

MISSOURI DEPARTMENT OF MENTAL HEALTH
Division of Comprehensive Psychiatric Services
OFFICIAL MEMORANDUM

October 6, 2010

TO: Certified Adult CPR Provider Agencies

FROM: Tom Rehak, Coordinator of Policy and Programs
Division of Comprehensive Psychiatric Services

SUBJECT: Disease Management 3700 Project Implementation

This is to provide you with information regarding the implementation of the Disease Management 3700 (DM 3700) project. The start date for the project is November 1, 2010.

Project Overview

DM 3700 is a collaborative two (2) year project between the Department of Mental Health (DMH) and the MOHealth Net Division (MHD), targeting high cost Medicaid clients who have impactable chronic medical conditions. Criteria for inclusion in the project include:

- \$30,000 or greater in combined Medicaid pharmacy and medical costs between June 2009 and May 2010
- A diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Major Depression-Recurrent
- Are not current clients of DMH
- Have no medical claims between June 2009 and May 2010 for hospice, dialysis, hemophilia, ICFMR
- Have no nursing home claims between March and May 2010

The Department has agreed to contact these identified persons, provide outreach and engagement, enroll them in the Community Psychiatric Rehabilitation (CPR) program, and provide necessary services, focusing on community support/case management to coordinate and manage their medical/psychiatric conditions. We believe our services and interventions will reduce the cost to the state of providing care and treatment and improve outcomes for the identified clients. While the outreach and initial enrollment will be through the CPS division and the CPR program, if the assessment of the client indicates a substance abuse disorder, they may be referred to ADA-CSTAR programs as appropriate.

All CPS administrative agents and six affiliate agencies (Preferred Family Healthcare, Comprehensive Health, New Horizons, Adapt, Places for People, and Independence Center) will be participating in this project.

MHD is making funding available to pay for Medicaid CPR/CSTAR claims for persons enrolled in this project. Payment of these claims will come from that fund source, not from current provider allocations.

DMH and MHD intend to target approximately 3,700 clients for this project. To begin the project we have identified the first 2,400 clients, and will identify additional clients no later than January 2011.

Communication

Each provider agency participating in the project has identified a single contact person for communication of policies and procedures. That person is expected to keep other agency staff informed as appropriate. There will be an initial conference call held on **Thursday, October 14 from 11 am-12:30 pm** to review this memo and the client list format and discuss outreach strategies. Additional information for the conference call will be sent under separate cover. The Department will be scheduling periodic phone conferences with the project contact persons to review progress and share information.

Assigning Clients and Client Lists

Attached you will find a listing of client counts by CPS Service Area for the initial 2,412 clients identified. Lists assigning specific clients to specific provider agencies for outreach and engagement have been placed on the DMH FTP site. They are in the Reports/CPS folders, and are titled **“Disease Management Client List SAxx”**. Please inform your fiscal staff of this, and have them assist you in downloading and accessing your DM client list list. Your fiscal staff has access to the FTP site as this is where we post a variety of fiscal reports currently.

In service areas where there is more than one certified Adult CPR program, clients will be initially assigned to providers based on the relative size of their CPR program. In addition, if a client has had a history with DMH, they will be assigned to the provider with whom the client had their most recent episode of care, to the extent possible.

Assigning clients to specific providers at the beginning of the project is intended to give all providers a starting point as they develop their outreach and engagement strategies, and to avoid duplication of effort in services areas with multiple providers. As the project is implemented, providers in those joint service areas need to communicate and coordinate regularly with respect to their respective client lists. It is fine for providers to mutually agree to outreach a client on another providers list based on a stronger prior service history, for example. Also, a client assigned initially to one provider may come into contact with another provider due to urgent service needs, not through a planned DM 3700 outreach strategy. In those cases it is appropriate for the agency to serve that client;

they just need to inform the other agency the client is now in service with them. In those joint service areas each provider will have access to a service area wide list to enhance coordination and communication as clients are found and enrolled.

We will be developing a reporting mechanism to identify when DM 3700 project clients are admitted anywhere in the state. Your client lists on the FTP site will be updated to show when and where these clients are admitted, whether at your agency or another.

Initial Outreach and Engagement

In the statewide aggregate, the Department projects 50% of the DM 3700 clients to be enrolled during year one and 50% during year two. However, providers are encouraged to try and reach as many clients as possible in year one as capacity allows. We anticipate that varying capacities for program expansion will mean some providers will reach more of their assigned clients faster than other providers.

After reviewing their respective client lists, providers will need to develop their own outreach and engagement strategies. We expect outreach strategies may involve but not be limited to: mailings and phone calls to the client, home visits, and contact/coordination with other known service providers. We strongly encourage providers to become familiar with Medicaid provider/service/claim history of assigned clients by reviewing CyberAccess.

As providers decide which clients to find first, they may consider a variety of factors, including prior history with the agency, cost, and risk factors. Known risk factors will be identified on the client lists for as many clients as possible to assist with prioritization, including MPR's (medication possession ratios) for certain drug classes, persons on three (3) or more antipsychotics, and counts of ER and Hospital visits in the recent 12 month cost period.

To assist providers in the outreach and engagement process, the Department is developing a template of a letter that could be sent to clients. Providers may format part or all of this letter with agency specific contact information, or may develop a different process for contacting client by mail, if they choose to use that strategy. In addition, the Department is developing a letter from Dr. Parks that may be useful in explaining to other health care providers (primary care physicians, hospitals, pharmacies, etc.) the purpose of the project as you contact them to coordinate care. We encourage your staff present this letter to other health care providers involved with the clients as you coordinate care. Both letters referenced above will be sent later this week under separate cover.

Billing Outreach and Engagement Time

The Department will set aside a new funding pool to reimburse providers for outreach and engagement activities by case managers that occur prior to enrollment of the client in CIMOR. All activities during the outreach period, up until client admission,

should be billed to DMH as outreach (administrative agents) or case management (affiliates), using a non-client ID number. These services must be billed in CIMOR on the non-consumer services screen. Billable activities may include time spent researching medical care history on CyberAccess. Outreach activities will be paid after they occur. Each month providers must report the total amount of outreach services provided in the prior month for DM 3700 clients. This information should be reported to the attention of Tom Rehak (tom.rehak@dmh.mo.gov). Funds will then be allocated in CIMOR in order for the provider to bill and receive payment.

CPR Admission and CIMOR Enrollment

After client contact has been established and they agree to receive CPR services, the provider should enroll them in CIMOR and create the episode of care (EOC), and assign them to the Adult CPR service category and any other service categories as appropriate. This is the point in time where financial and other outcomes will begin to be tracked. The Department will create a table in CIMOR with the DCN's of the DM 3700 clients, and when those clients are enrolled in CIMOR, a Referral Source code for DM 3700 will be automatically assigned. While the client 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 consumers entered into CIMOR. In addition, while you can register and enroll a client without the SSN, the SSN will be required before services can be billed for the client.

DM 3700 clients are considered to be presumptively eligible for CPR. The provider is not required to complete a bundled Intake Evaluation establishing eligibility for CPR. The provider is still responsible for assessing the client's needs and developing a plan of care (treatment plan) based on that assessment no later than 30 days following admission, and updating the treatment plan as appropriate. Treatment plans must be formally reviewed at least every 90 days. All assessment and treatment planning activities by mental health professionals for DM 3700 clients should be billed as Brief Evaluation (procedure code 90801 HO). Assessment and treatment planning time by Community Support workers is billed as Community Support (procedure code H0036).

Billing Services After Admission

All services to DM 3700 clients after enrollment must be billed in CIMOR, by entering claim information on the online service entry screen. Providers may batch claim information to CIMOR for DM 3700 clients, but only if/when they are batching Medicaid services for all their DMH clients to CIMOR. If a provider wants to batch all Medicaid services to CIMOR they must first inform Hope Berhorst (hope.berhorst@dmh.mo.gov) at DMH and go through a testing process in order to be approved for batching all services.

There are no new contracts, provider numbers, service categories, or procedure codes in CIMOR for DM 3700 clients. Providers will enter claim information in CIMOR the same as they do for other clients. Most of the claims will be in the Adult CPR service

category, but other service categories may be used as appropriate if non-CPR services are provided. Claims for DM 3700 clients will be identified using the table referred to above. When invoices are generated in CIMOR, a separate Medicaid invoice will be created and sent to MHD for processing, and the payment will come from MHD appropriations.

Please note that allocations will not be established in CIMOR to pay for services post-admission until after the first payment cycle in November 2010. We are planning to establish allocations in CIMOR for DM 3700 clients on Monday, November 8. If you find and enroll a client and deliver services prior to November 8, you will need to hold the submission of claims for those services until on or after November 8.

Outcomes and Data

DM 3700 clients must have an Adult Status report entered in CIMOR within 30 days of admission. In addition, a Metabolic Screening must be completed within 180 days of admission.

The Department is evaluating the use of additional outcomes reporting tools for the DM 3700 project. We will notify you shortly if additional tools are required and how they should be reported.

Other outcome collection data we plan to identify from MHD/DMH systems at this time include the following:

- ER visits per thousand patient months
- Hospital admissions per thousand patient months
- Hospital re-admissions within 30 days of discharge per thousand patient months
- Episodes of outpatient care per thousand patient months (excluding CPRC)
- Aggregate MPR by drug class (antipsychotics, antidepressants, mood stabilizers, diabetes medications, antihypertensives, cardiovascular medications)
- HEIDIS indicators
- Total healthcare utilization (cost and units) trended for inflation and broken out by: inpatient, outpatient, pharmacy, CPRC, and categorized by behavior health vs. not behavior health

Incentive Payments

DMH will be earning additional revenue by billing services for DM 3700 clients through the Intergovernmental Transfer (IGT) reimbursement methodology. Those funds will be used to pay an incentive bonus to providers, currently calculated at approximately \$24 PMPM (per member per month), at the end of the first year if providers meet the goal of reducing total healthcare spending enough to cover the cost of the additional behavioral healthcare services. If this goal is not met, the IGT earnings will be used to offset the increased costs of the additional behavioral health services.

If you have any questions about any information in this memorandum, please contact me. This memo and associated documents and future memos and instructions for the DM 3700 project will also be posted to the Community Provider Bulletin Board on the DMH website.