March 29, 2006

Nora L. Duncan
Public Policy Specialist/Nonprofit Cabinet Project Director
Connecticut Association of Nonprofits
90 Brainard Road, Suite 201
Hartford, Connecticut 06114

Dear Ms. Duncan:

First of all we apologize for the lateness of the response. We have been reviewing the issues and concerns that your letter discussed. We have reviewed the status of the penetration rates across the State, the role of the LMHA's and the status of the clients upon discharge. We also met with DSS to determine whether there were any issues with the program and to review the authorization process and the claims payment information.

The issues with the LMHA's are primarily with the State-operated programs because the Private-Non-Profit LMHA's are managing their own beds. The CEO's of these programs have determined that there will be one member of their team with whom the group homes can coordinate. We will get this information to you by April 7, 2006.

The CEOs also agreed to develop a waiting list for clients to minimize the number of empty beds whenever possible. They understand that this has now become a business for the group homes and the paperwork should be timely. There has been an identified Utilization Management process in each state LMHA and that process will help to identify potential discharges and establish a waiting list for the regions. The LMHA's would like for the managers of the group homes to expedite the assessment and transition process for admission because this can be quite lengthy and will keep a bed empty for longer than necessary. This also creates impasses and contributes to the gridlock. The Department has discussed whether to bring the group homes in under the established review of the state hospital beds, but at this time would like to keep the review process local. This issue will be revisited as the Department reviews all the Utilization Management procedures.

We have scheduled a Group Home Review Meeting for April 26th where we will review the issues relating to documentation, penetration and linkages. We will also be asking the successful group home managers to present how they have been successful at what they are doing.

The Department has a years' worth of data which shows that the penetration rate has been met by most of the group homes, and the numbers of the reimbursable treatment hours from home to home are similar. As always with averages there are 2-3 providers at each end of the scale, and the providers with the lowest rate of reimbursable hours will have a program review with the Regional Managers, through the Division of Healthcare Systems When providers are having difficulty with the treatment hours with an

individual client, the goals may be too broad, and/or the staff is unavailable when the client is ready. We recommend that if this happens frequently with providers that their clinical review process evaluate the program and the goals/tasks for and with each client. There may also be a need for providers to have staff be available in the early evening hours when clients are in the facilities rather than during the day when there are more opportunities for community integration.

Attached are the answers to the questions that were posed in the letter to DMHAS and DSS regarding the implementation of the Medicaid Rehab Option for group homes.

Sincerely,

Patricia A. Rehmer, MSN
Deputy Commissioner
Department of Mental Health & Addiction Services

Mark C. Schaefer, Ph.D.
Director, Medical Policy & Behavioral Health
Department of Social Services

Attachments

Cc: Thomas A. Kirk, Jr., Ph.D., Commissioner, DMHAS

Questions to DMHAS and DSS
Medicaid Rehab Option Mental Health Group Homes

1) **How long would Medicaid records need to be maintained for audit purposes and how far back does our liability extend?**
    a. Providers must retain all required records for at least 5 years or longer if required by state statutes or regulations.
    b. In the event of a dispute, concerning a service provided, documentation shall be maintained until the end of the dispute or 5 years or whichever is longer.
2) **Does the date of signature by Paul Piccione on the initial authorization effect the "date of service" for billing purposes?**
    a. No: the dates of service are listed in fields 17 and 18 of the authorization request form.
    b. The date the form is signed is by DSS staff, is independent of the services.
3) **What can a home do if the reauthorization is not signed and dated until after the prior authorization has ended?**
    a. As indicated in response to question 2) above, the date of the DSS signature does not impact covered service dates.
    b. DSS intends to return all authorization and re-authorization requests to providers by the end of the first month requested, assuming they are submitted in a timely manner. Consequently providers may bill for each month's service by the first billing cycle after month's end.
4) **What do MHGHs do in situations where DMHAS wants them to hold the bed for someone, however, DSS says that the home can't get payment for the bed a month after the discharge date, negatively impacting both finances and utilization rates? What are the formula/rules/guidelines for bed-holds from DMHAS and is there a means of reimbursement for this type of bed-hold? The grant is not a means of reimbursement for bed-holds.**
    a. During the start of the MRO for group homes, we would expect some beds to be held while clients are admitted. As this process develops, we would expect that this bed-hold issue would become less of a problem.
    b. We would expect that the admissions and the need for the placement of clients would end this practice. The UM process (locally) should help define this practice.
5) **Spend downs present a problem for providers that DMHAS and DSS are familiar with. There are also cases where the residents' income exceeds the "needs" e.g. retroactive checks, lawsuit award, inheritance, social security. MHGH residents sometimes spend the money, notification of the spend-down comes after-the-fact, etc., and circumstances leave no resources to bill. There are some ways which may help remedy this, but clarity and/or action is needed:**
    - **How is the MHGH expected to account for money that is given to a resident directly?**
    - **May the MHGH bill the resident in advance to assist in facilitating the spend-down process?**
    - **If so, may the MHGH home escrow the money that is billed to the resident in advance?**
    - **When MHGHs are unable to bill, how is DMHAS/DSS planning to support MHGHs that have resident(s) on DSS/Medicaid spend-down?**

- **Is it possible to have a gross public rate in excess of $1,800 to address spend down issue more quickly? This is a common practice for hospitals and home care facilities.**
    - Medicaid expects that all facilities have a rate that is available for the self-pay client. This self-pay rate may be greater than what Medicaid reimburses, but must be a legitimate rate. The rate can be subject to a sliding fee scale for clients who are of limited means.
    - This rate, as it is applied, during a spend-down, should help with the re-activation of Medicaid.

6) **According to the draft of the rate time line, reimbursement rates will be adjusted and grants will be reduced accordingly. How will provider payments be adjusted to make up for COLA's, inflation and any other adjustments not connected to the provider rates?**
    a. The grant component of a provider's revenues may be adjusted for COLA. The Medicaid rate will factor in changes in time spent and changes in the cost of care. Any change in program cost in a given year will be reflected in the rates derived from the audited cost reports for the year in question. This rate increase would not happen until year 2 after the cost report.
    b. This payment issue still must reflect the cost neutrality of this program until otherwise specified by OPM.

7) **What can agencies do about clients who are able, but unwilling to participate in the groups provided by the programs? How does DMHAS recommend that these clients are discharged when there does not appear to be anywhere for them to go due to the gridlock of the system? Without timely discharges coordinated by DMHAS or other case management providers, the MHGHs may be extremely financially vulnerable.**
    a. We do not expect that these clients would be discharged. We expect that there would be a review of the treatment/recovery plan with the clinical provider and that the goals be adjusted to better reflect what the client needs.
    b. The expectation is that there will be a case conference with a team or a review with the client and if necessary work to develop a new site with wrap-around services.