MEMORANDUM

TO: Individuals Interested in the Proposed Regulation – "Requirements for Payment of Services Provided Under the Behavioral Health Partnership" §§17a-22a-1 to 17a-22a-16, inclusive, of the Regulations of Connecticut State Agencies

From: Michael P. Starkowski, Commissioner, Department of Social Services and Susan I. Hamilton, Commissioner, Department of Children and Families

RE: The Department of Social Services Response to Comments on the Proposed Regulation

Date: August 31, 2010

Response to Comments

A. Comments submitted by Rep. Peggy Sayers and Jeffrey Walter, Co-chairs, CTBHP Oversight Council

1) Comment: The Behavioral Health Partnership Oversight Council is referred to as the "committee" in several places, beginning with the definition (item #9 on page 2). Please change it to "Council."

   Response: The requested revisions have been made.

2) Comment: Section 17a-22a-12(b): The 60 day timely filing requirement for denials contradicts Provider Bulletin 2007-36, sent to providers in May of 2007, which extended that requirement to 120 days. This section should be corrected to reflect that change.

   Response: The requested revision has been made.

3) Comment: We would also request that the Department add the Council to the legislative Committees of Cognizance distribution list for state agency proposed regulations that affect the Behavioral Health Partnership populations. We understand that the Department is not obligated by statute to do. However, the Council and its subcommittees provide a forum for discussing and resolving potential issues with regard to policies and regulations for the Behavioral Health Partnership. Cooperation between the Partnership departments and the Oversight Council has been the hallmark of the program since its inception.

Response: The Department will provide a copy of any correspondence to the Legislative Regulatory Review Committee regarding the publication or submission of the related regulations to the Council as requested.

B. Comments submitted Jeffrey Walter, Co-chair, CTBHP Oversight Council

1) Comment: I am curious to understand the rationale for requiring BHP rates to not exceed Medicare in all cases (22a-13(g))? Is this a CMS rule governing state Medicaid plans? If not, does DSS have this policy in regulations governing other parts of the state Medicaid program (e.g., nursing homes, home health, HUSKY?)

Response: Federal Medicaid law establishes Medicare as the basis for determining the upper payment limit under Medicaid for various provider types such as hospitals and freestanding clinics. The Medicare upper limit requirement does not apply to some areas of Medicaid coverage such as physician services. However, federal law does require that Medicaid rates be "economic and efficient." By establishing Medicare as the upper limit for all services payable under the Behavioral Health Partnership (BHP), at least in those areas priced by Medicare, we ensure economy and efficiency without having to conduct analyses to demonstrate economy and efficiency.

C. Comments submitted Kimberly Skehan, RN, MSN; Vice President for Clinical & Regulatory Services The Connecticut Association for Home Care, Inc.

1) Comment: From what I can see, these regulations define to authorization and case management responsibilities of the ASO. I am trying to determine the impact these regulations have on home care providers, and how they relate to the nursing/medication administration and HHA guidelines that were approved by the BHP Oversight Council. It looks as though these do not have a current impact on home care providers, but I am guessing that this is the process (or similar process) which will be implemented once the home care guidelines are implemented. Could you please clarify for me the impact these new regulations have on home care providers? And have the providers been notified of these new processes? I just want to make sure that I understand it so that I can provide members with accurate information.

Response: The CT BHP regulations articulate the policy and procedures that have been in place since the program transition to CT BHP on January 1, 2006. The Department of Social Services (DSS) has not yet implemented prior authorization for home health under CT BHP due to system limitations. When DSS and the Department of Children and Families (the Departments) introduce prior authorization for home health under BHP, it would be in accordance with the BHP regulation. The BHP regulation has no bearing on management of home health agency services under Medicaid Fee For Service (FFS).

D. Comments submitted by Sharon D. Langer, M.Ed., J.D. Senior Policy Fellow and Mary Alice Lee, Ph.D. Senior Policy Fellow, representing Connecticut Voices For Children

1) Comment: While we applaud the DSS for issuing the regulations and for the collaboration of both departments with the many interested parties in implementing the BHP, we are disappointed that the regulations were not presented or discussed at recent meetings of either Council, in order to give the wide-array of stakeholders an opportunity to provide input on the regulations before they were formally promulgated. In this way, perhaps many of the questions and concerns listed below (and those of others) could have been addressed upfront. This approach is particularly important where proposed regulations, such as those of the BHP, are actually implemented prior to finalization. As you know, these regulations became effective November 1, 2007.

   Response: The Department had an obligation to promulgate regulations as near to the date of program implementation as possible. This provided limited opportunity to undertake a more inclusive and potentially lengthy public discussion prior to publication. Moreover, the Departments recognized that, once published, there would be a formal process for recognizing public input. This public input can be the basis for amending a draft regulation prior to promulgation through policy transmittal, as will be the case with the CT BHP regulation. In the future, the Departments will make an effort to solicit input through the BHP Oversight Council in advance of publication of regulations that directly affect BHP covered services. We recognize that the BHP Oversight Council and its various subcommittees have been invaluable in helping to develop initiatives and review program changes prior to implementation.

2) Comment: We suggest that the regulations contain a clear explanation of the types of services and levels of care that may be provided to the program's beneficiaries, and the providers from whom they may receive care.

   Response: The types of services and levels of care available under the BHP are the same as those available under the Medicaid FFS program. Consequently, the Departments have elected in the BHP regulation to reference the Medicaid FFS regulations that establish covered provider types and services.

3) Comment: Nowhere does the BHP regulation address the three eligibility bands in HUSKY B, and whether the provision of services differs depending on which income band a child is in. These regulations should be reviewed for consistency with the recently promulgated proposed HUSKY B regulations. As set forth below, we found some discrepancies in the use of terminology and incorrect eligibility criteria for the HUSKY program.

Response: The eligibility bands under HUSKY B are not referenced in the regulation because BHP coverage is uniform across eligibility bands.

4) Comment: In addition, the regulations will likely need to be revised in light of the Governor's recently announced changes in responsibilities of the managed care organizations (MCOs).

Response: The definition of MCO has been revised to remove reference to "comprehensive" and section 17a-22a-6 has been revised to remove reference to "pharmacy services."

5) Comment: **Section 17a-22a-1. Scope.** This introductory section doesn't explain sufficiently where a description of the services covered is set forth. The regulation should provide such an explanation of the range of services covered for HUSKY A and B enrollees, as well as those eligible for the "Limited Benefit Program". At a minimum, the reference to the "contract between the Administrative Services Organization and the departments" and the regulations related to specific types of providers should include an explanation of where this information can be found on the web or whom to contact to obtain a hard copy of the referenced information.

Response: The covered services are limited to those specified in the program specific state plans and the various Medicaid regulations specific to each category of services. It is unnecessary and inefficient to duplicate the covered services provisions that are otherwise set forth in each Medicaid regulation applicable to the various Medicaid categories of service (e.g., home health, hospital, physician, APRN, etc.). The services covered under the BHP are essentially those Medicaid services for the treatment of psychiatric and substance abuse disorders, except where such services have been carved out. These exceptions are summarized in general terms. A reference to the website where covered services are posted has been provided in section 17a-22a-5(f).

6) Comment: **Section 17a-22a-2 Definitions.** (3) "Adult" means a person 18 years of age or older; (12) "Children" means individuals under eighteen (18) years of age. These definitions are incorrect as to the HUSKY program. Under HUSKY, whether a person is treated as an "adult" depends on which "coverage group" a person is assigned to for purposes of eligibility. In HUSKY A (Medicaid), a person under the age of 21 may be treated as a "child". In HUSKY B, a "child" is under the age of 19. Adults are not eligible for HUSKY B.

Response: The commenter is correct that the definition of adult and child tends to vary by program and purpose. That said, the definition offered is for the purpose of the BHP and in the interest of distinguishing individuals who are likely to use the child service system versus the adult service system. In general, providers licensed by Department of Children and Families (DCF) or funded through DCF grants serve children under 18 and providers licensed by the Department of Public

Health (DPH) or contracted with the Department of Mental Health and Addiction Services (DMHAS) tend to provide services to individuals no younger than 18 and over, though there are exceptions (e.g., adult emergency departments). The age limits established in this regulation have no bearing on eligibility for a program such as HUSKY B, or rights to additional services that may be conferred through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Consequently, we have left the definitions unchanged in the proposed regulation.

7) Comment: (7) This paragraph defines the term "BHP" and references who may be eligible for services under the BHP to include "other children, adolescents and families served by DCF;" It would be helpful to explain or provide an example of which persons may be included in this catch-all category of "other children. . . served by DCF".

Response: The Departments believe that the legislature's intent in section 17a-22a of the Connecticut General Statutes was to provide the agencies with some flexibility in extending BHP coverage to individuals who might be served by DCF, but who would otherwise be ineligible for BHP services. At this time, the program is limited to children who are involved with DCF through child welfare, juvenile justice or voluntary services, but who do not qualify for HUSKY A or HUSKY B. Moreover the services available to such individuals under the Limited Benefit Program are currently limited to one model of home-based service. The language proposed in regulation will allow the Departments to further and incrementally extend coverage under the Limited Benefit Program in the interest of achieving a more fully integrated system.

8) Comment: (8) "Behavioral health services" means health care that is necessary to diagnose, correct or diminish the adverse effects of a psychiatric or substance related disorder: This definition is not consistent with the definition of medical necessity found elsewhere in this regulation. In addition, there is no definition of "substance-related disorder", leaving us to ask whether "tobacco dependence", a serious substance addiction of youth, will be included. We therefore suggest the following changes to this paragraph:

> "Behavioral health services" means health care that is necessary to diagnose, correct, or diminish the adverse effects of a psychiatric or substance related disorder, or to prevent a condition from reoccurring, including tobacco dependence, in order to attain or maintain optimal health"

Response: The Departments appreciate the concern that this definition may conflict with the definition of medical necessity. Consequently, we have amended the definition to simply read: "Behavioral health services" means health care services for psychiatric or substance abuse disorders." Tobacco dependence and the treatment thereof are not appropriate to include in the definition because it

is an issue of coverage. Specific coverage decisions are based on the definitions of medical necessity, BHP level of care guidelines, the fee schedules that establish coverage for specific health care procedures, and the medications covered under the pharmacy program.

9) Comment: (11) "Certificate of Need" definition. Is this definition used interchangeably with "concurrent review" or other similar terms? It would be best to use one term consistently to reduce confusion.

   Response: The use of the term "certificate of need" admittedly introduces some confusion. It is a federal term specific to hospital inpatient care and eligibility for reimbursement for hospital inpatient care under Medicaid. We use this regulation to align the certification of need process, to the extent possible, with the authorization process. This reduces the need for duplicative or overlapping administrative processes for establishing the need for hospital inpatient care. The term authorization applies to most providers and services and it is used consistently across providers and services under the BHP.

10) Comment: (13) "Clinical management" definition. (14) "Clinical Management Committee" definition. This paragraph does not explain who will provide clinical management. If it is the "clinical management committee" then it should be referenced in paragraph (13). Paragraph (14) should spell out the membership of the Committee as well as citing to the state statute that authorizes the Committee.

    Response: Clinical management is provided by the ASO. The Departments recognize the concern raised by the commenter and have amended the definitions for administrative service organization and clinical management to address this concern. The definition of Clinical Management Committee has been amended to including the membership as cited in the statute.

11) Comment: (15) "Commissioner" means the commissioner of the Department of Social Services or the commissioner's agent:" It is unclear why there is a reference to the "Commissioner" of DSS and not to DCF's since both Commissioners oversee the Partnership. Either this paragraph should be eliminated or it should also include a reference to DCF's Commissioner.

    Response: The definition of Commissioner has been eliminated.

12) Comment: (17) "Complex behavioral health service needs" definition. This definition should take into account the co-morbidity of physical needs and/or the need for primary care management. We suggest the following changes: "Complex behavioral health service needs". . . .that require specialized, coordinated physical and/or behavioral health services across several services, for example, school, mental health, and court systems;

Response: The Departments have revised the definition to read, "Complex behavioral health service needs" means behavioral health needs that require specialized, coordinated care across several service systems, for example; medical, school, mental health and court.

13) Comment: (22) Defines EPSDT by referencing the federal statute. This definition should include a citation to or insertion of the language from the following Connecticut state statute that requires the EPSDT program to conform to the federal EPSDT statutes in effect, as of December 31, 2005: The Commissioner of Social Services shall provide Early and Periodic Screening, Diagnostic and Treatment program services, as required and defined as of December 31, 2005, by 42 USC 1396a(a)(43), 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal regulations, to all persons who are under the age of twenty-one and otherwise eligible for medical assistance under this section. [Gen. Statute, Sec. 17b-261(j)].

Response: The requested reference to section, correctly cited as 17b-261(i) of the Connecticut General Statutes, has been added.

14) Comment: (24) "HUSKY A" definition. (25) "HUSKY B" definition. These two definitions should be consistent, and also reference the popular names of the federal programs that help fund HUSKY. To that end we suggest the following changes:

> (24) "HUSKY A" means the [Connecticut] federally subsidized program of managed care health care authorized by Title XIX of the Social Security Act (Medicaid) and operated pursuant to section 17b-266(b) of the Connecticut General Statutes;
>
> (25) "HUSKY B" means the federally subsidized program. . . [established pursuant to] authorized by Title XXI of the Social Security Act (State Children's Health Insurance Program (SCHIP)) and operated pursuant to sections 17b-289 to 17b-303, inclusive, of the Connecticut General Statutes;

Response: The requested revisions have been made.

15) Comment: (26) "Intensive care management" definition. This definition should include reference to intensive care management of co-morbid conditions since often those with "complex behavioral services needs" also have co-morbid physical conditions.

Response: The language of the regulation has been revised to address this concern.

16) Comment: (27) "Limited Benefit Program" definition. This definition should include a definition of "limited coverage" or cross-reference where this term is defined. Again, the reader is left wondering who would be eligible for the "limited benefit program". Are these families who have exhausted private employer sponsored coverage? Under what circumstances would families be eligible? This needs to be spelled out some where in the regulation.

Response: There is no restriction with regard to who is eligible beyond the statement that "children and families involved with DCF who have complex behavioral health service needs, as determined by DCF, and who are not otherwise eligible for HUSKY A or HUSKY B." Coverage is established in section 17a-22a-5(c) of the proposed regulations.

17) Comment: (28) "Managed care organization" or "MCO" definition. This definition should be consistent with the definition provided in the recently published proposed HUSKY B regulation. The HUSKY B regulation uses the term Managed Care Program (MCP). It is not clear why the term MCP was chosen over MCO, the more common acronym. In addition, nowhere does the BHP regulation address the three eligibility bands in HUSKY B, and whether the provision of services differs depending on which income band a child is in.

Response: The Departments acknowledge that there is inconsistency among state statutes, regulations, and contracts with regard to the various terms for DSS's managed care contractors. The state statutes authorizing HUSKY A use descriptive language rather than the term "managed care organization" or other similar terms. The federal managed care regulations use the term "managed care organization" for pre-paid health plans and "managed care entity" when including other arrangements such as primary care case management. The state children's health insurance plan uses the term "managed care entity" and makes no reference to "managed care organization." However, there is a HUSKY B statutory definition of "managed care plan," which is "a plan offered by an entity that contracts with the department to provide benefits to the entity on a prepaid basis." Conn. Gen. Stat. §17b-290(17). In the end we decided to use the term "managed care organization" because the current contract (used by DSS for HUSKY A, HUSKY B and Charter Oak) defines "Managed Care Organization or Contractor" as "the managed care plan signing this agreement /contract with the Department."

The eligibility bands under HUSKY B are not referenced in the regulation because BHP coverage is uniform across eligibility bands.

18) Comment: (33) "Member services" definition. Nowhere does the definition include the provision of "scheduling assistance", i.e., help with scheduling appointments for behavioral health services, or the affirmative obligation to inform members of the full range of services available to them under the BHP. These obligations should be included in this paragraph, as follows: (33) "Member services" means administrative services provided by ASO staff, such as: assisting

members with selection of providers, informing members of the services available to them, answering members' questions, providing information on how to access services, assisting with scheduling appointments, responding to complaints and resolving problems informally;

Response: The requested revision has been made.

19) Comment: (34) "Notice of Action" definition. This definition is missing a reference to the HUSKY B program, therefore, we suggest the following additional language: (34) "Notice of action" means a written notice that informs a HUSKY A, HUSKY B or Limited Benefit Program member of a denial, partial denial, termination, suspension or reduction of a covered good or service;

Response: HUSKY B members receive a Denial Notice rather than a Notice of Action. Neither term is used in the regulation (apart from the definition), so the definition of Notice of Action has been eliminated.

20) Comment: (37) "Provider services" definition. The ASO's responsibilities vis a vis providers should include the development of measures to monitor access to services and utilization of care. Such responsibilities would include monitoring the quality of care received by members and the adequacy of the provider networks.

"Provider services" means ASO responsibilities to develop measures for monitoring the access to services by members and utilization of care. The ASO will monitor the quality of care received by members, ensure adequate provider networks, [and] enhance provider relations with the community of providers, and ensure proper handling of provider claims;

Response: The responsibilities identified above are better defined in section 17a-22a-4(g) of the Regulations of Connecticut State Agencies, and are generally not considered provider services. The provider services definition has been revised to better parallel the member services definition and eliminate and reference to network development activities. The ASO does not process claims so this function is not included in the provider services definition or as an ASO responsibility. Providers are instead referred to Hewlitt Packard ("HP," formerly Electronic Data Systems or "EDS") for assistance with claims processing issues.

21) Comment: (40) "Psychiatric residential treatment facility" definition. This paragraph is difficult to understand since it is written in the negative. It would be easier to comprehend if it could be written in the positive. We assume the definition is attempting to distinguish a residential treatment program from a psychiatric hospital for young people under the age of 21. At a minimum, we therefore suggest that the federal definition be set forth in the regulation as well as the CFR cite.

Response: The requested revision has been made.

22) Comment: (42) "Registration" definition. It is not clear from reading this paragraph who notifies the "departments of the initiation of a behavioral health service". Is it the ASO? the provider? The member? This paragraph needs some clarification.

Response: The requested revision has been made.

23) Comment: (43) "Residential Services" definition. This is an excellent definition of the term but needs to be expanded to include services provided to children and youth with "co-morbid" physical conditions. To that end, we suggest the following added language: (43) "Residential Services" means. . . for the purpose of effecting positive change and normal growth and development for children and youth with significant and complex physical and/or behavioral health services needs;

Response: The BHP and the ASO only have a role in the administration of residential services for children with complex behavioral health services needs. Consequently, the term is defined more narrowly for the purpose of this regulation although, the definition does not imply that children may not have co-occurring physical health needs. The proposed definition suggests that the BHP would have a role in the management of residential services for children who have only physical health needs.

24) Comment: (46) "Utilization management" definition. This definition doesn't explain who will be providing "utilization management". We assume that the ASO will assess through prospective (i.e., prior authorization?), retrospective or concurrent (i.e., certification of need?) assessment that the services meet the definition of medical necessity and appropriateness. The term "utilization management" is commonly understood to mean efforts to reduce health care costs by controlling the use of health care services through mechanisms, such as "prior authorization", "discharge planning" that affects length of stay in residential or hospital settings. We would hope that utilization management includes proactive measures on the part of the ASO to assist members in obtaining the services that they need.

Response: The ASO's responsibility for utilization management is established in section 17a-22a-4(e) of the Regulations of Connecticut State Agencies. Collectively, utilization management, intensive care management, and quality management (all ASO responsibilities) include the proactive measures to promote access and quality mentioned above.

25) Comment: **Section 17a-22a-3. Eligibility.** This paragraph explains that BHP services are available to clients in HUSKY A and B, as well as those enrolled in the Limited Benefit Program, "subject to the limits and conditions that apply to

the services available to each category. . ." There needs to be an explanation of what benefits are available to persons eligible for the Limited Benefit Program, as well as an explanation of the "limits and conditions that apply to the services available to each category" – or where the information about benefits and limitations can be found.

Response: The requested revision has been made. The regulation now references the section containing program specific limitations.

26) Comment: **Section 17a-22a-4. Administrative Services Organization** (b) The responsibilities of the ASO are described in detail in the contract between the ASO and the departments. If the contract between the ASO and the departments set forth additional or a more detailed description of the ASO's responsibilities then those contained in the regulation, this paragraph should so state. The full array of responsibilities of the ASO should be set forth in the regulation. At a minimum, the contract should be included in an appendix to the regulation, or the regulation should explain how to obtain a copy of the contract electronically or in hard copy.

Response: The regulation has been amended to explain how to obtain a copy of the contract.

27) Comment: (d) The ASO shall be responsible for quality management. . ." (1) member and provider satisfaction surveys; this paragraph doesn't explain how frequently the surveys will be disseminated and does not include a "secret shopper" survey mechanism to assist the ASO and departments in evaluating the adequacy and quality of the provider networks. We, therefore, suggest the following additions: . . . (1) member and provider annual surveys; (2) "secret shopper" annual surveys. . .

Response: The requested revision has been made.

28) Comment: (f) The ASO shall develop policies and procedures for the provision of intensive care management for individuals with complex health care needs. . . This section, like several others, references "complex health care needs" or "complex behavioral health care needs." The term should include complex physical and/or behavioral health needs and should be used consistently throughout the regulation. We assume that substance abuse is subsumed under behavioral and/or physical health needs in this context. We, therefore, suggest the following additional language in this paragraph: (f) . . . for individuals with complex physical and/or behavioral health care needs.

Response: The CT BHP was in part established to better serve HUSKY eligible individuals with complex behavioral health service needs. Consequently, the term is defined more narrowly for the purpose of this regulation. The regulation has been amended to ensure that the term is used consistently throughout. In addition,

the use of the term "complex health care needs" was eliminated from section 17a-22-4(f) since this term is not entirely consistent with the definition of intensive care management in section 17a-22a-2 and its use is unduly limiting as it relates to the qualifications for the provision of intensive care management services.

29) Comment: (g) The ASO shall assist the departments in developing, managing and maintaining a comprehensive network of providers . . . all of the goods and services reimbursable under the BHP program as outlined in the contract between the ASO and the departments. This paragraph, like others above, reference the contract between the ASO and the departments. The "goods and services reimbursable under the BHP program" should be inserted into this paragraph and/or the contract terms should be included in an appendix to the regulation.

Response: The Departments have eliminated the reference to the contract and instead references the covered goods and services as established in 17a-22a-5.

30) Comment: (i) The ASO shall manage member appeals. This paragraph doesn't comply with the requirements in HUSKY which are governed by state and federal Medicaid statutes and regulations, HUSKY B regulations, and should be in conformance with regulation 17a-22a-15 discussed below.

Response: State and federal Medicaid statutes and regulations do not preclude the administration of a member appeals process so long as it does not conflict with the member's access to the administrative hearings process administered by the Department.

31) Comment: (k) The ASO shall develop and maintain policies and procedures for the coordination of medical services with behavioral health services. . . This paragraph should state that the "ASO shall develop, maintain, and implement policies and procedures for the coordination of physical [services] and behavioral health services", in order to make clear that the ASO is responsible for making sure that the policies lead to actual coordination of care for those with co-morbid physical and behavioral health conditions.

Response: The requested revision has been made.

32) Comment: **Sec. 17a-22a-5. Services covered and limitations.** (a) and (b) These paragraphs explain that the BHP provides services to HUSKY A clients in conformance with federal and state Medicaid law and state plan. HUSKY B clients receive services as required by the state's SCHIP state plan, and the BHP also provides DCF funded services. The BHP is not responsible for Medicaid or SCHIP services provided by the MCOs, such as transportation or drug coverage. This regulation is difficult to decipher. The services covered should be set forth in the regulation. The only place in the regulation where there is a list of services available to clients is in the description of the Limited Benefit Program, in Sec.17a-22a-5(c).

Response: Please see response to D.5 above.

33) Comment: (e) for HUSKY A members, the Medicaid program shall pay for special services ordered pursuant to an EPSDT encounter. What does "special services" mean in this context? HUSKY A members are entitled to all medically necessary and appropriate health services, including behavioral health and substance abuse services.

Response: This provision has been revised to more closely reflect the language of the Social Security Act as follows: "For HUSKY A members, the Medicaid program shall pay such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate behavioral health conditions ordered pursuant to an EPSDT encounter, whether or not such services are covered under the Connecticut Medicaid State plan."

34) Comment: Paragraphs (f) and (g) explain that the departments are to pay for BHP services according to a fee schedule but then provides discretion for the departments to pay for services outside of the fee schedule. At first reading these two paragraphs appear to contradict one another and to inappropriately limit the services that may be covered, i.e., paid for by the BHP. Also, it is unclear whether paragraph (g) which limits additional services to those "within available appropriations" refers only to HUSKY B and/or the Limited Benefit Program. Under HUSKY A, individuals are entitled to all medically necessary services, and children are entitled to any medically necessary services determined by an EPSDT screen or encounter. Does the limitation refer to services, not normally covered under any of these programs, such as respite care? Paragraph (g) needs to be clarified and we suggest the following changes to paragraph (f): (f) The departments shall pay [only] for services that are listed on the Partnership fee schedule for the participating provider when medically necessary and appropriate;

Response: The regulation would allow the Departments to cover additional services that are not otherwise available under the HUSKY B or Limited Benefit Programs and services or supports that are not available under Medicaid (including EPSDT) because they do not meet the requirements of a health care service under 1905(a) of the Social Security Act.

35) Comment: **Section 17a-22a-6. Services not covered by the Partnership.** The HUSKY A and HUSKY B MCOs are responsible for the following services. (1) primary care services including, but not limited to: . . . (C) treatment of behavioral health disorders that can be safely and appropriately treated in a primary care setting. Who decides what "can be safely and appropriately treated in a primary care setting"? The MCOs? There needs to be safeguards set forth that prevent inappropriate referrals from the primary care setting in order to prevent unnecessary cost-shifting from the MCOs to the BHP program, and vice versa.

This speaks to the whole issue of how coordination of care is being instituted in order to ensure access to care in appropriate settings.

Response: The regulation is intended to establish a principle. Anything more specific would be inappropriate for a regulation and possibly contrary to the interests of our members. There is no definitive and immutable standard regarding the scope of primary vs. specialty care in any area of medicine. Physicians decide what disorders they can appropriately treat and these decisions will vary based on the training of the physician and the current understanding of the risks associated with various treatment options (e.g., SSRIs and the black box warning). The risk of cost-shifting exists, but the principle as established in regulation sets the stage for collaborative work in this area with primary care physicians, psychiatric providers and the managed care organizations.

36) Comment: (5) laboratory, radiology, and other ancillary services. What are "ancillary services" not covered by the BHP? Who pays for drug screens ordered by a BHP provider? Who pays for blood tests to determine the therapeutic levels of medications prescribed by behavioral health providers? Is this subsumed under "laboratory" services, and therefore payable by the MCOs?

Response: Drug screens and laboratory services such as those noted above are covered by the MCOs. A regulation is not the place to provide such coverage specificity. Instead, the Departments have established a detailed matrix of covered services specific to the full range of covered provider types and specialties and payable codes. This matrix is available at http://www.ctbhp.com/provider/Covered_Services_with_Fees.htm.

37) Comment: **Section 17a-22a-7. Critical access agreements.** The departments may negotiate and enter into critical care agreements to address critical care access issues including, but not limited to: . . .(5) provision of other support services, at the discretion of the departments within available appropriations, necessary for the success of a child with complex behavioral health service needs. We applaud the departments for providing "other support services." It would be useful to give examples of the type of services that may be provided. In addition, such discretionary services should be available to adults, as well as children, with complex needs. Finally, this paragraph should reference "complex *physical and/or* behavioral health service needs" in order to acknowledge that individuals may have co-morbid medical conditions. We therefore suggest the following modifications to paragraph (5): (5) provision of other support services, including but not limited to [give a couple of examples], at the discretion of the departments and within available appropriations, necessary for the success of a child or adult with complex physical and/or behavioral health service needs.

Response: The Departments have elected not to provide examples as doing so would essentially invite requests for such as examples as though they were covered services. The Departments are not prepared to extend 17a-22a-7(5) to

adults at this time. The CT BHP was in part established to better serve HUSKY eligible individuals with complex behavioral health service needs. Consequently, the term is defined more narrowly for the purpose of this regulation. This does not preclude the use of this option for a youngster with complex behavioral health and physical health needs.

38) Comment: **Section 17a-22a-8 Provider responsibilities.** (d) All Connecticut Medical Assistance Program (CMAP) enrolled providers shall comply with all medical services policies and regulations applicable to their respective provider types and specialties with respect to the provision of BHP covered services, including, but not limited to: This paragraph and the following paragraph (e) are difficult to understand given the wording and many citations to the DSS Medical Services Manual, and/or state regulations. Paragraph (d) should include an easy to read list of types of providers that can be reimbursed. And paragraph (e) should contain a plain English list of exceptions. Here is a suggested edit to the initial paragraph in (d). (d) All CMAP enrolled providers shall comply with all medical services policies and regulations as set forth in the DSS Medical Services Administration Manual and regulations applicable to their respective provider types and specialties with respect to the provision of BHP covered services, including, but not limited to:

Response: The Departments appreciate that the current language is not especially user friendly. However, the specific citations are in our opinion necessary for the sake of precision and completeness.

39) Comment: (h) General hospital providers . . . shall participate in the maintenance of a roster of available, psychiatric beds. . . This paragraph raises several practical questions. Who keeps this information? Who updates it? How will it be accessed? How will it be transmitted to ambulance drivers, and others? Do the MCOs have a role in the maintenance of this roster?

Response: The language of the regulation has been modified making participation optional, not mandatory.

40) Comment: (i) Effective July 1, 2007, licensed psychologists . . . enrolled independently or within a group, shall be required . . . to identify a medical professional who will provide psychiatric evaluation and medication management for members seen by the non-medical psychiatric practitioner. This paragraph only speaks in terms of "identification" of a "medical professional". There is no mention in this paragraph about how this relationship between a medical and nonmedical behavioral health provider will be effectuated – through written agreements? Referrals? Is co-management of the patient required?

Response: This requirement has been eliminated.

41) Comment: (j) Providers shall practice in accordance with clinical management guidelines developed and approved by the Clinical Management Committee. . . (2) The departments shall publish notice of changes in the clinical management guidelines on the BHP Web site at least thirty days prior to implementing such changes. It is unclear whether publication of changes to the clinical management guidelines "at least thirty days" in advance of instituting the changes provides sufficient lead time for providers, or whether such guidelines need to be promulgated as regulations since they affect the substantive rights to receive care. Also, there is nothing in this paragraph that tells providers that they will be directly notified of the changes. Will there be direct notification to providers (by email or other method) advising them to view the website for changes in the guidelines? We recommend that notice be given at least ninety days prior to the effective date of changes as follows: (2) The departments shall publish notice of changes in the clinical management guidelines on the BHP Web site at least [thirty] ninety (90) days prior to implementing such changes.

Response: Providers do not need to take any action to adjust to new guidelines and, in their comments; they raised no concerns about the 30 day timeframe. However, we have revised the regulation to specify that providers will be notified at least 60 days prior to implementing such changes.

42) Comment: (k) The departments may make exceptions to the requirements set forth in subsections (a) through (j) of this section for services that are not covered under HUSKY A, HUSKY B or the Limited Benefit Program. This appears to say that the departments have the discretion to pay for services that are not normally authorized under the three programs listed. If that is the case, the paragraph should state so, and broadly describe under what conditions such discretion may be exercised, and what types of services may fall into this exception. At a minimum, we suggest the following additional language to this paragraph: (k) The departments may make exceptions to the requirements set forth in subsections (a) through (j) of this section in order to pay for services that are not otherwise covered under HUSKY A, HUSKY B or the Limited Benefit Program. For example, . . .

Response: The Departments already reference such coverage exceptions in sections 17a-22a-5(h) and 17a-22a-7(5). The provision referenced above is simply intended to allow for exceptions to provider responsibilities in the case of coverage exceptions that might otherwise be the basis for audit findings and adjustments. The language in sections 17a-22a-5(h) and 17a-22a-7(5) is intended to permit the CT BHP to pay for services and supports to meet the needs of individual children or otherwise achieve the goals of the program. Citing specific examples may result in expectations that the services cited are currently available at the request of providers or members.

43) Comment: **Section 17a-22a-9 Authorization and registration requirements** (a) The departments shall establish a schedule of authorization and registration

requirements, shall post such requirements on the BHP Web site and shall provide notification of changes to the schedule not less than thirty days prior to implementing such changes. Again, it is not clear whether thirty days provides sufficient lead time for providers and their patients to be notified of such changes. We offer the following changes: (a) The departments shall establish . . . notification of changes to the schedule to providers and members not less than [thirty] ninety days prior to implementing such changes.

Response: The Departments believe that thirty days provides ample time for providers to adapt to typical changes in authorization and registration requirements. Moreover, providers raised no concerns about this time frame in their comments. The Departments will make every effort to provide more time if the changes are likely to require substantial changes in providers' internal policies, procedures or operations.

44) Comment: (g) A provider shall contact the departments and obtain authorization before admitting a member to a covered behavioral health service that requires authorization. Does the provider contact the "departments" or the ASO for prior authorization? Is this an exception to the written PA process, allowing for verbal authorization from the "departments". In any event, this paragraph needs to clarify what is being required of the provider.

Response: "Departments" is defined as DSS, DCF or any of their agents which, in this case, includes the ASO. Our intent in this regulation is to avoid unnecessary procedural specificity. Other provider communications establish the specific procedures with respect to obtaining authorization or registration.

45) Comment: (i) and (j). Requests for continued authorization . . . and maintenance of documentation to support continued authorization. These paragraphs are redundant and should be consolidated into one paragraph.

Response: The Departments agree. There is also some redundancy with (f). Consequently, (f) has been deleted and subsection (j) (now subsection (i)) has been substantially revised to eliminate redundancy.

46) Comment: (o) The departments may deny authorization or registration based on non-compliance by the provider with clinical management policies and procedures. We suggest the following additional language to make clear that there may be circumstances in which technical non-compliance with applicable policies and procedures can be waived: (o) The departments may deny authorization or registration based on noncompliance by the provider with clinical management policies and procedures, unless individual circumstances of the patient based on medical necessity and appropriateness necessitate a waiver such compliance.

Response: The language of (o) (now subsection (n)) is permissive, which means that the Departments may or may not deny authorization or registration based on non-compliance by the provider. The Departments' intent in the use of permissive language is to allow for circumstances when a denial might not be reasonable or appropriate, even beyond the patient circumstances identified in the above comment. Also, note that subsection (m) specifically allows exceptions in the case of emergency for inpatient psychiatric care.

47) Comment: **Section 17a-22a-10. Retrospective review.** (a) The departments may, at their discretion, perform retrospective reviews. . . There is no outer time limit in which the departments may conduct such retrospective reviews. Such a time limit should be included and be reasonable taking into account industry practice and the need to ensure the integrity of the program.

Response: DSS does not have time limitations with respect to retrospective reviews in any of its medical care administration programs and as such, we do not wish in this case to establish a limitation that would not be consistent with the administration of other populations or coverage areas.

48) Comment: **Section 17a-22a-11. Bypass program** (a)-(e). The departments may administer a bypass program in which the departments permit a provider to use registration procedures in lieu of authorization procedures. . . If the departments decide to "administer a bypass program" the standards should be set forth in regulation rather than published solely on the BHP Web site. In this way such standards will be subject to public comment from all interested parties. For example, it is not clear on what basis the "performance" of one provider will be compared to the performance of other providers" to determine whether the designation of "bypass" is warranted.

Response: This comments lies at the core of the dilemma that exists when a state agency self-administers a managed care program rather than "carving out" to a capitated managed care organization. A capitated managed care organization (MCO) has great flexibility in the management and administration of benefits in order to maximize access, quality or cost-effectiveness. An MCO can move quickly, changing policies and procedures and implementing flexibility, and adjusting to a changing environment. This flexibility is in contrast to a typical state administered program in a regulatory environment where rules are spelled out in great detail and any change or adjustment to those rules requires introduces lengthy delays. If all aspects of the CT BHP were spelled out in advance, any new CT BHP endeavor, such as performance initiatives, enhanced care clinics, or the bypass program, would require regulatory development, public notice, public hearing, and so forth with no action until the regulation is passed. At that point, it would be impossible to make the course corrections necessary when launching any innovation in management or administration. Since the publication of this regulation, the bypass program has been launched in consultation with providers and with reasonable success, though adjustments will be necessary. The same is

true of the enhanced care clinic initiatives and pay for performance incentives. We would like to avoid unnecessary specificity in this and other areas of the CT BHP regulation.

49) Comment: **Section 17a-22a-13. Payment** (g) Payment shall be made at the lowest of: (1) the provider's usual and customary charge; (2) the lowest Medicare rate; or (3) the amount in the provider's rate letter or the amount on the applicable fee schedule as published by DSS. Under what circumstances would the "amount in the provider's rate letter" be less than the "amount on the applicable fee schedule" since the fees set forth in the schedule have been historically very low? How does the payment schedule set forth in this paragraph affect the rates paid to HUSKY B providers? Does this formula mean that HUSKY B providers can never be paid a higher rate or fee than HUSKY A providers?

Response: Providers offer a range of services and the rate of reimbursement for those services will either be established in a rate letter or one a fee schedule. Some providers have rate letters for some of their services and a fee schedule applicable to the others. Provision (g)(3) simply references these two methods for setting forth the applicable reimbursement. Other Medicaid regulations tend to refer to one or the other because they are concerned with only one provider type. The CT BHP regulation must take into consideration the range of payment methods for the range of participating providers. This language does not preclude different rates for HUSKY A and B program services if the rate letter or fee schedule applicable to the provider establishes program specific rates.

50) Comment: (h) The departments may establish higher reimbursement for providers, other than federally qualified health centers, that meet special requirements. This paragraph appears to allow for the development and financing of "enhanced care clinics" and similar programs or services that provide improved "access, quality, and outcomes" to BHP members. While the departments' efforts in this area are commendable, this paragraph is quite vague. It does not define these programs or services; it does not define the application process by which providers may apply for this designation, etc. At a minimum, the enhanced care clinic guidelines and similar guidelines should be published in an appendix to the regulation.

Response: See response to D.48. Additional language has been added to address this concern in the area referenced under subsection (h). Specifically, the regulation has been amended to allow for the establishment of terms and agreement by the participating providers through letters of agreement and in some cases policy transmittals.

51) Comment: **Section 17a-22a-15. Client appeals** (a) The ASO shall have an organized appeal process under which a client may request review of an ASO decision. This paragraph needs to be amended as set forth below to include the right of HUSKY B members to appeal an ASO decision to *terminate, suspend or*

reduce services in order to make their rights consistent with those of HUSKY A and Limited Benefit program members and to be in conformance with federal, state, and constitutional rights to due process. See, in particular, federal regulation, 42 CFR Sec. 457.1130(b).

Response: The provisions found in section 42 CFR 457.1130 apply to program specific review. The Department did not choose to utilize program specific review but instead, chose to utilize a state-wide standard of review which is provided as an option under section 42 CFR 457.1120(a)(2).

52) Comment: (a) The ASO shall have an organized appeal process under which a client may request review of an ASO decision. HUSKY A, HUSKY B, and Limited Benefit Program members have the right to appeal an ASO decision to deny, partially deny, terminate, suspend, or reduce services. [HUSKY B members have the right to appeal an ASO decision to deny or partially deny services.] HUSKY A, HUSKY B, and Limited Benefit Program members shall have sixty (60) days from the date of the ASO's determination to file an appeal. . . (b) HUSKY A members shall fax or mail appeals of BHP decisions to DSS. We suggest that the BHP be required to transmit BHP decisions to DSS in order to expedite the process. We also suggest that such appeals, whether transmitted by the HUSKY A member or BHP, be allowed to be sent via email, again in order to save time and money. In some situations, a provider, a representative or advocate of the client, or the client him/herself may have access to a computer, thus allowing for the easy transmission of the appeal. Other departments or agencies allow for such electronic appeals, such as the employment security appeals division (unemployment compensation appeals). In this day and age there is no reason to limit such appeals to fax or postal mail.

Response: Administratively, it is not reasonable for the Department to accept all BHP decisions, regardless of whether or not an appeal is requested. The Department acknowledges the convenience provided by permitting the submission of appeal requests via email; however, the current system cannot accommodate this request at the present time due to security concerns.

53) Comment: (j) The ASO shall issue written appeal determinations to BHP members. We suggest the following additions to this statement: (j) The ASO shall issue written appeal determinations to BHP Members, and simultaneously forward a copy to DSS. Such written determinations shall be in a form and manner prescribed by the departments. At a minimum, the determination shall set forth the basis of the appeal, and explain the reasons for the determination, with citation to any applicable statutes, regulations, guidelines, or other references utilized by the ASO in arriving at its decision.

Response: A portion of the recommended edits have been incorporated into the regulation. However, routine notification of DSS regarding appeal determinations is unnecessary. A decision to overturn a denial is not sufficient to cancel a

scheduled administrative hearing. The Department must hear directly from the member or the member's authorized representative. If the member (HUSKY A only) proceeds with the administrative hearing, the appeal determination and other material necessary to support the determination in the administrative hearing will be submitted by the MCO to the Department.

54) Comment: (m) If a HUSKY B client is dissatisfied with the outcome of an ASO appeal, the client may file an external appeal to the Department of Insurance. The appeal must be filed with the Department of Insurance not later than thirty days after the client's receipt of the ASO determination. There is an error in this paragraph. The time period for filing an external appeal to the Department of Insurance is now sixty days pursuant to P.A. 07-75. The second sentence of paragraph (m) should be revised as follows: (m) . . . The appeal must be filed with the Department of Insurance not later than [thirty] sixty (60) days after the client's receipt of the ASO determination.

Response: The requested revision has been made.

55) Comment: Section 17a-22a-16. Provider appeals. This regulation should make clear that nothing in this section that allows providers to appeal medical necessity determinations or administrative non-compliance decisions of the ASO shall jeopardize the appeal rights of clients.

Response: The requested revision has been made.

E. Comments submitted by Alyssa Rose, Public Policy Specialist, on behalf of the Connecticut Community Providers Association.

1) Comment: The groundbreaking creation of the BHP signified Connecticut's commitment efficient and effective care for its most vulnerable children. This cannot be accomplished without the cooperation of multiple constituencies. Providers supported the establishment of the BHP and continue to work to improve service delivery. **They cannot, however, continue to meet that need without investments in their infrastructure and regular rate increases reflecting the increased costs of caring for children and families in Connecticut.**

To this end, it is important that the rates under the BHP receive increases in the same percentage that the Managed Care Organizations ("MCO") receive. For the first half of 2006 the 3.88% increase was passed along to all rates. This set a positive precedent for supporting all of the partners in the BHP. In the second half of 2006, provider rates received only a 1% increase, while funds were used to implement the Enhanced Care Clinics ("ECC"). We supported and continue to support the development of the ECCs but other rates must be increased to match inflation as well. While the success of ECCs play a critical role in the State's plan for children's behavioral health, it is clear that all behavioral health providers are

equally in need of the State's support.

Programs such as Family Support Teams (FST) and Multidimensional Family Therapy (MDFT) are in need of more than a 1% rate increase in order to continue providing the essential services they deliver. We support the position taken by the BHP Oversight Council at their November 14, 2007 meeting to require rate increases not less than the average increase given to MCOs.

Rate increases, along with strategic investments in critical areas are essential to maintaining the impressive work done to date and expanding services to meet the changing needs of the community. Such investments in the provider system are critical to the survival of the BHP and the sprit of partnership in which it thrives.

To that end, we offer the following comments on specific portions of the regulations in order to insure the most efficient and effective service delivery system possible for Connecticut children and families.

Response: The Departments recognize the importance of adequate financing (in the form of economic and efficient rates and fees) in achieving the long term goals of the Partnership. In the absence of specific statutory authority with respect to rate increases of the sort described above, the Departments are unable to introduce such provisions in the proposed BHP regulation.

2) Comment: **Section 17a-22a-2(8):** The term substance abuse should be replaced with substance use to reflect current accepted language in the field. We suggest the term 'substance use disorder.'

   Response: The Departments have revised the regulation to use the terminology contained in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, except where the regulation references provisions in other state regulations that use the term "substance abuse."

3) Comment: **Section 17a-22a-2(23):** The definition of "Emergency" should include examples that refer to behavioral health conditions, not physical health conditions and should reference a layperson's assessment of an emergency.

   Response: The Departments will amend the definition of "emergency," addressing the above concerns, to read as follows: "Emergency" means a medical condition, including a behavioral health condition, manifesting itself by acute symptoms of sufficient severity, such that a prudent lay person with average knowledge of health and medicine, could reasonably expect that the absence of medical treatment to result in serious jeopardy to the individual; serious impairment to bodily function; serious dysfunction of any bodily organ or part; or any situation deemed an "emergency medical condition" in accordance with the Emergency Medical Treatment and Laboratory Act, 42 U.S.C. 1395dd(e)(1), as amended from time to time.

4) Comment: **Section 17a-22a-2(25):** The use of "children up to the age of nineteen" in this section is inconsistent with the definition of children under (12) of this same section, which defines children as "individuals under eighteen (18) years of age."

   Response: The regulation has been revised to eliminate the inconsistency. The Departments have retained the definition of "children" as individuals under 18 years of age for the purpose of the CT BHP regulation because this is the traditional limit in Connecticut, including under DPH and DCF clinic licensure regulations, that distinguishes the child vs. the adult behavioral health service systems.

5) Comment: **Section 17a-22a-2(31):** Add "substance use disorder" after medical condition or mental illness.

   Response: The Department will continue to use the established definition of "medical necessity" in the administration of behavioral health services for purposes of consistency throughout the various Medicaid programs.

6) Comment: **Section 17a-22a-5(g):** There is no mention of reimbursing outpatient clinics, only specific provider types.

   Response: This provision of the regulation establishes limitations on reimbursement only for services rendered by individuals "enrolled as an independent or group practitioner..." This limitation does not exist for outpatient clinics and, accordingly, outpatient clinics are not mentioned.

7) Comment: **Section 17a-22a-8(j)(1):** Add: "Following review and comment the department shall implement the guideline within 30 days." If guidelines are not implemented providers are unable to bill appropriately.

   Response: The Departments may, based on review and comment, elect not to proceed with a proposed change in guidelines or may undertake additional review, in excess of 30 days, before implementing such guidelines. Consequently, the Departments do not support a requirement that the Departments implement guidelines or changes in guidelines within a specified timeframe.

8) Comment: **Section 17a-22a-9(d):** Add: "All verbal authorizations will be followed by electronic or e-mail confirmation within 48 hours." Without a written authorization the burden of proof is on the provider if there is a payment issue.

   Response: The Departments have provided a requirement for written notification.

9) Comment: **Section 17a-22a-9(h):** There have been ongoing communication issues with the ASO. This section should clarify what happens when a provider has repeatedly tried to contact the ASO and has not received a reply.

   Response: See response to D.46. The departments may make exceptions if the provider can demonstrate that he or she made reasonable efforts to comply with

the utilization management requirements (e.g., timely request for continued authorization).

10) Question: **Section 17a-22a-9(l):** Are there any limits associated with retroactive authorization? If so, they should be described here.

Response: There are no limits associated with retroactive authorization. This is consistent with other areas of medical care administration under DSS.

11) Question: **Section 17a-22a-11(b):** Does designation as a bypass provider apply to all BHP authorized levels of care that the agency provides or to specific designated programs?

Response: At this time, the Departments intend to administer the bypass program such that it would apply to specific levels of care (e.g., adult psychiatric inpatient) rather than all of a provider's programs. That said, the administration of the bypass program including selection of levels of care, eligibility criteria for the bypass program, and other methods will be established in consultation with the CT BHP Oversight Council. Alternative methods such as qualifying for multiple programs could be considered.

12) Comment: **Section 17a-22a-12(b):** The 60 days timely filing requirement for denials contradicts Provider Bulletin 2007-36, sent to providers in May of 2007 which extended that requirement to 120 days. This section should be corrected to reflect that change.

Response: The requested revision has been made.

13) Comment: **Section 17a-22a-13(d):** A definition for "brief collateral contacts" should be provided either within the text or by reference.

Response: The requested revision has been made.

14) Question: **Section 17a-22a-13(h) and (h)(1):** Is this section referring solely to Enhanced Care Clinics or are their other opportunities for enhanced rates? If it is not only ECCs, will there be a formal process established for awarding these enhanced rates or will it be decided on a case-by-case basis? The determination criteria should be spelled out here.

Response: This section refers to any and all initiatives that result or may result in either higher reimbursement or performance related payments. Such initiatives include but may not be limited to enhanced care clinics and pay for performance initiatives. Any such initiatives would be established in consultation with the BHP Oversight Council. The provisions in this section have been revised to better reflect the range of reimbursement or payment related initiatives that the departments intend to address with this section.

15) Comment: **Section 17a-22a-14(a):** The section reads "current and all prior treatment plans prepared by the provider" need to be included. As providers