

# DM3700 Q & A

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## POLICY, IMPLEMENTATION, & LAYOUT

**Q: What is the purpose of DM3700?**

A: 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.

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

A: 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. For example, if a client is not yet enrolled, but the provider reports they are still outreaching to the client, then they will continue on the list. If the status is "refused services" or "not eligible," then they will not. Other more ambiguous status values (i.e. have not found client) will result in the client continuing on the list if costs are still high.

**Q: What should we do with clients who are on our Cohort list, but the address is not in our service area?**

A: You will transfer these clients by emailing the appropriate DM3700 Coordinator for the agency in that service area and copy Tara Crawford and Clive Woodward.

**Q: It is my understanding that these clients are presumptively eligible for SCLP as well as for CSS services.**

A: DM3700 clients are not presumptively eligible for SCLP. They should go through the normal SCLP admission procedure, and if determined ineligible for housing assistance according to SCLP regulation, the case may be appealed and reviewed jointly by the provider and SCLP staff.

**Q: If a DM3700 client was discharged and wants to be re-admitted, would they continue to be eligible as long as they are Medicaid eligible?**

A: Correct, as long as they were not explicitly made ineligible when discharged. If made ineligible, then the new EOC will not show as DM. Also, you need to initiate a new EOC not simply delete the discharge from the old EOC.

**Q: How can I find a list of DM3700 enrollees in my agency?**

A: Go into CIMOR, go to Reports, choose EOC, then choose DM3700 Enrollees.

**Q: We have a DM3700 client that is refusing all services except from the doctor. Does he stay in DM3700 or is he taken out?**

A: The client may continue in DM3700 with only the physician services. You can try and re-engage (for CPRC) throughout his medication management treatment.

**Q: Can DM3700 clients transition to Maintenance Level of Care of lower levels of care in the community?**

A: Yes, if this is the most appropriate level of care and the appropriate level of services are being provided to maintain health and wellness.

## HEALTHCARE HOME

**Q: Where does DM3700 fit into HCH?**

A: DM3700 is viewed as the outreach component for Healthcare Home.

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**Q: Do all DM3700 clients have to be enrolled in Healthcare Home?**

A: 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 DM3700 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.

**Q: If we enroll a DM3700 client, will they automatically be enrolled in HCH?**

A: You still need to submit an enrollment form with the DM3700 box marked, and they still must be ME eligible.

## DOCUMENTATION REQUIREMENTS

\*Note Annual Review, Annual Assessment, and Annual Evaluation are all synonymous.\*

\*Behavioral Health Assessment is synonymous with Brief Evaluation\*

**Q: When are the adult status reports due for DM3700?**

A: No later than 30 days after admission.

**Q: When are Metabolic Screenings due for DM3700?**

A: MSS must be completed within 180 days of admission.

**Q: At the annual review, should we be doing the brief evaluation or a psychosocial evaluation?**

A: The requirements for Annual Assessment depend on the client level of care. For CPR Maintenance clients, you should complete an update of the Brief Evaluation. For the CPR Rehabilitation level clients, you should complete the full Annual Assessment. The brief evaluation is only for the initial assessment for (DM3700) CPR Rehab level clients. The annual assessment must be the complete package.

**Q: When a DM3700 client does not want to see a psychiatrist, and therefore does not have a current Axis I diagnosis, what should we put in the annual assessment?**

A: 9 CSR 30-4.035, 14 K states, *“The annual evaluation shall include consultation between a physician and/or psychologist and the mental health professional(s) conducting the psychosocial/clinical evaluation addressing the client’s need and appropriateness for continued outpatient rehabilitation.”* Therefore, you can use the diagnosis that is in Cyber Access that qualified the individual for DM3700. It is expected that a psychiatrist will be involved in the annual assessment and treatment plan. Please document efforts your staff has made to engage the client in those services and clearly state the client’s refusal.

**Q: We enrolled a client from the DM3700 project. He was discharged and we are re-enrolling him. Do we complete an annual or just re-enroll him from the brief evaluation completed, which is still within the year? He is not considered to be in the DM project any longer though?**

A: He would still be a DM client unless explicitly excluded. Mere discharge doesn’t exclude from future admission to DM. It is a new episode of care, so you would need an admission status report, etc. You would update the behavioral health assessment (brief evaluation) and treatment plan as much as needed and bill service codes H0002 (BHA) and H0032 (treatment plan).

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## BILLING

**Q: How do we bill the extensive travel time for outreach?**

A: There is an outreach code that can be used for the time spent for outreach when trying to engage the client into treatment. For more information, you may view the policy memo on the providers' bulletin board.

**Q: We have a DM3700 consumer with a \$700 spend down that he cannot meet. How should we proceed in these instances?**

A: If a provider has already outreached to a client and offered services, then they need to follow through even if the client has lost Medicaid.

**Q: Can we provide DM3700 services to someone living in a skilled nursing facility?**

A: CPR and other clinical services are not Medicaid reimbursable when the client is in a skilled nursing facility.

**Q: Can we provide DM3700 services to someone living in an assisted living facility?**

A: This would be reimbursable under the PMPM (HCH services) and CPR.

**Q: Do DM clients have their own funding source regardless of the services?**

A: The Medicaid CPRC/CSTAR funding source for DM3700 has a separate funding source in that they are paid 100% by DSS.

**Q: If we have a client that entered services through DM, but he loses his Medicaid after being admitted, how does this work for payment in the future?**

A: You can work with the client to get the Medicaid 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.

**Q: Does Medicare Part B make clients ineligible for DM3700 or just part A?**

A: Neither Medicare Part A or B makes the client ineligible for DM. As long as the client has Medicaid and meets the ME eligibility, they are still eligible for DM. However, if you discover the client has Medicare A or B and have not yet offered services, you can consider making the client ineligible for DM. If you choose to make the client ineligible, for this reason, then you must email Clive Woodward and copy Tara Crawford. 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.

## OUTCOMES

**Q: What outcome measurements are being collected for DM3700?**

A:

- 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

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- 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
- 12 month status report data

**Q: Has DM3700 been successful?**

A: Yes, a recent cost analysis estimates savings of 22 million.