



# ADA DISEASE MANAGEMENT (ADA DM)

## Q & A

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### **GENERAL**

#### **What is the purpose of the ADA Disease Management project?**

- Many individuals with substance use disorders have other chronic medical conditions (lung and liver disease, hepatitis, HIV/AIDS, heart disease, cancer, high blood pressure, diabetes). Often, some of these conditions go undetected or untreated resulting in *fragmented care, poor outcomes, and high costs to the health care system*.
- The **ADA DM project** targets **Medicaid-eligible** adults with high medical costs and a history of substance use disorders. These individuals will also be likely to have other chronic health conditions.
- DMH contracted behavioral health providers engage in outreach activities to locate and enroll identified individuals in CSTAR or other appropriate DMH services (CPR/HCH if eligible). Once enrolled, services are coordinated with primary care and other providers to *improve consumer outcomes and save Medicaid costs* for the state of Missouri.

#### **Other than having a substance use disorder, what qualifies a Medicaid eligible adult for the ADA DM project?**

- The criteria are:
  1. Diagnosis of a substance use disorder in their Medicaid claims history;
  2. Meet CSTAR eligibility requirements;
  3. Combined Medicaid pharmacy and medical costs are \$20,000 or greater;
  4. NO medical claims for hospice, dialysis, hemophilia, ICFMR during specified timeframe;
  5. NO previous DM cohort status (DM 3700);
  6. NOT assigned to a Health Home;
  7. NO current Episode of Care for Developmental Disabilities.

#### **How do individuals get assigned to DMH contracted providers so they can engage in outreach activities to locate and enroll them into appropriate services?**

- DMH generates a quarterly report (time period may vary) which is referred to as the ADA DM *cohort list*. This list is generated from Medicaid claims data and identifies people with diagnosed substance use disorders and medical costs of \$20,000 or more for the specified time period.
- The individuals are identified by county using the most recent address on file and are divided among providers based on contracted service area(s) for substance use treatment services. In areas where there is more than one provider, the individuals are assigned based on the percentage of CSTAR clients served by the provider, by county, in the previous fiscal year *OR* they are assigned to the provider where he/she most recently received services.

#### **How do providers get their cohort lists from DMH?**

- Lists assigning clients to specific providers are placed on the DMH FTP site in **Reports/ADA folders** and are titled **ADA Disease Management Client List SA##.xls**. Providers are notified when new or revised cohort lists are deployed to the FTP site.

### How long do individuals stay on the cohort list?

- Individuals remain on the list at least until the next quarter's cohort report is generated. Information from the *provider status reports* and review of *medical costs* are the primary factors that determine whether an individual will continue to be on the next cohort's list.
  1. If an individual is not yet enrolled in services but the provider status report indicates they are still outreaching to him/her, *they remain on the cohort list.*
  2. If a provider has not been successful in locating an individual but his/her medical costs are still high (exceed \$20,000 annually), *they remain on the list.*
  3. If the status report indicates "refused services" or "not eligible" *they will be removed from the cohort list. You should carefully consider the section, "Responses from Individuals during Outreach" in the DM Outreach Toolkit when determining whether an individual "refused services". "Refused services" should only be selected if the individual's response leads you to believe they will never be interested in services. Similarly, you should only report "not eligible" if it is understood the individual will not be eligible in the near future.*

**Please review the Outreach Toolkit** <http://dmh.mo.gov/docs/ada/DMOutreachToolkit.pdf> for more information about situations in which DMH staff should be notified in order to remove individuals from the cohort list.

### If we discover a consumer has moved into another region of the state, do we notify you (DMH) or the provider in order to transfer the client to a different cohort?

- You should contact the provider in the consumer's current service area and ensure they are willing to outreach/engage the individual in services. If so, provide them with consumer information and **e-mail Greg Wood at [greg.wood@dmh.mo.gov](mailto:greg.wood@dmh.mo.gov)** to notify him of the transfer and copy the provider in which the individual will be transferred. **Greg will make the necessary changes to the cohort lists.**

### What if we have individuals in our cohort who are found to be incarcerated?

- If it is likely to be a reasonably **long** incarceration, it is best to exclude the individual from the cohort, otherwise the data will reflect a failed outreach. **Notify Greg Wood at DMH of these cases: [greg.wood@dmh.mo.gov](mailto:greg.wood@dmh.mo.gov).**

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

- Many agencies allow specific staff to have access due to the PHI, 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.missouri.gov>. Click the *DMH File Transfer* link to get to the list of organizations by facility code.

### 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 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*.

### Is the DM 3700 housing money available for the ADA DM project?

- The housing funds are available to ADA DM consumers. These funds are *extremely limited* and are to be used as follows:
  1. For DM consumers not currently housed with Supported Community Living or other source of funding;
  2. Must be housing settings that are licensed by DMH/included in accreditation OR meet Housing Quality Standards (HQS);

3. For rental subsidies, support services, past bills that prevent current housing, security deposits, utility deposits, first/last month's rent, residential care facilities and similar payments that lead to safe, decent housing.
  - Documentation sufficient to justify these billings must be maintained by the provider and are subject to DMH review.

**Do you plan on requiring the ADA DM project to complete a metabolic syndrome screening as is done with the DM 3700 project?**

- The Metabolic Syndrome Screening (MSS) is *not currently required* for the ADA DM project. Since DM 3700 providers have trained staff and the equipment needed for this activity, it is *recommended* they complete the metabolic screening for the ADA DM population.
- Nursing staff should bill **Extended Day Treatment** for MSS-related activities. The following activities apply:
  - Obtaining initial participant medical histories and taking vital signs;
  - Monitoring general health needs and meeting with participants about medical concerns;
  - Providing disease prevention, risk reduction and reproductive health education;
  - Monitoring lab levels including consultation with physicians, participants, and clinical staff;
  - Monitoring medication side-effects including the use of standardized evaluations;
  - Monitoring physician orders for treatment modifications requiring participant education.
- The same procedures currently in place for metabolic screenings in CPR apply to ADA providers in order to bill for this service:
  - The form, "Metabolic Syndrome Screening and Monitoring Tool," must be completed by an RN or LPN to verify that the metabolic syndrome screening is completed. The form is posted to the ADA DM web page. Providers may use this form or develop their own, as long as the content is consistent. The form must be approved by the Department prior to implementation.
  - Completing the screening may involve direct time the nurse spends with the recipient, phone calls, and referrals to physicians and labs, and indirect time completing the form. It is our expectation that the nurse will take the vital signs, obtain data required for a BMI, measure weight circumference, and then verify the lipid level, and blood glucose and/or HgbA1c, in one of the following ways:
    - The nurse or other qualified staff may conduct the lab tests to assess lipid level and blood glucose levels and/or HgbA1c by using the Cholestech LDX analyzer or other machine approved by the Department.
    - The nurse may arrange for and coordinate lab tests from a health care provider to assess lipid level and blood glucose levels and/or HgbA1c.
    - The nurse may obtain results of recently completed lipid panel and blood glucose levels and/or HgbA1c from other health care providers. When the client is already being followed regularly by a health care provider, the nurse may obtain results of the most recently completed lipid panel and blood glucose levels and/or HgbA1c from that provider in order to complete the metabolic syndrome screening process for Department clients.
    - We estimate that the activities involved in this screening will average about 30 minutes per client.
- **Metabolic Syndrome Screening** – Assuring that clients are screened annually for the following risk factors: obesity, hypertension, hyperlipidemia, and diabetes.

Specific activities may include but are not limited to the following:

- Taking and recording of vital signs.

- Conducting lab tests to assess lipid level and blood glucose levels and/or HgbA1c. If the lab tests are conducted by the nurse, they must use the Cholestech LDX analyzer or other machine approved by the Department.
- Arranging for and coordinating lab tests to assess lipid level and blood glucose levels and/or HgbA1c.
- Obtaining results of lab tests to assess lipid levels and blood glucose levels and/or HgbA1c.
- Recording the results of all required vital signs and lab tests on the Metabolic Syndrome Screening and Monitoring Tool.
- **Documentation Requirements:**
  - Completion of the “Metabolic Syndrome Screening and Monitoring Tool”, and a summary progress note verifying the completion of the screening and the plans for ongoing monitoring of the individual based on the results of the screening. Both must be filed in the client record and available for review and verification by Department and other authorized staff.
  - In order to bill this service the provider must complete the Metabolic Syndrome Screening and Monitoring Tool or a preapproved form with the required data fields. Two units of EDT may be billed for completion of the MBS.
- Although *not yet required*, the following health screenings are *recommended* for the ADA DM population, in addition to other lab work that may be necessary (prior to utilization of MAT, for example):
  - Hep B Profile
  - Hep B Series, if warranted
  - Liver Profile
    - SGOT
    - SGPT
    - Alkaline phosphatase
    - Total bilirubin
- These lab procedures **are Medicaid-reimbursable** but *cannot be billed through CIMOR*. Providers may choose to make arrangements with their local laboratory to bill these screenings directly to MO HealthNet. If providers bill lab services through CIMOR (code 80076) the cost is paid from the DBH medication pool (if funds are available) *OR* payment comes from the provider’s non-Medicaid allocation.
- Introduction of laboratory procedures may not be well received by some consumers. It may be necessary to delay such tests until he/she has been engaged in services and is comfortable with the staff and environment.

**Will you be involving ADA DM providers with ProACT, the tool the original DM 3700 project report morphed into?**

- Not initially. This may be phased in incrementally as the project progresses. The emphasis on this data resource is primarily related to the *Health Home project*, not necessarily DM 3700.

**CONSUMER ELIGIBILITY & ENROLLMENT**

**Do ADA DM consumers need to be enrolled in a specific level of care in CSTAR?**

- ADA DM consumers should be placed in the level of care that meets their individual needs to maintain health and wellness.
- Initially, providers may want to enroll DM consumers in **Level 1 CSTAR** as this population will likely have significant service needs.

**When consumers are enrolled in CSTAR, can there be a different package? We primarily want community support billings at the beginning for most clients.**

- 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.

**What if an individual is enrolled in CSTAR and then starts to refuse services except those from his/her doctor? Do they stay in ADA DM services (CSTAR) or should they be discharged?**

- Engagement with a primary care physician is a positive step and should continue regardless of their involvement in substance abuse treatment services. Attempts should be made to reengage the individual in services, but if it is the professional opinion of agency staff that the consumer is not benefitting from CSTAR and he/she is unlikely to reengage they should be discharged and/or referred to an appropriate provider.
- If you are referring to an individual who is receiving Medication Assisted Treatment (MAT) through your agency’s physician, they may continue to be enrolled in the CSTAR program as an ADA DM consumer. As is the case with anyone receiving MAT, close monitoring by the agency nurse and some level of contact with the primary counselor should continue, as well as overall coordination of services by a Community Support Specialist.

**If an ADA DM consumer is discharged and then wants to be re-admitted, do they continue to be eligible as a DM consumer as long as they are still Medicaid eligible?**

- Yes, they may be re-enrolled and provided they have not lost their Medicaid eligibility, will still be served as an ADA DM consumer. **A new Episode of Care (EOC) must be created in CIMOR; do not simply delete the discharge from the old EOC.**
- In the event they specifically requested to be excluded during their previous EOC or have since become ineligible for Medicaid, the new EOC will not indicate they are a DM consumer. They may still be served in CSTAR; provider reimbursement will be through different fund sources.

**Can ADA Disease Management consumers be enrolled in a CMHC Health Care Home (HCH), with added HCH slots, as is the practice with the DM 3700 project?**

- Consumers may be enrolled in a CMHC HCH as long as they are Medicaid eligible, receive at least one other service at the CMHC, 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 and CPS*). Non-DM HCH slots **are limited** and providers should be tracking their slot allocations.

**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. Eligibility criteria for PCHH:
  1. Persons covered by MO HealthNet, including those covered through MO HealthNet Managed Care Plans;
  2. Persons who have two chronic conditions; *or*
  3. Persons who have one chronic condition **AND** the risk of developing another chronic condition.

**Chronic conditions** include:

- Asthma
- COPD (Chronic Obstructive Pulmonary Disease)
- Chronic bronchitis
- Emphysema
- Diabetes
- Heart Disease/Cardiovascular Disease
- BMI over 25
- Developmental Disability

**At-Risk Conditions:**

- Tobacco Use
- Diabetes

**NOTE:** Diabetes stands alone as an eligible criterion since it is both a chronic condition and a risk factor for other chronic conditions.

**Are there Medicaid Eligibility (ME) code exclusions for ADA Disease Management?**

- The following ME codes **exclude** an individual from being enrolled in a CSTAR program *as part of the ADA Disease Management project:*

02 – Blind Pension	65 – Group Home/Health Initiative Fund <i>(Parent/Guardian Placement)</i>
08 – Child Welfare Services/Foster Care	80 – Extended Women’s Health Services
52 – Division of Youth Services/GR	82 – Missouri Rx/Medicare Part D Wraparound
55 – Qualified Medicare Beneficiary	89 – Uninsured Women’s Health Services
57 – Child Welfare Services/Adoption Subsidy	91 – Gateway to Better Health <i>(Tier 1, Joint)</i>
59 – Presumptive Eligibility (Non-Subsidized)	92 – Gateway to Better Health <i>(Tier 2; 133% FPL)</i>
64 – Group Home/Health Initiative Fund <i>(State Placement)</i>	93 – Gateway to Better Health <i>(Tier 2; 134- 200% FPL)</i>

**NOTE:** Individuals with the above ME codes should NOT appear in the ADA DM cohort. However, there is always a possibility for errors or changes in ME codes from the time the report is generated. Providers should ensure that all individuals are appropriately screened during the outreach and engagement period. You may also encounter situations in which individuals have temporarily lost Medicaid due to untimely processing of paperwork; they may need assistance in reapplying in order to regain their benefits.

**We determined that an individual in our cohort is now in hospice. Are they eligible for CSTAR services?**

- Individuals in hospice should not be in the cohort. There are instances in which the hospice claims were not in the system at the time the cohort report was generated. If you determine an individual is in hospice care and services have not been offered, notify DMH and the individual will be removed from the cohort. If DMH services have been offered, this should be addressed on an individual basis by

agency administrators who should *consult with DMH officials prior to enrollment in CSTAR or other DMH services.*

## **CLINICAL ASSESSMENT**

**In the DM3700 project, consumers are presumptively eligible for CPR and only need a brief assessment. Is that the case for ADA DM/CSTAR? If so, can we bypass the full intake? We hope to do intakes out in the community.**

- Consumers in the ADA DM cohort are **presumptively eligible for CSTAR**. They are **not** presumptively eligible for CPR and may only be enrolled in CPR if they meet eligibility criteria (i.e. serious and persistent mental illness).
- A brief assessment is **not** available for ADA DM consumers being enrolled into a CSTAR program. The Division of Behavioral Health has **revised the timeline for completion of the initial assessment and treatment plan to 30 days from the date of CSTAR admission**. This applies to the **ADA DM population** only and allows providers to bill for services while the assessment and treatment plan are being completed. Refer to the assessment policy and CIMOR work around for this population: <http://dmh.mo.gov/ada/provider/ClinicalAssessmentPolicyforADADMPopulation.htm>.
- Obtaining information for the assessment **may begin in the community** during the outreach and engagement period and should be documented accordingly by the outreach worker(s). As long as a QSAP reviews and interprets the assessment data and meets face-to-face with the consumer to develop treatment recommendations, and a licensed diagnostician renders a formal diagnosis, this process is acceptable and will likely enhance consumer engagement during the outreach period.
- **It is acceptable for staff to use a paper version of the ASI instrument to obtain the required information from the consumer. The basic information must be entered in CIMOR in order for the assessment to be saved in a Completed status (refer to work around instructions). The paper copy and Interpretive Summary must be placed in the consumer record.**

## **OUTREACH, ENGAGEMENT & BILLING**

**Are there any specific billing instructions for the ADA DM consumers that differ from the CPS DM 3700 clients? I can't seem to find any instructions.**

- The ADA DM and CPS DM 3700 projects have separate billing instructions.
- ADA DM provider contracts are amended to add a **non-consumer specific outreach billing code 15010-HF**. *All outreach and engagement activities prior to enrollment in CSTAR must be billed to this code.* This code is billed from the Serv-Non-Cons page in CIMOR.
- Services provided at or after enrollment should be billed specific to that individual as you would any other CSTAR consumer. **The major difference is CSTAR services for ADA DM consumers are reimbursed 100 percent from MO HealthNet Division appropriations and will not deplete provider allocations for serving other populations.**
- Refer to the *ADA DM Policies and Procedures* for more information: <http://dmh.mo.gov/docs/ada/ADADMPoliciesProcedures.pdf>

**What code should providers use to bill outreach activities for individuals in their cohort?**

- The code for outreach billings is **15010-HF Clinical Outreach (non-consumer specific)**.

**Do outreach billings come out of provider allocations for the ADA DM project?**

- A separate fund source has been established for outreach activities related to this project; provider allocations *are not impacted*. Provider allocations will be back-filled on a quarterly basis for all billing to code 15010-HF. *It is essential that providers use the correct billing code.*

**What types of activities can be billed as outreach?**

- The intent is to provide reimbursement for functions that are *directly related* to locating, contacting, or being in discussions *with or about individuals in the cohort*. **Allowable** activities include:
  1. Looking up information in CyberAccess to learn more about the individual such as diagnoses, prescribed and filled medications, and treatment history with other Medicaid providers (doctors, pharmacies, etc.)
  2. Calling individuals in the agency's cohort to explain available services and arranging to meet with them.
  3. Meeting an individual in the home or other community location to discuss available services, including the time it takes to get to and from the location. This could include meeting the individual in a neutral location such as a restaurant.
  4. Calling or meeting with other Medicaid providers to discuss a specific individual to facilitate contact with him/her for outreach purposes.
  5. Contacting other DMH community providers to coordinate referral/outreach information for an individual in the cohort.
  6. Calling consumers (or their collateral contacts) and/or attempting to locate in the community to reengage them in services when they are not complying with their treatment plan (missed appointments, refusal to participate in services). **NOTE:** Providers must document that routine attempts to contact the individual are made within 48 hours of any missed appointment unless a more urgent response is warranted, per certification standards. *These routine attempts to contact are not billable.*

#### **What types of activities cannot be billed as outreach when I am performing work related to the ADA DM project?**

- The following activities are **not billable**:
  1. Time spent participating in DMH conference calls/meetings related to the ADA DM project.
  2. Time spent preparing for the project, including discussion of implementation details.
  3. Time spent reviewing the agency's cohort list to develop outreach plans.
  4. Time spent preparing and mailing letters or other information to individuals in the agency's cohort.
  5. Time spent receiving training related to the project, including use of CyberAccess or CIMOR.
  6. Time spent entering client information into data systems.

#### **Which agency staff can provide outreach for the ADA DM population and is there a different code or rate depending on who provides the service?**

- The billing code (15010-HF) and reimbursement rate (\$11.53/qtr. hr. unit) **is the same** for staff who may provide this service:
  1. Qualified Substance Abuse Professional
  2. Qualified Mental Health Professional
  3. Community Support Specialist
  4. Missouri Recovery Support Specialist (MRSS)
  5. Missouri Recovery Support Specialist/Peer (MRSS/P)
  6. Certified Missouri Peer Specialist
  7. Registered Nurse
  8. Licensed Practical Nurse

### Is it allowable for two staff to conduct outreach, especially in areas where it may be unsafe to go alone?

- Outreach team members may choose to go in pairs on home or community visits **if there is a concern for safety**. It is **acceptable** for both staff to bill for outreach activities in these cases. Providers should be able to present appropriate documentation that justifies this practice. It is a priority for DMH that its contracted providers keep outreach team members safe when working in unknown conditions and environments.

### Can two staff bill for outreach when it might help to get the consumer engaged in services? For example, our CSS has established rapport with a consumer and wants the nurse to accompany him to talk about health issues which might help get the individual to agree to services.

- In these situations, only **one staff person can bill outreach**. It is acceptable for the CSS to accompany the nurse, but since the nurse will be providing the primary service, he/she would bill for the outreach activity.

### For situations in which a DM consumer disengages from services, is it possible to bill clinical outreach when we are trying to find him/her in the community to get them back into services?

- Providers participating in the ADA DM project may bill consumer-specific clinical outreach to locate and re-engage individuals enrolled in CSTAR who are not currently involved in services. **This applies to ADA DM consumers only**.
- The billing code that must be used is **H0023-HF**.
- A QSAP must verify the need for clinical outreach with a brief progress note in the consumer record.
- Prior to providing and billing clinical outreach, routine attempts to contact the consumer should be made and documented in the consumer record (telephone calls and/or attempts to find him/her in the community, if feasible).
- During the time that clinical outreach is occurring, all activities for the identified DM consumer must be billed to service code H0023-HF. Community support cannot be billed while clinical outreach is taking place.
- Services must be documented in the consumer record with a progress note and the usual required components.

### Will there be consideration for peers or others in the recovery community interested in working with this population to have a six-month timeframe to become certified or credentialed?

- The Division will not make any adjustments to the existing process for individuals to become certified or provide peer-related services. Those interested should follow the established procedures for becoming certified or credentialed.
- Peers in training may accompany qualified staff during outreach activities but cannot bill for services until they become certified.
- A training plan must be developed by the agency and adequate supervision and oversight must be provided by qualified staff.

### Will the Division of Behavioral Health provide assistance for Recovery Support Specialist or Peer Specialist training?

- No special training events or financial assistance will be offered.
- Recovery support and peer specialists have two options for training and certification. The information for becoming a Missouri Recovery Support Specialist (MRSS) or Missouri Recovery Support Specialist/Peer (MRSS/P) can be found at: <http://www.msapcb.com/>.
- Information for becoming a Certified Missouri Peer Specialist can be found at: <http://www.peerspecialist.org/peerspecialist1.0/default.aspx>

### Can the agency nurse conduct outreach and bill their time through the outreach code?

- Yes, RN's and LPN's may provide outreach and bill accordingly.

### We have hired a LPN for the project but it doesn't seem there is a lot for her to do at this point. I know that she is able to bill outreach, but after enrollment what services does the nurse provide?

- Providers do not necessarily need to hire a nurse specifically dedicated to the ADA DM project. If they already have nursing staff and caseloads allow, they may provide services for the ADA DM population as well.
- Providers may use their nurse(s) to take part in outreach activities so they can address health-related issues and questions.
- Once enrolled in 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, including risk screenings; assisting in securing a PCP if they don't have one; discussing medical issues with the physician; following up after hospital discharge; overseeing and monitoring labs.

**NOTE:** The current CSTAR Medicaid State Plan requires that nursing services, referred to as Extended Day Treatment, 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 LPNs as qualified practitioners to provide Extended Day Treatment.

### Will there be any limits placed on the number of outreach units for this population?

- There will be *no daily, weekly, or monthly limits* placed on outreach services for the ADA DM population. Considerable outreach may be necessary to locate and enroll these individuals in services. Agency administrators should provide close oversight to avoid excessive or inappropriate utilization of the service. *DBH staff will closely monitor expenditures to ensure adequate funding is available.*

### Are there any limits to the amount of time providers can stay in touch with an individual while they are only receiving outreach services? For example, if we are able to maintain contact over a three-month period but he/she still doesn't want to come to the agency for services, can I continue follow-up?

- As long as you believe you are making progress with the individual and they are receptive to your visits, there is no limited timeframe for these activities. Trained outreach workers should be able to determine whether an individual is receptive to some level of services and when continued follow-up is unnecessary.

### Understanding that travel time is billable with outreach, does it require successful contact with the targeted participant in order to submit this for reimbursement?

- Direct contact with the targeted individual is not required to bill outreach. The goal is to engage as many in the cohort as possible. Numerous attempts may be necessary before the individual is located and engagement takes place. Close supervision and monitoring of caseloads can help to minimize such occurrences.

### Can we admit people to CSTAR who are not "ready" to work on their substance use issues but are willing to work on other issues in their life which will likely be the vehicle that results in getting them to address substance use?

- It is acceptable to enroll them in CSTAR because they are *presumptively eligible*. 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 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.

**Our QSAP reported that someone in the ADA DM cohort says they don't have a substance use problem. After the QSAP completed the full assessment, he doesn't think they meet the criteria for enrollment in CSTAR. What should we do?**

- 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 substance use disorder. Keep in mind, a *substance use diagnosis* is in their Medicaid claims history; therefore, they are *presumptively eligible* for CSTAR and may be enrolled if interested.
- Continued interaction with the consumer or significant others may lead to discussions about their substance use disorder. Appropriate services should be offered when the consumer is receptive.
- Be sure to check for prior Episodes of Care (EOC) in CIMOR to determine if he/she has previously received DMH services, specifically with another ADA provider.
- Many individuals in the ADA cohort will have co-occurring substance use and mental health disorders. If he/she *meets the criteria for CPR* (serious and persistent MI), they *may be enrolled with the CPR provider in their service area*. Otherwise, their co-occurring needs should be addressed by the CSTAR provider as is currently required and billable.
- The ultimate goals of the project are to make services available that assist individuals in *maintaining* their recovery, achieve better overall health, and reduce costs to the state's Medicaid program. Every effort should be made to engage them in services that meet their individual needs and link them with other community resources.

**What type of documentation is required for outreach activities?**

- Documentation must meet DMH requirements by adequately describing the activity and the individual's response, date of service, beginning and ending times, location of service, and staff signature and title. The notes should be filed in the consumer's chart once they enroll in services or be kept in a separate non-consumer specific file. In either case, notes must be available for review by DMH staff upon request.

**Some of the consumers in our cohort have a Medicaid spend down. What should we do in those cases?**

- It is not unusual for individuals who are receiving Medicaid benefits to have a spend down which is similar to an insurance deductible. This helps people who have too much income to qualify for MO HealthNet benefits. Individuals with spend down can pay-in their required amount each month to the MO HealthNet Division or incur medical expenses equal to their spend down. **Mental health services, including CSTAR, count towards spend down.**
- Providers typically have internal policies and procedures related to spend down, so be sure to check with your agency's business office if you are not familiar with those policies.