Sec. 17-134d-68. Requirements for monitoring psychiatric admissions to nursing homes

(a) **Scope**

(1) Medicaid is a program of "cooperative federalism" wherein federal financial participation is available for a percentage of the cost of medical assistance provided by a state under its Medicaid program. Under federal requirements, however, federal financial participation is not available for the cost of nursing facility services that are provided by facilities that are also considered to be institutions for mental diseases (IMDs) except for patients aged 65 and older. The purpose of these regulations is to establish requirements designed to prevent nursing homes which participate in the Medicaid program from being characterized as IMDs unless the IMD serves only patients aged 65 and older or unless the IMD is prepared to accept payment from some source other than Medicaid for all patients under 65 years of age. Specific remedies available to the Department under these regulations include the denial of authorization for the admission of psychiatric patients, the termination of Medicaid provider agreements, and the imposition of fiscal sanctions equal in amount to the loss of federal financial participation attributable to the facility's characterization as an IMD.

(b) **Definitions**, for purposes of this section, are as follows:

(1) "Department" unless otherwise specified, means the Department of Income Maintenance.

(2) "Facility" means a nursing home as defined in subsection (b) (5) below.

(3) Institution for mental disease (IMD), is defined as an institution which is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care and related services in accordance with 42 CFR 435.1009 as amended from time to time. Interpretive guidelines issued by the Health Care Financing Administration indicate that a final determination of a facility's status rests on a cumulative weighing of all applicable guidelines and that a key criterion is the presence in the facility of 50% or more patients with a disability in mental functioning.

(4) "Mental disorder" means a mental disease as defined in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) with the exception of mental retardation, senile dementias (including Alzheimer's disease) and organic brain syndromes. Specifically, nursing home placements primarily for ICD-9-CM diagnosis 295.0-309.9 and 312-314.9 are considered psychiatric placements. Alcoholism is not treated as a psychiatric condition except in the cases in which federal guidelines so direct.

(5) "Nursing Home" means any chronic and convalescent facility or any rest home with nursing supervision, as defined by Section 19a-521 of the general statutes, which has a provider agreement with the Department of Income Maintenance to provide services to recipients of medical assistance pursuant to Part IV of Chapter 302 of the General Statutes of Connecticut and to accept reimbursement for the cost of such services pursuant to said program, or which receives payment from the state for rendering care to indigent persons. For purposes of this regulation only, intermediate care facilities for the retarded are specifically excluded from this definition.

(6) "Patient Review Team" means the unit of the Department of Income Maintenance

which is responsible for completing inspections of care in nursing homes in accordance with the requirements of federal law.

(7) "Provider" means a nursing home as defined in subsection (b)(5) above or the designated representative(s) of the facility.

(8) "Psychiatric patient" means a patient whose primary reason for institutionalization is a mental disorder as defined in subsection (b) (4) above. For purposes of residence in the nursing home, a patient admitted primarily for non-psychiatric reasons and who also has a psychiatric condition that is stable will not be considered a psychiatric patient. If the condition changes such that the primary reason for continued institutionalization falls inside the diagnoses specified above as mental disorders, the patient will be considered a psychiatric patient. If the condition of the patient changes during residence in a nursing home such that the primary reason for continued institutionalization falls outside the diagnoses specified as mental disorders, the patient will no longer be considered a psychiatric patient for purposes of residence in the nursing home.

(c) **Remedies**

(1) In order to assure that a facility which participates in the Medicaid program does not operate as an institution for mental diseases, the Department is authorized to impose any combination of the following remedies:

(A) require the facility to submit a plan of correction;

(B) require the facility to receive prior authorization for new admissions of psychiatric patients who are or will be eligible for Medicaid;

(C) refuse payment to the facility for new psychiatric admissions or newly eligible psychiatric patients;

(D) terminate the provider agreement; and

(E) recover the amount of all federal disallowances from the facility by recoupment from current Medicaid payment to the facility as per Regulations of Connecticut State Agencies, Section 17-311-53 or by bringing any appropriate legal action against the facility.

(2) Whenever a federal disallowance is made as a result of a facility being determined to be an institution for mental diseases, the facility shall be deemed to be indebted to the Department in the amount of such disallowances unless such penalties are waived under the terms in subsection (f) (5).

(3) Nothing herein shall authorize the Department to impose sanctions against facilities on the basis of these regulations for services delivered prior to the effective date of these regulations.

(d) **Procedures**

The following procedures will be instituted in order to assure that nursing homes which participate in the Medicaid program do not operate as institutions for mental disease:

(1) The Department of Income Maintenance will identify facilities which are at risk of classification as institutions for mental disease.

(A) Determination that a facility is "at risk" of classification as an institution for mental disease does not mean that the facility is, in fact, an IMD as defined above. Rather, the "at risk" determination is an early warning signal designed to allow the Department and the facility to initiate advanced corrective measures to avoid endangering future federal financial participation.

(B) Criteria which shall be considered in making a determination that a facility is at risk of IMD classification may include any of the following:

(i) The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;

(ii) The facility is accredited as a psychiatric facility by the Joint Commission on Accreditation of Hospitals;

(iii) The facility specializes in providing psychiatric care and treatment;

(iv) The facility is under the jurisdiction of the Connecticut Department of Mental Health;

(v) More than 40% of the facility's Medicaid patients are psychiatric patients as defined in subsection (b) (8) above;

(vi) More than 40% of the patients in the facility have been transferred from a state mental institution for continuing treatment of their mental disorders;

(vii) The average age in the facility is significantly lower than that of a typical nursing home;

(C) Information which will be used in making the determination that a facility is at risk of IMD classification includes but is not limited to:

(i) Primary diagnoses as reported on billing documents submitted to the Department by the facility;

(ii) Information about the primary reason for institutionalization as collected by the Patient Review Team from the facility's medical records; and

(iii) Statistics on discharges provided by the Department of Mental Health.

(2) Any facility which meets the criteria listed in subsection (d) (1) (B) above may be determined to be at risk of IMD classification. The Department of Income Maintenance shall notify each facility in writing that has been determined to be at risk of IMD classification that the facility:

(A) is considered at risk of classification as an institution for mental diseases;

(B) must receive prior authorization from the Department prior to the admission of Title XIX psychiatric patients or psychiatric patients with a Title XIX application pending;

(C) will normally not receive prior authorization for Medicaid payment for new psychiatric admissions or newly eligible psychiatric patients until the Medicaid psychiatric population is below 45% of the total Medicaid patient population or until the total psychiatric population is below 50% of the facility's total census;

(D) must submit an acceptable plan of correction as a condition of continued participation in the Medicaid program; and

(E) will be held responsible for any federal financial penalties imposed on the Department because of the failure of the facility to comply with federal requirements.

(3) Although the Department will provide guidance through this monitoring effort, the burden of responsibility shall rest with the facility to assure that it is in compliance with federal regulations and interpretive guidelines issued by Health Care Financing Administration in relation to its total patient census.

(4) The Department may, at its discretion, terminate the provider agreement for failure to comply with these regulations.

(e) **Plan of Correction**

(1) A facility which is determined to be at risk of being classified as an IMD must submit an acceptable plan of correction to the Department. The plan of correction must:

(A) be submitted in writing to the Department within thirty (30) days from the issuance of notice by the Department;

(B) include steps which have been taken and/or steps which shall be taken in order to assure that the facility will be in compliance with this regulation and applicable federal requirements;

(C) include a timetable which outlines the deadlines for each step;

(D) establish a procedure for internal evaluation to assure that the plan of correction will be implemented properly; and

(E) be approved by the Department.

(2) Among the options available to the facility in order to continue participating in the Medicaid program, are the following steps as appropriate depending upon the circumstances of the facility:

(A) Gradually decrease the percentage of psychiatric patients through attrition;

(B) Develop plans for orderly transfer of psychiatric patients; or

(C) Request reclassification of the facility or a unit within the facility as an institution for mental diseases with Title XIX reimbursement available only for persons aged sixty-five (65) and older.

(f) **Effective Date of Adverse Action**

(1) Adverse action taken by the Department shall be effective on the eleventh (11th) day following the issuance of notice by the Department provided that the facility has not perfected a timely appeal.

(2) The provider shall have the opportunity to appeal provided that the appeal is received in writing by the Commissioner of Income Maintenance on or before the tenth (10th) day following the issuance of notice by the Department. If such appeal is filed, the adverse action shall be effective on the date the decision is reached.

(3) Regardless of whether an appeal has been filed, the provider shall submit a plan of correction within thirty (30) days following the issuance of notice by the Department.

(4) Computation of time in subsections (f) (1) and (f) (2) above and in subsection (g) (1) below shall be subject to the exclusion of weekends and holidays to the extent that they are excluded in Section 17-311-15 of the Regulations of Connecticut State Agencies, as amended from time to time.

(5) The Department may waive the imposition of remedies against a facility which has submitted an approved plan of correction and which has demonstrated good faith in attempting to implement the terms of the plan of correction, but which has been prevented from compliance due to conditions out of its control.

(g) **Appeals**

(1) Appeals Process for Providers

The provider may appeal a decision of the Department in accordance with Section 17-311-27 through 17-311-40 of the Regulations of Connecticut State Agencies, provided that the appeal is received on or before the tenth (10th) day after the issuance of notice by the Department. The following actions may be appealed:

(A) determination that the facility is at risk of classification as an IMD;

(B) imposition of fiscal sanctions against the facility; or

(C) termination of the provider agreement.

(2) Appeals Process for Recipients

The recipient may appeal the following actions by the Department:

(A) classification as a psychiatric patient in accordance with the definition above;

(B) abuse of discretion in denying prior authorization to the facility determined to be at risk of IMD classification; or

(C) determination to suspend, reduce or discontinue assistance.

(h) Admission policies which limit admissions of psychiatric patients to nursing homes which have been determined to be at risk of classification as institutions for mental diseases under the terms of these regulations shall not be deemed or considered in violation of Section 19a-533 of the General Statutes of Connecticut (the "waiting list" statute) provided that:

(1) the admission policy was fairly and consistently applied to all applicants for admission, irrespective of the source of payments for each applicant;

(2) the intent of the admission policy is not to discriminate against indigent applicants and that the policy, fairly and consistently applied, has not had the effect of discriminating against such applicants by denying admission to a disproportionate number of such applicants.

(Effective February 3, 1989)