Residential Rehabilitation Under the Medicaid Rehabilitation Option
Frequently Asked Questions
As of 12/17/04

ABOUT THE MEDICAID PSYCHIATRIC REHABILITATION OPTION

1. What is the Medicaid Rehab Option?

A state's Medicaid program must offer medical assistance for certain basic services such as inpatient hospital, outpatient hospital, laboratory and x-ray, physicians' and dentists' services, home health services and pregnancy related services. The state and the federal government share the cost of these mandatory services. States may also receive Federal matching funds to provide certain *optional* services such as freestanding clinic services. When the federal government approves a state to provide optional services it agrees to pay a portion of the expenditures, thereby relieving some of the burden on the state. Psychiatric rehabilitative services are an optional service.

The Psychiatric Rehab Option defines services to populations that require rehabilitation, rather than cure. Psychiatric Rehabilitation services covered under the option usually are community-based, and build extensively on principles of recovery and on enhancing a client's ability to use natural resources. While there are many services that can be included under the Psychiatric Rehabilitation Option, Connecticut is currently only approved to offer Residential Rehabilitation Services in Mental Health Group Homes as a rehab option services.

2. Who is responsible for oversight of the Rehab Option?

The Department of Social Services (DSS) is the single state agency responsible for the oversight of all Medicaid services including rehabilitative services provided in mental health group homes. DMHAS and its designees will provide support and technical assistance, and will monitor all activities associated with rehabilitative services provided by mental health group homes at local and regional levels to assure the successful implementation of this initiative. LMHAs will provide oversight within the CA/regional service systems.

3. How will the Rehabilitation Option affect the funding of mental health group homes?

Group homes will receive funding from at least two sources: direct Medicaid fees and DMAHS grant funds. Current grant funds will be reduced proportionate to expected Medicaid billing. DMHAS will work carefully to determine grant adjustments to ensure that agencies maintain sufficient fiscal resources to operate successfully. Each group home provider will receive specific information about their grant funding adjustments.

4. Why are DSS and DMHAS doing this?

Implementing the Medicaid Rehabilitation Option allows Connecticut to benefit in two distinct ways. First, the Rehabilitation Option reinforces the kinds of practice changes that are necessary to fully apply a Recovery Model of Care. Secondly, the Rehab Option brings Connecticut an investment of federal dollars. The Mental Health Strategy Board has been tasked by the Legislature to reinvest these federal dollars into services that will directly benefit recipients of Medicaid-reimbursed psychiatric services.

5. What is necessary for our agency/program to participate?

The provider must meet the enrollment criteria developed by the Connecticut's Medicaid agency (the Department of Social Services) for residential rehabilitation services in a mental health group home. The Medicaid State Plan requires that group homes be licensed by the Department of Public Health and certified by the DMHAS as providers. The provider must

also agree to abide by the state and federal regulations pertinent to the provision of rehabilitation services. The provider must bill the Department of Social Services' fiscal agent for the services provided and cooperate in such processes as rate setting and auditing.

6. Where can we find copies of the State Plan amendment?
Links to the state plan amendment and the corresponding regulations will be posted on the DMHAS website under the Rehabilitation Option section.

7. How do we get certified by DMHAS as a provider of residential rehabilitation in mental health group homes?
DMHAS has granted provisional certification to all existing mental health group homes as of January 1, 2005. In the spring of 2005, DMHAS will publish the requirements and process for ongoing certification as a provider of residential rehabilitation services in a mental health group home.

8. *How does the Rehabilitation Option Relate to the Recovery Initiative?*
The Psychiatric Rehabilitation Option is built explicitly on principles of rehabilitation and recovery. The Recovery Initiative and Residential Rehabilitation in a group home will complement and enhance each other.

CLIENT ELIGIBILITY AND MEDICAL NECESSITY

9. Which clients are eligible for these services?
All people enrolled in the Medicaid program who meet medical necessity criteria for rehabilitation services in a mental health group home and who are residing in a mental health group are eligible to receive those rehabilitation services.

10. What is medical necessity?
Under the rehabilitation option, medical necessity means that services are required by a client to assist them in overcoming the effects of their psychiatric illness. It assumes certain factors:

- **A primary psychiatric diagnosis and level of functioning as outlined for a specific level of care**
- **The diagnosis and the treatment plan that specifies the services necessary services are developed and overseen by licensed practitioners of the healing arts. In Connecticut, licensed practitioners of the healing arts include psychiatrists, licensed psychologists, licensed clinical social workers, and advanced practice registered nurses.**
- **That the intensity and duration of any interventions delivered are sufficient to be effective.**

11. Who determines medical necessity?
Medical necessity if determined at several levels within the Connecticut system. The primary responsibility for determining medical necessity is borne by the service delivery system – the LMHA and the group home. At the LMHA level, a diagnostic assessment signed by a licensed practitioner of the healing arts determines that a client meets psychiatric and diagnostic criteria and can benefit from a particular level of care. The LMHA Master Treatment Plan based on that assessment then "orders" the services that a client needs to assist in meeting the goals. If the LMHA Master Treatment Plan specifies that a client meets the admission criteria for a mental health group home AND needs a minimum of 40 hours per month of residential rehabilitation services, the first vital links in establishing medical necessity have been met.

DSS or its agent also conducts a medical necessity review as part of its prior authorization and continued authorization procedures to determine that the service is medically necessary according to the Department's criteria.

The group home staff continue to establish and meet medical necessity by working with the client to develop a residential rehabilitation plan that is directly related to the goals on the Master Treatment Plan, and that the interventions to assist the client in meeting the goals and objectives of both plans are of a sufficient duration and intensity to be effective.

12. How often is medical necessity reviewed?
For residential rehabilitation services in a mental health group home, medical necessity is reviewed every 90 days by the LMHA Master Treatment Plan Review and Update, and by the updating of the Residential Rehabilitation Plan.

DSS or its agent will re-authorize this level of care at intervals determined by them, but at least annually.

13. How long will it take to get authorization from DSS once Rehab Option eligibility has been established?

Authorization from the Department of Social Services must be obtained prior to admission. Authorization for continued stay must be obtained prior to the expiration of the previous authorization. Requests for authorization should be submitted approximately two weeks in advance of the begin date requested to permit the DSS review to be completed.

14. Must all residents in the Group Home be on the Rehab Option?

No, some people may qualify for rehabilitation services in a group home setting, but the services that they receive may not qualify for coverage under Medicaid, either because they are not enrolled in Medicaid OR because they do not receive the minimum number of documented rehabilitative service hours to qualify for the monthly payment.

15. On January 1, 2005, how will we know which clients who are already in mental health group homes will be eligible for residential rehabilitation services?
Prior to January 1, 2005, each LMHA will ensure that current Medicaid-eligible group home residents have a current diagnostic assessment and a Master Treatment Plan built on that assessment.

Because current residents may not have received rehabilitation services prior to January 1, 2005, all current residents who otherwise meet medical necessity requirements will be considered as able to benefit from residential rehabilitation services. Their ability to benefit from these services will be re-evaluated at the 90-day Master Treatment Plan Reviews and Residential Rehabilitation Plan Updates.

16. If current residents do not meet Medical Necessity requirements, will they have to leave the group home?
No current residents will have to leave the group home during this implementation.

17. Why do we need both a LMHA Master Treatment Plan and Residential Rehabilitation Plan?
The LMHA Master Treatment Plan establishes medical necessity by linking the client's diagnosis, problem list, and goals to specific services that are considered to be medically necessary to assist the client in eventually meeting those goals and objectives. It "orders" the service of residential rehabilitation services in a mental health group home.

The Residential Rehabilitation Plan builds on the goals and objectives contained in the LMHA Master Treatment Plan, making them into specific, achievable, prioritized 90-dayobjectives for the client. It becomes the driving force behind all residential rehabilitation interventions with the client.

18. What does show "progress mean"?

In order to maintain medical necessity, a client must be able to benefit from the residential rehabilitation received in the group home. Benefits are usually measured through a client's progress toward the goals and objectives specified on the Master Treatment Plan and the Residential Rehabilitation Plan. Progress toward those goals and objectives can be in small increments.

19. Serious and persistent mental illness is cyclical by nature. If a client gets worse, does that mean that medical necessity is lost?

No. However, the provider must document -- through the encounter and progress notes at the Group Home, review and updating of treatment and residential rehabilitation plans, and through any diagnostic assessments – that the client has regressed or relapsed, and that the plans and interventions have been modified to assist the client in regaining their optimal level of functioning. For some clients in acute phases of their illness or during crises, the plan and interventions may be geared to maintaining their current level of functioning until such time as they might move forward again.

20. What will be the process for determining that a client no longer meets rehabilitation guidelines? How will payment be handled?

For implementation, all clients currently in group home will be assumed to be able to benefit from rehabilitative services.

WHAT IS INCLUDED IN AS RESIDENTIAL REHABILITATION?

21. What kinds of interventions are included as residential rehabilitation in a mental health group home?

Residential rehabilitation services are designed to help clients who have functional disabilities secondary to serious and persistent mental illness achieve maximum functioning in self-care and independent living. Covered services include:

- **assessment and treatment planning,**
- **supportive counseling,**
- **behavior management training and interventions,**
- **psycho education groups,**
- **teaching, coaching and assisting with daily living and self-care skills (such as the use of transportation, meal planning, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication, teaching of recovery skills in order to prevent relapse, teaching of medication management, health education, etc. Other services may be covered under the rehabilitation option if they are rehabilitative in nature and if the Connecticut Medicaid State Plan is amended to allow for their coverage.**

22. How much service must be provided?

Clients must receive the amount of services required by their Residential Rehabilitation Plan. A minimum of forty (40) hours of rehabilitative service must be provided within a month for a unit of service to be billed. If the client is not in residence for the entire month, the number of hours required is prorated based on the number of days in residence.

23. What is a "day in residence"?
If the client is present at the group home at 12:01 a.m. on any given day, that day is considered as a day in residence for purposes of computing the minimal service hours required for billing.

24. Where can residential rehabilitation services occur?
Residential rehabilitative teaching and training can occur both within and outside the facility in community settings that enable the person to learn and use the skill *in vivo*. The setting must be appropriate to the intervention. Interventions must be provided by group home staff. Interventions must relate to specific goals and objectives on the Residential Rehabilitation Plan and all activities must be clearly and accurately documented in the client's record.

25. Can the LMHA or clinical provider deliver a group at a residence with a residential staff person co-facilitating and count that toward the rehab hours?
Yes, as long as one facilitator is a group home staff member.

26. What are the staffing requirements for providing residential rehabilitation services?
The mental health group home must be staffed in compliance with DPH licensing regulations. Staffing requirements specific to the Residential Rehabilitation Service Profile are:

- **The Facility Director will hold a bachelor's degree in a human service discipline and a minimum of three years experience in a mental health services related position. The Director or other manager will be accessible after-hours by telephone or pager to staff on duty.**
- **Direct service staff will hold either a bachelor's degree in a behavioral health related specialty or have two years experience in the provision of mental health services.**
- **All group home staff will be certified in First Aid and CPR.**
- **A licensed clinician (Doctor of Medicine or Osteopathy; Licensed Psychologist; Licensed Marriage & Family Therapist; Licensed Clinical Social Worker; Advanced Practice Registered Nurse, Registered Nurse with 1 year MH experience; or Licensed Professional Counselor) will provide clinical supervision and oversee the formulation of residential rehabilitation plans as evidenced by the clinician's signature on the plan (and plan updates) and on monthly progress notes.**

BILLING

27. How will mental health group homes bill for residential rehabilitation?
Group Homes will bill Medicaid directly through EDS each month for the rehabilitative services for all Medicaid-eligible participants who received at least 40 hours of documented residential rehabilitation that month, and who have a monthly progress note co-signed by a licensed clinician in their record.

28. What are the billing requirements?
The provider will submit one claim per month for each client that has been authorized by the Department of Social Services for this level of care and has received sufficient services to qualify for billing that month. Claims can be submitted electronically or on paper using the HCFA 1500 form. (Note: Claims received electronically are processed faster and payment will be received sooner).

29. How often must billing be done?

Billing *may* be done monthly for any person who has been authorized for admission to or continued receipt of residential rehabilitative services provided in a mental health group home.

30. For billing purposes, does it matter if an absence is excused or unexcused?
No. Billing is based on a monthly rate with a minimum number of service hours prorated for the days that a client is "in residence." Whether a client is out of residence for excused or unexcused reasons is not a consideration for billing.

31. How do we count the minimum 40 hours of rehabilitation services in order to bill?
For purposes of calculation, the 40 hours may be made up of 15-minute sub-units, using a rounding convention where any time between 8 and 22 minutes equals 15 minutes.