

**MEMORANDUM OF UNDERSTANDING**

**CONNECTICUT DEPARTMENT OF SOCIAL SERVICES,**

**CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES,**

**AND CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND**

**ADDICTION SERVICES CONCERNING THE DEVELOPMENT**

**OF A PUBLIC BEHAVIORAL HEALTH SERVICE SYSTEM**

**FOR CHILDREN AND ADULTS**

THIS AGREEMENT is made by and between the State of Connecticut Department of Social Services, 25 Sigourney Street, Hartford, Connecticut 06106 (“DSS”), the Connecticut Department of Children and Families, 505 Hudson Street, Hartford, Connecticut 06106 (“DCF”), and the Connecticut Department of Mental Health and Addiction Services, 410 Capitol Avenue, Hartford, Connecticut 06106 (“DMHAS”). This Memorandum of Understanding, upon execution replaces the previous Memorandum of Understanding signed by DSS, DCF, and DMHAS in September 2002.

WHEREAS, subsection (a) of section 17a-22a of the Connecticut General Statutes directs the Commissioner of Social Services and the Commissioner of Children and Families to develop and administer an integrated behavioral health service delivery system to be known as Connecticut Community KidCare for children who are eligible to receive services from the HUSKY Plan, Part A or the federally subsidized portion of Part B, or voluntary services provided through DCF;

WHEREAS, subsection (d) of section 17a-22a of the Connecticut General Statutes directs the Commissioners of Social Services and Children and Families to enter into a memorandum of understanding (“MOU”) for the purpose of the joint administration of an integrated behavioral health delivery system;

WHEREAS, DSS is the single state agency responsible for the administration of Title XIX of the Social Security Act (“Medicaid”), a health

insurance program for enrolled low-income individuals, including enrolled low-income children who participate in the HUSKY A managed care program;

WHEREAS, DSS is the single state agency responsible for the administration of Title XXI of the Social Security Act, also known as the State Child Health Insurance Program (“SCHIP”) or HUSKY B, a publicly supported health insurance program for uninsured children;

WHEREAS, DSS is responsible for providing eligibility services to applicants and recipients of Medicaid, SAGA, HUSKY A and HUSKY B;

WHEREAS, pursuant to section 17a-3 of the Connecticut General Statutes, DCF is the state agency responsible for administering and evaluating a comprehensive and integrated statewide program of behavioral health services for children and youth;

WHEREAS, DCF is committed to the goal of providing behavioral health services that are clinically appropriate and that ensure an appropriate continuum of care in the most cost-effective way, including, but not limited to, treating children in less costly community settings whenever such care is clinically appropriate;

WHEREAS, pursuant to section 17a-11 of the Connecticut General Statutes, DCF is responsible for maintaining a voluntary services program;

WHEREAS, DCF is the state agency responsible for providing eligibility services to applicants and recipients of Title IV-E of the Social Security Act (“Title IV-E”);

WHEREAS, pursuant to section 17a-540 of the Connecticut General Statutes, DMHAS is the state agency responsible for promoting comprehensive client-based services for adults in the area of mental health and substance abuse treatment and providing a statewide program of behavioral health services to adults with serious and persistent mental illness and substance abuse problems;

WHEREAS, pursuant to section 17a-453a of the Connecticut General Statutes, DMHAS is the agency designated to provide behavioral health services to recipients of State Administered General Assistance (“SAGA”)

and General Assistance (“GA”) who are mentally ill, and/or who abuse substances;

WHEREAS, DMHAS is committed to the goal of providing behavioral health services that are clinically appropriate and ensuring an appropriate continuum of care in the most cost-effective way, including, but not limited to, treating adults in less costly community settings whenever such care is clinically appropriate;

WHEREAS, DMHAS is awaiting legislative action that would permit DMHAS to manage behavioral health clinical management services for adults who are eligible for benefits pursuant to a state plan under Title XIX or Title XXI of the Social Security Act.

WHEREAS, the Commissioners of DSS, DCF, and DMHAS agree to develop the most efficient means for administering an integrated public behavioral health delivery system that supports the clinical policies of DCF and DMHAS and includes joint policy-making with DSS;

WHEREAS, the Commissioners of DSS, DCF, and DMHAS agree that an integrated approach between all three agencies is in the best interest of their respective clients that a single MOU, consistent with the above-noted DSS/DCF statutory directive, is a necessary means to achieve such integrated approach;

NOW, THEREFORE, it is hereby agreed that:

## **I. PURPOSE**

- A. This MOU delineates each agency’s roles and responsibilities and associated terms and conditions necessary for the effective and efficient implementation and management of the integrated behavioral health system in accordance with each agency’s statutory authority and policy objectives.

## **II. DEFINITIONS**

For purposes of this agreement, the following definitions apply:

- A. Adults means individuals eighteen years and older. DCF may have obligations to individuals under 21 pursuant to subsection (g) of section 17a-11 and subsection (j) of section 46b-129 of the Connecticut General Statutes.
- B. Authorization means the requirement of approval of a service by a designated management entity that is necessary for the service to be reimbursable.
- C. Administrative Services Organization (“ASO” means an organization that contracts with the state and performs administrative services. Although the ASO is subject to performance requirements and associated incentives and penalties, it does not assume capitated risk under the Behavioral Health Partnership. Services provided by the ASO may include, but are not limited to utilization management, quality management, data reporting, fiscal management, recipient services and network management services.
- D. The Behavioral Health Partnership (“Partnership”) means a collaboration involving DSS, DCF, and DMHAS (collectively referred to as “the Departments”) to develop a jointly administered integrated public behavioral health service delivery system (“integrated system”) that subsumes Connecticut Community KidCare and the Recovery Healthcare Plan for Adults, for individuals who are eligible to receive services from the HUSKY Plan, Part A, the subsidized portion of Part B, the DCF voluntary services program, all Medicaid beneficiaries who are not enrolled in managed care with the exception of the spend down coverage groups, and beneficiaries of the SAGA and GA programs. The goal of the Partnership is to provide access to a more complete, coordinated and effective system of community-based behavioral health services and supports. The Departments are committed to making enhancements to the current system of care in order to improve access, quality, and individual outcomes.
- E. Behavioral Health Services means both Behavioral Health Treatment Services and Non-Medical Support Services. Behavioral Health Treatment Services are those services needed for the individual to correct or diminish the adverse effects of a mental health or substance abuse disorder. Non-Medical Support Services are those services that

- help an individual to function safely and independently in the community or support the ability of an individual's family to care for the individual in the community.
- F. Billing Provider means a provider billing Medicaid, SCHIP and/or GABHP on behalf of a performing provider who is not billing Medicaid directly.
- G. Children or children and youth means individuals under eighteen years old.
- H. Claims processing means an administrative process that involves the adjudication and payment of claims submitted by a service provider or another entity acting on the provider's behalf.
- I. Clinical Management means the process of evaluating and determining the appropriateness of the utilization of behavioral health services, as well as providing any needed assistance to clinicians or patients to promote the effective and appropriate use of clinical resources. Clinical management includes, but is not limited to, authorization, concurrent and retrospective review, discharge planning, case management, quality management, provider certification, and provider performance enhancement.
- J. Commissioners means the Commissioner of Social Services, the Commissioner of Children and Families, and the Commissioner of Mental Health and Addiction Services.
- K. Community Collaborative means a local consortium of public and private health care providers, parents and guardians of children with behavioral health needs and service and education agencies that have organized to develop coordinated comprehensive community resources for children or youth with complex behavioral health service needs and their families in accordance with principles and goals of Connecticut Community KidCare.
- L. Connecticut Community KidCare means the DSS and DCF led initiative to reform the delivery and financing of Behavioral Health Services for children throughout the State of Connecticut. Key features include the enhancement of local service delivery systems,

- incorporation of nontraditional services, and an emphasis on family participation, accountability and cost-effectiveness.
- M. Compliance audit means a methodical examination and review of an entity's compliance with applicable statutes, regulations or contractual requirements.
- N. Data management means an administrative process that involves the storage, integration, manipulation, analysis, and reporting of data, which may come from multiple sources, for the purpose of supporting program management, performance measurement, and contract enforcement.
- O. Eligibility Services means services related to accepting and evaluating applications and determining whether an individual is eligible for benefits.
- P. General Assistance Behavioral Health Program ("GABHP") means a Fee-For-Service ("FFS") managed care carve-out program administered by DMHAS and contracted through an ASO that manages the behavioral health care for eligible recipients of SAGA and GA.
- Q. HUSKY Plan, Part A or HUSKY A means the Department of Social Services' Medicaid managed care program.
- R. HUSKY Plan, Part B or HUSKY B means the subsidized portion of the health insurance plan for individuals established pursuant to the provisions of section 17b-289 to 17b-303, inclusive, and section 16 of Public Act 97-1 of the October 29 special session, as amended by Public Act 01-137 and Public Act 01-2, section 23 (June Special Session).
- S. HUSKY Plus Behavioral Program means the specialized health insurance benefit established pursuant to the provisions of section 17b-294 of the Connecticut General Statutes.
- T. Intensive Care Management means specialized care management techniques used for a subset of the population that are activated when

- an individual is experiencing a barrier that can prevent or delay recovery and/or impede improved outcomes.
- U. The International Classification of Diseases or “ICD” means the most recent edition of this disease classification system, as amended from time to time.
- V. Managed Care Organization (“MCO”) means an entity that contracts with DSS and that offers a managed care plan, as defined in section 17b-290 (17) of the Connecticut General Statutes, for HUSKY A and/or HUSKY B. (Note: HealthNet is an MCO under HUSKY A but does not participate in B).
- W. Medical appropriateness or medically appropriate means health care that is provided in a timely manner, meets professionally recognized standards of acceptable medical care; is delivered in an appropriate medical setting and is the least costly of multiple, equally effective alternative treatments or diagnostic modalities.
- X. Medical necessity or medically necessary means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; or to diagnose a condition or prevent a medical condition from occurring.
- Y. Performing Provider means an entity or individual that is enrolled as such in the Medicaid program, and is under contract with a billing provider, and that provides diagnostic or treatment services that are recommended by a licensed practitioner of the healing arts within the scope of his or her practice and in accordance with an individual service plan.
- Z. Quality Management means a comprehensive program of quality improvement and quality assurance activities responsive to the Partnership’s objectives.
- AA. Readiness Audit means a methodical examination and review of an entity’s readiness to assume responsibilities under a proposed contract or agreement.

- BB. Recipient Services means a function of the Administrative Services Organization (ASO) that provides information to recipients and when appropriate provides immediate access to clinical staff for care-related assistance.
- CC. Recovery Healthcare Plan for Adults means the DSS and DMHAS led initiative to reform the delivery and financing of Behavioral Health Services for adult consumers of publicly financed behavioral health services throughout the State of Connecticut. Key features may include the clinical management of behavioral health services by DMHAS, the emphasis of care on recovery and rehabilitation, and the coverage of rehabilitation services under Medicaid.
- DD. Regional Management means a function of the Administrative Services Organization (ASO) that promotes community-based and recovery oriented care planning and service system development, including helping to eliminate the major gaps and barriers that exist in the adult and child behavioral health delivery systems.
- EE. The State Administered General Assistance (“SAGA”) and General Assistance (“GA”) means programs administered pursuant to section 17b-111 and section 17b-116, as amended in Public Act 01-9, section 108 (June Special Session), of the Connecticut General Statutes.
- FF. Telephone Call Management Services means a function of the ASO that facilitates recipient and provider access to information and services in an efficient, convenient, and user-friendly manner.
- GG. Title IV-E means the federal reimbursement program operated by DCF under Title IV-E of the Social Security Act and Amendments pursuant to PL 104-432. Title IV-E allows states to qualify for federal reimbursement for certain administrative costs associated with states’ administration of their foster care program, and for room and board charges for children in out of home placements.
- HH. Title XIX or “Medicaid” means the medical assistance program operated by DSS under Title XIX of the Social Security Act and sections 17b-261 of the Connecticut General Statutes.

- II. Title XXI or “SCHIP” means the children’s health insurance plan operated by DSS under TITLE XXI of the Social Security Act and sections 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the October 29 special session.
- JJ. Voluntary Services Program means services for children or youths who might otherwise be committed as neglected, uncared for, or dependent, as provided for in section 46b-129 of the Connecticut General Statutes in order to secure Department services and who meet criteria set forth in sections 17a-11-4 to 17a-11-27, inclusive, of the Regulations of Connecticut State Agencies.

### **III. STRUCTURE OF PARTNERSHIP AND DEVELOPMENT OF POLICIES AND PROCEDURES**

- A. DSS, DMHAS, and DCF agree to maintain joint committees and teams established under the Partnership to develop and monitor policies and procedures for the administration of an integrated public behavioral health service system (“integrated system”). The committee structure will provide an operational framework that supports each agency’s roles and responsibilities under the Partnership. A representative from DSS and DMHAS and/or DCF will chair each committee. The number of co-chairs will be determined as follows, (a) if the committee addresses issues that primarily relate to children and families it shall be co-chaired by DSS and DCF but will also include a representative from DMHAS, (b) if the committee addresses issues that primarily relate to adults it shall be co-chaired by DSS and DMHAS but will also include a representative from DCF and, (c) if the committee addresses issues that relate to all three agencies it shall be jointly chaired by all three agencies.
- B. The committee structure will ensure the efficient management of inter-agency work and communications. This communication process will provide for, at a minimum, (a) development and distribution of agendas prior to all meetings, (b) preparation of written notes documenting attendance, key points and decisions made at each meeting, (c) distribution of these agendas and notes within and across Committees through listserv, (d) development of a work plan

- establishing a list of deliverables for each Committee and dates for completion of agreed upon deliverables, (e) revision of such work plans to keep them up to date, and (f) reports of progress at each scheduled meeting. The co-chairs of each Committee will be responsible for updating the work plans and providing the updates at each scheduled meeting. The host agency will be responsible for the above-referenced points, (a) through (c) and distribution thereafter.
- C. The committee and implementation teams shall include representation from DSS, DMHAS, and DCF and shall include, but not be limited to, the following committee and teams with the following functions:
1. The Partnership Policy Committee (“Policy Committee”)
    - a) The Policy Committee shall consist of the Commissioners, the co-chairs of the Implementation Teams, the Secretary of OPM or his designees, and any additional members approved by the Commissioners. The Policy Committee shall be co-chaired by the Commissioners. The co-chairs shall set the agenda for the meeting. All Commissioners must be present in order for the Policy Committee to convene, unless the absent Commissioner designates an alternate with voting authority. The Policy Committee shall convene as frequently as necessary, but not less than every other month.
    - b) The Policy Committee shall review and resolve, as necessary, policy questions related to the administration of the integrated system. These include, but are not limited to, the following:
      - (i) Requests for policy decisions submitted by any of the three Implementation Teams.
      - (ii) Issues that may change the nature or impact of the integrated system.
    - c) The co-chairs shall make final decisions, as necessary, regarding policy questions. The Commissioners of DCF and DSS shall act on all requests for decisions referred by the CIT. The Commissioners of DMHAS and DSS shall act on all requests for decisions referred by the AIT. All three

Commissioners shall act on all requests for decisions referred by the AFT.

- d) In the event that agreement of the co-chairs cannot be reached, the dispute resolution procedures identified in this MOU.

## 2. Child Implementation Team

- a) The Child Implementation Team (“CIT”) shall be responsible for decisions related to the service delivery system, policy, design, and quality under KidCare, and the implementation of rehabilitation services, and extensions of service coverage under the Medicaid rehabilitation option, if any.
- b) The DSS and DCF Commissioners shall designate the co-chairs of the CIT. In addition to the co-chairs, the CIT shall consist of representatives of DSS, DCF, OPM and DMHAS, who are designated by their respective agency heads, and others as jointly determined by the Commissioners. The Medical Directors of both DCF and DMHAS or their designees and the Medicaid Director of DSS shall be ex-officio members of the CIT.
- c) The CIT shall include a parent representative and may also provide for the input of parents and advocates by utilizing the Children’s Behavioral Health Advisory Committee.
- d) The CIT shall allow for provider input by utilizing the Children’s Behavioral Health Advisory Committee.
- e) The CIT shall develop a project plan that outlines all the tasks and deliverables necessary for full implementation of the Partnership.
- f) The CIT shall establish an Interagency Quality Management Subcommittee responsible for reviewing ASO quality related materials, KidCare evaluation and performance measurement, and for other quality related issues as determined by the CIT.

- g) The CIT may establish subcommittees and time-limited workgroups as necessary to fulfill its responsibilities.
- h) Areas of responsibility for the CIT may include, but are not limited to, the following:
  - (i) Service system design and development
  - (ii) Service definitions, profiles and certification criteria
  - (iii) Network management
  - (iv) Review and approval of ASO UM, ICM, and QM programs
  - (v) Rehabilitation option planning & implementation, if any
  - (vi) Credentialing/certification policies and procedures
  - (vii) Regulation development and review
  - (viii) Service system evaluation and performance measurement
  - (ix) Pharmacy benefit management

### 3. Adult Implementation Team

- a) The Adult Implementation Team (“AIT”) shall be responsible for decisions related to the service delivery system, policy, design, and quality under the Recovery Healthcare Plan for Adults and the implementation of rehabilitation services, and extensions of service coverage under the Medicaid rehabilitation option, if any.
- b) The DSS and DMHAS Commissioners shall designate the co-chairs of the AIT. In addition to the co-chairs, the AIT shall consist of representatives of DSS, DCF, OPM and DMHAS, who are designated by their respective agency heads, and others as jointly determined by the Commissioners. The Medical

Directors of both DCF and DMHAS or their designees and the Medicaid Director of DSS shall be ex-officio members of the AIT.

- c) DMHAS shall allow for consumer input by expanding the scope of responsibility of its Consumer Advisory Council.
- d) DMHAS shall allow for provider input by expanding the scope of the Provide Advisory Council.
- e) The AIT shall develop a project plan that outlines all the tasks and deliverables necessary for implementation of the Partnership.
- f) The AIT shall establish an Interagency Quality Management Subcommittee responsible for reviewing ASO quality related materials and for other quality related issues as determined by the AIT.
- g) The AIT may establish other subcommittees or time-limited workgroups as necessary to fulfill its responsibilities.
- h) Areas of responsibility for the AIT may include, but not be limited to, the following:
  - (i) Service system design and development
  - (ii) Service definitions, profiles and certification criteria
  - (iii) Network management
  - (iv) Review and approval of ASO UM, ICM, and QM programs
  - (v) Rehabilitation option planning and implementation, if any
  - (vi) Credentialing/certification policies and procedures
  - (vii) Regulation development and review
  - (viii) Service system evaluation and performance measurement
  - (ix) Pharmacy benefit management

#### 4. Administration and Finance Implementation Team

- a) The Administration and Finance Implementation Team (“AFT”) shall make decisions related to shared administrative tasks and operations, shared policy (e.g., grievance and appeals), and financial analysis.
- b) The DSS, DCF and DMHAS Commissioners shall designate the co-chairs of the AFT. In addition to the co-chairs, the AFT shall consist of representatives of DSS, DCF, OPM and DMHAS, who are designated by their respective agency heads, and others as jointly determined by the Commissioners.
- c) The AFT shall develop a project plan that outlines all the tasks and deliverables necessary for implementation of the Partnership.
- d) The AFT shall establish a Fiscal Subcommittee to address fiscal issues related to the implementation of the Partnership
- e) The AFT shall establish an ASO Contract Management Subcommittee for the purposes described in Section IV.
- f) The AFT may establish additional subcommittees and time-limited workgroups as necessary to fulfill its responsibilities.
- g) Areas of responsibility for the AFT may include, but not be limited to, the following:
  - (i) Accounting
  - (ii) Administrative appeals
  - (iii) Administrative contracts (claims, data management, clinical management, revenue maximization)
  - (iv) Administration of ASO withholds and sanctions
  - (v) ASO contract management
  - (vi) Auditing

- (vii) Budget development
- (viii) Communications (internal and external)
- (ix) Legislation
- (x) Memoranda of understanding/interagency agreements
- (xi) Operations
- (xii) Rate setting
- (xiii) Recoupments
- (xiv) Reduction/expansion options
- (xv) Refinancing (e.g., conversion of grants to fee-for-service)
- (xvi) Revenue Maximization

## 5. General Provisions Applicable to Implementation Teams

- a) All decisions made by an Implementation Team within its scope of responsibility shall be by consensus of the members and shall be binding. No decision made by any Implementation Team shall be binding without representation from all three Departments.
- b) In the event consensus cannot be reached or if an Implementation Team or any representative thereof believes that an issue warrants review and approval by the Policy Committee, the issue shall be so referred. In the event of a conflict between a decision of the Policy Committee and that of an Implementation Team, the decision of the Policy Committee shall prevail.
- c) Day-to-day operational decisions may be made outside of the Policy Committee and Implementation Teams. Such decisions that may bear on the work of the Implementation Teams shall be reported to the Implementation Teams. Such decisions that may alter policy or otherwise conflict with decisions made by the Policy Committee or Implementation Teams shall be referred to the Implementation Team with authority over the matter in question.
- d) All Partnership policies and procedures shall comply with applicable state and federal Title XIX and Title XXI requirements, any requirements set forth in Title IV-E, and state statutes governing SAGA and GA.

## **IV. ASO CONTRACT MANAGEMENT & ADMINISTRATION**

- A. The Partnership has undertaken the procurement of an ASO, which will provide administrative services under the direction of the Departments. As part of the procurement process, the Departments have established a Core Review Committee responsible for evaluating and scoring the proposals and for making a recommendation to the Commissioners regarding the selection of a successful bidder.

- B. Upon selection of the successful bidder by the Commissioners, the Core Review Committee shall be dissolved and the AFT shall establish an ASO Contract Management Subcommittee to support contract development and negotiation. Upon execution of the contract, the ASO Contract Management Subcommittee shall be responsible for integrated ASO contract management activities.
- C. Each Department shall designate an ASO Contract Manager. The Contract Managers shall serve as co-chairs of the ASO Contract Management Subcommittee and oversee management of the ASO.
- D. The ASO Contract Management Subcommittee shall report to the AFT.
- E. The AFT shall grant the ASO Contract Management Subcommittee specific authority so that management of the ASO will be seamless and efficient.
- F. The ASO Contract Management Subcommittee shall manage the ASO in accordance with the contractual requirements and report to the AFT on any matters of policy or on issues that cannot be resolved through established procedures.
- G. Prior to contract execution, the ASO Contract Management Subcommittee will be responsible for the following:
  - 1. Contract development,
  - 2. Contract negotiations,
  - 3. Attorney General's office communications,
  - 4. Administration of the contract executive process,
  - 5. ASO pre-implementation readiness review,
  - 6. Development of methodology to monitor compliance regarding performance targets and withholds allocation,
  - 7. Development of internal triage and response protocols when complaints are received by the Departments,
  - 8. Development of project timeline to assist in meeting key deliverables through the contract negotiation signing process,
  - 9. Solicitation of AFT approval of ASO contract, and
  - 10. Administration of the contract execution.

- H. Upon execution of the contract, the ASO Contract Management Subcommittee will be responsible for the following:
1. Oversight and management of the ASO Implementation Plan,
  2. Approval of the ASO's key personnel,
  3. Oversight and monitoring of the ASO Operations Project Plan,
  4. Oversight and management of the ASO's performance according to the terms and conditions of the Contract,
  5. Response to all ASO inquiries and other communications related to implementation, operations, and program management,
  6. Rendering of opinions or determinations with respect to applicable state and federal regulations and policies as the need arises and upon request of the ASO. Such opinions, determinations, and communications shall require consensus of the chairs and, when written communication is necessary, shall be communicated in writing on Partnership letterhead by the Committee to the ASO,
  7. Development of a methodology to manage the corrective action process, and
  8. Development of formal updates to the Policy Committee, AFT, AIT, and CIT.
- I. The Contract Managers shall be the first contacts regarding issues that arise related to Contract implementation, operations, and program management. As such, the Contract Managers will be responsible for all inter-departmental communications related to the ASO.
- J. The ASO Contract Management Subcommittee shall meet on a regularly scheduled basis and shall make decisions according to a consensus of the chairs.
- K. At least once monthly, the ASO Contract Management Subcommittee meeting shall include the ASO and shall focus on technical issues associated with the administration of the Contract including matters of Contract interpretation, the performance of the State and ASO in meeting Contract terms and conditions, and the administration of performance incentives and sanctions.
- L. At least once monthly, the ASO Contract Management Subcommittee meeting will include the ASO and shall focus on access, quality, and

clinical management including the review of related data and reports, and the ASO's Quality Management Program Plan,

M. The Partnership has appointed the DSS Contract Administrator to serve as an agent under the direction of the Partnership's Contract Managers. The Contract Administrator's responsibilities include the issuance of formal opinions with regard to interpretation of the contract terms and conditions, the ASO's performance under the terms of the Contract, and the administration of incentives and sanctions.

N. Dispute Resolution

1. Any dispute arising under the Contract that is not resolved by agreement between the Partnership's Contract Managers shall be referred to the AFT for resolution.
2. The Partnership shall resolve disagreements among the Partnership Contract Managers within thirty (30) days for routine matters and within five (5) days for matters requiring urgent resolution.

O. The DCF Contract Manager will be responsible for resolving issues that arise involving clinical care, quality of care, or safety of a child recipient or an adult with a DCF identifier.

P. The DMHAS Contract Manager will be responsible for resolving issues involving clinical care or quality for an adult recipient.

## **V. CONFIDENTIALITY**

A. DSS, DCF, and DMHAS shall abide by applicable state and federal statutes, regulations, and policies concerning confidentiality.

## **VI. SERVICES ADDRESSED BY THE INTEGRATED SYSTEM UNDER THE PARTNERSHIP**

A. DCF is fully responsible for the provision of behavioral health services to children and youth unless otherwise excepted by statute. As such, DCF and its contractors or subcontractors are responsible for defining and implementing the covered services to be included in the

- continuum of care, with the approval of DSS for Medicaid and SCHIP covered services, and for developing statewide training programs on the systems of care approach for providers, families and other persons.
- B. DMHAS is fully responsible for the provision of services to adults unless otherwise excepted by statute. As such, DMHAS and its contractors or subcontractors are responsible for defining and implementing the covered services to be included in the continuum of care, with the approval of DSS for Medicaid and SCHIP covered services, and for developing statewide training programs on the recovery services approach for providers, families and other persons.
- C. Behavioral health services for HUSKY A enrollees and non-spend down Medicaid beneficiaries shall include all behavioral health services contained in the Connecticut Medicaid Program that are medically necessary and medically appropriate for the treatment of diagnoses within the ICD range 290-319, with the exception of primary behavioral health care, pharmacy, school-based child health, Connecticut Birth to Three, and non-emergency medical transportation. Additional service and diagnostic inclusions and/or exclusions may apply with the approval of DSS, DCF, and DMHAS.
- D. Behavioral health services for HUSKY B enrolled children or youth shall include all of the behavioral health services listed in the HUSKY B State plan (including HUSKY Plus Behavioral services), as may be amended from time to time, that are medically necessary and medically appropriate for the treatment of diagnoses within the ICD range 290-319, with the exception of primary behavioral health care and pharmacy. Additional service and diagnostic inclusions and/or exclusions may apply with the approval of DSS and DCF.
- E. Behavioral health services for children or youth enrolled in the DCF voluntary service program. Additional services may be covered within available appropriations.
- F. Behavioral health services for adults enrolled in the SAGA and GA programs are covered under a separate MOU between DMHAS and DSS executed in June 1999, and as amended from time to time.

- G. Other services may be made available to individuals served by the integrated system within available appropriations.
- H. DSS, DCF, and DMHAS and their contractors or subcontractors shall comply with all state and federal Medicaid and SCHIP requirements in defining and maintaining responsibility for the scope of services for which DCF and DMHAS are responsible.

## **VII. AGENCY ROLES AND RESPONSIBILITIES**

- A. DSS and its contractors or subcontractors are responsible for administrative activities, including, but not limited to, the following:
  - 1. Managing Medicaid provider agreements with billing providers and performing providers;
  - 2. Administering federal reporting and claiming for Medicaid and SCHIP;
  - 3. Applying for necessary federal Medicaid and SCHIP waivers;
  - 4. Enacting necessary changes to the Medicaid and SCHIP state plans;
  - 5. Promulgating necessary regulations or regulatory amendments to establish the clinical management program and coverage of rehabilitation services through the Uniform Administrative Procedure Act;
  - 6. Managing the interface between MCOs and the entities responsible for the administration and delivery of behavioral health services for Medicaid, SCHIP, and Voluntary Service recipients under the integrated system;
  - 7. Managing data to support Medicaid and SCHIP eligibility, budget and federal claiming and providing such data and support to DCF and DMHAS to support their respective management needs;
  - 8. Ensuring compliance with notice of action requirements;

9. Managing and monitoring quality, cost, and access as it relates to the provision of Medicaid and SCHIP covered services under the integrated system, in partnership with DCF and DMHAS; in particular, this aspect of the Partnership would focus on determining the rate structure and reimbursement policies that support the management of quality, cost, and access;
    - a) In order for DMHAS and DCF to participate with DSS in managing and monitoring quality, cost, and access as it relates to the provision of Medicaid and SCHIP covered services, DSS will disclose to DMHAS and DCF that client material or information which is necessary for DMHAS and DCF to participate in this activity.
    - b) Assigning representatives from DMHAS and DCF that agree to regard such material or information as confidential, and take all necessary steps to safeguard the confidentiality of such material or information in conformance with federal and state statutes and regulations. DMHAS and DCF agree not to further release any client material or information provided by DSS without the express consent of DSS' Manager of Behavioral Health;
  10. Conducting administrative hearings for Medicaid and SCHIP covered services;
  11. Issuing new or amended provider policies and regulations to support modified requirements or new provider types established as part of the clinical management initiatives or the coverage of rehabilitation services;
  12. Enacting necessary changes to its claims processing vendor contract and system to support modified requirements or new coverage groups or provider types established as part of the clinical management initiatives or the coverage of rehabilitation services.
- B. DCF and its contractors or subcontractors are responsible for the implementation of certain management services, including, but not limited to, the following:
1. Defining covered child behavioral health services, with the approval of DSS for Medicaid and SCHIP covered services;

2. Developing policies and procedures pertaining to the clinical management functions for children and collaborating with DMHAS in the development of such policies for individuals ages 18 through 21 pursuant to subsection (g) of section 17a-11 and subsection (j) of section 46b-129 of the Connecticut General Statutes;
3. Developing policies and procedures that ensure the provision of services that are sensitive and responsive to the cultural preferences and environmental needs of children and families;
4. Developing policies and procedures pertaining to the management and monitoring of child behavioral health quality and access;
5. Managing data to support Title IV-E eligibility, enrollment, budget and federal claiming;
6. Conducting periodic audits related to IV-E and other program requirements not related to Medicaid and SCHIP;
7. Establishing minimum standards for referral management and service delivery;
8. Coordinating and facilitation training of all willing persons involved in Connecticut Community KidCare, including, but not limited to, employees in education and child care and appropriate employees within the judicial system;
9. Defining the roles and obligations of DCF contracted and funded providers in delivering and clinically managing behavioral health services;
10. Determining what data and reports are necessary to support the implementation and ongoing operations of the child clinical management system;
11. Establishing policies and protocols to assure that, in clinically managing behavioral health services, there is necessary coordination with physical health services and behavioral health

services provided by primary care providers in the HUSKY managed care organizations.

- C. DMHAS and its contractors or subcontractors are responsible for the implementation of certain management services, including, but not limited to, the following:
1. Defining covered adult behavioral health services, with the approval of DSS for Medicaid and SCHIP covered services;
  2. Developing policies and procedures pertaining to the clinical management functions for adults;
  3. Developing policies and procedures that ensure the provision of services that are sensitive and responsive to the cultural preferences and environmental needs of adult recipients;
  4. Developing policies and procedures pertaining to the management and monitoring of adult behavioral health quality and access;
  5. Establishing minimum standards for referral management and service delivery;
  6. Determining what data and reports are necessary to support the implementation and ongoing operations of the adult clinical management systems;
  7. Defining the roles and obligations of DMHAS divisions and vendors, in delivering and clinically managing behavioral health services;
- D. All actions, standards, protocols and procedures concerning activities set forth in this MOU shall be reviewed by DSS in order to determine whether there is compliance with Medicaid and SCHIP state and federal regulations and statutory requirements in accordance with DSS' responsibility as the single state agency for Medicaid and SCHIP. If DSS determines that there is non-compliance with such statutes or regulations, DSS shall require corrective action prior to implementation.

## **VIII. ELIGIBILITY**

- A. DSS or its agent shall determine eligibility for Medicaid, SAGA and SCHIP, except in such areas in which DSS has delegated this responsibility to DCF (e.g., D01/D02).
- B. DCF shall develop Connecticut Community KidCare eligibility policies and procedures and make eligibility determinations for those children who are not eligible for benefits under Medicaid, HUSKY A or HUSKY B.
- C. DSS shall establish a mechanism to regularly (at least weekly) share information pertaining to the enrollment and disenrollment of individuals under Medicaid, SAGA, and SCHIP, as is necessary to support efficient clinical management activities as directed by DCF and DMHAS or their agents.

## **IX. SECTIONS TO BE ADDED AT A LATER DATE**

- A. Information Systems
- B. Data Issues
- C. ASO Contract/Transition HUSKY
- D. ASO Contract/Transition GABHP
- E. Utilization Management
- F. Provider Relations
- G. Regional Management
- H. Intensive Care Management
- I. Young adult/transitional youth services
- J. Recipient information and services
- K. Notice of action, grievances and administrative hearings

L. Quality Management

**X. CONTRACTING FOR ADMINISTRATIVE SERVICES**

- A. All contracts and subcontracts involving DSS, DCF, DMHAS, and the ASO shall comply with all applicable federal and state law requirements pertaining to Title XIX and Title XXI and any other relevant provisions of state and federal law.
- B. All contracts and subcontracts involving DCF or DMHAS that pertain, wholly or in part, to the provision of Medicaid or SCHIP covered services or to administrative activities under the BHP, shall be reviewed by DSS. Prior to the signing of any such contracts or subcontracts, DSS shall determine whether there is compliance with state and federal regulatory and/or statutory requirements and DSS capacity to support such contract or subcontract in accordance with DSS's responsibility as the single state agency. If DSS determines that there is non-compliance with such statutes and/or regulations, DSS shall require changes to such contracts or subcontracts in accordance with said statutes and regulations prior to the contracts being signed.
- C. DCF, DMHAS and DSS shall coordinate on the development of any Requests for Proposals ("RFPs") or Requests for Applications ("RFAs") related to the provision of services or to administrative activities under the Partnership. All RFPs and RFAs shall be approved by the affected agencies prior to their issuance.

**XI. INFORMATION SYSTEMS**

- A. DSS shall allow authorized DCF and DMHAS staff, authorized contracted staff, or other authorized representatives access to the automated eligibility management systems, known as EMS, to the extent required for the administration of the integrated system.
- B. DSS, DCF, and DMHAS agree to use the most efficient and effective methods for meeting each agency's information management and

processing requirements pertaining to the integrated system. The Departments shall develop a data management strategy that supports each agency's management and contracting responsibilities pertaining to the integrated system. This may include use of a data warehouse in DMHAS or DCF and/or use of a data warehouse to be established by DSS. In the event that DCF or DMHAS decides to retain the services of an MIS contractor or subcontractor for the management of healthcare information pertaining to the provision of Medicaid or SCHIP covered services, DSS shall review any such contracts or subcontracts prior to the signing of such contracts or subcontracts.

## **XII. FINANCIAL PLANNING AND MANAGEMENT**

- A. DSS, DCF, and DMHAS shall jointly engage actuaries, as necessary to conduct policy and finance related research and analysis regarding current and potential future costs associated with the goals of the Partnership. The publication or dissemination of any reports of findings based on such analyses requires written approval from the DSS Commissioner or his/her designated representative, from the DCF Commissioner or his/her designated representative, and from the DMHAS Commissioner or his/her designated representative.
- B. DSS, DCF, and DMHAS shall establish a collaborative process to review provider reimbursement policies and rate setting methodologies that support the community-based goals of Connecticut Community KidCare and the Recovery Healthcare Plan for Adults.
- C. Unless otherwise provided by contract, DSS or its agent, shall calculate rates and publish payment and reimbursement policies for Medicaid and SCHIP-covered services. DCF or its agent shall calculate rates and publish payment and reimbursement policies for child Behavioral Health Services that are not covered by Medicaid or SCHIP. DMHAS or its agent shall calculate rates and publish payment and reimbursement policies for adult Behavioral Health Services that are not covered by Medicaid or SCHIP, including services provided to recipients under the SAGA program and the GA program.

- D. The agencies shall develop a claims processing approach that allows for the efficient administration of a comprehensive behavioral health benefit.
- E. Fiscal appropriations under the Partnership will remain in each agency's individual budget. At the first quarter under the Partnership, a fiscal projection will be made and a payment based on that projection would be transferred to DSS by DCF and DMHAS. At intervals to be determined a budget to actual reconciliation will be conducted and subsequent payments to DSS will be made based upon the budget to actual reconciliation process. In the event of deficiencies, DCF, DSS and, DMHAS will be prepared to testify/justify reasons for those deficiencies.
- F. The Departments shall develop policies and procedures to govern financial transfer of monies and other financial transactions related to activities undertaken by the Partnership three (3) months prior to the budgeted effective date of such transfers or transactions.
- G. As DSS remains the single state agency for Medicaid, DSS will take the lead for audits of Medicaid providers under the Partnership. DMHAS retains lead responsibility for auditing Behavioral Health SAGA. In the event of an overlap in terms of the DMHAS provider network and the Connecticut (DSS Network), DSS/DMHAS/DCF will develop an annual audit plan to avoid duplication of effort. Audit findings, as a result of any audit of a program under the Partnership, will be reviewed through AFT, before issuance of draft reports. The AFT will ensure that credits and/or recoupments will be made to the appropriate agency accounts.
- H. DSS, DCF, and DMHAS agree to the following:
1. The development and administration of a public behavioral health services system as contemplated in this MOU shall be within the appropriations (and/or other funds) available for such purpose; and
  2. Nothing in this MOU shall be construed to obligate or otherwise require a signatory agency to expend funds beyond those committed for purposes of this MOU.

### **XIII. RESPONDING TO DISCOVERY AND FREEDOM OF INFORMATION REQUESTS AND OTHER INQUIRIERS**

- A. DCF, DMHAS, and DSS shall coordinate responses to discovery requests and other requests for information concerning the integrated system. In the event that a request for information or documents is not directed to a specific agency, responses shall be provided by the agency that has particular expertise in the subject matter of the request.
  
- B. DCF, DMHAS, and DSS shall cooperate with regard to providing information to each other and gathering documents for each other, as necessary to respond to interrogatories, requests for production or freedom of information requests.

### **XIV. LEGISLATION**

- A. To the extent that legislation is necessary to achieve any of the goals of the Partnership, DSS, DCF and DMHAS shall jointly develop and approve proposed bills prior to their submission to the Office of Policy and Management (“OPM”).

### **XV. COMPLIANCE MONITORING**

- A. DSS or its agent, DCF, and DMHAS shall conduct regular operational and financial reviews of the integrated system to ensure operational and financial program compliance with Title XIX and Title XXI requirements.
  
- B. Pursuant to its responsibility as the single state agency for Title XIX and Title XXI, DSS shall require corrective action to ensure compliance with state and federal regulations and/or statutory requirements for those aspects of the integrated system that are the responsibility of DCF or DMHAS. DSS must provide written notice to DCF or DMHAS of any contemplated corrective action.
  
- C. If DSS determines that DCF or DMHAS operations under the Partnership are not compliant with state and/or federal regulatory and statutory requirements pertaining to Medicaid or SCHIP, and these

agencies fail to take immediate correction action, then DSS, pursuant to its responsibility as the single state agency for Title XIX and Title XXI, may take whatever action is deemed appropriate to return the program to full compliance.

- D. DSS, DCF, and DMHAS shall be responsible for detecting potential fraud and abuse.
- E. DSS, DCF, and DMHAS shall coordinate respective efforts to conduct audits of behavioral health providers. The Departments shall develop a plan for the coordination of such audits no later than October 1, 2003.
- F. Any financial recoupments resulting from said audits shall be credited to the appropriate agencies.

## **XVI. DISPUTE RESOLUTION**

- A. In the event of a dispute concerning the implementation of any aspect of this MOU, the designated contact people, as identified below, or their designees, may attempt to resolve the dispute:

DSS Designated Contact Person, Address and Telephone Number:

Manager, Behavioral Health  
25 Sigourney Street  
Hartford, CT 06106  
(860) 424-5067

DCF Designated Contact Person, Address and Telephone Number:

Director of Mental Health  
505 Hudson Street  
Hartford, CT 06106  
(860) 550-6683

DMHAS Designated Contact Person, Address and Telephone Number:

Director of Managed Care

Dept. of Mental Health and Addiction Services  
410 Capitol Ave., Hartford, CT  
(860) 418-6885

- B. Further resolution, if necessary, shall be done at the Commissioner level.
1. In the event that the Commissioners are unable to resolve the dispute and, if requested by any of the Commissioners, the parties shall request the Secretary of OPM to mediate and resolve any disputes through a dispute resolution process.
  2. Notwithstanding the above:
    - a) If a dispute involves requirements under Title XIX or Title XXI, DSS shall have the final authority concerning the dispute.
    - b) If a dispute involves requirements under Title IV-E, DCF shall have the final authority concerning the dispute.
    - c) If a dispute involves requirements under SAGA, the MOU governing the administration of SAGA shall apply.
  3. If a dispute involves requirements that have been imposed by a court order, the agency that is subject to the court order shall have final authority concerning the dispute.

## **XVII. TERM**

- A. DSS, DCF, and DMHAS shall review this MOU at least annually and make any necessary changes that are acceptable to all parties.
1. DSS, DCF, and DMHAS shall make any necessary changes to this MOU to support the joint administration of an integrated public behavioral health system prior to full implementation of such system.
  2. With the consent of DSS, DCF, and DMHAS, amendments to this MOU may be made at any time to ensure coordinated

implementation of activities under the Partnership. All amendments to this MOU shall be in writing.

3. Should the GABHP no longer be a fee-for-service program all references to the GABHP will be eliminated from this document.
- B. Termination of DSS' or DCF's participation in this MOU may occur only if there is no longer a statute requiring a memorandum of understanding or if the Partnership ceases to exist.
- C. Termination of DMHAS' participation in this MOU may occur by mutual agreement of the Commissioner of DMHAS and the Commissioner of DSS or if the Partnership ceases to exist.

**XVIII. ASSIGNMENT**

This MOU shall apply to and bind any successor agency or entities of DCF, DMHAS, or DSS.

For DSS:

For DCF:

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Patricia A. Wilson-Coker, J.D., MSW  
Commissioner of Social Services

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Darlene Dunbar, MSW  
Commissioner, Children & Families

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Date

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Date

For DMHAS:

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Thomas A. Kirk, Ph.D.  
Commissioner, Mental Health and  
Addiction Services

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Date