DISEASE MANAGEMENT
DM 3700/ADA DM
Q & A

COHORTS

1. In addition to the inclusion criteria, are there any disqualifications for inclusion of the disease management project?

- Disqualifications include *at time of cohort generation:
  1. Claims for dialysis, hospice, hemophilia, intermediate care facility, or mental retardation in past 12 months
  2. Already established with a Health Home
  3. Medicare Part A or B insurance
  4. Previous DM Cohort status
  5. Current Episode of Care for Developmental Disabilities
  6. At least one nursing home claim (Skilled Nursing Facility) in the past 12 months

2. How long do the clients stay on the list; do they keep circulating until contact of some form is made?

- The clients will stay on the list until the next cohort. At the next cohort a determinate of whether or not a client will continue on the list is a function of the providers' status report and continued high cost.

3. I am in the process of getting CIMOR access so I can view my agency's cohort list on the DMH FTP site. What roles do I need to request in order to view the list?

- Many agencies allow limited staff access due to the protected health information (PHI) within the cohort lists, so you should first obtain supervisory approval. Once you have a DMH UserID and an active password, you can access the FTP folder reports through the DMH portal: https://portal.dmh.mo.gov/. Click the *DMH File Transfer* link to get to the list of organizations by facility code.

4. On the cohort list, what is the difference between "ZipCodeText" and "Patientzip"?

- Patientzip is the address in the Medicaid system at the time Care Management Technologies (CMT) ran the various medication possession ratios for these individuals. ZipCodeText is the address shown for the individual when the final cohort list was generated – also from Medicaid data and *the most recent*.

5. Sometimes we find consumers that seem more appropriate for the other program's cohort? What is the process for determining which program's outreach list a consumer is assigned to?

- It is possible some consumers could have qualified for either (DM 3700 or ADA DM) outreach list if the individual had both CPR and CSTAR eligible diagnoses. In these cases it would really depend on the timing the cohort was ran, the timing of recent episodes of care (EOCs) if applicable, the associated cost at the time of the cohort creation, along with other applicable criteria.

6. What do we do with consumers on our outreach list who are in another catchment area or closer to another agency?

- You should contact the DM Coordinator in the area where you need to transfer the consumer. After the DM Coordinator has accepted the request, you must email Greg Wood (Greg.Wood@dmh.mo.gov) requesting the transfer. You must copy the DM Coordinator who accepted the transfer.

7. Can consumers be transferred between ADA and CPS cohorts?

- No.

OUTREACH, CONSUMER ELIGIBILITY, and ENROLLMENT

1. If a DM consumer is discharged and then wants to be re-admitted, do they continue to be eligible for DM?

- Yes, once a person is identified as a DM consumer, they will always remain a DM consumer unless they were specifically excluded from the most recent cohort list. They will still need to be Medicaid eligible. **A new EOC must be created in CIMOR; do not simply delete the discharge from the old EOC.**

2. In what ways can a nurse be utilized in this project?

- Providers may use their nurse(s) to take part in outreach activities. This may include addressing health-related issues and questions and assisting with prioritizing the outreach list.
- Once enrolled in CPR/CSTAR, the nurse should be involved in all medical aspects of the consumer's services: educating them about medication usage and other health interventions; assisting in identifying actionable areas to improve health (participate in treatment planning), including risk screenings; assisting in securing a primary care physician (PCP) if they don't have one and providing care coordination with other health providers; discussing medical issues with the physician; following up after hospital discharge; and overseeing and monitoring labs including metabolic screening.
- Nurses may provide training to staff regarding medical conditions and pertinent interventions, provide education sessions, and make referrals.

  CMHC NOTE CMHCS may use their Healthcare Home Nurse Care Manager in this role versus a clinic nurse.

  CSTAR NOTE The current CSTAR Medicaid State Plan requires that nursing services, referred to as Extended Day Treatment (EDT), be delivered by a Registered Nurse. The Division of Behavioral Health is pursuing a State Plan Amendment with the Centers for Medicare and Medicaid Services (CMS) to add Licensed Practical Nurses (LPNs) as qualified practitioners to provide EDT. Currently LPN EDT services may be billed to a provider's non-Medicaid service allocation.

3. Can we admit people into CPR/CSTAR who are in the pre-contemplative or maintenance stage of change?

- Providers will likely encounter situations in which individuals in the cohort have been in recovery and will respond in this manner or deny having a mental health or substance use disorder. We must meet the consumers where they are at. Keep in mind, a serious mental illness or substance use diagnosis is in their Medicaid claims history; therefore, they are presumptively eligible for CPR/CSTAR and may be enrolled. The goal is to enroll and engage these individuals in services so their health care needs can be better managed. After they have been involved in CPR/CSTAR, if the clinical staff believes they may be better served in a different setting, steps should be taken to assist them in enrolling with a health care provider that best meets their needs. Oftentimes, working on other treatment plan goals will be the vehicle that results in getting them to address their mental health or substance use disorder.

4. Are consumers from the DM 3700 Cohort presumptively eligible for CSTAR? Are the consumers from ADA DM presumptively eligible for CPR?

- Many individuals in the cohorts will have co-occurring substance use and mental health disorders; however, at this time the consumer is only **presumptively** eligible for the rehabilitation program tied to his/her respective cohort.

5. Do DM consumers need to be enrolled in a specific level of care?

- DM consumers should be placed in the level of care that meets their individual needs to maintain health and wellness.

6. When DM consumers are enrolled in CSTAR, can there be a different package?

- Community support may be the primary service provided at the beginning for most DM consumers and changes to the CSTAR packages are not necessary in this scenario. Other than *daily limits on community support (24 units per day)*, CIMOR will allow any constellation of services to be billed under the basic package**, including predominantly community support services**, until the package amount is exceeded. Changes have been implemented in CIMOR that allow for greater flexibility and ease of use for providers when the package limits have been fully utilized and additional services are needed. The behavioral health field is changing rapidly and moving towards a "whole person approach." This typically involves a **significant amount of community support** throughout the consumer's engagement in services.

7. Can ADA DM consumers be enrolled in a CMHC Healthcare Home (HCH), with added HCH slots, as is the practice with the DM 3700 project? Where does DM fit into HCH?

- ADA DM consumers may be enrolled in a CMHC HCH as long as they are Medicaid eligible, receive at least one other service at the CMHC (including CSTAR services), and *meet one* of the HCH eligibility requirements:
    1. A serious and persistent mental illness (CPR eligible adults); *or*
    2. A mental health condition and substance use disorder; *or*
    3. A mental health condition and/or substance use disorder and one other chronic health condition.
- There are no limits for DM HCH slots (including ADA DM and DM 3700). Non-DM HCH slots are limited and providers should be tracking their slot allocations.DM (primarily DM 3700) is viewed as the outreach component for Healthcare Home. When engaging DM clients into services, HCH should be presented as part of a "package" of services with CPR, CSTAR and any other programs the client requires. You do need to introduce HCH and ensure they want the service before enrolling them. If presented correctly, there should be very few DM 3700 clients declining HCH. They are all "presumptively eligible" for HCH, and they are expected to be enrolled in the HCH program once outreached and engaged, unless the client specifically declines the HCH benefit or is otherwise ineligible for HCH.

8. Can ADA DM consumers be enrolled in a Primary Care Health Home (PCHH)?

- It is unlikely there will be individuals in the ADA DM Cohort who qualify for a PCHH because they should have been identified through previous Medicaid claims history as being eligible for that program. You may encounter someone who is eligible for a PCHH *if they do not currently have a*

primary care provider. Individuals may be referred to a PCHH provider who will determine whether to enroll them.

9. I have a DM client who was discharged and then returned for services. Is she still eligible for DM?

- In general, once a DM always a DM, unless the DM was specifically excluded for some reason (e.g. excluded due to safety concerns). You will have individuals identified as DM come in from previous cohorts, other agency's cohorts, and on their own accord and you would treat them as if you outreached them from your current outreach list. The person's Medicaid will still need to be active. You will need to open a new EOC.

10. Can two people outreach at the same time? If so, what are the documentation and billing expectations?

- There should be sufficient documentation to justify the need (e.g. safety concern) for two staff to outreach together. Both outreach workers may bill. Documentation for both outreach workers would be very similar but should not be verbatim since each is written from their own perspective and should include their specific interventions. Documentation should include the name(s) of the individual (s) outreached. The expectations for billing and documentation are the same regardless if contact was made.

11. Is it allowable to bill outreach when a DM is in a Skilled Nursing Facility (SNF)?

- In general, consumers in a skilled nursing facility should have been excluded from inclusion of the project; however, it is possible the consumer's level of care has changed from the time the cohort was generated and time you were able to locate the individual. It would only be appropriate to continue outreach with an individual in an SNF if they will be transitioning out of that setting. The outreach would be billable in these situations.

ENROLLMENT POLICY and SERVICES

1. Can part of the assessment be gathered while outreaching?

- Assessment information may be gathered during the outreach and engagement period and will likely enhance consumer engagement; although, providers should refrain from providing services that should occur after a person is enrolled in services. The QMHP/QSAP must review and interpret the assessment data and meet face-to-face with the consumer to develop treatment recommendations and a licensed diagnostician must render a formal diagnosis in accordance with DBH policy.

2. If we have a consumer who is home bound, can we provide services in the home?

- The majority of services may be delivered in the home. You should refer to the Medicaid Manual with regard to place of services that are acceptable for the particular service you need to provide.

3. When are the adult status reports due for DM 3700?

- No later than 30 days after admission.

4. We have a DM consumer with a $700 spend down he cannot meet. How should we proceed in these instances?

- If you have already outreached to a client and **offered services**, then you should provide those services.

5. Can we provide services to a DM individual living in a SNF?

- CPR/CSTAR services are not Medicaid reimbursable when the individual is in an SNF.

6. If we have a client that entered services through DM, but then lost his Medicaid, what should we do?

- You can work with the client to get their Medicaid eligibility reinstated. Medicaid is usually retroactive and will cover the past billing of services. If the client does not get Medicaid reinstated, then the billings come from your "non-Medicaid" allocation.

7. Does Medicare make clients ineligible for DM?

- Medicare does not necessarily make the client ineligible for DM. As long as the client has an eligible Medicaid (ME) code, they are still eligible for DM. However, if you find out about their dual eligible status prior to outreaching them, you are not required to outreach them. Please send their names and DCNs in an encrypted email to Brin Ballard at Brin.Ballard@dmh.mo.gov, and we can void their DM status. If the client is already in services or if you have already offered services before discovering the client's dual eligibility, then you should continue serving the individual.

8. Where can I find more information about the DM Housing funds?

- There is a DM Housing Funds policy memo and Q & A on the DM webpages.