MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Behavioral Health and Developmental Disabilities Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: October 1, 2022
Policy Number: *455*	**Subject:** Montana Assertive Community Treatment (MACT)

Definition

MACT 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 who reside in a rural or frontier area. MACT service delivery is provided by a multi-disciplinary, clinical team, 24 hours a day, 7 days a week, 365 days a year. MACT is an evidence-based practice that is intended to be provided in the community setting were problems may occur or where support is need, rather than in offices or clinics.

Medical Necessity Criteria

(1) The member must meet the SDMI criteria as defined in this manual and score as impaired in areas of functioning as outlined in the LOI worksheet at https://dphhs.mt.gov/amdd/FormsApplications/index;

(2) Member has history of poor engagement with traditional outpatient services and is at risk of recurrent psychiatric hospitalization or institutionalization.

(3) Member is assessed to be not at risk of imminent danger to self or others.

(4) The member must need weekly contact and at least three of the core MACT service bundle options listed under service requirements below.(5) The member is able and willing to actively engage in MACT services.

Provider Requirements

(1) MACT may be provided by a Montana Medicaid provider by a MACT team that has been approved by the department to provide MACT.

(2) For department approval, the provider must submit a request for MACT approval to the Behavioral Health and Developmental Disabilities Division. The department will not approve a MACT team where there is not demonstrated need for services.

(3) Each MACT team may provide services for up to 50 members.

(4) MACT teams must consist of the following full-time equivalency (FTE) staff:

(a) Prescriber, .375 FTE;

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

(c) Team Lead, one FTE;

(d) Nurse, one FTE;

(e) Professional staff, one FTE;

(f) Care Coordinators, one FTE;

(g) Paraprofessionals, one FTE;

(h) Certified Behavioral Health Peer Support Specialists (CBHPSS), two FTE; or one FTE CBHPSS and one FTE paraprofessional; and

(i) Administrative Assistant, 1 FTE.

(5) MACT teams may have a Registered Nurse or a Licensed Practical Nurse (LPN), with RN supervision. The RN supervisor must create the initial care plan and have a check-in with the LPN every 24 hours.

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

(7) MACT 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 MACT staffing requirements.

(9) MACT teams must submit a MACT monthly report and other MACT quality measures at a frequency established in the MACT Quality Measures guidelines.

(10) MACT must be billed as the appropriate bundled service.

Service Requirements

(1) The provision of MACT services must comply with the fidelity standards of Assertive Community Treatment, as modified for the Montana specific requirements for this service, as demonstrated by MACT fidelity reviews. MACT programs that fail to comply with Assertive Community Treatment fidelity standards as modified for the Montana specific

requirements for this service are subject to corrective action, remediation, and possible suspension of the MACT team.

(2) The core MACT service components which must be available by each MACT team are as follows:

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

(b) care management;

(c) 24-hour crisis response;

(d) psychosocial rehabilitation;

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

(f) peer support.

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

(a) monitor all of 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, as needed.

(4) It is not required that each member receiving MACT 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.

(5) MACT 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.

(6) MACT teams must complete the following documentation for each member receiving MACT:

(a) a 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 diagnosis, 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) MACT teams must meet and discuss the status of their members at least four days per week and discuss the status of each member each time and complete a staff meeting log for each member which includes:

(i) date and time of meeting;

(ii) staff present;

(iii) member's name discussed;

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

(v) member's progress and updates to the continuing care plan.

(7) MACT teams may be reimbursed for the weekly rate for a MACT 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 must continue to meet medical necessity criteria for MACT services; and

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

(8) If the MACT member is not hospitalized or in an inpatient setting and the MACT member is unable to receive the weekly contacts as required under medical necessity criteria, MACT 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 MACT 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 MACT services; and

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

Utilization Management

(1) Prior authorization is not required.

(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.