DIVISION OF BEHAVIORAL HEALTH
Disease Management
DM 3700 (CPS DM) and ADA DM

POLICIES AND PROCEDURES

OVERVIEW

The Disease Management (DM) projects are a collaborative effort among the Department of Mental Health's (DMH) Division of Behavioral Health (DBH), the Department of Social Services' (DSS) MO HealthNet Division (MHD), and the Coalition for Community Behavioral Healthcare. The project targets Medicaid-eligible adults with high medical costs who have a serious mental illness or substance use disorder and who are not currently receiving behavioral health services. The goal is to locate and enroll these individuals in services, who frequently have impactful chronic medical conditions, in order to improve health outcomes and reduce related medical costs.

Inclusion for project

- $20,000 (subject to change) or greater in combined Medicaid pharmacy and medical costs
    - Inclusion criteria is based off of previous 12 months
- A Medicaid claims diagnosis of a serious mental illness or substance use disorder
    - SMI: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder
    - SUD: alcohol, opioid, sedative hypnotics or anxiolytics, stimulant (cocaine, amphetamine) cannabis, and hallucinogen use disorder, other (or unknown) substance use disorder
    - Inclusion criteria is based off of previous 12 months
- Current qualifying rehabilitation Medicaid eligibility
- Are not currently being served - no open episode of care (EOC) with DMH
    - for CPS only - no open EOC in the past six months
- 18 years of age and older

Background and Purpose

Many individuals with a mental illness or a substance use disorder also have chronic physical health conditions resulting in premature mortality. Despite this fact, behavioral and physical health services have historically been delivered through separate systems with little cross-system coordination. This results in poor individual outcomes and excessive costs to the healthcare system.

The DMH has adopted a whole person approach regarding treatment and services. To make any impact in reducing premature mortality and costs and to increase individual outcomes, services can no longer be delivered in silos. An integrated approach must be embraced. Services should be delivered based on a chronic care model rather than an acute care model. This model enables providers to assist consumers with their overall health care needs and gain an understanding of their strengths and barriers which may impact their recovery and quality of life. Disease management is a philosophy that embraces the above models and involves coordinating complex care with multiple providers. For individuals with chronic health conditions, high quality care truly requires integrated, person centered, and coordinated care. Individuals identified through DM may come into services at any stage of change (pre-contemplative – when the individual is not ready to discuss his/her mental health or substance use - to the maintenance stage – when the individual

simply needs to maintain his/her mental health or substance use stability). Providers must meet the individual where he or she is at and individualize services to the needs and wishes of the person.

DBH contracted service providers contact individuals identified through this project, provide outreach and engagement, enroll them in the respective rehabilitation program, and provide necessary services focusing on community support/case management and nursing services to coordinate and manage their medical/behavioral health conditions. DBH believes our services and interventions will reduce costs to the state and improve outcomes for the identified individuals.

The Disease Management 3700 project (DM 3700) began as a two year pilot in November 2010 on the mental health side. The project proved promising and saved the state's Medicaid program millions of dollars and more importantly improved the health and well-being of thousands of people in Missouri. Because of the associated savings, the DM 3700 project was continued beyond the two year pilot. The Disease Management initiative was then expanded to include substance use treatment providers in February of 2014, referred to as ADA Disease Management (ADA DM).

ASSIGNMENT OF INDIVIDUALS

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 Community Psychiatric Rehabilitation (CPR) or Comprehensive Substance Treatment and Rehabilitation (CSTAR). In areas where there is more than one provider, the individuals are assigned based on the percentage of CPR/CSTAR persons 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.

Lists assigning individuals to specific providers for outreach are placed on the DMH FTP site in Reports->ADA/CPS folders and are titled DM 3700/ADA Cohort # Client List _ Date.xls.

Alternate cohorts are distributed every six months:

- DM 3700: December & June
- ADA DM: March & September

Providers in joint service areas will need to communicate and coordinate regularly regarding their respective individual lists. Providers may mutually agree to outreach with an individual on another provider's list based on a stronger prior service history or closer proximity for easier outreach, for example. Outreach efforts should be coordinated among agencies. In addition, an individual initially assigned to one provider may come into contact with another provider due to urgent service needs and not through a planned outreach strategy. In these cases, it is appropriate for the provider to serve the individual and inform the other provider that the person is in services with them.

NOTE: In cases where there is overlap among providers in a particular service area, each provider will have access to a service area-wide list to assist with coordination and communication.

Individuals remain on the cohort lists at least until the next 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.

OUTREACH AND ENGAGEMENT

Providers are expected to find and enroll as many individuals as possible in their assigned cohort, as quickly as possible. Providers should prioritize individual outreach based on known clinical factors. Nurses or other medical staff should assist in this prioritization. Please refer to the DM Outreach Toolkit and the DM Strategies for Success power point for additional information regarding outreach methods.

HIPAA – The provision of treatment, as well as the coordination/management of health care and related services among one or more health care providers, is permitted under HIPAA so this interaction does not require patient consent.

42 CFR Part 2 – The only care that requires a signed consent is that which relates to substance use treatment; permission is not needed to share other health-related information with another provider as long as it is known that the individual has received services from them. The Federal Confidentiality Regulation (42 CFR Part 2) does not apply to primary care providers who render alcohol and substance use services incident to their medical care function and these services are not considered their principal practice. The Federal regulations apply to programs for which their principal practice is the provision of substance use disorder diagnosis, treatment, or referral for treatment and they "hold themselves out" as providing those services (Fed.Reg, 52:110, 6-6-87,21803). If the patient decides to enroll in services for a diagnosed substance use disorder with a specialty provider, that provider is responsible for obtaining all required consents in order to discuss any further care and treatment.

It is important to remember these individuals may not be interested in traditional services and the outreach process may be intense. Individuals will be much more receptive if they understand services will be highly individualized and each person will be met where they are.

Some agencies may need to restructure staff to create the increased capacity to serve this population.

- Consumers in the DM cohorts are *presumptively eligible for the respective Rehabilitation Program*
    - CPR for DM 3700
    - CSTAR for ADA DM

Following the initial letter DMH will send to individuals, outreach and engagement strategies by providers should include but not be limited to: follow-up letters, follow-up phone calls and correspondence, home visits, and contact/coordination with other known MHD healthcare providers (hospitals, physicians, pharmacists, etc.). Please refer to the *Disease Management: Strategies for Success* power point for outreach and engagement strategies reported by DM providers.

Billing for Outreach

Billable activities during the outreach period, *up until the individual is enrolled in CPR or CSTAR*, must be billed to DMH as non-consumer specific outreach.

- Specific to CPS DM - please refer to the provider bulletin located on the DMH website for program specific billing.
- Specific to ADA DM
    - All activities during the outreach period, up until the individual is enrolled in CSTAR, must be billed to DMH as outreach using the following code: 15010-HF Clinical Outreach (non-client specific)
    - Qualified Staff
        - Qualified Addiction Professional

- Qualified Mental Health Professional
- Community Support Specialist
- Missouri Recovery Support Specialist-Peer
- Certified Missouri Peer Specialist
- Registered Nurse
- Licensed Practical Nurse

Billable Outreach Activities

The following activities ***are*** appropriate for billing outreach for this population:

- Looking up information on CyberAccess to identify diagnoses, medications, and treatment history involving other MHD providers (doctors, pharmacies, etc.).
- Calling an individual to discuss available services and arranging to meet with them.
- Meeting an individual at the agency to discuss available services.
- 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 at a neutral location such as a restaurant.
- Calling or meeting with another MHD provider (pharmacist, doctor) to discuss a specific individual to facilitate contact with him/her for outreach purposes.
- Contacting other DMH community providers to coordinate referral/outreach information.

There are no daily, weekly, or monthly limits placed on outreach activities for this population as it is anticipated there will be wide variation in the number of units utilized per individual. Ongoing contact will be essential in order to engage this population. Direct contact with the targeted individual will not be required in order to bill for outreach. Understanding the complexity in engaging this population, it is anticipated that numerous attempts to locate and engage individuals may be necessary. Close supervision and monitoring of caseloads can help to minimize such occurrences. Outreach team members may go in pairs on home or community visits **if** there is a clear 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.

In general, documentation must support outreach billings and 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 individual'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. Clinical outreach services for individuals in the DM cohort will be paid from a separate fund pool and will not impact provider allocations.

The following activities are not appropriate to bill outreach:

- Time spent participating in DMH conference calls/meetings related to the DM projects.
- Time spent preparing for the project, including discussion of implementation details.
- Time spent reviewing the agency's cohort list to develop outreach plans.
- Time spent preparing and mailing letters or other information to individuals in the agency's cohort.
- Time spent with community agencies to develop incentives for individuals to participate.
- Time spent receiving training related to the project, including use of CyberAccess or CIMOR.
- Time spent entering information of persons served into data systems.

ADMISSION AND ENROLLMENT

- After contact is established and the individual agrees to receive services, he/she should be enrolled in the appropriate CPR/CSTAR Episode of Care (EOC) in CIMOR. **It is very important old EOCs are not re-opened. This will result in the failure of the referral source to be defaulted to DM. Without DM as the referral source, any services billed through CIMOR will not be identified as a claim for DM. This includes eligibility to bill DM Housing funds.**
- Providers should be cognizant of the defined differences between outreach services and case management/community support services. This contrast can sometimes be overlooked when individuals are engaged, but not yet enrolled in services. When outreach becomes case management, the individual must be enrolled to prevent recoupment.
- Providers may find a list of DM enrollees in CIMOR by logging into CIMOR ->Reports-> EOC-> DM3700 Enrollees. *The report is a historical database; however, the information can be sorted and filtered to include only current enrollees. Current enrollees show an end date of 12/31/9999.
- After an individual has been identified as DM, any EOC after this date will automatically be assigned a referral source of DM. This referral source code will enable the creation of distinct Medicaid invoices that will be paid from DSS appropriations, not DMH.
    - **Reopening old EOCs (including those that were auto-discharged) or failure to open an EOC in a timely manner (i.e. more than a month later) will result in the failure of the automatic assignment of the DM referral source.*
- While the individual's SSN is not required in order to register and enroll someone in CIMOR, we are encouraging providers to enter the SSN as it assists us in validating the DCN and reducing the number of duplicate persons entered into CIMOR. In addition, while you can register and enroll an individual without the SSN, the *SSN will be required before services can be billed* for the individual.
- Please review the program specific assessment and treatment bulletins located on the DMH website.

ADA DM Specific

- CIMOR no longer requires the ADA assessments to add for ADA DM CSTAR enrollees.
- The Treatment Episode Dataset (TEDs) information should be updated in CIMOR as soon as this information is collected.
- For metabolic screenings requirements, please review bulletin located on the DMH website.
- In addition to metabolic screenings, ADA DM providers may consider the following tests:
    - Hepatitis B Profile
    - Hepatitis B Series, if warranted
    - Liver Profile
    - SGOT
    - SGPT
    - Alkaline phosphatase
    - Total bilirubin

CPS DM Specific

- DM 3700 individuals must have an Adult Status Report entered in CIMOR within 30 days of admission.
- Metabolic screenings must be conducted on DM 3700 individuals within 180 days of enrollment.

For Healthcare Home Agencies

- DM individuals should also be enrolled in Healthcare Home. This should be presented as a packaged deal when outreaching.

Services will be highly individualized and these individuals may be difficult to engage and retain in services. Individuals will be engaged in care for indefinite durations. It is critical for providers to assign the "right" staff to work with this population. Particularly for the CSTAR providers, case management versus community support work versus counseling can at times be blurred for this population. Staff will need to meet people where they are and work with them to engage in services.

Both programs have the option to bill consumer specific outreach for those individuals who become disengaged in services. Consumer specific billing should only occur after the provider has gone above and beyond the traditional attempts to re-engage an individual. Consumer specific outreach may be billed for up to six months. After six months, outreach should be switched to non-consumer specific outreach. CIMOR auto-discharge rules do apply to DM individuals. Please see program specific bulletin for further details regarding billing consumer specific outreach.

BILLING FOR SERVICES AFTER ADMISSION

- After enrollment, all services provided for DM enrollees will be billed to the assigned CPR/CSTAR program through CIMOR.
- Providers enter claim information in CIMOR the same as they do for other individual. Claims for DM enrollees will be identified using the referral source. This is why it is important old EOCs are not re-opened. This will result in the failure of the referral source to be defaulted to DM. Without DM as the referral source, any services billed through CIMOR will not be identified as a claim for DM.
- It is important providers ensure individuals new to their outreach lists were not receiving services at the time they were identified as DM. If you find the individual was in fact receiving services you should check with the DBH staff to determine if the person does in fact qualify for DM.