MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Behavioral Health and Developmental Disabilities (BHDD) Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: October 1, 2022
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 the 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:

(1) The member must meet the SDMI criteria, as defined in this manual.
(2) The member has a history of poor engagement with traditional outpatient services and is at risk of recurrent psychiatric hospitalization or institutionalization.
(3) Member is assessed to not be at risk of imminent danger to self or others.

(4) Member is willing and able to actively engage in PACT services.

Additional Medical Necessity Criteria for each tier is below.

Additional Medical Necessity for InPACT:

(1) The member is discharging from Montana State Hospital or the Montana Mental Health Nursing Care Center or is at risk of involuntary hospitalization as indicated by recently receiving services at a behavioral health unit or crisis stabilization home.

(2) Member requires daily clinical support and direct care at the residential level in order to address the needs of the member specific to post-acute/crisis which cannot adequately be provided at a lower level of care.

Additional Medical Necessity for PACT:

(1) Member requires at least three contacts per week to address the needs of the member which cannot adequately be provided at a lower level of care.

Additional Medical Necessity for CMP:

(1) Outside of a structured residential setting with the help of long-term, ongoing support member can be maintained successfully in the community and remain out of higher levels of care.

(2) Member requires at least four contacts per month to address the needs of the member which cannot adequately be provided at a lower level of care.

Provider Requirements

(1) PACT tiers may be provided by a Montana Medicaid provider 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 Behavioral Health and Developmental Disorders (BHDD) 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 on 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 Behavioral Health 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) PACT teams 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 met PACT staffing requirements.

(10) PACT Teams 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

(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) The core PACT service options which must be available by each PACT team are as follows:

(a) medication management, administration, delivery, and monitoring;

(b) care management;

(c) 24-hour crisis response;

(d) psychosocial rehabilitation;

(e) vocational rehabilitation;

(f) substance use disorder treatment;

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

(h) peer support.

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

(4) PACT must be provided in the member's natural setting such as where the member lives, works, or interacts with other people at least 60% of the time.

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

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

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

(c) identify, restore, and maintain 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.

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

(a) an assessment that follows the guidelines in the BHDD 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 diagnosis, strengths, areas of concern, goals, objectives, or interventions;

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

(e) a progress note for each service contact provided as required in Policy 130, Progress notes.

(7) PACT teams must complete a staff meeting log for each member discussed in the PACT team meeting which includes:

(a) date and time of meeting;

(b) staff present;

(c) member name(s) discussed;

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

(e) member's progress and updates to the individualized treatment plan or continuing care plan.

(8) PACT teams may be reimbursed for the weekly rate for each PACT member when the team meets and completes a staff meeting log for each PACT member four days per week for each core PACT member and each InPACT member.

(9) PACT teams may be reimbursed for the daily rate for each PACT member receiving CMP up to a total of six times per month as follows:

(a) up to two times per month when the team meets to discuss the member and completes a PACT team meeting log; and

(b) for up to four contacts per month.

(10) PACT teams may be reimbursed for the weekly rate for a core PACT member, up to four weeks, who is hospitalized or in an inpatient setting provided the following are met:

(a) services provided must not duplicate services that are available and/or provided in the hospital/inpatient setting;

(b) services provided must be focused on member's transition to the community; and

(c) member is discussed at team meetings four times per week.

(11) If the PACT member is not hospitalized or in an inpatient setting and the PACT member is unable to receive the weekly contacts as required under medical necessity criteria, PACT teams may still be reimbursed for the weekly rate, up to two weeks, before the member must be reassessed for appropriateness for this level of care if the following conditions are met:

(a) the provider must document all efforts to engage the PACT member which must include community outreach, telephonic outreach, and any other form of attempted contacts;

(b) member must continue to meet the medical necessity criteria for PACT services; and

(c) member is discussed at team meeting four times per week.

Utilization Management

Utilization Management for PACT

(1) Prior authorization is required and may be approved for up to 180 days.

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

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

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 in the residential setting, 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.

(4) The provider must document in the file of the member that the member meets the medical necessity criteria.

Utilization Management for CMP

(1) Prior authorization is not required.

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

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