convert to electronic medical records it will not be possible to have old paper treatment plans included as part of the new records unless they are scanned in or are available on site through separate paper files. It will save providers considerable time and resources if older paper files can simply be made available on site.

Response: Previous plans, if separate, must be maintained and made available on site.

16) Comment: **Sections 17a-22a-16:** Provider due dates for appeals should not be based on "calendar days," such a designation actually shortens the timeline for providers since there is not postal service 7 days per week. Also, no such designation of a calendar day requirement is placed on the ASO in responding, their timeline is based on "business days." This is clearly an unfair burden on providers.

Response: The Departments feel that they time is sufficient given that the clock starts as of *receipt* of the ASO's decision and the provider is permitted to request such appeal verbally, so the issue of postal service appears to be irrelevant. Moreover, although the ASO is held to a business day standard, the timeframes that apply to the ASO are substantially more restrictive.

F. Comments submitted by Vicki Veltri, General Counsel, on behalf of the Office of the Healthcare Advocate (OHA).

1) Comment: We appreciate the efforts of DSS to draft regulations concerning the BHP. Most of our comments relate to making the regulations more understandable to BHP members, and where the regulations address the HUSKY programs, making the regulations consistent with other HUSKY regulations. Generally, however, we suggest that the regulations may need revision to reflect the very recent developments concerning the changes in the responsibilities of the managed care organizations (MCOs) involved in the HUSKY program. To make the regulations more understandable and complete, we also recommend the inclusion of detailed descriptions and/or definitions of the actual services covered under each of the programs, levels of care and the providers from whom members can seek care.

Our specific comments are numbered as follows:

Response: With respect to the comment regarding inclusion of detailed descriptions of covered services, please see our response to D.6. above.

2) Comments: ***17a-22a-2***

a. Subsection (3) – Definition of "Adult" needs to be corrected to reflect the age differences of eligibility in the three programs referred to in the

regulations. For HUSKY A, an adult is over the age of 21, in HUSKY B, over the age of 19 and in the Limited Benefit Program it is age eighteen or over.

Response: See response to D.6. The definition of child vs. adult for the purpose of this regulation is unrelated to the definitions that may exist for the purpose of medical assistance program eligibility.

b. Subsection (7) – Definition of "BHP." It is unclear to whom DSS is making reference in the clause "and other children, adolescents and families served by DCF." Please clarify who these other eligible people are.

Response: See response to D.7.

c. Subsection (8) – Definition of "behavioral health services" should include reference to the full definition of medical necessity. The definition should include reference to health care that is necessary to attain or maintain optimal health or to prevent a condition from occurring.

Response: The term "behavioral health services" is used in the regulation without regard to whether the services have been found to be medically necessary. Requests for authorization for behavioral health services (broadly defined) are reviewed to determine medical necessity. If they are determined not be medically necessary for a given member in a given circumstance, it does not mean the service is not a behavioral health service.

d. Subsection (12) – Definition of "children" needs to be corrected to reflect the different definitions in each program. For HUSKY A, a child is < 21, for HUSKY B, <19 and for the Limited Benefit Program, < 18.

Response: See response to D.6. The definition of child vs. adult for the purpose of this regulation is unrelated to the definitions that may exist for the purpose of medical assistance program eligibility.

e. Subsection (17) – Definition of "complex behavioral health needs" should make reference to specialized services across the medical service system, particularly for children with complex behavioral and medical needs.

Response: See response to D.12.

f. Subsection (22) – Definition of "EPSDT" should include a citation to, or text from, state law requiring EPSDT to continue as it was as of December 31, 2005.

Response: See response to D.13.

g. Subsection (24) – Definition of "HUSKY A" should state that it is the Connecticut program of "Medicaid managed health care."

Response: See response to D.14 and proposed revised language which should address this concern.

h. Subsection (26) – Definition of "intensive care management" should also make reference to children with complex behavioral and/or medical needs.

Response: See response to D.15 and proposed revised language which should address this concern by eliminating the focus on individuals with complex behavioral health needs.

i. Subsection (33) – Definition of "member services" should make reference to the duty to provide scheduling assistance.

Response: The requested revision has been made.

j. Subsection (34) – Notice of action requirements should extend to HUSKY B members.

Response: See response to D.19.

k. Subsection (40) – The definition of "psychiatric residential treatment facility" is confusing.

Response: Please see proposed revision in subsection (36).

l. Subsection (42) – It is unclear who is responsible for notifying the departments of the initiation of a behavioral health service. Is it the provider?

Response: Please see proposed revision in subsection (39).

m. Subsection (43) -- Residential services should be available for children and youth with significant and complex behavioral health service needs and/or "complex co-occurring behavioral health and medical service needs." Will any residential services be available to HUSKY A adults under the BHP?

Response: Please see response to D.23. HUSKY members have access to the full array of behavioral health services covered under the Connecticut Medicaid state plan, which includes adult mental health group homes. However, as a practical matter, the adults who meet medical necessity for these long term programs

typically qualify for Medicaid as aged, blind or disabled and as such are exempt from enrollment in managed care.

n. Please include a definition of "Enhanced Care Clinic"

Response: The term "Enhanced Care Clinic" is not used in the regulation and as such is not a term that we are permitted to include as a definition.

o. Please include definitions of levels of care; i.e., IOP, PHP, acute care.

Response: These terms are not used in the regulation and as such they are not terms that we are permitted to define. We anticipate the release of a behavioral health clinic regulation in the next year, which will include definitions of the terms PHP, IOP, etc.

3) Comment: ***17a-22a-3*** The following items should be included for each of the numbered subparagraphs of the section: eligibility requirements, or at a minimum, a cross-reference to the eligibility requirements; the age limits for each program; a description of the services of each program, or at minimum a cross-reference to section 17a-22a-5, which in turn should contain detailed covered service descriptions.

Response: The revised section now references section 17a-22a-5, which summarizes covered services and limitations.

4) Comments: ***17a-22a-4***

a. Subsection (b) should be unnecessary. All ASO responsibilities should be listed in the regulation.

Response: We do not agree. We have listed major areas of responsibility, including those where the ASO's authority with respect to provider actions may be questioned. No reference is made to other areas that are specified in contract and which may from time to time be modified through contract amendment. Flexibility is important if this program is going to be responsive to changing needs, be cost-effective and efficient with regard to use of the administrative dollars established for the program, and be accommodating with respect to activities requested by the Council.

b. Subsection (2) on quality management should require the ASO to use secret shopper surveys on a frequent basis to evaluate access and appointment availability

Response: The regulation has been revised as requested.

c. Subsection (e) on Utilization Management should actually include the utilization management requirements or at least be transparent and provided to providers and members in a public location.

Response: Documents developed by the ASO in relation to the administration of the BHP are available to the public upon request. We will post the approved Utilization Management and Quality Management Programs on the CT BHP website (www.ctbhp.com).

d. Subsection (f) should include, although it may already include this, intensive care management for members with co-occurring medical and behavioral health needs

Response: See response to D.28. Please note that certain co-occurring behavioral and medical conditions are on the trigger list for intensive care management review.

e. Subsection (g) should include a listing of all of the actual goods and services reimbursable under the program and "outlined in the contract between the ASO and the departments".

Response: Please see response to D.5 above.

f. Subsection (h) – financial reporting should include a description of the reporting to take place, including a report on profits. There should be a cap on the profits of the ASO.

Response: The ASO does not pay claims, monitor expenditures or otherwise have a role that would require financial reporting. The Departments produce a range of financial reports related to the administration of various medical assistance programs or program components including the CT BHP. Regulatory language is not necessary to compel the Departments to produce such reports. The enabling legislation for the CT BHP makes no reference to establishing a cap on ASO profits. It is not clear why a cap on profits should be a program requirement given that the ASO is not capitated. Nonetheless, the Departments have established a cap on profits (7.5% of the administrative contract cost) with respect to the current ASO contract, a limit that has been in place since the inception of the program.

g. Subsection (i) should be clearer in stating that the member review processes must comply with specific regulations. E.g., "The ASO shall administer a member appeal review process in compliance with HUSKY A requirements in Title XIX and 17b-60, HUSKY B requirements in HUSKY regulations, including notification of the right to external appeal and in compliance with section 17a-22a-15 herein."

Response: The Departments have revised this provision to reference the appeal process described in section 17a-22a-15 of the regulation as follows: "The ASO shall administer a member appeals review process in accordance with section 17a-22a-15."

h. Subsection (k) should be revised to require "implementation" of the policies and procedures.

Response: The regulation has been revised as requested.

i. Subsection (l) (1) should state that any reviews are subject to the requirements of HIPAA concerning disclosures and privacy.

Response: It is not clear from the comment why a reference to HIPAA is necessary in this section, given that HIPAA applies to all aspects of the administration of this and all other health care programs. It also is not clear whether the intent here is to suggest that there should be some limit on disclosure to the ASO as it relates to chart audits for the purposes of addressing quality of care concerns.

5) Comments: ***17a-22a-5***

a. Subsection (a) should be revised. There are no coverage limits for services in HUSKY A. If what DSS is trying to say is that a provider can only perform services for which he or she is licensed, then that should be clarified. The actual kinds of services should be described in detail here. Reference to the state plan is insufficient to provide clear notice of what services are covered. References to the MCOs should be clarified or broadened to indicate which entity, DSS or the MCO is actually responsible for services.

Response: The regulation is referencing coverage limitations that exist for services in HUSKY A and Medicaid more generally. For example, this would include services that are not covered such as cosmetic surgery. It would also include limits under regulations or the state plan such as the limitation on psychiatric evaluations to one per episode of care per performing provider or the limitation on group therapy to no more than 8 patients in attendance. Also see response to D.5.

b. Subsection (b) – same comments, including comments re MCO responsibilities.

Response: Please see response to F.5.a. above.

c. Subsection (c) –same comments although some services are listed.

Response: Please see responses to D.7 and D.16.

d. Subsections (d) and (h) should be combined as they could be read to contradict each other.

Response: Combining subsections (d) and (h) might create the impression that the additional coverage is applicable to non-medically necessary behavioral health services and supports. The intent of section (h) is to provide the departments with the latitude to pay for services without regard to the limitations established in section 17a-22a-5.

e. Subsection (e) – special services is not defined, but it is also not used as a designation of type of service any longer.

Response: This subsection has been revised to address this concern.

6) Comments: ***17a-22a-6***

a. Generally, this section needs to be revised to reflect recent events concerning the MCO contracts with DSS

Response: This section has been revised to reflect the carve-out of pharmacy services from the managed care organization contracts.

b. Subsection (1) (B) – screening should be covered if the screening is performed in a behavioral health setting if the BH setting is the first contact. Since children are allowed to enter the BHP directly via referral from anyone, including a community member, screenings need to be covered.

Response: This subsection is intended to outline areas of behavioral health services that remain the responsibility of the MCOs and thus might otherwise be a point of confusion. In this case, the MCOs are responsible for behavioral health screening in a primary care setting. If the BH setting is the first contact, the BH provider will conduct an evaluation (CPT 90801 or 90802) rather than screening and such evaluations are a covered service.

c. Subsection (1) (C) - Who makes the determination that treatment of a BH disorder, can be safely and appropriately treated in a primary care setting? The choice of treatment provider should be made by the parent of a child. How does this subsection guard against inappropriate use of PCPs for BH treatment?

Response: The determination regarding safe and appropriate treatment would be made by the clinician. A parent cannot decide what a clinician feels is within the clinician's scope of practice or level of comfort. Primary care

providers differ greatly with regard to the behavioral health conditions that they would be comfortable treating. A parent can always discuss with the primary care provider options for receiving treatment from the primary care provider or a specialist. A parent is always free to self-refer to a behavioral health specialist.

d. Subsection (1)(D) – Ancillary services related to BH should be described here;

Response: Subsection (4) references laboratory and radiology, which are the main ancillary services associated with behavioral health conditions. Further explication seems unnecessary.

7) Comments: ***17a-22a-7***

Subsection (5) should allow for other support services for children with complex behavioral health service needs and/or complex co-occurring behavioral and physical health needs.

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. This definition would encompass children with co-occurring physical health needs.

8) Comments: ***17a-22a-8***

a. This section is lengthy and confusing. It would perhaps be enough to state in subsection (d) that all CMAP providers shall comply with medical policies and within the medical policies for specific exceptions.

Response: We considered this option, but ultimately determined that specific exemptions need to be cited.

b. Same comment with respect to subsection (e)

Response: We considered this option, but ultimately determined that specific exemptions need to be cited.

c. Subsection (f) should make reference to the requirement that even a quality of care review of a provider has limitations under HIPAA for certain disclosures, e.g., treatment notes.

Response: The State is not absolved from their responsibility to comply with Federal law. The absence of a specific reference to HIPAA does not negate the need to meet privacy requirements.

d. Subsection (g) should clarify that notice should only be required when either the admission is a behavioral health admission or a child with complex medical and behavioral health needs is admitted to a general hospital

Response: The language of this provision has been modified to require sharing of information when requested by the Department.

e. Subsection (h) – it is not clear who keeps the roster of beds described in this subsection. It is also unclear how administration of a roster of beds by the departments works alongside commercial plans and arrangements between hospitals and insurers for the provision of hospital and residential beds.

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

f. Subsection (i) – the last line should be changed to "non-medical behavioral health practitioner" to be more accurate.

Response: This requirement has been eliminated.

g. Subsection (j) – The regulation needs to be clarified that the clinical management guidelines are governed by the definition of medical necessity. It needs to be made clear that providers are not constrained by the guidelines in trying to obtain medically necessary care for their patients. It would also be helpful to extend to lead time for changes in guidelines to sixty days. Members should receive notice of the changes to the clinical guidelines if they are currently receiving a service for which the guidelines have changed.

Response: See response to D.41. Providers have plenty of notice with regard to changes, considering the advance work that must occur with the BHP OC (60 days). The guidelines themselves and the Value Options (VO) contract make clear that the medical necessity definition is the basis for any final determination. Members will receive notice (of action or denial) if the change in guidelines results in a denial. A change in the guidelines themselves does not warrant advance notice to clients.

h. Subsection (k) is unclear. If this is meant to be read as a possible expansion of coverage, we support that reading. However, other than the medical necessity restriction, there are no "non-covered" services in HUSKY A for children < 21, so we suggest clarification that that is the case.

Response: Subsection (k) (now subsection (j)) is meant to be read as a possible expansion of coverage. There are indeed non-covered services in HUSKY A for children <21. ESPDT only provides coverage for medically necessary services covered under 1905(a), whether or not they are included in the state plan. Other services are not covered such as non-health care services or services only available under a 1915(c) waiver such as respite, habilitation, homemaker, or personal care services.

9) Comment: ***17a-22a-9***

a. Subsection (a) should provide that prior authorization requirements and changes thereto should be communicated to BHP members.

Response: Changes to prior authorization requirements under Medicaid fee for service are communicated to providers. Providers need to be apprised of such requirements so that they can obtain authorization for payment before services are rendered. Members are not financially liable when a provider fails to obtain prior authorization. The notification policy under CT BHP is the comparable to that under Medicaid fee for service.

b. Subsection (c) should include a provision that requires the departments to notify the provider and the member exactly what information is required to approve a request, although other than administrative information, all that should be necessary is proof of medical necessity. The subsection should also provide examples of what other requirements there are for payment if a service is authorized.

Response: For the same reasons offered under the response to Comment F.9.a above, members do not need to know what information is necessary to obtain authorization in order to access services. However, the information necessary to obtain authorization is readily available from the Departments or the ASO upon a provider's or member's request. Moreover, the level of care guidelines that are the basis for authorization reviews are published at www.ctbhp.com. Providers who do not have necessary information when they call for authorization are given the opportunity to gather necessary information before a decision is rendered.

c. Subsections (g) and (n) should be combined since they can be read to be contradictory.

Response: The requested change has been made.

d. Subsections (i) and (j) are mostly redundant can be combined to make the substance clearer.

Response: These provisions have been edited to reduce redundancy, but remain separate since the latter provision addresses multiple authorization types.

e. Subsection (k) should possibly be combined with (g) and (n) as stated above. There is no clear statement of when a retroactive authorization can take place, other than for emergency admissions.

Response: These provisions have been further consolidated to eliminate redundancy and to clarify the circumstances under which retroactive authorization can take place, other than for emergency admissions.

f. Subsection (o) should be clarified to provide that the failure to follow clinical management policies and procedures cannot be a basis for denial if the procedure is otherwise medically necessary. We ask that you keep in mind that such a regulation may cause members to not receive medically necessary behavioral health care.

Response: The Departments believe that strict requirements with regard to clinical management policies and procedures support the efficient conduct of authorization reviews and help avoid the provision of services that could be safely and effectively provided at a lower level of care. In addition, reviews conducted after the service has been provided do not offer the same opportunity for care coordination, in fact, coordination can be hampered if the ASO does not have real time information as to where and from whom a member is receiving clinical services.

10) Comments: ***17a-22a-10***

a. Subsection (a) should be modified to provide for an outer limit on the departments' ability to perform retrospective reviews. We suggest the following: "Retrospective reviews may only be conducted within six months of the final date of the timely filing period, unless such review is conducted for the purpose of investigating possible criminal activity, such as fraud."

Response: The regulation has been amended to provide for a timeframe of one year from the date of service.

b. Subsection (b) should not allow for the recoupment or denial of payment when a service has already been authorized. We suggest some additional language at the end of the subsection that states, "Except that where

services have previously been authorized, the departments shall not deny or recoup payment unless a member was not eligible for services at the time they were authorized. The departments shall not be prohibited from denying or recouping payment where fraud or criminal activity is proven."

Response: The purpose of the retrospective review is to determine whether the documentation in the medical record supports medical necessity. If the documentation does not support medical necessity, the validity of the telephonic review is in question and a recoupment or audit adjustment may be appropriate.

11) Comment: ***17a-22a-11*** We are concerned that the bypass program, despite its well-intentioned development could create a two-tiered system of access to care, with some people getting prompt access to care and others waiting for care. With geographical issues and historical access issues affecting access to care, it is unclear how the bypass program will work, and where and to whom it should be targeted.

Response: The Departments have developed the initial bypass program in consultation with the BHP Oversight Council. Any revisions to this program will also be developed in consultation with the Council where issues such as those raised in the comment can be addressed. The initial bypass program focused on frequency of continued care reviews rather than admission reviews so there is no access related risk. If extended to bypass of admission reviews, the BHP already has high response time standards for prior authorization so any variation in timely access is likely to be negligible.

12) Comments: ***17a-22a-15***

a. Subsection (a) – There is no reason for HUSKY B members to have any less of a right to appeal than HUSKY A members. Federal regulation, 42 CFR § 457.1130(b), requires an appeal right for HUSKY B members who face a decision to terminate, suspend or reduce their services, in addition to the other grounds included in 17a-22a-15. DSS should clarify that the basis for an appeal is identical in all three programs.

Response: See response to comment D.51 above.

b. Subsection (b) should be changed to require that the ASO mail the BHP decision. The ASO is in the best position to fax, e-mail or mail its decision to the DSS fair hearing office.

Response: Subsection (b) does not pertain to the submission of a BHP decision. It pertains to the submission of an appeal of the decision, signed by

the member. Only the member or their authorized representative is in a position to fax or mail the appeal to DSS.

c. Subsection (e) appears to have a typo. The third line should say "Limited Benefit Program" instead of "DCF".

Response: The proposed regulation has been corrected.

d. Subsection (h) allows for provider appeals to be expedited. Why is an appeal directly from a member treated differently?

Response: A trained health care professional is in a better position, by virtue of his or her training, to assess the clinical risks associated with the routine 30 day timeframe. Consequently, their request for expedited appeal review is presumed to be valid. This is the reason for the differential standard. If member appeals were automatically granted expedited status without clinical review, there is a risk that such requests for expedited appeal review would become the default request from members who wish to have a speedy resolution. Expedited appeal review requires a much greater administrative burden relative to a routine review.

e. Subsection (j) should be clarified to require the ASO to include the basis for its decision and to provide notice of the right to external appeal in the case of HUSKY B members.

Response: The departments have amended the proposed regulation to address this concern.

f. Subsection (m) contains an error. The time period for filing an external appeal to the Insurance Department is now sixty (60) days pursuant to P.A. 07-75.

Response: The departments have amended the proposed regulation to address this concern.

g. Members, at least those enrolled in HUSKY B, should have two levels of appeal as providers are allowed in 17a-22a-16, and as most insurance plans allow members in Connecticut.

Response: The departments believe that the current proposed arrangement is more uniform and equitable, in which HUSKY A and HUSKY B members both have access to a single appeal through the ASO and an external appeal either through DSS for HUSKY A or through the Department of Insurance (DOI) for HUSKY B. Providers are also granted two appeals, both administered through by the ASO.

13) Comment: ***17a-22a-16***

a. An additional subsection should be added that states the following: "The filing of an appeal by a provider shall not jeopardize or exhaust the individual member's right to appeal to the ASO or to DSS, or in the case of HUSKY B members, to the Insurance Department via an external appeal."

Response: The department has amended the proposed regulation with the addition of subsection (e) to address this concern.

G. Comments submitted by Stephen A. Frayne, Senior Vice President, Health Policy, on behalf of the Connecticut Hospital Association (11/21/07)

1) Comment: **The rules as promulgated are invalid.** As you know, the Connecticut Law Journal notice indicates that DSS is relying on General Statutes Section 17b-10 for the authority to implement and operate under these proposed regulations as of November 1, 2007 before completing the otherwise necessary course for adoption of regulations. A fair reading of Section 17b-10, however, demonstrates that the conditions to permit implementation without following the normal rulemaking process do not exist. As such, immediate implementation of the proposed regulations is improper, and places BHP providers in an untenable position of having to abide by invalid regulations.

Response: The Department disagrees. The Behavioral Health Partnership is a program which is a joint federal and state program administered by the state, as such; the Department has the authority under section 17b-10 of the Connecticut General Statutes to implement and operate under the proposed regulations until the regulations are fully promulgated.

2) Comment: **Failure to satisfy an administrative task should not trump the provision of medically appropriate and necessary care.** It is hard to imagine a more upside down situation than this: everyday any hospital that provides care to a member of the BHP does so without the expectation of ever being able to recover its cost. In addition, the labyrinth of rules, notices, and timeframes operate to disable rather than enable. Given this state of affairs, equity demands that medical necessity has to trump an administrative denial on appeal.

Response: Much of the value from managed care accrues through prospective review processes that offer the opportunity to review both care and medical necessity, thus improving quality and reducing excessive utilization. Retrospective review processes are administratively burdensome and they do not provide for an interactive review, or peer review, in which a members presentation and proposed treatment can be more carefully considered. The

proposed change would likely result in a substantial increase the more burdensome and cost-inefficient retrospective reviews.

3) Comment: **Contracts governing BHP participation should be entered into with all hospitals**. Hospitals are unclear what contract, if any, governs their participation in BHP. Given the importance of the program, specific BHP participation agreements should be in place within the year that specify the mutual obligations, contract term, and the ability of both parties to terminate participation in the program.

   Response: The current agreements govern. DSS, however, has revised the provider agreements to clarify that the terms and obligations are applicable to any and all DSS health programs, including BHP. The Department intends to implement the revised provider agreements within the next 6 months.

4) Comment: The definition of "emergency", section 17a-22a-2(23) does not reference behavioral health, a prudent layperson standard, or acknowledge EMTALA screening requirements. This definition should read:

   > "Emergency" means a medical condition, including a behavioral health condition, manifesting itself by acute symptoms of sufficient severity, including sever pain, 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 Labor Act, 42 U.S.C., 1395dd and any subsequent amendments thereof.

   Response: The departments have amended the proposed regulation to address this concern (the definition of "Emergency" is now found at 17a-260a-2(22)).

5) Comment: The definition of "medical appropriateness: section 17a-22a-2(30) fails to recognize that the current delivery system is inadequate and, therefore, incapable of making available on demand the most appropriate treatment setting. Sadly, the foreseeable future does not hold the promise of the dramatic improvement that is desperately needed. In order for dramatic improvement to occur, the number of providers and treatment settings must be significantly expanded. Such expansion is unlikely if providers and facilities are unable to cover the cost of the care being delivered. Absent relief targeted at the root cause of the gridlock, underfunding, it is hard to imagine substantive change. The definition, therefore, needs to recognize that the "right setting" is the one that is "immediately available".

   Response: The departments have established level of care guidelines (see page 4 of child level of care guidelines at www.ctbhp.com "for providers"), which are

approved by the statutorily established Clinical Management Committee. These guidelines recognize that a request for authorization may be considered medically necessary if the appropriate level of care is not available.

6) Comment: The definition of "Notice of Action", section 17a-22a-2(34) should be amended to require a copy of the NOA be sent to the provider.

   Response: The revised regulation no longer contains a definition of the term "Notice of Action." Authorization decisions are sent to both the member and the provider.

7) Comment: Section 17a-22a-4(b) specifies that the responsibilities of the ASO are described in detail in the contract between the ASO and the departments. The current ASO contract should be readily available to providers. At a minimum, the entire current contract should be posted to the web site. Providers should have an opportunity for input and comment on the contract and amendments to it.

   Response: The contract was made available to the BHP Oversight Council for review and comment. The contract and its amendments continue to be available to providers and members upon request to the departments. The departments do not currently post contracts to the WEB although this will be considered.

8) Comment: Section 17a-22a-4(g) specifies that the ASO shall assist the departments in developing, managing, and maintaining a comprehensive network of providers. Missing are the standards for measuring the adequacy of the network and the requirement that the ASO formulate and recommend to the departments the strategies to make the network adequate; both of these are critical to improving the access for these populations.

   Response: The departments have amended the proposed regulation and established specific instructions to address this concern (See, section 17a-260a-13(h)). The departments believe that standards for timely access are more important than standards for network adequacy (e.g., numbers of providers in a geographic region) and that the standards, which may vary by provider and service type, should be developed, monitored, and modified over time in consultation with the CT BHP Oversight Council. This has been done in the context of the Enhanced Care Clinic initiative and is also being considered in areas such as residential treatment.

9) Comment: Section 17a-22a-4(1) specifies that the ASO may investigate and address concerns related to the quality of care. "Quality of care" is not and should be defined. In addition, there should be provisions added regarding advance notice to providers of reviews and the hours that reviews are conducted, e.g., during normal business hours.

Response: Quality of care issues include any action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk. This definition has been added to the regulation and the regulation has been amended to use the term consistently. The regulation has also been amended to stipulate that "On-site reviews of quality of care issues conducted by the ASO will take place during normal business hours with at least 24 hours advance notice.

10) Comment: Section 17a-22a-5(d) specifies that the Partnership shall only pay for covered services and goods that are medically necessary and appropriate; it should be amended to acknowledge in the setting "immediately available".

Response: See response to G.5.

11) Comment: Section 17a-22a-5(g) specifies that the Department shall only reimburse "licensed" providers, thereby precluding payment for "license eligible" providers. At this point, it is unclear the effect, if any, such a change will have on access. "License eligible" providers should not be excluded if such exclusion will negatively affect access.

Response: This provision is not a change in reimbursement policy as it applies only to such clinicians who are independently enrolled (i.e., in solo or group practice). Moreover, this is already a requirement under state licensing rules.

12) Comment: Sections 17a-22a-8(b) specifies that BHP providers shall comply with all participation agreements. At this point, hospitals are unclear what contract, if any, governs their participation in BHP. Given the importance of the program, specific BHP participation agreements should be in place within the year that specify the mutual obligations, contract term, and the ability of both parties to terminate participation in the program.

Response: Hospitals and any other providers enrolled with the Department of Social Services are required to comply with the Connecticut Medical Assistance Program provider participation agreements, regardless of the medical assistance program under which they are providing reimbursable services. See also, response to comment G.3.

13) Comment: Section 17a-22a-8(f) specifies that the providers shall cooperate with investigations of quality concerns. "Quality of care" is not and should be defined. In addition, there should be provisions added regarding advanced notice to providers of reviews and the hours within which reviews are conducted, e.g., during normal business hours.

Response: See response to G.9.

14) Comment: Section 17a-22a-8(g) specifies that hospital providers shall notify the ASO when a BHP member is in an emergency department for more than twelve hours or when the hospital encounters a barrier to disposition. Missing is how the department or the ASO expect the availability of this information to improve timely patient disposition. Hospitals desperately need solutions that move individuals to the setting of care that is most appropriate as quickly as possible. Hospitals do not need administrative tasks that add little value to patient disposition. In short order, the efficacy of this effort, along with those initiatives yet to be suggested, need to be rigorously tested and if found to be of dubious value, quickly abandoned. Hospitals, other providers, the departments, and the ASO can ill afford to waste time no work that is not producing results.

Response: The departments have amended the proposed regulation to address this concern.

15) Section 17a-22a-8(h) specifies that hospitals and other providers shall participate in a bed roster of available psychiatric beds. Again, missing is how the department or the ASO expect the availability of this information to improve timely patient disposition. Hospitals need solutions that move individuals to the setting of care that is most appropriate as quickly as possible, not administrative tasks that add little value to patient disposition. The efficacy of this effort, should be rigorously tested, and if found to be of dubious value, quickly abandoned.

Response: The language of the regulation has been amended to make participation optional, not mandatory.

16) Comment: Section 17a-22a-8(i) specifies that licensed psychologists, among others, need to have an affiliation agreement with a medical professional that will provide psychiatric evaluation and mediation management. Given the existing access challenges, this provision should not be enforced until at least 98% of those that need an affiliation agreement have one in effect.

Response: The departments appreciate the importance of this concern and have eliminated this requirement.

17) Comment: Section [17a-22a-8(h)] specifies that notice of changes in clinical guidelines will be published on the web site. Providers should receive written notice changes, be given an opportunity to comment, and if unable to resolve issues, the opportunity to withdraw from the program.

Response: The regulation (now section 17a-22a-8(i)(2)) actually states that the departments shall provide notification of changes to the schedule at least thirty days prior to implementing such changes. The regulation does not refer to notice of changes by means of posting to the website. The Clinical Management Committee does rely on consultation from the BHP OC with regard to any

proposed changes. Consequently, changes thus far have been made with ample provider input and generally have not been controversial.

18) Comment: Section 17a-22a-9(a) specifies that authorization and registration requirements and notice of changes will be published on the web site. Providers should receive written notice of changes, be given an opportunity to comment, and if unable to resolve issues, the opportunity to withdraw from the program.

Response: See response to G.17.

19) Comment: Section 17a-22a-9(d) specifies that a provider shall obtain and the departments my give authorization verbally, electronically, or by mail. This section should make it clear that the mail option is only to provide written confirmation of authorizations previously provided. In addition, there should be a requirement that the ASO provide the authorization within a certain time, e.g., by 3:00 p.m.

Response: In many cases, the ASO will already have provided verbal authorization and the written notification will be a confirmation of the verbal. For certain non-urgent services, written notice of the decision may be the only notice of the decision. For these non-urgent cases, the Departments believe that the timeframe is reasonable. The Departments have amended the rule to provide a reference for the 5 day requirement. The term "confirming" has been eliminated to allow for the fact that the written notice may be the only notice of authorization provided. The Departments recognize that the contract requirements for the ASO are more stringent than the requirements established in the regulation

20) Comment: Section 17a-22a-9(l) specifies that it is always the provider's responsibility to ask for a medical necessity review on all cases granted retroactive eligibility if the provider would like to be paid, but, the department does not have to review the case to make payment. Given a review by the departments is optional, the process could be significantly streamlined by the department automatically making payment except in those instances it wants to do a review.

Response: We have amended the regulation to require medical necessity review by the departments in case of retroactive eligibility.

21) Comments: Section 17a-22a-9(o) and (n) sets forth requirements that we just do not understand and, therefore, it should be deleted.

Response: We believe that both provisions are appropriate and should be retained. In the first case (now subsection (m)), we are making an exception to the requirement for prior authorization in cases where a hospital admits an individual emergently. Ordinarily, such cases would be denied for administrative reasons. Under this provision, review may be undertaken after the admission.

However, there remains the possibility that authorization for payment would be denied for reasons of medical necessity.

In the second case (now subsection (n)), we have added clarifying language. This provision is intended to establish the basis for administrative denials.

22) Comment: Section 17a-22a-10 allows the department to do retrospective review. The ability to recover payment should not apply to those cases where prior authorization, pre-certification, and/or concurrent review were conducted. In addition, the time-period open to retrospective review should be the same as the time allowed for billing in section 12 of the proposed regulations. It is patently unfair to require providers to figure it all out in 120 days while the department has limitless time.

Response: The purpose of retrospective reviews is to determine whether the patient's actual presentation as documented in the chart is consistent with the presentation represented to the care manager for the ASO in the course of requesting authorization. It allows the departments to retract authorization and recover payment if the documentation does not support medical necessity. Chart reviews are well-established for determining the validity of information that is the basis for billing or, in this case, prior authorization. With regard to the look back, the lack of a time limit is consistent with the administration of post-payment review and audits in other areas of medical assistance.

23) Comment: Section 17a-22a-12 specifies timely billing requirements. This section should be modified to coincide with the requirements for FFS billing.

Response: The timely filing requirements are broadly consistent with the requirements in place under the HUSKY managed care program for medical services, which served as the reference for the BHP.

24) Comment: Section 17a-22a-13 sets forth the requirements for rates but not how frequently the rates will be updated. Rates should be updated annually; there should be adequate notice of the rate change before the beginning of the year, and providers should have the ability to terminate if the rates are not adequate.

Response: Increases in rates are subject to the appropriations process. The Departments cannot establish in regulation, without specific statutory authority, any assurance that rates will be updated. A provider does have the ability to terminate their participation as a Connecticut Medical Assistance Program provider if the provider believes that his or her rates are inadequate. The Departments do not believe that the statute requires that providers be given the option to discontinue participation with individual medical assistance programs (e.g., CT BHP, SAGA).

25) Comment: Section 17a-22a-15 clients should have 120 days to appeal.

Response: The Departments believe that sixty (60) days provides adequate time for a member to submit an appeal.

26) Comment: Section 17a-22a-16 providers should have 120 days to initiate an appeal. Providers must have the ability to appeal administrative denials if the services were medically necessary and appropriate.

Response: The Departments believe that a brief appeals window provides for timely and efficient resolution of authorization related issues. The Departments have established similarly high standards for the ASO's response to provider authorizations (e.g., one hour for inpatient requests) and appeals (e.g., peer review within one business day). The regulation does allow providers to appeal administrative denials, whether or not the services were medically necessary and appropriate.

H. Submitted by Stephen W. Larcen, Ph.D., President & CEO of Natchaug Hospital

1) Comment: Section 17a-22a-8(g). This provision requires that hospital providers shall notify the ASO when a BHP member is in the emergency department for more than 12 hours or when the hospital encounters a barrier to disposition. This provision is a departure from the current practice by the ASO to contact emergency departments on a daily basis to determine if there are members needing assistance with disposition. This practice has been in place since July 2006, and based on reports by representatives of the ASO at the Operations Sub-committee this practice is working to achieve the goals of the BHP and the provisions of the BHP statute. This provision will only add a new administrative task to the compliance responsibility of hospitals, one that is currently being performed by the ASO. Since there has not been any information provided the Oversight Council that this practice is not working, we would suggest leaving such reporting by hospitals as voluntary, rather than required.

Response: See response to G.14 above.

2) Comment: Section 17a-22a -8(h). This provision expands the current voluntary bed roster to include both children and adults. There has been no information provided the Oversight Council that such reporting would be required for adult admissions of BHP members, or that there are disposition problems for adults, and this requirement would increase administrative requirements for many more than the eight hospitals that currently provide services to children or adolescents covered by the BHP. It also leaves to the Departments the discretion to increase the scope and frequency of reporting without provision for review and comment by the Oversight Council. Given the difficulty of changing regulations once

adopted, we would urge the Department to reconsider this proposed requirement. Expanding participation in the current voluntary bed roster program, and a periodic evaluation of its effectiveness in finding timely disposition for members should be completed and reported to the Oversight Council before the Department increasing administrative requirements to all hospitals.

Response: This requirement has been modified so participation is not mandatory.

3) Comment: Section 17a-22a-12. The regulation as proposed is not consistent with current Department practice, which provides for 120 days from the denial of a claim to resubmit the claim for payment. It is also silent on the payment of claims where BHP is secondary to other payers. Given that the BHP has more administrative requirements to submit a clean claim as compared to the Medicaid FFS program, we would urge the department to consider making the timely filing requirements for the BHP consistent with the Medicaid FFS requirements. Increasing provider write-offs due to administrative billing requirements that are more onerous than those under other programs administered by the State of Connecticut, or Medicare, only serves to reduce the amount of reimbursement for otherwise medically necessary services provided to BHP members.

   Response: Please note response to G.23. While the Departments acknowledge the points made above, the adoption of a less restrictive timely filing standard would result in unbudgeted costs and, as such, cannot be considered in the regulation at this time.

4) Comment: Section 17a-22a-13(g). Subsection (2) requires that payment be the lower of Medicare or the applicable fee. Given that Medicare has professional services unbundled from facility services provided by hospitals and clinics, and given that for many services provided by the BHP there are no comparable Medicare services (e.g. Intensive Outpatient, Extended Day Treatment, IICAPS, etc) there will be many cases where no comparable service will exist. Would recommend deleting this subsection, or adding language such as "the lowest Medicare rate if a comparable service is applicable" or similar.

   Response: This is a commonly occurring provision in Medicaid payment regulations and has been interpreted by the Department to mean the lowest Medicare rate, where a Medicare rate for the service exists.

5) Comment: Section 17a-22a-15. Clients should have 120 days to appeal. This rationale is based on the 120 days provided to resubmit denied claims, and the research that may be required to support such appeals.

   Response: See response to G.25. No significant research is necessary for a client to appeal a notice of action or authorization denial by the ASO. The Departments' emphasis is on rapid identification and efficient resolution of client

and provider issues, whether related to authorization, claims, or other matters. Older issues generally require more effort to research and resolve.

6) Comment: Section 17a-22a-16. Providers should have the same appeal period as members, and as described above, since denied claims may be resubmitted within 120 days the appeal associated with that claim may also be submitted at the same time.

   Response: See response to G.26.