

District of Columbia
Department of Mental Health



District of Columbia Presentation

December 7, 2008

Presentation Overview

- Provide an overview of the District of Columbia Mental Health system FY 2008 accomplishments, with a focus on two successful programs: the Court Urgent Care Clinic and the Compliance Program.

District of Columbia 2008 Demographics

- 588,000 residents
- 144,000 enrolled in Medicaid
 - 90,000 (predominately TANF moms and non SSI adults and youth) served by Managed Care Organizations (MCOs)
- 50,000 individuals served through a District funded health plan for uninsured individuals
- 13,000 consumers served through DMH system of private providers and District operated services

History

- 1974** Dixon case filed by class of plaintiffs receiving services at Saint Elizabeths Hospital against the federal government and District of Columbia.
- 1987** Saint Elizabeths Hospital transferred from the federal government to the District of Columbia.
- 1997** District's public mental health system placed in receivership for failing to comply with requirements of Dixon consent decree.
- 2001** DMH established as a cabinet level agency, pursuant to the Dixon Final Court-Ordered plan.
- 2003** 19 Exit Criteria agreed upon by the parties to the Dixon case.

2008 Accomplishments

Completed 9 month crisis emergency services planning process.

- Included stakeholders from police, fire and EMS in planning process
- Developed and implemented mobile crisis service for adults.
- Instituted same-day service program for walk-in/urgent care.
- Opened Court Urgent Care Clinic.
- Completed Phase 1 of CPEP renovations.

2008 Accomplishments

- In partnership with the District Department of Housing and Community Development to develop \$14 million of affordable housing for consumers in FY 2008 and FY 2009.
- Expansion of assertive services including child wraparound project; new rates to stimulate increased capacity for ACT and child in-home services.

Highlights

- Court Urgent Care Clinic
- Compliance Program

Court Urgent Care Clinic

H. Carl Moultrie II
Courthouse of the District of Columbia
FAMILY COURT





**Urgent Care Clinic at
Superior Court**



Intake Coordinator

Background

- Opened June 26, 2008
- Operated by the Psychiatric Institute of Washington (PIW) through a contract with the District of Columbia Department of Mental Health
- Budget: \$525,000
- Hours of operation: 8:30 a.m. – 5:00 p.m., Monday - Friday

Mission

The mission of the Court Urgent Care Clinic (CUCC) is to provide immediate treatment for court-involved individuals with potential mental health problems.

Objectives

1. Provide immediate access to mental health services for individuals involved in the criminal justice system.
2. Reduce the incidence of arrests and incarceration among individuals with mental health problems who commit lifestyle crimes and misdemeanors.
3. Increase the accessibility and connectedness to mental health services for hard-to-reach, transient populations with a history of court involvement.

Clinical Team

- **Psychiatrist:** diagnostic evaluation, emergency assessments and intervention, medication management services, initiating a comprehensive treatment plan.
- **Clinical Social Worker:** conduct psychosocial assessments identifying barriers to service delivery and compliance and identifying natural resources in the client's life.
- **Outreach and Case Management Services:** successfully linking client to needed services and assuring the client follows up with those services.
- **Intake coordinator:** conducting eligibility for services, and initial screening for services and tracking outcomes to assist in assessing program success.

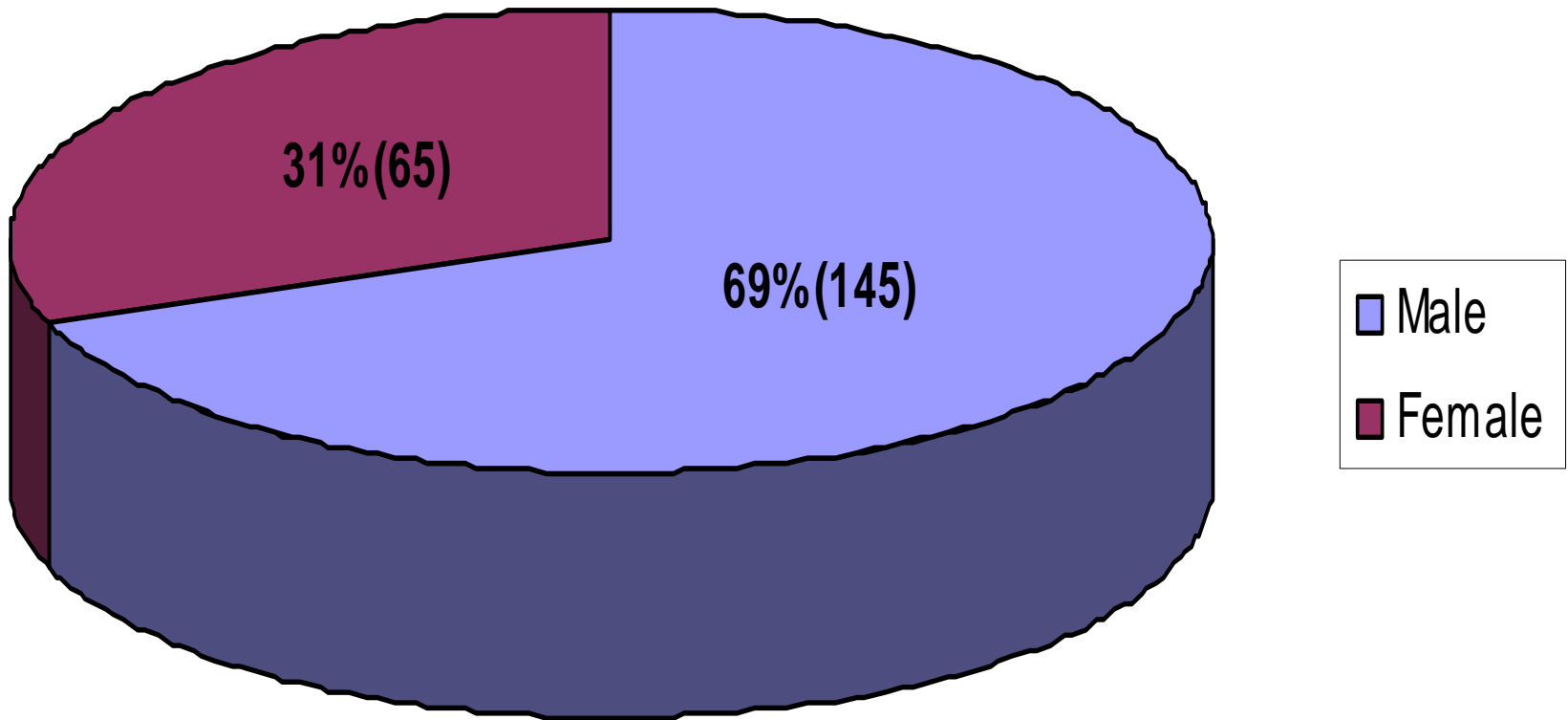
Referral Sources

- Misdemeanors and Traffic Court
- Mental Health Diversion and Criminal Court
- Attorneys
- Pretrial Services Administration
- US Marshal Service
- Office of the Attorney General
- Department of Mental Health (Court Liaison)

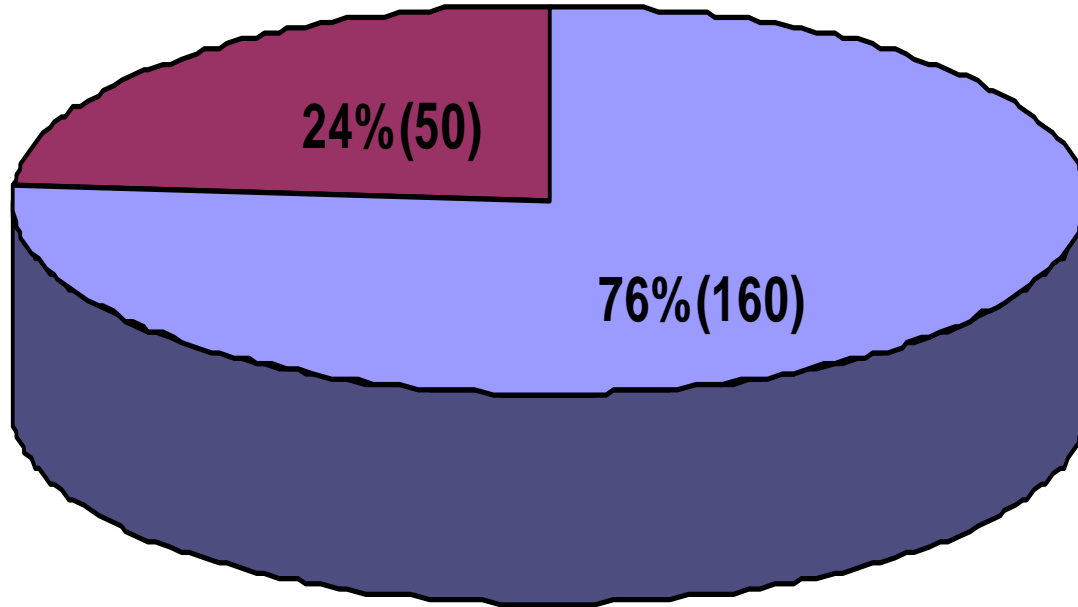
Description of the Service Model

Referral	Screening/Intake	Clinical/Support Services
<ol style="list-style-type: none"> 1. Consumer escorted to CUCC from the Court Room 2. Referral form completed by referring agent 	<ol style="list-style-type: none"> 1. Consumer interviewed 2. Service needs evaluated 3. Psychosocial assessment completed (if needed) 	<ol style="list-style-type: none"> 1. Immediate care provided by CUCC staff which may include: <ul style="list-style-type: none"> • Psychiatric Evaluation • Medication administration/Management • Treatment planning/Updates • Counseling and other Therapeutic Services • Case Management • Crisis Intervention • Referral to Primary Care • Referral and Linkage 2. Continued care at CUCC indefinitely or Transition to Community Service Agency (CSA)/Follow-up 3. Discharge Evaluation/Planning

Gender Distribution of Service Population (N=210)

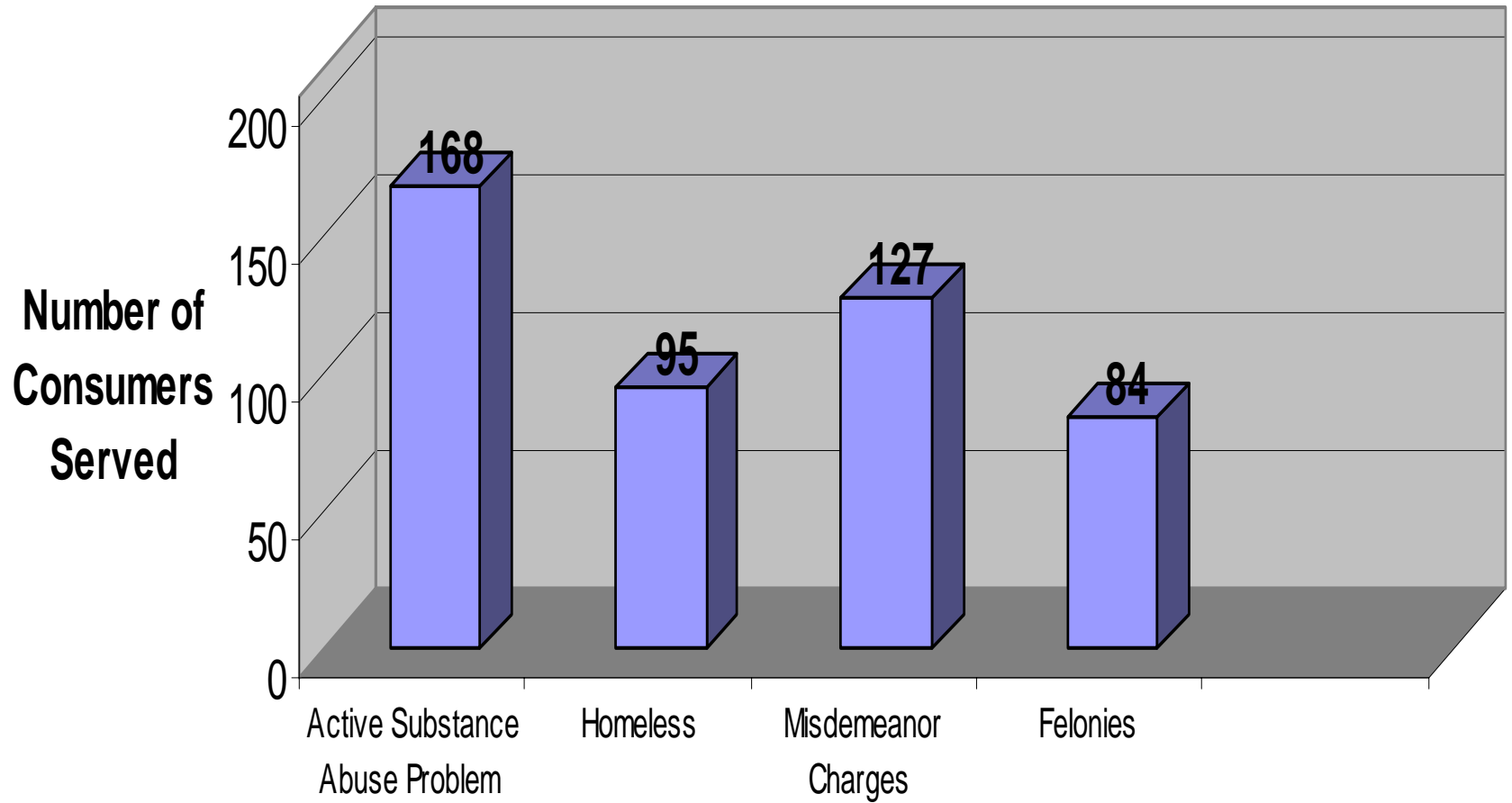


Consumer Enrollment in the Public Mental Health System (N=210)

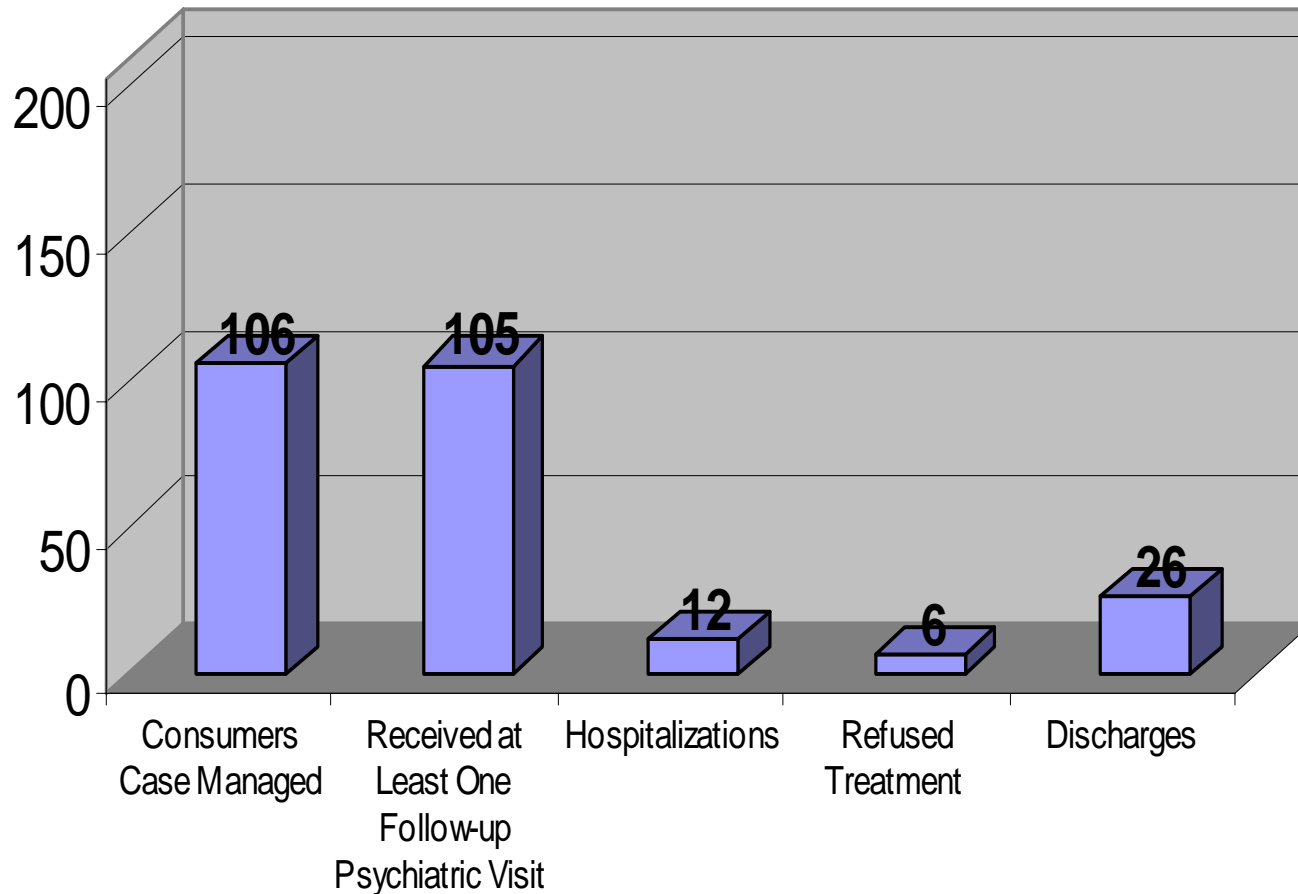


- Prior Enrollment
- No Prior Enrollment

Characteristics of Service Population (N=210)



Service Data for June - October 2008 (N=210 Referrals; Average of 3-6 Referrals Per Day)



Early Results: Demonstrated Value to Stakeholders

- Proximity to the Court Room
- Immediate access to care for individuals identified by judges in need of mental health services rather than court involvement
- Walk-in psychiatric services for consumers

Compliance Program

Developing An Audit Process

- New Director of Accountability brought to DMH, December 2006.
- Claims Audits: no valid sampling methodology; desk audits vs. on-site audits; flawed audit tool; no recoupment processes in place; multi-year backup.
- Deficit Reduction Act (DRA): increased Medicaid auditing by Feds; aggressive recovery of overpayments.
- Misuse or Over-use of service now being interpreted as False Claims in many federal audits.

New Claims Audit Process

- Office of Accountability senior staff consulted with James Sheehan, New York State Medicaid Inspector General and OMIG leadership.
- Augmented focus of claims audits from an “IS IT THERE?” approach to the rising bar of CLINICAL NECESSITY.
- Services must reflect rehabilitation and not maintenance.

New Claims Audit Process

- Adopted RAT-STATS as valid statistical sampling methodology (per DHHS).
- Sample is pulled from each provider's pool of claims, per defined audit period.
- Sample information sent to providers prior to audit: claim number, consumer name and DOB.

New Claims Audit Process

- Office of Accountability staff perform claims audit using newly developed audit tool.
- Audit results are tabulated.
- “Potentially Failed Claims” are identified.
- DMH sends certified letter to providers identifying potentially failed claims and reasons for failure.

New Claims Audit Process

- Top reasons for failure: no treatment plan (establishes medical necessity); treatment plan not signed by Approving Qualified Practitioner; treatment plan not dated (or date is beyond authorization period).
- Providers must respond with any mitigating documentation with 10 business days.

New Claims Audit Process

- Upon review of new documentation, or by passage of 10 business days, “potential” failures are converted to passes or actual failures.
- DMH then sends the final audit results to the Department of Health Care Financing (DHCF) (formerly, Medical Assistance Administration), the sole Medicaid state agency for the District.

Audit/Recoupment Process

- DHCF reviews the audit results
- DMH and DHCF send a joint demand (recoupment) letter to the provider, including notice of appeal rights.
- DHCF repays CMS within 60 days for identified overpayment – regardless of recovery.
- DMH pays DC treasury the 30% match.

Claims Audit Results

- Baseline failure rate: 31.6% (FY05).
- A second, larger sample is pulled every audit period for each provider failing at a >15% rate.
- Same audit/repayment/recoupment process is repeated.
- Continuous improvement each consecutive year audited.
- FY08 claims: auditing took place in real time.

General Audit Findings

- Primary reason for failed claims: missing or invalid treatment plan.
- Other causes of failure: progress note does not substantiate claim (duration; rehabilitation, longevity of service).
- Community Support and Medical Necessity.
- Lack of clinical supervision.

Feedback To Providers

- Upon notification of audit results, detailed exhibits provided indicating reasons for failure.
- If troubling trend is noted, Office of Accountability schedules meeting with provider.
- Potential Fraud and Abuse referrals.

The Duet

- When you begin auditing your providers, just tell them: “We are the government and we are here to help you!”
- And they will tell you, “And we’re so glad you’re here!”



Questions?
