affirm that these standards are operationalized in many settings. However, variability in implementation and persistent workforce, financial, and administrative pressures continue to challenge providers' ability to consistently meet and sustain these standards statewide. Addressing these structural threats will be critical to ensuring that nationally recognized provider qualifications translate into uniformly high-quality residential SUD treatment across Montana.

Milestone 4: Sufficient provider capacity at critical levels of care, including for medication-assisted treatment (MAT) for opioid use disorder (OUD)

Qualitative findings indicate that while the HEART demonstration expanded eligibility for IMD services and allowed facilities to exceed the federal 16-bed limit, actual provider capacity and availability have not expanded proportionally. Capacity constraints are driven less by the number of licensed beds and more by treatment duration limits, workforce availability, geographic distribution, and the lack of step-down infrastructure, all of which shape how much care the system can realistically deliver.

From the beneficiary perspective, capacity limitations were most often experienced as treatment ending too soon. Many beneficiaries described 30-day residential stays as insufficient to stabilize recovery or address underlying needs, frequently noting that they were still physically detoxing, cognitively overwhelmed, or not yet ready to engage fully in treatment activities. Several beneficiaries emphasized the need for dedicated detoxification periods prior to participation in group programming, describing situations in which they were expected to engage in treatment while still actively using or medically unstable. These experiences highlight capacity constraints not simply as access issues, but as limits on how treatment time can be sequenced and used effectively. For example, one participant reported, “it takes about three to seven days of detox... and then I wasn’t able to detox. They wanted me to go to groups right away.”

Beneficiaries also described capacity limitations through staffing and resource strain, including understaffing, delays in receiving medications, and insufficient staff-to-client ratios. While many beneficiaries reported rapid admission to residential care, others experienced delays related to bed availability or specific clinical circumstances. Geographic distance further shaped capacity experiences, with beneficiaries describing challenges transitioning back to communities far from

treatment sites and expressing a desire for treatment options closer to home to support continuity of care.

Provider and stakeholder interviews clarify why expanded eligibility has not translated into sustained increases in available care. Montana's IMD system remains highly concentrated, with a small number of ASAM 3.5 providers serving the entire state and very limited ASAM 3.1 and 3.3 capacity. Recent program closures—driven by financial unsustainability, building issues, or low census—have further narrowed capacity, particularly in Eastern Montana and rural regions. Although some facilities maintain open beds, providers emphasized that bed counts alone overstate usable capacity, given staffing constraints and shortened treatment duration per client.

Workforce shortages emerged as a central limiting factor. Providers consistently reported difficulty recruiting and retaining qualified clinical staff, especially in rural and tribal areas, citing inadequate reimbursement rates that prevent competitive wages. Retention challenges since COVID have reduced stability and increased pressure on remaining staff, limiting the number of clients facilities can safely serve and constraining throughput even where beds are physically available.

Across interviews, providers emphasized that regulatory and financial constraints effectively reduce capacity per client, compounding workforce limitations. Fixed expectations around residential length of stay and strict continued-stay approvals constrain providers' ability to retain clients until clinically stable or until appropriate step-down placements become available. Rather than increasing system efficiency, these constraints were described as creating churn, with clients discharged prematurely, relapsing, and re-entering treatment—consuming capacity inefficiently and undermining recovery.

Geography further limits effective capacity. While major providers serve clients statewide and have adopted telehealth innovations such as virtual IOP, respondents emphasized that centralized residential capacity cannot fully meet decentralized need. Discharging clients back to communities without services remains a recurring challenge, and while telehealth expands reach, it does not substitute for in-person residential or step-down care. Limited availability of lower-intensity residential options in many regions constrains both discharge planning and bed turnover.

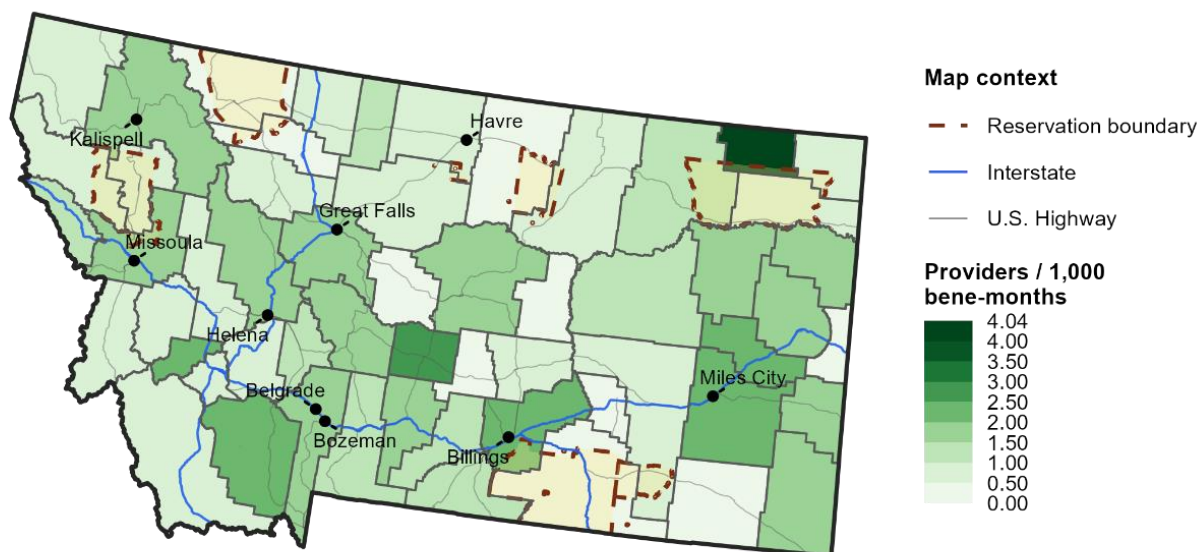
In summary, qualitative findings suggest that the HEART demonstration increased the theoretical capacity for IMD services, but actual availability remains constrained by how long clients can stay, how many staff facilities can support, and where services are located. Beneficiary experiences reinforce that capacity limitations are most acutely felt as truncated treatment duration, staffing strain, and difficult geographic transitions—not simply as delays in admission. Addressing these structural constraints will be critical for translating expanded eligibility into durable increases in residential treatment capacity and equitable access statewide.

Provider capacity metrics for Milestone 4 require interpretation on two levels: primary raw counts and supplemental per-enrollment rates. The primary monitoring values for M13 and M14 are raw counts of unique providers billing Medicaid — the most direct measure of whether network capacity has expanded. Supplemental rates per 1,000 average monthly enrolled beneficiaries are also reported for cross-DY context, but these rates must be interpreted with caution: rate increases reflect the smaller enrolled population during DY2 rather than growth in the provider network. Geographic distribution of providers is shown in Figures 4a and 4b.

Milestone 4 Critical Metrics

Table 3: Milestone 4 Critical Monitoring Metrics								
Metric #	Metric name	Monitoring metric rate or count ¹²				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		DY1 (Jul 2022–Jun 2023)	DY2 (Jul 2023–Jun 2024)	Absolute change	Percent change			
13	SUD Provider Availability — unique provider count (primary)	2,704	2,637	–67	–2.5%	Increase	Decrease	No
13§	<i>SUD Provider Availability — per 1,000 avg monthly benes (supplemental)</i>	14.96	18.91	+3.95	+26.4%	Increase	Increase	Yes§
14	MAT Provider Availability — unique provider count (primary)	17	17	0	0.0%	Increase	No change	No
14§	<i>MAT Provider Availability — per 1,000 avg monthly benes (supplemental)</i>	0.09	0.12	+0.03	+33.3%	Increase	Increase	Yes§
¹ Primary rows: unique counts of providers with active Medicaid claims for qualifying SUD or MAT services within each DY. Avg monthly enrolled benes: DY1=180,792; DY2=139,418.								
§ Supplemental rate rows: providers per 1,000 average monthly enrolled beneficiaries. Rate increases reflect the ~23% decline in average monthly enrollment during Medicaid unwinding and do not indicate expansion of the provider network. Primary progress assessment is based on raw provider counts.								
² Claims data available for DY1 and DY2 only. DY3 data not yet available.								

Figure 4a: SUD treatment providers by county, DY2



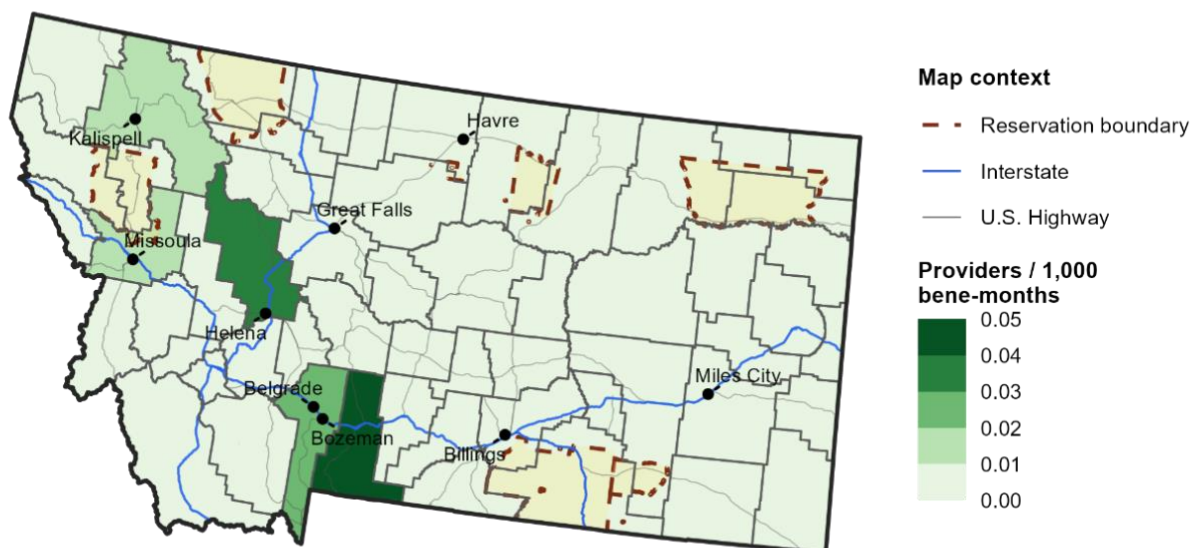
County-level map of Montana displaying the rate of unique SUD treatment providers billing Medicaid for qualifying services per 1,000 enrolled beneficiary-months in DY2 (July 2023–June 2024). Darker green counties have higher provider-to-enrollment ratios; gray counties indicate insufficient data to calculate a rate. Dashed amber polygons indicate tribal reservation boundaries; blue lines indicate interstate highways; gray lines indicate U.S. highways. Of 2,637 unique DY2 SUD treatment providers, 2,508 (95.1%) are mapped to a Montana county; 129 (4.9%) could not be assigned to a county and are excluded from the map. The map reflects provider billing locations and does not represent treatment site locations, patient travel distance, or whether a provider is accepting new patients.

Metric 13

In DY1, 2,704 unique SUD providers billed Medicaid for qualifying services, representing a primary count of 2,704 providers and a supplemental rate of 14.96 providers per 1,000 average monthly enrolled beneficiaries (denominator: 180,792 avg monthly benes). Figure 4a illustrates the county-level distribution of SUD providers in DY2. In DY2, 2,637 providers billed qualifying SUD services, for a count of 2,637 (–2.5% decline from DY1) and a supplemental rate of 18.91 per 1,000 avg monthly benes (+26.4%). On the primary count basis — which is the appropriate measure for assessing whether provider capacity expanded — the network declined slightly, indicating that the number of SUD providers actively serving Medicaid beneficiaries contracted modestly during the evaluation period. The rate-based increase of +26.4% reflects enrollment contraction during unwinding rather than network growth (see Section E). This finding is consistent with qualitative reports of provider closures, workforce shortages, and financial sustainability challenges that have constrained capacity expansion, particularly in rural and tribal areas of Montana. While the demonstration has

supported provider engagement through training and technical assistance, these structural barriers have limited the translation of expanded eligibility into a larger active provider network.

Figure 4b: MAT providers by county, DY2



County-level map of Montana displaying the rate of unique MAT providers billing Medicaid for qualifying services per 1,000 enrolled beneficiary-months in DY2 (July 2023–June 2024). Darker green counties have higher MAT provider-to-enrollment ratios; gray counties indicate insufficient data to calculate a rate. Dashed amber polygons indicate tribal reservation boundaries; blue lines indicate interstate highways; gray lines indicate U.S. highways. Because the statewide MAT provider count is small, individual county rates may reflect a single provider and should be interpreted with caution. Of 17 unique DY2 MAT providers, 14 are mapped to a Montana county; 3 could not be assigned to a county and are excluded from the map. The absence of any MAT provider expansion during the evaluation period (DY1 N=17; DY2 N=17), combined with geographic concentration in urban counties, highlights persistent access gaps for beneficiaries in rural, frontier, and tribal communities.

Metric 14

In DY1, 17 unique providers billed Medicaid for MAT services, for a supplemental rate of 0.09 MAT providers per 1,000 average monthly enrolled beneficiaries. In DY2, the number of MAT-prescribing providers remained unchanged at 17, for a supplemental rate of 0.12 per 1,000 avg monthly benes (+33.3%) — again reflecting enrollment decline rather than capacity growth. On the primary count basis, MAT provider capacity was completely flat during the evaluation period. The absence of any MAT provider expansion during the first two years of the demonstration, in a state as geographically large as Montana (147,040 square miles), underscores the severity of the access gap for medication-based OUD treatment. With only 17 MAT prescribers serving the statewide Medicaid population, geographic access to this evidence-based treatment modality remains highly

constrained, particularly for beneficiaries in rural, frontier, and tribal communities who may face substantial travel barriers or have no local prescribers. Figure 4b illustrates the county-level distribution of MAT providers in DY2. Qualitative findings confirm that workforce shortages, credentialing challenges, and reimbursement inadequacy are the primary barriers to MAT provider recruitment and retention.

Milestone 5: Implementation of comprehensive strategies to address prescription drug abuse and opioid use disorders

Qualitative findings from beneficiary, provider, stakeholder, and DPHHS interviews indicate that the HEART demonstration has meaningfully expanded the availability and normalization of evidence-based strategies to address opioid use disorder (OUD) within IMD settings, particularly through increased access to medication-assisted treatment (MAT). At the same time, systemic barriers—including stigma, cost, coverage gaps, and community-level resistance—continue to limit continuity and full effectiveness of these strategies beyond residential care.

From the beneficiary perspective, many individuals described continued access to medications and counseling for opioid use disorder following IMD discharge, including ongoing MAT, psychiatric care, and outpatient therapy. Beneficiaries who successfully maintained medication continuity emphasized its importance for stability and relapse prevention, particularly during the high-risk post-discharge period. For these individuals, medication access was described as a core component of recovery rather than an optional adjunct to counseling.

However, beneficiaries also reported uneven experiences with medication continuity and support, particularly when transitioning to sober living or community settings. Some described difficulty accessing medications due to insurance coverage gaps, delays in approvals, or lack of providers willing to continue MAT. Others encountered resistance or outright exclusion from sober living environments due to prescribed medications, underscoring how community-level stigma undermines otherwise evidence-based treatment pathways. Experiences of stigma were described as directly shaping care interactions, with one beneficiary stating that “they treat you like you’re just there to try and drug seek.”

Provider and stakeholder interviews confirm that IMD facilities are actively implementing comprehensive, evidence-based opioid treatment strategies, with a strong emphasis on MAT. Facilities described offering a range of medications, including Suboxone, Vivitrol, and injectable formulations, supported by prescribers and interdisciplinary care teams. Several providers emphasized deliberate efforts to shift organizational culture toward harm reduction, including retraining staff and removing personnel resistant to MAT. These actions reflect alignment with CMS expectations for comprehensive OUD strategies and were echoed in beneficiary reports of supportive, non-judgmental care.

At the same time, providers identified persistent barriers that weaken system-wide implementation of OUD strategies. High costs of certain MAT formulations—particularly injectable medications—were frequently cited as limiting access for individuals without Medicaid or with commercial plans that do not cover injections. Providers also described challenges securing timely approvals for MAT, contributing to delays or interruptions in care. These barriers were described as particularly destabilizing during transitions, when medication continuity is most critical.

Stigma remains a cross-cutting challenge. Providers noted that abstinence-based philosophies persist in some settings, including among staff, partner organizations, and sober living facilities, creating friction with harm-reduction approaches. Even where IMD providers strongly support MAT,

downstream resistance can effectively negate in-treatment gains, forcing patients to choose between housing and medication adherence.

Administrative and policy constraints further complicate implementation. Medicaid redetermination and coverage lapses disrupt access to MAT mid-treatment or immediately post-discharge, creating ethical dilemmas for providers and increasing relapse risk. Providers also described billing system limitations and unclear points of contact for resolving medication-related coverage issues, diverting resources from clinical care.

Importantly, respondents emphasized that the primary threats to effective opioid-specific treatment are not lack of clinical knowledge or provider willingness, but rather misalignment across systems responsible for coverage, housing, and community-based care. Where coordination succeeds—through proactive case management, prescriber continuity, and early planning—beneficiaries are more likely to sustain medication-based recovery. Where it fails, even well-implemented IMD strategies are undermined.

In summary, qualitative findings suggest that Montana has made meaningful progress toward Milestone 5 by expanding MAT availability within IMD settings and embedding opioid-specific strategies into residential treatment. Beneficiary experiences largely affirm the value of these approaches when medication continuity is maintained. However, cost barriers, coverage disruptions, stigma, and lack of alignment with sober living and community providers continue to limit the full impact of comprehensive OUD strategies, particularly during transitions out of IMD care. Addressing these system-level barriers will be essential for translating expanded in-treatment capacity into sustained reductions in opioid-related harm.

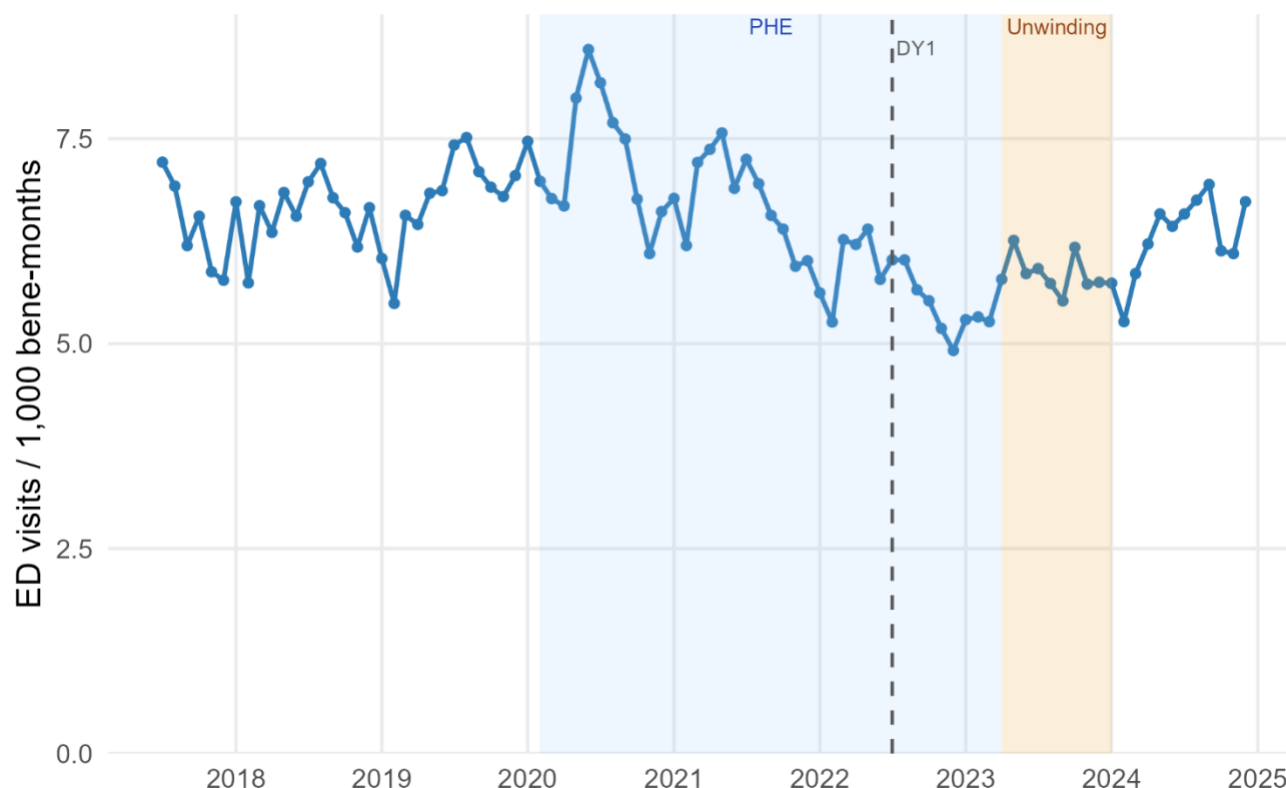
Milestone 5 Critical Metrics

Quantitative metrics for Milestone 5 cover four distinct domains: high-dose opioid prescribing (M18), concurrent opioid and benzodiazepine prescribing (M21), SUD emergency department utilization (M23), and overdose mortality (M27). Results across these domains are mixed. SUD ED utilization trends are shown in Figure 5a; prescribing safety metrics are shown in Figure 5b; overdose mortality trends are shown in Figure 6. The all-drug overdose death rate declined meaningfully (–12.1%), providing the strongest population-level positive signal within the available data. Concurrent opioid/benzodiazepine prescribing was essentially unchanged. SUD ED visit rates and high-dose opioid prescribing increased slightly, both warranting monitoring. Detailed findings are presented below.

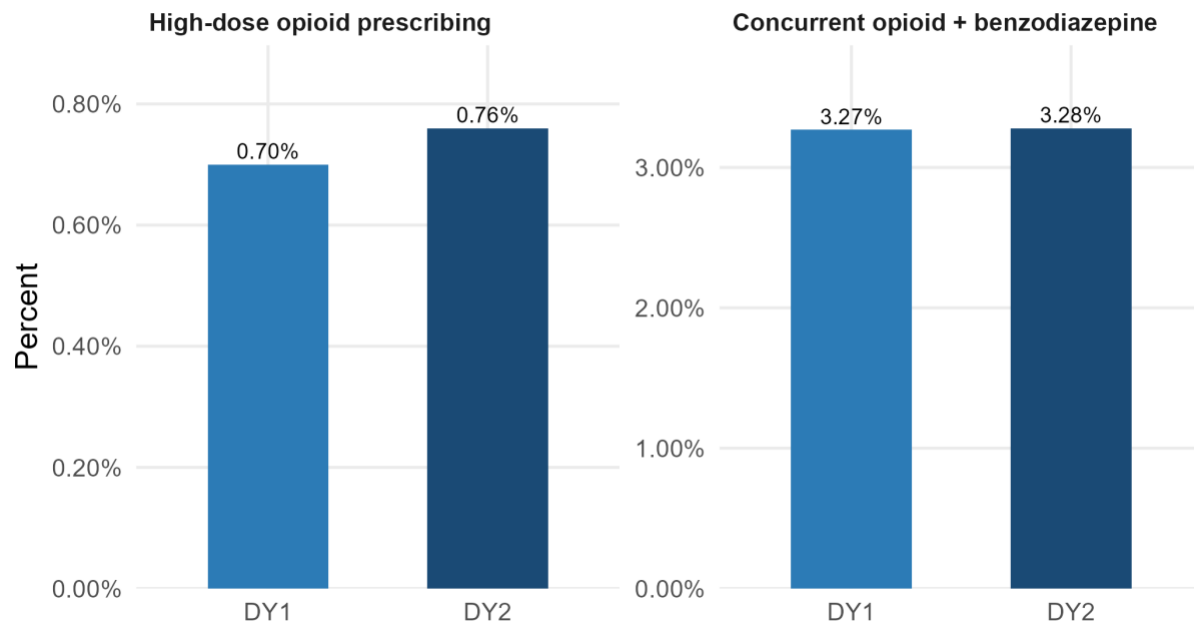
Table 4: Milestone 5 Critical Monitoring Metrics								
Metric #	Metric name	Monitoring metric rate or count ¹²				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		DY1 (Jul 2022–Jun 2023)	DY2 (Jul 2023–Jun 2024)	Absolute change	Percent change			
18*	High-Dose Opioid Prescribing [NQF #2940] (%)	0.70%	0.76%	+0.06 pp	+8.6%	Decrease	Increase	No
21°	Concurrent Opioid & Benzodiazepine Use [NQF #3389] (%)	3.27%	3.28%	+0.01 pp	+0.3%	Decrease	Increase	No°

23	ED Visits for SUD per 1,000 Medicaid Beneficiaries	5.59	5.90	+0.31	+5.5%	Decrease	Increase	No
26‡	All-Drug Overdose Death Rate (per 100,000 MT pop.) [DPHHS OVS]	19.0	16.7	-2.3	-12.1%	Decrease	Decrease	Yes
27‡	Opioid Overdose Death Rate (per 100,000 MT pop.) [DPHHS OVS]	10.7	11.3	+0.6	+5.6%	Decrease	Increase	No
* M18: numerator = benes meeting high-dose threshold (≥90 MME/day, ≥90-day coverage window): DY1 N=80; DY2 N=66. Denominator = benes with ≥2 qualifying opioid fills, post-exclusion: DY1 N=11,359; DY2 N=8,666. Small absolute numerator — interpret with caution.								
° M21: change of +0.01 percentage points (+0.3%) is negligible; interpret as essential stability rather than a directional trend. Numerator: DY1 N=908; DY2 N=703. Denominator: DY1 N=27,768; DY2 N=21,424.								
‡ M27: Deviates from CMS specification. MT death certificates do not include Medicaid payer information; Medicaid-linked numerators are not computable. Values are statewide age-adjusted rates per 100,000 MT population from the DPHHS Injury and Overdose Indicators dataset (Office of Vital Statistics). CY2022 proxies DY1; CY2023 proxies DY2.								
¹ M23: raw visit counts DY1 N=12,132; DY2 N=9,871. Denominator: beneficiary-months DY1=2,169,502; DY2=1,673,019.								
² Claims data available for DY1 and DY2 only. DY3 data not yet available.								

Figure 5a: Emergency department visits for SUD, July 2017–December 2024



Dual-axis trend of Medicaid SUD-related emergency department visits (Metric 23). Solid line: raw monthly count of qualifying SUD ED visits (left axis). Dashed line: rate per 1,000 enrolled beneficiary-months (right axis). The rate increased modestly from DY1 (5.59 per 1,000) to DY2 (5.90 per 1,000, +5.5%), despite a decline in raw visit counts (DY1 N=12,132; DY2 N=9,871, -18.6%), reflecting enrollment contraction during Medicaid unwinding. The expected direction is a decrease; the modest rate increase may partly reflect improved SUD identification and coding in ED settings. The light-blue band marks the PHE continuous enrollment period; the amber band marks the Medicaid unwinding period; the dashed vertical line marks the start of DY1 on July 1, 2022.

Figure 5b: High-dose opioid prescribing and concurrent opioid-benzodiazepine use, DY1 versus DY2

Two-panel bar chart comparing pharmacy safety metrics across DY1 (July 2022–June 2023) and DY2 (July 2023–June 2024). Left panel: percentage of qualifying opioid prescription fills meeting the high-dose threshold (Metric 18, ≥ 90 morphine milligram equivalents per day over a ≥ 90 -day coverage window); DY1 = 0.70%, DY2 = 0.76% (+8.6%). Right panel: percentage of qualifying opioid fills with concurrent benzodiazepine coverage (Metric 21); DY1 = 3.27%, DY2 = 3.28% (+0.3%, interpret as stability). Each panel uses its own percentage scale. Note: M18 numerators are small (DY1 N=80; DY2 N=66 beneficiaries meeting threshold out of DY1 N=11,359; DY2 N=8,666 qualifying fills); percentage-point differences should be interpreted with caution. Both metrics are calculated from Montana Medicaid pharmacy claims using PQA value sets (OPIOIDS, OPIOIDS_COB, BENZODIAZEPINES).

Metric 18

In DY1, 80 of 11,359 Medicaid beneficiaries with qualifying opioid prescription fills met the high-dose prescribing threshold (≥ 90 morphine milligram equivalents [MME] per day over a coverage window of ≥ 90 days), a rate of 0.70%. In DY2, 66 of 8,666 qualifying beneficiaries met this threshold, a rate of 0.76% — an absolute increase of 0.06 percentage points (+8.6% relative change). The expected direction for this metric is a decrease, reflecting the demonstration's goal of reducing prescription drug misuse risk. The slight rate increase should be interpreted cautiously given the small absolute numerators involved: 80 and 66 beneficiaries meeting the high-dose threshold represent a very small fraction of the overall opioid prescribing population, and year-to-year fluctuation of this magnitude is not uncommon with small numerators. Given the small numerator, this change is not sufficient to infer a meaningful shift in prescribing behavior. Nonetheless, this metric will be monitored in future evaluation periods to determine whether the upward trend persists. Pharmacy claims data were processed using the PQA OPIOIDS value set with MME conversion factors applied.

Metric 21

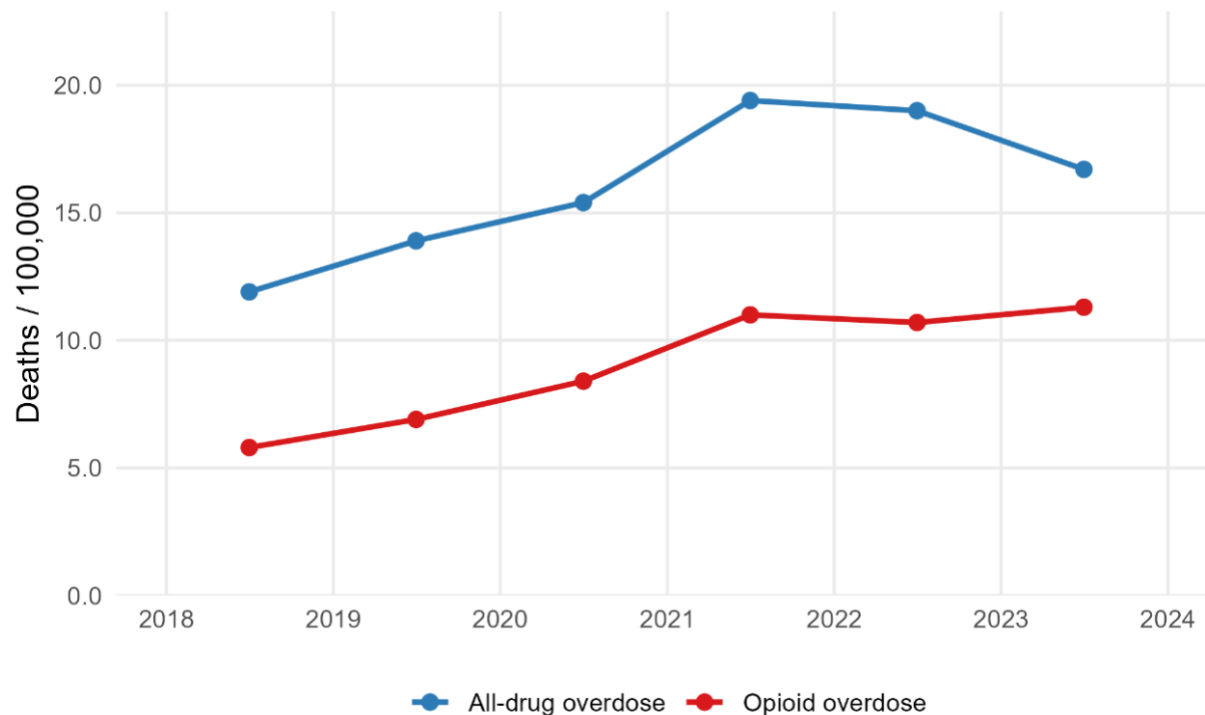
In DY1, 908 of 27,768 Medicaid beneficiaries with qualifying opioid prescription fills also had concurrent benzodiazepine coverage, a rate of 3.27%. In DY2, 703 of 21,424 qualifying beneficiaries had concurrent coverage, a rate of 3.28% — an absolute change of +0.01 percentage points (+0.3%

relative change). This change is negligible and should be interpreted as essential stability rather than a meaningful directional trend.² The expected direction for this metric is a decrease. While the rate has not improved, it has also not worsened, suggesting that Montana's prescribing practices for opioid-benzodiazepine co-prescribing were stable during the evaluation period. The substantially smaller denominators in DY2 (21,424 vs. 27,768 qualifying opioid fills) reflect both reduced overall opioid prescribing volume and the enrollment decline during unwinding. Pharmacy claims were processed using the PQA OPIOIDS_COB and BENZODIAZEPINES value sets.

Metric 23

In DY1, Medicaid beneficiaries had 12,132 qualifying SUD-related emergency department visits, a rate of 5.59 per 1,000 enrolled beneficiary-months (denominator: 2,169,502 beneficiary-months). In DY2, there were 9,871 qualifying SUD ED visits, a rate of 5.90 per 1,000 beneficiary-months (denominator: 1,673,019 beneficiary-months) — an increase of 0.31 per 1,000 beneficiary-months (+5.5%). Although raw visit counts declined by 2,261 (–18.6%), the rate-based increase indicates that per-beneficiary SUD ED utilization rose modestly during the demonstration. The expected direction for this metric is a decrease, reflecting the demonstration's goal of reducing avoidable ED utilization through improved access to community-based SUD care. The modest rate increase may partially reflect improved SUD identification and coding in ED settings during the evaluation period, as provider training and engagement have increased awareness of SUD-specific billing codes. It may also reflect continued reliance on emergency departments as access points for individuals who are not engaged with outpatient or residential care. This metric warrants continued monitoring in DY3 to assess whether the modest increase reflects a persistent trend or a transitional effect of the unwinding period.

² The +0.3% change in M21 is statistically negligible and is flagged in the monitoring metric table accordingly. It should not be interpreted as a directional trend.

Figure 6: Montana age-adjusted overdose death rates

Annual statewide age-adjusted overdose death rates per 100,000 Montana population for all-drug overdose (blue) and opioid-specific overdose (red), calendar years 2018–2023. Series are directly labeled at the terminal data point. The all-drug overdose death rate declined from 19.0 (CY2022, DY1 proxy) to 16.7 per 100,000 (CY2023, DY2 proxy), a decrease of –12.1%. The opioid-specific rate increased slightly (10.7 to 11.3, +5.6%), within expected year-to-year variation for small-state mortality data. Note: CMS Metric 27 specifies Medicaid-linked overdose mortality data; Montana death certificates do not include Medicaid payer information, making a Medicaid-specific numerator incomputable. Values are statewide all-payer age-adjusted rates from the Montana DPHHS Office of Vital Statistics, Injury and Overdose Indicators dataset.

Metric 27

Montana death certificates do not include Medicaid payer information, making it impossible to compute a Medicaid-linked overdose death numerator as specified by CMS. Additionally, the claims-based proxy approach — using “norm_recip_death_date” — was assessed and found to be unviable due to reporting lag in 2023–2024 data that would introduce systematic bias. Accordingly, M26 and M27 are reported using the DPHHS Injury and Overdose Indicators dataset, which provides statewide age-adjusted overdose death rates per 100,000 Montana population from the Office of Vital Statistics. This approach deviates from the CMS specification and is noted in the monitoring metric table. Calendar year 2022 serves as the DY1 proxy and calendar year 2023 serves as the DY2 proxy.

Using this source, the all-drug overdose death rate (M27/M26) declined from 19.0 per 100,000 MT population in CY2022 (DY1 proxy) to 16.7 per 100,000 in CY2023 (DY2 proxy) — a decrease of 2.3 per 100,000 (–12.1%). This decline is the most positive signal in the Milestone 5 metric set and is consistent with the demonstration’s goal of reducing overdose mortality. The opioid-specific overdose death rate increased slightly from 10.7 to 11.3 per 100,000 (+5.6%), within expected year-

to-year variation for small-state mortality data. Because these are statewide rates rather than Medicaid-specific values, they reflect population-level trends that may not be entirely attributable to the demonstration. The overall decline in all-drug overdose mortality during the demonstration period is nonetheless an encouraging finding that aligns with the waiver's intent to reduce opioid-related harm. Figure 6 displays both the all-drug and opioid-specific age-adjusted overdose death rates for CY2022 and CY2023.

Milestone 6: Improved care coordination and transitions between levels of care

Qualitative findings from beneficiary, provider, stakeholder, and DPHHS interviews indicate that the HEART demonstration has strengthened within-facility care coordination and discharge planning, while transitions across levels of care—particularly into housing, outpatient treatment, and community-based supports—remain uneven and highly dependent on local capacity and administrative stability.

From the beneficiary perspective, many individuals described receiving clear aftercare plans upon discharge from IMD treatment, often including referrals to outpatient counseling, medication management, peer support, and community-based recovery groups such as NA or AA. Case managers and peer support staff were frequently identified as central to these transitions, helping beneficiaries understand next steps, schedule follow-up appointments, and navigate complex systems. When these supports were present and active, beneficiaries described feeling prepared and supported during discharge.

Housing was consistently described as the most critical and fragile element of transitions, underscoring the importance of the anticipated implementation of HEART tenancy support services. Some beneficiaries reported receiving (non-Medicaid) assistance with sober living placements, housing applications, connecting with organizations that can assist with deposits and vouchers, and those who secured stable housing described it as essential to maintaining recovery after residential treatment. However, a substantial subset of beneficiaries reported not receiving housing support or encountering long delays, resulting in discharge to unstable environments. These beneficiaries often described housing instability as the primary factor undermining otherwise well-planned transitions, highlighting how care coordination breaks down when downstream supports are unavailable. Beneficiaries emphasized the consequences of housing instability, with one noting that without support, “I probably would have relapsed or even been back out on the streets again.”

Beneficiaries also described mixed experiences with continuity of clinical care. Many successfully continued individual therapy, psychiatric services, or medication-assisted treatment (MAT) after discharge, particularly when appointments were scheduled before leaving residential care. Others experienced gaps due to Medicaid coverage disruptions, difficulty securing timely appointments, transportation barriers, or lack of providers in their home communities. Several beneficiaries noted limited follow-up contact after discharge, especially when not stepping directly into sober living or structured programs, increasing vulnerability during the post-treatment period.

Provider and stakeholder interviews reinforce these patterns and clarify the mechanics of coordination. IMD facilities consistently described early and interdisciplinary discharge planning, often beginning at admission and involving care coordinators, clinicians, and peer support specialists. Providers emphasized that internal coordination within facilities is generally strong, with routine case reviews and proactive planning for next levels of care. Telehealth innovations,

such as virtual IOP, were described as important tools for extending continuity to rural and frontier areas.

However, respondents emphasized that effective discharge planning does not guarantee successful transitions when coordination across systems falters. The shortage of step-down housing and structured residential options remains a central barrier, frequently delaying or derailing transitions despite provider efforts. Providers described situations in which clients were clinically ready to step down but could not secure placements within the allowable timeframe, resulting in discharge to unsafe environments and increased risk of relapse or readmission.

Administrative processes were repeatedly identified as points of fragmentation. Medicaid redetermination and coverage lapses disrupt transitions mid-treatment or immediately post-discharge, forcing providers to choose between unreimbursed care and discharge without adequate supports. Providers described significant time spent navigating documentation requirements, billing issues, and unclear points of contact across Medicaid and behavioral health systems, diverting effort away from direct coordination activities.

Information sharing across levels of care was described as variable. Tools such as health information exchange and direct provider-to-provider communication support some transitions, but respondents noted that coordination often relies on individual relationships rather than standardized systems, making continuity vulnerable to staff turnover and regional variation. Transportation barriers, lack of reliable communication for some beneficiaries, and limited services in rural communities further weaken transition pathways.

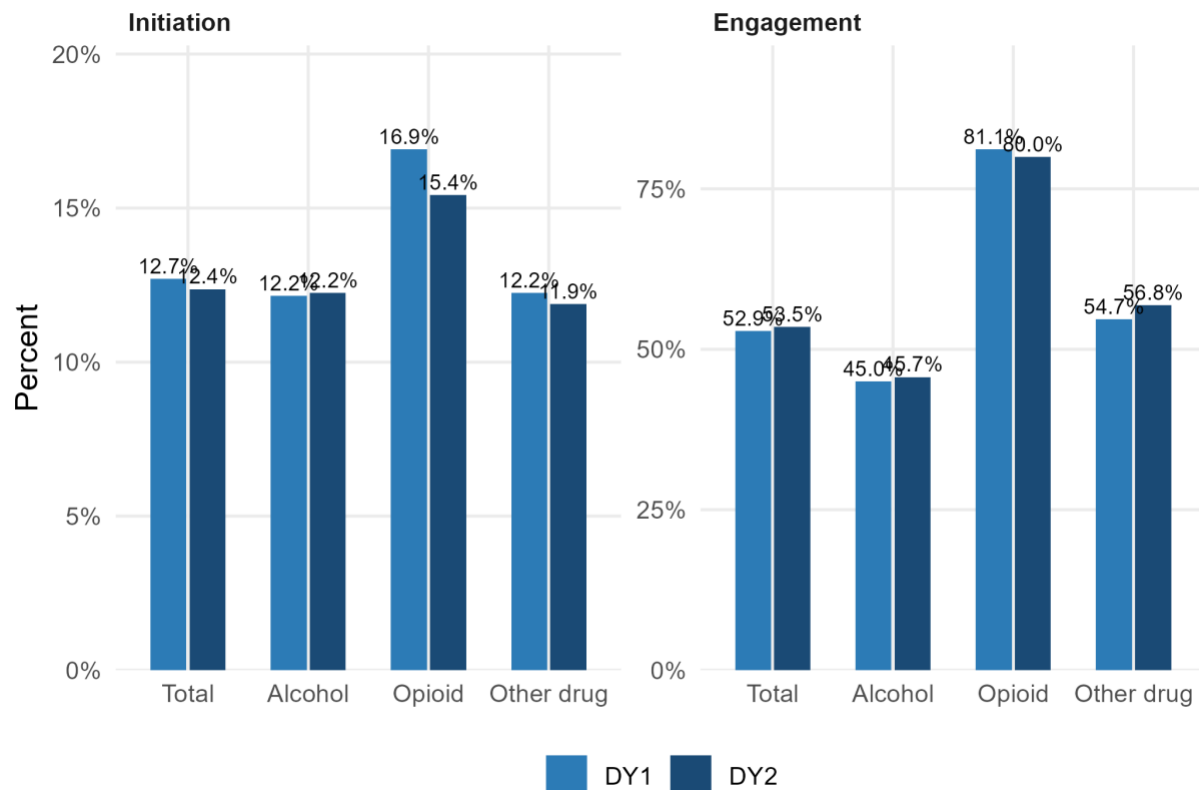
In summary, qualitative findings suggest that Montana has made progress toward Milestone 6 by strengthening within-facility coordination, discharge planning, and short-term transitional supports. Beneficiary experiences confirm that when case management, peer support, housing assistance, and pre-scheduled follow-up care are in place, transitions are more stable. However, system-level fragmentation across housing availability, Medicaid administration, and community-based service capacity continues to undermine continuity of care, particularly during the high-risk period immediately following IMD discharge. Addressing these coordination gaps will be critical for translating effective residential treatment into sustained recovery across levels of care.

Milestone 6 Critical Metrics

Quantitative metrics for Milestone 6 measure care initiation and engagement, follow-up after emergency visits, and readmissions — all key indicators of care continuity. Results are mixed with AOD treatment initiation and engagement trends are shown in Figure 7; post-ED follow-up rates are shown in Figure 8. AOD treatment initiation rates were essentially stable overall, with the alcohol cohort flat and the opioid cohort showing a more notable decline. Engagement rates held steady or improved modestly, with the opioid cohort maintaining the highest engagement by a wide margin. Follow-up after ED visits declined modestly across all four windows but remained high in absolute terms. SUD readmissions increased slightly. All values are expressed as percentages of eligible episodes and are based on true-date intervals derived from DPHHS Medicaid claims data (raw vintage files), processed through a dedicated interval computation pipeline.

Table 5: Milestone 6 Critical Monitoring Metrics

Metric #	Metric name	Monitoring metric rate or count ¹²				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		DY1 (Jul 2022–Jun 2023)	DY2 (Jul 2023–Jun 2024)	Absolute change	Percent change			
15†	Initiation of AOD Treatment — Total [NQF #0004] (%)	12.70%	12.37%	–0.33 pp	–2.6%	Increase	Decrease	No
15†	Engagement of AOD Treatment — Total [NQF #0004] (%) [*]	52.88%	53.49%	+0.61 pp	+1.2%	Increase	Increase	Yes
17a†	FUA: Follow-Up after AOD ED Visit — 7 days [NQF #2605] (%)	59.55%	57.43%	–2.12 pp	–3.6%	Increase	Decrease	No
17a†	FUA: Follow-Up after AOD ED Visit — 30 days [NQF #2605] (%)	67.90%	66.75%	–1.15 pp	–1.7%	Increase	Decrease	No
17b†	FUM: Follow-Up after Mental Health ED Visit — 7 days [NQF #2605] (%)	75.92%	72.89%	–3.03 pp	–4.0%	Increase	Decrease	No
17b†	FUM: Follow-Up after Mental Health ED Visit — 30 days [NQF #2605] (%)	82.18%	79.79%	–2.39 pp	–2.9%	Increase	Decrease	No
25†	SUD Readmissions within 30 Days (%)	24.79%	25.75%	+0.96 pp	+3.9%	Decrease	Increase	No
† M15, M17, M25: true-date intervals derived from DPHHS Medicaid claims data (raw vintage files). Values may be conservative estimates due to blurred-date approximations for continuous enrollment and negative history flags.								
* M15 Engagement: values are likely undercounts; blurred-date approximations affect precision of 30-day engagement window. M15 initiation denominators: total DY1=14,755/DY2=10,900 index episodes; alcohol DY1=7,808/DY2=5,664; opioid DY1=2,319/DY2=1,847; other DY1=6,759/DY2=4,933.								
¹ M17a denominators: DY1=3,498/DY2=2,854 qualifying SUD ED visits. M17b denominators: DY1=2,587/DY2=2,187 qualifying MI ED visits. M25: numerator=readmissions (DY1 N=4,487; DY2 N=2,096); denominator=qualifying inpatient SUD stays (DY1 N=18,097; DY2 N=8,140). DY assignment approximate.								
² Claims data available for DY1 and DY2 only. DY3 data not yet available.								

Figure 7: AOD treatment initiation and engagement, DY1 versus DY2

Two-panel grouped bar chart comparing alcohol and other drug (AOD) treatment initiation and engagement rates (Metric 15, NQF #0004) across four diagnosis cohorts (Total, Alcohol, Opioid, Other drug) for DY1 (July 2022–June 2023) and DY2 (July 2023–June 2024). Left panel: initiation, defined as a qualifying treatment service within 14 days of an AOD index episode; overall rate declined slightly (12.70% to 12.37%, –2.6%). Right panel: engagement, defined as two or more additional qualifying services within 30 days of initiation; overall rate improved marginally (52.88% to 53.49%, +1.2%). The opioid cohort maintained substantially higher engagement than other cohorts in both years (DY1: 81.12%; DY2: 80.00%). Panels use separate vertical scales and measure different denominators. Note: engagement values are likely undercounts due to blurred-date approximations in the 30-day engagement window. DY1 initiation denominators: Total N=14,755; Alcohol N=7,808; Opioid N=2,319; Other N=6,759. DY2: Total N=10,900; Alcohol N=5,664; Opioid N=1,847; Other N=4,933.

Metric 15

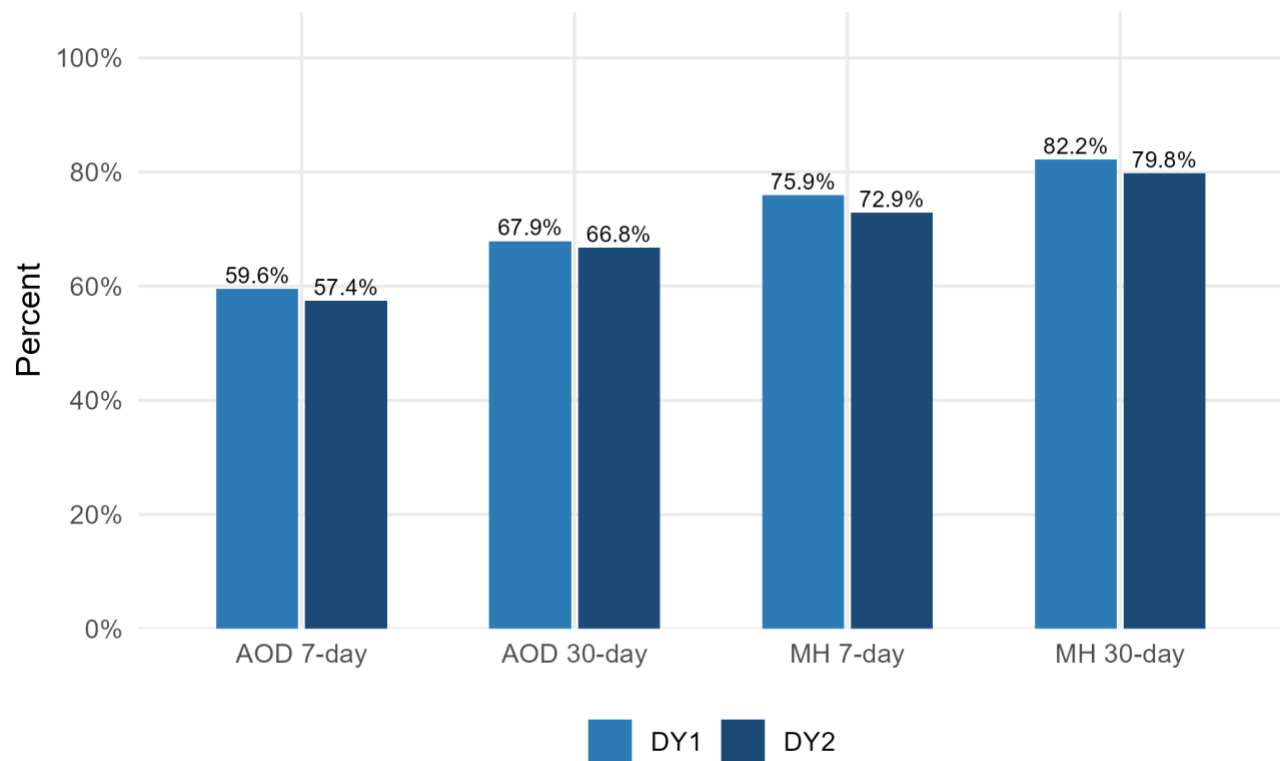
In DY1, 1,874 of 14,755 qualifying index AOD episodes resulted in treatment initiation within 14 days, a rate of 12.70%. In DY2, 1,348 of 10,900 index episodes resulted in initiation, a rate of 12.37% — an absolute change of –0.33 percentage points (–2.6%). By diagnosis cohort, initiation rates were essentially flat for the alcohol cohort (12.15% to 12.25%, +0.8%) and the other drug cohort (12.25% to 11.88%, –3.0%), while the opioid cohort showed a more notable decline (16.90% to 15.43%, –8.7%). The opioid cohort maintained the highest initiation rate across both years, reflecting the concentrated treatment-seeking behavior characteristic of opioid use disorder. The modest overall decline in initiation is not consistent with the target of increasing initiation rates, though the alcohol cohort result suggests stability in that subgroup. Possible explanations for the opioid cohort decline include changes in the composition of the episode-eligible population during unwinding or shifts in care-seeking patterns during coverage disruptions.

Treatment engagement — defined as two or more additional qualifying treatment services within 30 days of initiation — improved marginally overall: in DY1, 991 of 1,874 initiators engaged (52.88%); in DY2, 721 of 1,348 initiators engaged (53.49%), a change of +0.61 percentage points (+1.2%). The opioid cohort maintained substantially higher engagement than other cohorts in both years (DY1: 81.12%, DY2: 80.00%), with the marginal decline of 1.12 percentage points (–1.4%) best characterized as stable performance at a high level rather than meaningful deterioration. The alcohol cohort (44.99% to 45.68%, +1.5%) and other drug cohort (54.71% to 56.83%, +3.9%) both showed modest improvements. Note that engagement values are assessed as likely undercounts due to blurred-date approximations affecting the precision of the 30-day engagement window in the current pipeline; these values will be refined in subsequent analyses.

Metric 17

In DY1, 2,083 of 3,498 qualifying SUD-related emergency department visits had follow-up with a SUD treatment provider within 7 days (M17a-7d), a rate of 59.55%. In DY2, 1,639 of 2,854 qualifying visits had 7-day follow-up, a rate of 57.43% — an absolute change of –2.12 percentage points (–3.6%). At the 30-day window, 2,375 of 3,498 qualifying visits had follow-up in DY1 (67.90%), compared with 1,905 of 2,854 in DY2 (66.75%), a change of –1.15 percentage points (–1.7%). Figure 8 displays all four follow-up windows for both SUD and mental health ED visits.

For mental health ED visits (M17b), follow-up within 7 days was achieved for 1,964 of 2,587 qualifying visits in DY1 (75.92%) and 1,594 of 2,187 qualifying visits in DY2 (72.89%), a change of –3.03 percentage points (–4.0%). At the 30-day window, rates were 82.18% in DY1 (2,126 of 2,587) and 79.79% in DY2 (1,745 of 2,187), a change of –2.39 percentage points (–2.9%). All four measures declined modestly from DY1 to DY2, and the expected direction for this metric is an increase. However, the absolute levels remain high — particularly the 30-day MH ED follow-up rate, which exceeded 80% in DY1 and remained near 80% in DY2 — suggesting that Montana’s care coordination infrastructure, while under pressure, has maintained substantial performance on post-ED follow-up. These modest declines warrant monitoring and may reflect system strain during the unwinding period rather than a structural deterioration in coordination capacity. All values are based on true-date intervals from the DPHHS claims data pipeline.

Figure 8: Follow-up after emergency department visits, DY1 versus DY2

Grouped bar chart comparing rates of follow-up after qualifying emergency department visits at 7-day and 30-day windows for follow-up after an AOD-related ED visit (FUA, Metric 17a, NQF #2605) and follow-up after a mental health ED visit (FUM, Metric 17b). All four measures declined modestly from DY1 to DY2 (range: -1.7% to -4.0%), but absolute levels remain high, particularly 30-day MH ED follow-up (DY1: 82.18%; DY2: 79.79%). FUA denominators: DY1 N=3,498; DY2 N=2,854 qualifying AOD ED visits. FUM denominators: DY1 N=2,587; DY2 N=2,187 qualifying mental health ED visits. Values are based on true-date intervals from the DPHHS Medicaid claims data pipeline.

Metric 25

In DY1, 4,487 of 18,097 qualifying inpatient SUD stays were followed by a readmission within 30 days, a readmission rate of 24.79%. In DY2, 2,096 of 8,140 qualifying stays resulted in readmission within 30 days, a rate of 25.75% — an absolute increase of 0.96 percentage points (+3.9%). The expected direction for this metric is a decrease. The slight rate increase is modest and may be within normal variation but warrants monitoring. Notably, the denominator of qualifying inpatient SUD stays declined dramatically from DY1 to DY2 (18,097 to 8,140, -55.0%), reflecting the substantial reduction in inpatient SUD hospitalizations during the Medicaid unwinding period. This dramatic denominator decline may itself affect the readmission rate if the composition of qualifying stays shifted toward higher-acuity admissions in DY2. Note that DY assignment for this metric is approximate: calendar year is used as the assignment basis in the current output, meaning stays in CY2023 are assigned to DY1 regardless of the half-year in which they occurred. This will be refined in subsequent analyses.

IMD Qualitative Themes Summary

Across Milestones 1 through 6, qualitative findings from providers, stakeholders, DPHHS staff, and beneficiaries describe an IMD system that has expanded access to residential SUD treatment and

strengthened alignment with evidence-based clinical standards, while remaining constrained by structural and administrative factors that limit capacity, continuity, and durability of care across levels.

Milestone 1: Access to critical levels of care for SUD.

Qualitative evidence consistently indicates that the HEART demonstration substantially expanded access to residential SUD treatment through Medicaid coverage of IMD services. Beneficiaries frequently described Medicaid as the decisive factor enabling admission, often reporting rapid entry into care. Providers and DPHHS staff described clearer referral pathways, improved understanding of eligibility, and increased collaboration across facilities. At the same time, access remains uneven for individuals with complex needs, those requiring detoxification, or those in rural and tribal areas, where geography, workforce shortages, and limited provider distribution continue to constrain availability.

Milestone 2: Use of evidence-based SUD-specific patient placement criteria.

Providers and stakeholders reported widespread use of ASAM criteria to guide admission and reassessment, supported by regular state-led training and technical assistance. Beneficiary experiences largely corroborate that initial placement into IMD care is often clinically appropriate and responsive to severity of need. However, system constraints—particularly fixed expectations around length of stay, uncertainty related to the phase-out of certain ASAM levels, and severe shortages of step-down options—frequently prevent ASAM-concordant placement decisions from being sustained through discharge. As a result, appropriate placement at admission does not reliably translate into appropriate placement across the full continuum of care.

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.

Qualitative findings indicate strong alignment with nationally recognized SUD program standards across many IMD providers, including ASAM-based care models, evidence-based treatment modalities, medication-assisted treatment (MAT), and trauma-informed practices. Providers described maintaining qualified clinical staff, investing in training, and actively addressing internal resistance to evidence-based approaches. DPHHS oversight and training were widely viewed as reinforcing these standards. Beneficiary experiences largely confirm that these standards are operationalized in practice through respectful, supportive, and therapeutic care environments, though variation across facilities suggests that consistent implementation remains a challenge under workforce and financial pressures.

Milestone 4: Sufficient provider capacity at critical levels of care, including for MAT for OUD.

Across interviews, a clear distinction emerged between expanded eligibility and usable capacity. While the waiver increased the potential number of IMD beds, actual capacity remains constrained by workforce shortages, financial sustainability challenges, geographic concentration of services, and shortened treatment durations. Beneficiaries most often experienced these constraints as treatment ending too soon, limited detox sequencing, staffing strain, and difficult geographic transitions. Providers emphasized that these dynamics reduce throughput efficiency and contribute to repeated admissions, limiting the system's ability to meet demand despite expanded coverage.

Milestone 5: Implementation of comprehensive strategies to address prescription drug abuse and opioid use disorders.

Qualitative evidence points to meaningful progress in embedding opioid-specific strategies—particularly MAT—into IMD treatment. Providers described normalizing MAT as standard care, retraining staff, and enforcing alignment with harm-reduction principles. Beneficiaries who maintained medication continuity frequently identified it as central to recovery. However, downstream barriers—including stigma in sober living environments, medication costs, insurance coverage gaps, and misalignment with community providers—often undermine these strategies after discharge, limiting their effectiveness beyond the residential setting.

Milestone 6: Improved care coordination and transitions between levels of care.

Providers described strong coordination within IMD facilities, including early discharge planning, interdisciplinary care management, and reliance on case management and peer support. Beneficiary experiences confirm that when housing assistance, pre-scheduled follow-up care, and active navigation support are in place, transitions are more stable. Nonetheless, transitions frequently break down across systems. Housing shortages, Medicaid redetermination, administrative complexity, and uneven information sharing disrupt continuity during the highest-risk period following discharge. Coordination often depends on individual relationships rather than standardized infrastructure, making transitions fragile and variable across regions.

Taken together, qualitative findings across Milestones 1–6 suggest that the HEART demonstration has succeeded in opening access to residential SUD treatment, aligning providers with evidence-based standards, and delivering meaningful clinical benefit to many beneficiaries. However, these gains are consistently constrained by cross-cutting structural barriers—including length-of-stay policies, step-down shortages, workforce and reimbursement challenges, housing instability, and administrative fragmentation—that operate across milestones and limit continuity and sustainability of care. Providers and beneficiaries emphasized that these system-level factors, rather than deficiencies in clinical practice, are the primary obstacles to achieving seamless transitions and durable recovery statewide. Despite these constraints, many beneficiaries described transformative impacts of treatment, with one reporting that Medicaid-supported care “saved my life” and enabled a “totally new life.”

Beneficiary Survey Findings

All Medicaid beneficiaries who received eligible HEART waiver services at any point since July 1, 2022, were invited to participate in a beneficiary survey. Eligible participants were identified using Medicaid claims data, and recruitment letters were mailed by Montana Medicaid with a link to an electronic survey administered via REDCap, which could be completed on a smartphone, tablet, or computer. The survey included basic demographic questions, service-specific modules corresponding to HEART waiver components, and items assessing beneficiaries’ experiences with care. Participation was voluntary, and respondents could opt to enter a drawing for a \$100 gift card incentive.

A total of 93 beneficiaries completed the survey. Most respondents reported receiving services through an IMD/SUD facility, either alone or in combination with tenancy support services. The survey sample was gender-balanced and reflected a population with high clinical and social complexity, consistent with the populations served under the HEART demonstration. Survey findings are presented below to provide population-level context on beneficiary experience,

satisfaction, and social barriers, and are referenced throughout the report to triangulate with qualitative interview findings and claims-based analyses.

Survey Sample Characteristics

Survey respondents reflect a clinically and socially complex population consistent with those served under the HEART demonstration. The sample was gender-balanced, with 52.7% identifying as female and 47.3% as male. Among respondents who reported age ($n = 70$), the mean age was 40 years ($SD = 11.4$), with a range from 18 to 62, indicating representation across young adult to middle-aged populations commonly affected by substance use disorders.

Employment instability was common. At the time of survey, 41.9% of respondents were unemployed, while 24.7% reported full-time employment and 17.2% reported part-time employment. Smaller proportions identified as students, retired, or other employment status. Most respondents (80.6%) reported receiving both mental health and substance use services through Medicaid, underscoring the prevalence of co-occurring needs among beneficiaries receiving IMD and related services. Tribal enrollment data had substantial missingness (62.4%). Among respondents who answered this item, most reported being enrolled in a tribe; however, due to nonresponse, these findings should be interpreted cautiously and are not necessarily representative of the full sample.

Experience of Care in IMD Facilities

Nearly all survey respondents (95.7%, $n = 89$) reported receiving care in a substance use disorder treatment facility, either alone or in combination with tenancy support services, indicating that the survey findings are highly relevant for assessing beneficiary experience of IMD and residential SUD care. Among respondents who received facility-based care, most reported positive experiences related to safety, communication, and connection to follow-up supports. Of those who responded, 88.6% reported feeling safe at the facility, while 11.4% reported that they did not. Communication around treatment goals was reported to be strong, with 96.2% indicating that staff talked with them about their goals. Referral to additional help following treatment was also common (85.0%), though a notable minority reported not receiving referrals. These findings suggest that most beneficiaries experienced treatment environments that were safe and structured, with attention to planning and follow-up, while also indicating variation in experience across individuals or settings.

Person-Centered Care and Satisfaction

Survey responses indicate generally strong performance on key elements of person-centered care. Most respondents reported feeling listened to during their care (76.1% yes; 18.5% sometimes), and a large majority (90.2%) reported being helped to make decisions about their care. These findings align with the HEART demonstration's emphasis on individualized treatment planning and beneficiary engagement.

Experiences were more mixed with respect to whether beneficiaries felt they received all the help they needed. While 70.7% reported that they did, nearly one-quarter (23.9%) indicated that this occurred only sometimes, and 5.4% reported that they did not receive the help they needed. Overall satisfaction was high, with 81.5% reporting that they would recommend the services they received; however, nearly one in five respondents were unsure or would not recommend services, reinforcing that experiences were not uniformly positive.

Social and Practical Barriers Affecting Care and Recovery

Alongside generally positive reports of facility-based care, many beneficiaries reported significant social and practical barriers that affect engagement in treatment and recovery. The most reported challenge was difficulty paying for food, reported by 61.3% of respondents. Transportation barriers were also widespread, with 41.9% reporting difficulty getting to appointments. One-third of respondents (33.3%) reported trouble finding a safe place to live, highlighting housing instability as a major concern for a substantial portion of the sample. Access to outpatient providers remained a challenge for some beneficiaries, with 25.8% reporting difficulty finding a doctor or counselor. Childcare barriers were reported less frequently (10.8%) but still represent a meaningful obstacle for individuals with caregiving responsibilities. Notably, 21.5% of respondents reported experiencing none of the listed barriers, indicating heterogeneity in post-treatment circumstances.

Summary Survey Findings

Taken together, the beneficiary survey findings indicate that IMD and SUD facility services under the HEART demonstration are generally experienced as safe, respectful, and person-centered, with strong performance on goal-setting, shared decision-making, and communication. Most beneficiaries reported positive experiences within treatment settings and a willingness to recommend services.

At the same time, the survey highlights meaningful variability in experience and substantial non-clinical barriers that shape recovery trajectories. Food insecurity, transportation challenges, and housing instability were common and often co-occurring, reinforcing the importance of coordinated social supports alongside clinical care. The presence of respondents who did not feel safe, did not receive referrals, or only sometimes received needed help underscores the need for continued attention to consistency and follow-through across settings.

Overall, the survey findings provide important population-level context for interpreting qualitative interview findings and claims-based analyses presented elsewhere in this report. They underscore that while facility-based care under the HEART demonstration is broadly experienced positively, sustained recovery and continuity of care depend heavily on addressing social determinants and post-discharge supports beyond the treatment setting.

IMD: Implementation Evidence

Montana's HEART 1115(a) Medicaid demonstration has been implemented through a multi-layered, hands-on approach that blends regulatory reform, provider engagement, and targeted technical assistance. The Behavioral Health and Developmental Disabilities Division (BHDD) led a statewide provider engagement initiative in 2025 and early 2026, intentionally designed to support providers in understanding new Medicaid expectations, implementing Tenancy Support Services (TSS), and preparing for broader HEART Waiver changes.

Rules Promulgation and Regulatory Infrastructure

Montana's implementation strategy began with the promulgation of a comprehensive set of Administrative Rules of Montana (ARMs) to operationalize the HEART waiver. These rules authorized ASAM-aligned services, established provider qualifications, and enabled Medicaid reimbursement for residential SUD treatment in IMDs. Key regulatory updates included:

- ASAM Level Coverage:
 - Medicaid coverage expanded to ASAM Levels 3.1, 3.2-WM, 3.3, and bundled per diem rates (e.g., ARM 37.27.101, 37.27.105, 37.27.106, 37.27.107, 37.27.201, 37.27.203, 37.27.204, 37.106.1411, 37.106.1471, 37.106.1472, 37.106.1473, 37.106.1475, 37.106.1480).
- Licensure and Provider Standards:
 - New and revised licensure rules for residential and outpatient providers, including staffing standards, operational protocols, and requirements for MAT access (e.g., ARM 37.106.1425-1434, 1489).
- Care Coordination and Discharge Planning:
 - Rules mandating comprehensive discharge planning, warm handoffs, and continuity of care across treatment settings (e.g., ARM 37.27.120, 37.106.1440, 1454, 1456, 1471-1475, 1480).
- Documentation and Compliance:
 - Standards for treatment planning, progress notes, and compliance monitoring, ensuring providers meet evidence-based criteria and Medicaid requirements (e.g., ARM 37.27.115, 37.27.116, 37.27.117, 37.27.119, 37.27.902, 37.106.1434).

Providers and state staff described these actions as foundational, noting that they reduced financial barriers and expanded access, particularly for low-income and rural populations. Providers appreciated the clarity brought by new licensure standards and the collaborative approach to workforce development, though they also reported challenges in meeting staffing and training requirements, especially for 24/7 residential programs.

Outreach and Training Activities

BHDD conducted over 100 site visits across communities including Livingston, Butte, Missoula, Kalispell, Great Falls, Browning, Billings, and Helena. These visits were structured to maximize practical learning and real-time problem-solving. Each regional engagement included formal training sessions, facility tours, technical assistance, open office hours, and jail visits when available. More than 150 provider staff participated in training sessions, which emphasized interactive, scenario-based discussion. This format allowed providers to work through real-world cases, clarify eligibility and billing requirements, and reduce variation in interpretation across regions. Training and outreach topics were tailored to the needs of each community and provider type, but consistently covered:

- Tenancy Support Services (TSS):
 - Eligibility criteria, service scope, billing requirements, referral processes, and practical steps for enrollment.
 - Guidance on walk-through inspections, habitability standards, and documentation templates.
 - Common questions included how to bill for TSS, how to handle connecting with deposit assistance services, and how to coordinate with landlords and other agencies.
- Medicaid Service Alignment:
 - Consistent interpretation of behavioral health continuum of care, service definitions, documentation standards, treatment planning, discharge coordination, and addressing common areas of confusion.

- Discharge Planning and Continuity of Care:
 - Emphasis on warm handoffs, coordination with housing, tenancy specialist services, and case management supports, and preparation for CAA 5121 Phase 2.
- Justice-System Coordination:
 - Intake and discharge planning in detention facilities, communication with providers, and early identification of system gaps.
 - BHDD engaged with local jails and juvenile detention centers to align roles and prepare for new Medicaid-funded reentry supports.
- Documentation Practices:
 - Training on progress notes, treatment planning, and compliance with Medicaid and HEART Waiver requirements.
 - Providers were encouraged to set distinct goals and interventions for each service in treatment plans.
- Provider Enrollment and Billing:
 - Step-by-step guidance on enrolling as a TSS provider, troubleshooting slow processing times with Conduent, and clarifying taxonomy codes and team codes for claims submission.

Real-World Examples and System Impact

Facility tours provided opportunities to observe service delivery in practice, review staffing and documentation, and address concerns through real-time guidance. For example:

- Action Inc. (Butte): Shared community partnerships and rapid housing strategies, leading BHDD to incorporate walk-through inspections into new rulemaking.
- Great Falls Rescue Mission: Demonstrated a multi-level support model, including medical, dental, and chiropractic services for the homeless, aligning closely with TSS goals.
- Cascade County Detention Center: Showcased robust mental health services and monthly community staffing meetings to ensure continuity of care for justice-involved individuals.
- Temporary Safe Outside Space (TSOS, Missoula): Offered pallet houses and a pathway to permanent housing, illustrating innovative solutions for transitional living.
- Oxytocin Clinic (Kalispell): Rebuilt its space to be trauma-informed and welcoming, with dedicated group rooms and youth-focused programming.
- Recovery Centers of Montana: Emphasized the healing power of outdoor settings and peer support, with client feedback highlighting the impact of the environment and programming.

Providers in Missoula, Kalispell, and Billings highlighted unique approaches to homelessness, mental health, and SUD, with each community adapting to local needs and resources. The diversity of service models and local adaptations was a strength, with communities consistently finding ways to overcome barriers and meet local needs.

Training Survey Feedback and System Readiness

Survey feedback from 23 providers indicated increased clarity around TSS, improved understanding of Medicaid expectations, and appreciation for the collaborative, non-enforcement approach. Providers reported greater confidence in implementation following engagement, and the collaborative model has strengthened relationships and communication across agencies and communities. The initiative resulted in improved readiness for HEART and TSS implementation, greater consistency across services, stronger discharge planning, and early preparation for justice-system coordination.

Challenges and Barriers

Despite these successes, challenges remain. Providers reported confusion about the TSS enrollment process, slow processing times, and lost enrollments. The delivery process for TSS was also described as confusing, with recurrent questions about cuts to services and federal funding. Transportation barriers in rural areas and workforce shortages continue to limit access to care. Relationships between providers are not always optimal, sometimes creating local barriers, but communities consistently find ways to overcome these obstacles.

Staff Reflections and Leadership Insights

Staff reflected that the tours and trainings offered insights not possible without direct engagement. Personal connections increased communication and quality of care, and the “village” of Montana’s mental health and SUD services was strengthened through these efforts. Leadership summaries emphasized that HEART is a complex initiative requiring ongoing support, outreach, and relationship-building to maintain and improve quality care for Medicaid recipients.

Montana’s HEART demonstration is being implemented through a blend of regulatory reform—including robust rules promulgation—hands-on provider engagement, scenario-based training, and technical assistance. The specificity and breadth of outreach—covering TSS, Medicaid alignment, discharge planning, justice-system coordination, and documentation—demonstrate a robust commitment to system-building and quality improvement. These activities, paired with ongoing adaptations and feedback loops, position Montana for continued progress and align with CMS expectations for implementation evidence. Continued investment in training, technical assistance, regulatory clarity, and cross-system collaboration will be essential to sustaining this momentum and achieving the demonstration’s full potential.

3. Pre-Implementation Findings: Amended Components

Contingency Management

Contingency management services were in the early stages of pre-implementation during the timeframe covered by this interim evaluation. While comprehensive outcome evaluation is deferred until a later phase, we present here a brief overview of pre-implementation experiences and feedback from providers and stakeholders. Beneficiary perspectives on CM will be prioritized and incorporated into the summative evaluation as the program matures and more individuals receive these services. Early feedback from providers and stakeholders are shared to provide context for future assessment and to support continuous quality improvement as contingency management services are scaled up.

Provider and Stakeholder Perspectives

Many of the providers and stakeholders interviewed for this evaluation have experience implementing contingency management (CM) through prior grant-funded programs, and some were in the process of preparing for Medicaid-billed CM under the HEART waiver during the evaluation period. As a result, portions of the feedback and observations presented here reflect general perspectives on CM, lessons learned from previous grant-based implementations, and informed speculation about how the waiver program may function in practice. Where possible, findings specific to pre-implementation of HEART waiver components are highlighted, but it is important to interpret some themes as a blend of direct experience and provider expectations based on their broader history with CM delivery.

Information Sharing and Data Systems

The new SIMS tracker and CM portal were seen as robust, user-friendly tools that simplified tracking of incentives and urine tests, reduced human error, and enabled comprehensive data collection regardless of funding source. The state's development of a public-facing webpage for waiver services, including CM, was viewed as a positive step. However, communication from the state regarding CM implementation was sometimes described as fragmented, with multiple contact points and unclear guidance, leading to confusion among providers. The lack of a clear, centralized communication channel and the absence of a checklist for requirements before training began were cited as areas for improvement.

Alignment with Recovery Goals and Client Needs

CM was widely regarded as an effective practice for helping clients achieve and maintain sobriety, with incentives used for essential needs like gas, groceries, or significant purchases. The program approach is perceived to build rapport and trust, especially for clients struggling with substance use, by focusing on underlying reasons rather than punitive responses to positive urine tests. Providers considered CM the only successful treatment option for some patients with stimulant use disorder.

Summary

Overall, CM is recognized as a powerful tool for initial engagement and integration with broader SUD treatment,. Providers emphasized the need for streamlined communication, more flexible eligibility and training requirements, and sustainable funding mechanisms to fully realize the potential of CM within Montana's SUD treatment continuum.

Tenancy Supports

The following section briefly summarizes preliminary observations and provider and stakeholder perspectives on the rollout of tenancy support services, which are intended to inform ongoing monitoring and future evaluation as this component is implemented. Beneficiary perspectives on TSS will be prioritized and incorporated into the summative evaluation as the program matures and more individuals receive these services. Early feedback from providers and stakeholders are shared to provide context for future assessment and to support continuous quality improvement as tenancy services are scaled up.

Provider and Stakeholder Perspectives

Eligibility, Identification, and Initial Engagement

Providers employ a variety of strategies to identify eligible clients for their services, including leveraging assessments from drop-in centers, HUD housing lists, and standardized state screening tools, which they intend to employ in their implementation of HEART services. The program's broad eligibility criteria mean that most individuals with SUD or mental health needs can qualify, and state outreach has helped onboard a wide range of agencies, including non-traditional providers. However, engagement is anticipated to be complicated for clients who are not interested in permanent housing, lack basic documentation (such as IDs or Social Security cards), or have inconsistent contact information. Clients with severe behavioral health challenges may also struggle to keep appointments or follow through, and the administrative burden of helping clients obtain necessary documents is significant and not reimbursed.

Beneficiary Awareness and Communication Gaps

Providers report an anticipated need for more public-facing information and education, as well as clearer communication about the distinction between TSS and other Medicaid services. Clients

may not know about the availability of tenancy support specialists or the resources that specialist can connect them to.

Provider Network Growth and Onboarding Challenges

The network of TSS providers has grown significantly, with expansion into rural areas and the inclusion of non-traditional organizations. However, onboarding new providers is a lengthy and complex process, especially for those unfamiliar with Medicaid billing. Non-traditional providers face a steep learning curve, including obtaining NPIs, setting up EHRs, and navigating the Medicaid portal, which is described as “unusable” without specific guidance. Tribal organizations face additional bureaucratic hurdles, such as council approvals and adapting to specific billing systems. The lack of a dedicated state point person for provider enrollment and support adds to the challenge.

Workforce Capacity and Training

Many agencies have leveraged existing case managers for TSS specialist roles, and state-provided training and technical assistance are valued. However, hiring and retaining staff has been difficult during pre-implementation, especially in rural and tribal areas, due to workforce shortages and uncompetitive wages. The time required for training, enrollment, and property walkthroughs adds to staff workload, and uncertainty about referral volume complicates staffing decisions. High turnover and the need for specialized knowledge in housing navigation further strain capacity.

Housing Market Constraints and Landlord Relationships

Providers have built relationships with community partners, landlords, and property managers to expand housing options and support clients. However, the lack of affordable housing and long waitlists are persistent barriers, with some waitlists stretching for years. Landlords are often unwilling to rent to individuals with criminal backgrounds, poor credit, or eviction histories, even when financial support is available. In high-demand markets, landlords can be selective, and some who accept high-need clients may not maintain properties well. Sober living costs are high, and clients often lack income upon discharge, making it difficult to sustain housing.

Administrative and Financing Challenges

The waiver allows non-traditional providers to bill Medicaid for services previously provided pro bono, offering a more stable funding source. However, delays in reimbursement, the administrative burden of billing and documentation, and the need for multiple documentation systems are anticipated to create challenges. Providers spend significant, unreimbursed time on client engagement, referral forms, and Medicaid redetermination assistance, which limits their capacity and sustainability. The fee structure for TSS may not fully cover costs, especially for agencies using external billers, and small nonprofits struggle with cash flow due to delayed reimbursements for upfront costs.

Integration with Health and Social Services

TSS providers actively coordinate with mental health and medical providers to ensure clients maintain medications and receive appropriate treatment. Housing assessments help identify broader needs, and individualized care planning aligns housing support with overall recovery goals. However, the process for integrating TSS with other services can be complicated by administrative hurdles, lack of role clarity, and the need for better information sharing across systems. Providers will also help clients obtain vital documents, apply for benefits, and connect with food banks and employment resources, addressing fundamental needs that are prerequisites for housing stability.

Outcome Tracking, Data, and Sustainability

The state is establishing metric reporting for TSS, but data collection is still in early stages, and manual processes make it difficult to monitor effectiveness. Providers use HMIS and other systems to track housing outcomes, but the lack of active metric reporting and delays in billing make it challenging to evaluate impact. Sustainability is threatened by delayed reimbursements, administrative burden, and the risk of clients losing eligibility due to income changes. The lack of a clear off-ramp to other sustainable Medicaid services after TSS concludes creates uncertainty for long-term care planning.

Summary

The TSS component of the HEART waiver has expanded the provider network and established mechanisms for identifying and supporting individuals with housing needs. Proactive state engagement, training, and technical assistance have enabled a diverse range of providers to participate. However, significant challenges remain, including administrative complexity, workforce shortages, housing market constraints, and the need for more effective communication and integration with health and social services. Addressing these barriers—particularly the unreimbursed administrative burden, onboarding challenges for new providers, and persistent housing market shortages—will be essential to fully realize the potential of tenancy support services in promoting housing stability and recovery for high-need populations.

Reentry

While the reentry component of the HEART demonstration was not scheduled for full implementation during the interim evaluation period and is not a focus of outcome evaluation at this stage, we have collected preliminary findings related to early and pre-implementation activities. The following section provides a summary of initial stakeholder and provider feedback regarding the rollout of reentry services, intended to inform future evaluation and quality improvement efforts as this component matures. Beneficiary interviews were not conducted for the reentry component during this interim evaluation period. As the reentry component becomes more fully implemented and enrollment increases, beneficiary perspectives will be systematically collected and included in the summative evaluation.

Stakeholder and Provider Perspectives

Communication and Coordination

Implementation of the reentry component has benefited from regular meetings and responsive communication between DOC and DPHHS, with providers describing DPHHS as a supportive partner. Face-to-face meetings, a dedicated program specialist, and technical assistance have facilitated collaborative problem-solving. However, the lack of early DOC involvement in waiver design led to some initial misunderstandings about existing services and delayed alignment on data sharing and operational processes. Continued efforts to streamline communication and clarify roles will be important as implementation matures.

Identification, Enrollment, and Medicaid Activation

Systems are in place to identify Medicaid-eligible individuals at intake and prior to release, with proactive efforts to activate coverage up to 30 days before discharge. This has improved immediate access to services upon reentry. Nonetheless, data inaccuracies and manual reconciliation remain challenges, and upgrades to offender management systems are still in progress. Coverage continuity is sometimes disrupted by redetermination processes, address changes, and communication gaps, particularly for transient or high-need populations.

Provider Engagement, Training, and Outreach

DPHHS has conducted statewide trainings and developed a public-facing webpage to increase provider awareness and engagement. Monthly calls and responsive support have been helpful, but providers noted a need for clearer, ongoing communication about eligibility, operational processes, and billing. Some provider types were inadvertently excluded from early rulemaking, and additional follow-up training could further support readiness.

Access for Community Providers and In-Reach Services

The waiver aims to facilitate in-reach by community providers for face-to-face or virtual meetings before release, supporting warm handoffs and continuity of care. Privacy booths and telehealth applications have expanded these opportunities, though implementation varies across facilities. Scheduling and logistical challenges, as well as technology adoption, continue to be areas for improvement.

Data Sharing, Information Systems, and Monitoring

A data sharing agreement exists between DOC and DPHHS, and system upgrades are expected to improve tracking and evaluation. Currently, manual processes and system incompatibilities create delays and limit the ability to comprehensively monitor service delivery and outcomes. Continued investment in information system integration will be critical for robust evaluation and quality improvement.

Billing, Reimbursement, and Financial Alignment

The waiver allows Medicaid to cover services previously funded by DOC, supporting sustainability and potential reinvestment of state resources. DPHHS has supported provider enrollment and billing, but administrative complexity, unresolved issues with drug pricing programs, and the lack of a billing module in DOC's EHR have created financial and operational challenges. Streamlining billing processes and clarifying reimbursement pathways remain priorities.

Provider Capacity, Rural Access, and Workforce Shortages

While training and outreach have expanded, persistent workforce shortages and provider capacity gaps—especially in rural and tribal areas—limit the availability of reentry services. Service deserts, long waitlists, and high housing costs continue to pose barriers to successful transitions.

Summary

At this early stage, the reentry component of the HEART waiver has established foundational mechanisms for identification, Medicaid activation, and care coordination. While many core services were already provided by DOC, the waiver has formalized and sustained these supports within a Medicaid framework, introduced new opportunities for warm handoffs and provider engagement, and highlighted areas for ongoing improvement. Continued focus on system integration, communication, provider capacity, and client education will be essential to fully realize the waiver's potential as implementation progresses.

4. Cross-Cutting Outcomes / Integration

Across all milestones, findings from quantitative and qualitative analyses are highly consistent and point to a clear cross-cutting pattern: the HEART demonstration has expanded access to SUD treatment, but system-level constraints continue to limit continuity, care transitions, and sustained outcomes.

Improvements in access are evident across all service modalities, including outpatient care, residential and inpatient treatment, withdrawal management, and medication-assisted treatment.

These gains are reinforced by qualitative findings describing faster entry into care, stronger referral pathways, and broader availability of services. At the same time, multiple indicators of continuity and care coordination—including pharmacotherapy continuity, follow-up after emergency department visits, and readmissions—show limited improvement or modest decline, indicating that expanded access has not yet translated into consistent longitudinal care engagement.

Across both data sources, these patterns are consistently attributed to a shared set of structural constraints rather than variation in clinical practice or provider engagement. Key cross-cutting factors include workforce shortages, limited geographic availability of providers, gaps in step-down treatment capacity, housing instability, and administrative disruptions associated with Medicaid redetermination. These constraints operate across all stages of the care continuum, affecting treatment duration, discharge planning, and transitions into community-based services.

The findings also indicate that the demonstration is driving system-level alignment with evidence-based care. Providers report widespread adoption of ASAM criteria, normalization of MAT in residential settings, and improved coordination supported by state-led training and technical assistance. However, the effectiveness of these advances is moderated by variability in downstream supports, particularly housing and ongoing care infrastructure, which are critical to sustaining treatment gains.

Taken together, the cross-cutting evidence suggests that the HEART demonstration is functioning as intended at the point of access and within treatment settings, but that broader system capacity and integration challenges continue to shape outcomes beyond treatment initiation. Addressing these system-level constraints will be essential to converting gains in access into sustained improvements in continuity of care, recovery outcomes, and overall system performance.

G. Conclusions

The interim evaluation of the HEART Section 1115 demonstration indicates that Montana has made meaningful progress toward expanding access to SUD treatment and strengthening elements of the behavioral health care continuum. Across quantitative and qualitative evidence, the demonstration is associated with increased utilization of SUD services on a per-beneficiary basis, particularly for MAT, residential/inpatient care, and withdrawal management services. These findings suggest that the demonstration is achieving its central objective of improving access to clinically appropriate care.

At the same time, the evaluation highlights important limitations in the demonstration's ability to fully realize its intended impacts during the interim period. Improvements in access have not been uniformly matched by gains in continuity of care, treatment duration, or successful transitions across levels of care. Key indicators—including pharmacotherapy continuity, follow-up after emergency department visits, and readmissions—demonstrate areas of stagnation or modest decline, consistent with qualitative reports of disruption during Medicaid unwinding and persistent system constraints.

Across all milestones, findings consistently point to structural and contextual factors as the primary constraints on demonstration effectiveness. These include workforce shortages, geographic disparities in provider availability, limitations in step-down services, housing instability, administrative complexity, and coverage disruptions. Importantly, qualitative evidence suggests that these challenges are not driven by deficiencies in clinical practice or provider effort, but rather by broader system-level conditions that shape the implementation environment. As required for

interim evaluation reporting, these findings should be interpreted within the context of an evolving demonstration. Several waiver components—including tenancy support services, contingency management, and reentry services—were in pre-implementation or outside the primary evaluation period. In addition, major external disruptions, including the COVID-19 Public Health Emergency and Medicaid redetermination, introduced volatility that limits causal interpretation of observed trends.

Overall, the evidence suggests that the HEART demonstration is directionally aligned with its goals and is producing meaningful early benefits in access to care, while highlighting critical areas for continued system development and policy attention.

1. Effectiveness of the Demonstration

The available evidence indicates that the HEART demonstration has been partially effective in achieving its stated goals during the interim evaluation period, with the strongest evidence of effectiveness observed in expanded access to SUD treatment services. Rate-based analyses show consistent increases across all major service modalities, including outpatient care, residential and inpatient treatment, withdrawal management, and MAT. These trends are supported by qualitative findings describing improved referral pathways, increased provider engagement, and more rapid access to care following Medicaid coverage expansion for IMD services.

Effectiveness is more limited when assessed against goals related to continuity, quality, and transitions of care. Several key metrics—including continuity of pharmacotherapy, follow-up after emergency department visits, and readmission rates—did not improve and in some cases declined modestly during the evaluation period. Qualitative findings indicate that these outcomes are influenced by factors such as shortened treatment durations, lack of step-down care, and disruptions associated with coverage loss and administrative burden.

The evaluation also finds that the demonstration has been effective in strengthening alignment with evidence-based practices, particularly the use of ASAM criteria, implementation of MAT, and adoption of trauma-informed care approaches within IMD settings. However, the ability to sustain these practices consistently across the continuum of care is constrained by workforce shortages, provider capacity limitations, and variability in community-based supports. Importantly, the absence of a comparison group and the reliance on descriptive and trend-based analyses limit the ability to attribute observed changes solely to the demonstration. As noted in the methodology, external factors—including the COVID-19 PHE and Medicaid unwinding—substantially influenced enrollment and utilization patterns, complicating causal inference.

In summary, the HEART demonstration demonstrates clear improvements in access and advancing implementation of evidence-based care, while showing more modest or mixed effectiveness in improving continuity, coordination, and long-term treatment outcomes. These patterns are consistent with expectations for an interim evaluation during early and disrupted implementation phases.

2. Outcomes and Impacts of the Demonstration

The outcomes and impacts of the HEART demonstration during the interim evaluation period reflect a combination of measurable improvements in access to care, stabilization or modest changes in quality and transition measures, and broader system-level impacts on provider practices and implementation infrastructure.

The most consistent positive impacts are observed in service utilization outcomes. Across all Milestone 1 metrics, rates of SUD treatment increased from DY1 to DY2, including notable gains in medication-assisted treatment, residential and inpatient care, and withdrawal management services. These findings indicate that the demonstration has expanded the reach of SUD services among Medicaid beneficiaries, even in the context of declining enrollment during Medicaid unwinding.

Impacts on clinical outcomes and prescribing-related measures are mixed. The all-drug overdose death rate declined during the evaluation period, representing a positive population-level signal, while the opioid-specific overdose death rate increased slightly within the range of expected variation. Measures of high-risk prescribing and emergency department utilization showed modest increases or stability, suggesting that progress in upstream access has not yet fully translated into reductions in acute or high-risk utilization. Measures of care continuity and transitions show more limited improvement. Pharmacotherapy continuity declined, and follow-up after emergency department visits decreased modestly, while readmission rates increased slightly. Qualitative findings indicate that these outcomes are shaped by systemic issues such as coverage instability, insufficient treatment duration, limited availability of step-down services, and housing insecurity, all of which disrupt continuity of care during and after treatment.

Beyond measurable outcomes, the demonstration has had important system-level impacts. These include increased statewide alignment with ASAM criteria, normalization of MAT within residential treatment settings, expanded provider engagement through training and technical assistance, and the development of new service infrastructures such as tenancy support services and contingency management. These changes represent foundational shifts in how SUD treatment is organized and delivered, with potential long-term implications that extend beyond the interim evaluation period. At the beneficiary level, qualitative findings point to meaningful perceived impacts, including improved access to treatment, increased engagement in care, and, in some cases, transformative recovery experiences. However, these benefits are highly contingent on successful transitions to housing, outpatient care, and community supports, which remain unevenly available across regions and populations.

Taken together, the interim outcomes suggest that the HEART demonstration is producing important early gains in access and system alignment, while highlighting the critical role of structural supports—particularly workforce capacity, housing stability, and care coordination—in determining the sustainability and long-term impact of these improvements. Subsequent evaluation periods will be necessary to assess whether early access gains translate into durable improvements in health outcomes and system performance.

H. Lessons Learned and Policy Implications

Throughout this evaluation, findings were synthesized across quantitative and qualitative data sources to identify key implementation successes, persistent challenges, and areas requiring further system development. Based on these findings, the evaluation team formulated a set of targeted state considerations, designed to highlight critical policy and operational questions emerging from the evidence and to inform ongoing program refinement. These considerations were shared with DPHHS to provide an opportunity for response and clarification. The state responses that follow reflect DPHHS's current strategies, planned actions, and implementation perspectives, and are presented alongside the evaluation findings to support transparency, contextual interpretation, and alignment between evaluation evidence and programmatic decision-making.

1. Sustaining and Scaling Provider Engagement and Technical Assistance

Evaluation findings indicate that providers highly value ongoing technical assistance, scenario-based support, and real-time troubleshooting—especially as new services and requirements are rolled out. As the waiver expands, maintaining consistent engagement and support will be increasingly challenging, particularly for rural, tribal, and non-traditional providers.

State Consideration: What is the plan for sustaining and scaling technical assistance and provider engagement as the waiver matures? Will DPHHS dedicate staff, develop regional outreach strategies, or expand virtual office hours to ensure continued support for all provider types, including those in resource-scarce areas?

State Response: DPHHS has built technical assistance and provider engagement into the ongoing implementation of the HEART Waiver and anticipates that those efforts will continue as the waiver matures. Technical assistance is currently provided by HEART program staff, UCLA partners, and subject matter experts supporting specific service areas. DPHHS has also expanded capacity through the addition of dedicated HEART Waiver staff, including a position added specifically to support waiver implementation, provider engagement, and technical assistance activities. In addition to individualized support, DPHHS hosts recurring provider meetings by provider type, regular office hours, newsletters, trainings, and technical assistance calls. Beginning in July 2026, DPHHS will launch a monthly training series focused on topics identified through provider feedback, including Mental Health Continuum of Care, Substance Use Disorder Continuum of Care, and HEART Waiver Services. Provider feedback consistently shows that individualized support and site visits are among the most valuable forms of technical assistance. In 2025, DPHHS staff conducted trainings in six communities across Montana and visited more than 100 provider locations. DPHHS also continues to develop partnerships with Tribal Nations and organizations interested in implementing services such as Tenancy Support Services and Contingency Management. UCLA provides ongoing Contingency Management training, technical assistance, and fidelity support to providers implementing the model. Given the innovative and non-traditional nature of many HEART services, DPHHS expects technical assistance to remain an ongoing component of successful implementation.

2. TSS Enrollment, Billing, and Documentation Clarity

Evaluation interviews highlight persistent confusion about TSS enrollment, billing, and documentation requirements. Providers anticipate delays, unclear steps, and technical issues with Conduent, which impact timely access and service delivery. There is also uncertainty about walk-through inspections, habitability standards, and compliance documentation.

State Consideration: What concrete steps will be taken to clarify and streamline TSS provider enrollment and billing—including resolving technical issues, providing step-by-step guidance, and ensuring timely communication? How will DPHHS support providers in navigating documentation, inspections, and compliance requirements?

State Response: DPHHS recognizes that TSS providers have experienced challenges related to enrollment, billing, and implementation. Many TSS providers are community-based organizations that have not previously participated in Medicaid and are simultaneously learning enrollment requirements, documentation standards, staffing models, and billing processes. Enrollment remains the most significant challenge, with provider enrollment often taking several months and Conduent-related delays continue to create barriers. To support implementation, DPHHS provides provider enrollment guidance, office hours, provider meetings, written resources, and

individualized technical assistance throughout the enrollment process. DPHHS staff work closely with providers through their first billing cycle to identify and resolve issues, and billing outcomes have generally been successful once providers are enrolled and trained. Providers have also received significant support related to Medicaid documentation requirements, which often differ substantially from documentation expectations under grant-funded programs. Providers have noted challenges related to the time and effort required to assist individuals through eligibility and prior authorization processes, particularly because those activities are not billable and individuals maintain freedom of choice when selecting a provider. DPHHS will continue providing technical assistance and refining guidance based on provider feedback and implementation experience.

3. Workforce Shortages and Capacity for SUD, MAT, and Peer Support

Evaluation findings confirm that workforce shortages—especially for MAT-waivered clinicians, peer support specialists, and case managers—are a major barrier to access and service expansion. Providers cite recruitment, retention, licensure challenges, and difficulty sustaining 24/7 coverage.

State Consideration: What additional strategies or supports will be deployed to address workforce recruitment, retention, and training? Are there plans for incentives, loan repayment, expanded training modules, or partnerships with educational institutions to build capacity in critical roles?

State Response: DPHHS recognizes that workforce shortages continue to impact behavioral health services across the continuum of care. Providers consistently report shortages of addiction counselors, therapists, peer support specialists, case managers, tenancy support providers, MAT providers, and prescribers. These challenges are particularly pronounced in Montana's rural and frontier communities and are influenced by factors such as housing availability, salary competition, and workforce burnout. While DPHHS cannot directly address provider-specific recruitment and retention practices, the department continues to support providers through training opportunities, technical assistance, stakeholder engagement, and implementation support. DPHHS has also worked to engage non-traditional providers and expand participation in services that support recovery and community stability. Workforce shortages remain a significant challenge statewide and continue to affect access to care across multiple levels of service.

4. Discharge Planning, Care Transitions, and Loss of Step-Down Services (e.g., ASAM 3.1)

Evaluation findings and beneficiary perspectives reveal that the reduction or loss of step-down residential services—such as ASAM 3.1—has created significant gaps in discharge planning and care transitions. Without these lower-intensity residential options, individuals are often discharged from high-intensity treatment (e.g., ASAM 3.5) directly into unstable housing or outpatient care, increasing risk of relapse and undermining continuity of recovery. This gap is especially acute for justice-involved and unstably housed populations.

State Consideration: What strategies will be implemented to address the loss of step-down services like ASAM 3.1? How will DPHHS support discharge planning and care transitions for individuals who no longer have access to these intermediate levels of care? Are there plans to expand or reintroduce step-down options, or to enhance wraparound supports for those discharged from high-intensity treatment?

State Response: DPHHS recognizes concerns regarding the loss of ASAM 3.1 capacity and the impact it has on discharge planning and care transitions. Providers continue to report that there are not enough ASAM 3.1 providers available across the state, resulting in many individuals stepping directly from ASAM 3.5 services into outpatient treatment, living with friends or family, or other

community settings. This can create challenges for individuals who would benefit from a lower-intensity residential step-down option before returning to the community. Housing stability remains a significant concern, particularly for individuals who do not have a safe or stable place to live following discharge. While HEART Waiver services such as Tenancy Support Services can help support housing stability after discharge, individuals cannot apply for or receive TSS while residing in a residential treatment setting. As a result, these services are not a direct replacement for ASAM 3.1 care but may provide support once an individual returns to the community. DPHHS would welcome additional providers entering the ASAM 3.1 space and will continue working with providers and community partners to strengthen care transitions and recovery supports for individuals leaving higher levels of care

5. Data Systems, Tracking, and Performance Monitoring

Evaluation findings highlight the need for improved tracking of referrals, enrollments, outcomes, and compliance, as well as timely feedback on performance. Current systems are fragmented, limiting visibility into service delivery and beneficiary progress.

State Consideration: What are the plans for developing centralized data systems or dashboards to monitor service delivery, provider performance, and beneficiary outcomes, including real-time reporting and feedback loops? How will DPHHS ensure integration across Medicaid, justice, and housing systems?

State Response: DPHHS recognizes the importance of data in monitoring implementation, identifying trends, and supporting continuous quality improvement efforts. The department utilizes multiple data sources, provider feedback, technical assistance interactions, claims information, and evaluation findings to monitor HEART Waiver implementation and identify areas for improvement. DPHHS continues to work across programs and partners to improve data collection, reporting, and information sharing where appropriate and permissible. As implementation continues, the department will use available data and stakeholder feedback to evaluate service utilization, provider participation, and beneficiary outcomes. DPHHS remains committed to using data to inform decision-making and support ongoing program improvement.

6. Social Determinants, Housing Instability, and Transportation Barriers

Evaluation evidence shows that housing instability, transportation, and other social determinants remain persistent barriers to engagement and recovery. Providers and beneficiaries described long waitlists, limited affordable housing, and challenges accessing services in rural areas.

State Consideration: How will upstream barriers such as housing and transportation be addressed? Are new partnerships, policy changes, or targeted funding planned to expand affordable housing, transportation options, and wraparound supports for beneficiaries?

State Response: DPHHS recognizes that housing instability, transportation challenges, and other social determinants of health remain significant barriers to treatment engagement, recovery, and long-term stability. Housing availability continues to be a challenge in many communities across Montana and affects individuals across multiple service systems. Through the HEART Waiver, DPHHS has implemented services such as Tenancy Support Services to help individuals identify, obtain, and maintain housing in the community. While Medicaid cannot directly address housing supply, DPHHS continues to work with providers, community partners, and other stakeholders to support individuals experiencing housing instability. Addressing these barriers will continue to require collaboration across multiple systems and sectors.

7. Safeguarding DOC Cost Savings and Preventing Service Supplanting/Double Dipping

DOC feedback highlighted concerns that Medicaid-funded reentry and behavioral health services could undermine DOC's cost savings programs or result in "double dipping"—where Medicaid reimburses for services already funded or delivered by DOC or other agencies. There were also questions about whether HEART-funded services might supplant, rather than supplement, existing reentry supports.

State Consideration: How will DPHHS ensure that HEART waiver services do not supplant existing DOC-funded programs or result in double billing for the same service? What mechanisms are in place to track, coordinate, and distinguish Medicaid-funded reentry and behavioral health services from those already provided by DOC or other justice-system partners? How will DPHHS safeguard DOC's cost savings and clarify the boundaries of new versus existing services?

State Response: DPHHS and DOC continue to collaborate closely to support successful community reentry while maintaining clear distinctions between Medicaid-funded services and services funded through other sources. HEART Waiver services are intended to supplement existing supports and provide access to medically necessary Medicaid-covered services for eligible individuals. Existing Medicaid billing requirements, documentation standards, and program integrity processes help ensure services are appropriately billed and prevent duplicate reimbursement for the same service. DPHHS will continue coordinating with DOC and other partners to clarify service roles, responsibilities, and funding sources as implementation continues. Ongoing collaboration helps support continuity of care while maintaining accountability for public resources.