DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES (MONTANA DPHHS)	**Behavioral Health and Developmental Disabilities (BHDD) Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: October 1, 2024
Policy Number: **486 (new)**	**Subject:** Community Maintenance Program (CMP)

Definition

Community Maintenance Program is intended to provide medication and community support for members who require long-term, ongoing support, at a higher level than traditional outpatient services to be maintained successfully in the community and remain out of higher levels of care.

Medical Necessity Criteria

(1) The member must meet the SDMI criteria, as defined in this manual.
(2) The member must not be a danger to self or others, as defined in 53-21-102 MCA, (7)(a)(b), as an "emergency situation".
(3) The member must meet a moderate level of impairment, regardless of diagnosis, in ONE of the areas indicated below:

(a) Area 5 – Family/Interpersonal Relationships
(b) Area 6 – Mood/Thought Functioning

The State Plan LOI can be found at:
https://dphhs.mt.gov/assets/BHDD/AdultMHGeneralDocs/StatePlanSDMILOIForm508compliant.pdf

(4) The member is able and willing to actively engage in CMP services.

Provider Requirements

(1) CMP must be provided by a Montana Medicaid provider's PACT/MCT team, as defined in policies 460 & 455, that has been approved by the Department, to provide CMP services.

(2) CMP providers must comply with quality measure requirements described in Policy 455qm.
(3) Each team may provide CMP services for up to 20% of the total number of members receiving PACT/MCT services (e.g. 1 CMP member for every 5 PACT/MCT members)

Service Requirements

(1) The core service options which must be available by each CMP team member are as follows:
    (a) Medication management, administration, delivery, and monitoring;
    (b) Case/Care Management;
    (c) 24-hour crisis services;
    (d) Illness management and recovery skills;
    (e) Community living skills, including side-by-side assistance with activities of daily living;
    (f) Intervention with support networks;
    (g) Employment-support services;
    (h) Integrated treatment for co-occurring disorders, including substance use disorder treatment;
    (i) individual, family, and group therapy; and
    (j) Individual and/or group Peer support
(2) Medically necessary services that are billed must be documented clearly in the member's Individualized Treatment Plan in the member's file.
(3) Each member must receive weekly quality contacts, which may be provided using face-to-face contact, or telehealth. Quality contacts are comprised of services listed in (2) of this section. Quality Contacts are the purposeful interaction between the MCT team and members that contribute to the assessment and care planning processes. Quality contacts include:
    (a) Promotion of member's active participation in decision making and self-advocacy skills in all aspects of services and recovery;
    (b) Support for recovery and resilience activities, including assisting the individual to identify, improve, and sustain social determinants of health, which may assist in recovery/resiliency and how to use them; and identification of barriers to recovery/resiliency and how to overcome them;
    (c) Assistance in building and maximizing family/significant other support skills;
    (d) Assisting the member in identifying and utilizing community and social supports for treatment and recovery;
    (e) Monitor a member's health care; and

(f) Provide intensive treatment and rehabilitative services to aid the member in recovery and reduce disability.

(4) Team must meet each week to discuss the progress of each member.

(5) Each day that the member receives a contact in (4) qualifies as a billable day and can be billed at the daily rate, with up to 3 billable days per week.

(6) CMP must be billed as an appropriate bundled service.

Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are required every 365 days.

(3) The provider must document in the member's file that the member meets the medical necessity criteria.