MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Addictive and Mental Disorders Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health **Date effective:** July 1, 2020 **Date revised:** October 1,2020
Policy Number: *460*	**Subject:** Program for Assertive Community Treatment (PACT) – Tiered System

Definition

PACT is a member-centered, recovery oriented, mental health services delivery model for facilitating community living, psychosocial rehabilitation, and recovery for members who have not benefited from traditional outpatient services. PACT service delivery is provided by a multi-disciplinary, self-contained clinical team, 24 hours a day, 7 days a week, 365 days a year.

PACT is the core service of a tiered PACT delivery system which includes the following three tiers:

- Intensive PACT (InPACT);
- PACT; and
- Community Maintenance Program (CMP).

InPACT is an intensive transitional PACT service within a residential setting for members who need short-term supervision, stabilization, treatment, and behavior modification in order for a member to be able to reside outside of a structured setting.

CMP 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

For all three PACT Tiers:

- The member must meet the SDMI criteria, as described in this manual;
- The member must need PACT services as described in the Substance Abuse and Mental Health Services Administration, Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT, Training Frontline Staff, Module 1 at:

https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344.

Additional Medical Necessity Criteria for each tier is below.

Medical Necessity for InPACT:

- The member requires daily clinical support and direct care in order to address the needs of the member;
  AND
- The member is discharging from Montana State Hospital or the Montana Mental Health Nursing Care Center;
  OR
- The member is at serious risk of involuntary hospitalization (recently provided services at a behavioral health unit or a crisis stabilization home).

Medical Necessity for PACT:

- The member requires at least three contacts per week.

Medical Necessity for CMP:

- The member requires up to two contacts per month.

Provider Requirements

(1) PACT tiers may be provided by a licensed MHC by a PACT team that has been approved by the department to provide PACT services.

(2) For department approval, the provider must submit a request for PACT team approval to the Addictive and Mental Disorders Division. The department will not approve a PACT team where there is not demonstrated need for services.

(3) Each PACT team may provide services for up to 196 members when providing all three PACT tiers described above.

(4) The following ratios apply per PACT team providing all three PACT tiers:

(a) up to 80 total members per PACT team receiving the core PACT tier;

(b) up to 16 total members per PACT team receiving InPACT; and

(c) up to 100 total member per PACT team receiving CMP.

(5) PACT teams not providing InPACT may provide:

(a) PACT core services for up to 96 members; and

(b) CMP up to 100 members.

(6) Members who are receiving InPACT may reside in a Behavioral Health Group Home (BHGH). Providers must bill for the service being provided and may not bill for both InPACT and BHGH concurrently. The provider must meet the licensure requirements for the service

being billed. The member receiving services in InPACT must be provided services from the PACT team. PACT team members are dedicated staff; therefore, the clinical, care management, and certified behavioral peer support components in the BHGH cannot replace services of the PACT team nor can the PACT team provide services to members who are not admitted into the PACT program.

(7) PACT Teams must consist of the following full-time equivalency (FTE) staff, effective October 1, 2020, as described in the Program of Assertive Treatment Staff Roster Outline:

(a) Prescriber, one FTE;

(b) Physician/Psychiatrist Supervision; two hours per month;

(c) Team Lead, one FTE;

(d) Nursing staff, two FTE;

(e) Professional staff, two FTE;

(f) Care Coordinators, three FTE;

(g) Paraprofessionals, two FTE;

(h) Licensed Addiction Counselor, one FTE;

(i) Vocational Specialist, one FTE;

(j) Certified Peer Support Specialists, two FTE;

(k) Administrative Assistant, two FTE; and

(l) Tenancy Specialist, one FTE.

(8) PACT teams must submit a staffing roster to the department when there is a change in the team staff within 14 days of the change.

(9) Provider may request staffing waivers of up to 90 days to fill vacant positions. If the position cannot be filled within 90 days, the provider must bill for services fee for service until such time the team has been brought whole.

(10) Providers must submit a PACT monthly report and other PACT quality measures at a frequency established in the PACT Quality Measures guidelines.

(11) PACT must be billed as the appropriate bundled service based upon the PACT tier being provided.

Service Requirements - All three PACT Tiers

(1) The provision of PACT services must comply with the fidelity standards of Assertive Community Treatment as demonstrated by PACT fidelity reviews. PACT programs that fail to comply with PACT fidelity standards are subject to corrective action, remediation, and possible suspension of the PACT program.

(2) PACT teams must provide the following services, as identified in each member's individualized treatment plan:

(a) monitoring all of the member's health care needs including social determinants of health;

(b) providing intensive treatment and rehabilitative services to aid the member in recovery and reduce disability;

(c) identifying, restoring, and maintaining the member's functional level to their best possible functioning level;

(d) identify, improve, and sustain social determinants of health; and

(e) provide individualized crisis planning and 24-hour, seven days a week face-to-face crisis intervention; and

(f) Residential services for InPACT include behavior modification and management, assisting the member with identifying what they need for independent living within the community, putting what they identify into practice, and preparing the member to live independently in the community outside of a structured setting.

(3) PACT teams must complete the following documentation for each member receiving PACT tiered services:

(a) an annual clinical assessment that follows the guidelines in the AMDD Medicaid Provider Manual;

(b) a social determinants of health assessment upon admission and annually for each member who is authorized to receive services for more than 365 days;

(c) an individualized treatment plan that is updated every 90 days or when there is a change to the member's strengths, areas of concern, goals, objectives, or interventions;

(d) a Serious and Disabling Mental Illness and Level of Impairment worksheet upon admission and updated with each treatment plan update; and

(e) a progress note for each service provided as required in ARM 37.85.414.

Additional Service Requirements for each PACT tier is below.

It is not required that each member receiving a PACT tier receive every service listed below. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

Service Requirements for PACT

(1) The core PACT service bundle includes the following:

(a) medication management;

(b) medication administration, delivery, and monitoring;

(c) care coordination;

(d) 24-hour crisis response;

(e) psychosocial rehabilitation;

(f) vocational rehabilitation;

(g) substance use disorder treatment;

(h) individual, family, and group therapy, and;

(i) peer support.

(2) PACT teams may be reimbursed for the weekly rate for each core PACT member with the team when the team meets and discusses the status of each PACT member three days per week. PACT teams must complete a staff meeting log for each member in the core PACT service which includes:

(a) date and time of meeting;

(b) staff present;

(c) member's name discussed;

(d) services provided in the past 24 hours; and

(e) member's status.

Service Requirements for InPACT

(1) The PACT service bundle above in a residential setting.

(2) PACT teams may be reimbursed for the weekly rate for each InPACT member when the team meets and discusses the status of each InPACT members five days per week. PACT teams must complete a staff meeting log for each member which includes:

(a) date and time of meeting;

(b) staff present;

(c) member's name discussed;

(d) services provided in the past 24 hours; and

(e) member's staus.

Service Requirements for CMP

(1) The CMP service bundle includes:

(a) medication management;

(b) medication administration, delivery, and monitoring;

(c) 24-hour crisis response;

(d) care coordination;

(e) psychosocial rehabilitation;

(f) peer support; and

(g) two contacts per month.

(2) PACT teams may be reimbursed for the daily rate for up to two contacts per month and two team meetings per month when the team provides two contacts and meets and discusses the status of each CMP members two days per month, for a maximum of four reimbursable units per month. PACT teams must complete a staff meeting log for each member which includes:

(a) date and time of meeting;

(b) staff present;

(c) member's name discussed;

(d) services provided in the past 24 hours; and

(e) member's staus.

Utilization Management

Utilization Management for PACT

(1) Prior authorization is not required.

(2) Continued stay reviews are required every 180 days.

Utilization Management for InPACT

(1) Prior authorization is required and may be approved for up to 60 days.

(2) Continued stay reviews are required every 60 days.

(3) If a member requires services beyond 120 days, the member must be referred for screening and evaluation for the Severe and Disabling Mental Illness(SDMI), Home and Community Based Services(HCBS) waiver. If the member does not qualify for the SDMI HCBS waiver, the provider may request additional continued stay reviews as directed in (2) of this section.

Utilization Management for CMP

(1) Prior authorization is not required.

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