OAG Template 18
04/09

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONTRACT AMENDMENT

Contractor:	CONNECTICUT COMMUNITY CARE, INC.
Contractor Address:	43 ENTERPRISE DRIVE, BRISTOL, CT 06010-7472
Contract Number:	017CC-CHC-04/13DSS6501FO
Amendment Number:	A2
Amount as Amended:	$45,633,074.00
Contract Term as Amended:	07/01/13 – 06/30/16

The contract between **Connecticut Community Care, Inc.** (the Contractor and/or CCCI) and the Department of Social Services (the Department), which was last executed by the parties and approved by the Office of the Attorney General on 8/5/13 , is hereby further amended as follows:

1. The total maximum amount payable under this contract is increased by **$1,135,552.00** from **$ 44,497,522.00 to $45,633,074.00**. This increase is due to DSS's transitioning assessments, reassessments and status reviews for the Personal Care Assistance (PCA) Waiver and Care Management services within specified Home and Community Based Service (HCBS) Regions to CCCI.

2. The PCA Waiver provisions and Care Management services in this Amendment 2 (A2) serve to supplement the Original Contract between the Contractor and the Department. The services the Contractor provides for PCA Waiver and Care Management are in addition to the services it continues to provide the Department for the Connecticut Home Care Program (CHCP), where it serves as an Access Agency and the ABI Waiver Pilot Program, (AWPP), as amended in Amendment 1, (A1) of the Original Contract.

3. The Original Contract is hereby supplemented as follows:

    a. By inserting within the section labeled TABLE OF CONTENTS for PART I, located on pages 2 and 3, after the subsection labeled SECTION FOUR-THE ABI WAIVER I PILOT PROGRAM SUMMARY OF SERVICES of the Original Contract, the following new subsection, SECTION FIVE-THE PCA WAIVER and CARE MANAGEMENT SUMMARY OF SERVICES.

    b. By inserting in Part I, SECTION FOUR-THE ABI WAIVER I PILOT PROGRAM SUMMARY OF SERVICES after of the Original Contract the following new section:

    SECTION FIVE- THE PCA WAIVER/CARE MANAGEMENT SUMMARY OF SERVICES.

    A. OVERVIEW OF PCA WAIVER/CARE MANAGEMENT SERVICES

The purpose of the PCA Waiver is to have Connecticut Community Care, Inc. offer home and community based services to persons with disabilities ages 18-64 who are nursing facility level of care to the PCA Waiver population served by the Contractor.

The PCA Waiver is a partnership between the Department and the Contractor working together to provide services to those in need of supports and services to remain living in community settings. The Contractor will be responsible for conducting assessments, reassessments and status reviews for participants and applicants. The Contractor will also provide quality Care Management services within specified HCBS Region(s) to Clients.

The Contractor may not provide any other direct service to PCA waiver clients or purchase home care services from itself or any related parties.

The goals of the PCA Waiver are to determine whether cost-effective home care services can be offered to Applicants who are at institutional level of care and provide a full range of home care services to Clients who choose to remain in the community, if services are appropriate and cost effective.

Cost limitations for PCA Waiver Clients - Costs caps are based on the number of Activities of Daily Living (ADLs) for which the participant requires assistance.

Effective 1/1/15 the caps are as follows:

$5778.00 (100% NH CAP), 115% = $6645.00 all 5 ADLs
$4622.00 (80% NH CAP) 3-4 ADLs
$3467.00 (60% NH CAP) 2 ADLs

Based on the PCA collective bargaining agreement, hours of service may not be reduced solely based on a rate increase that resulted from the collective bargaining agreement. Any plans that go over the caps listed above due to the rate increase are not required to be reduced. This must be documented in the clinical record.

Eligibility - In order to be eligible for the PCA waiver, the applicant must require hands on assistance with a minimum of two ADLs. To qualify for the PCA waiver an applicant shall:

1. Be a Connecticut resident;

2. Be age 18-64 years old;

3. Meet the program's functional eligibility criteria as specified above and

4. Meet the program's income and asset guidelines for Medicaid under a waiver program as set forth below:

Medicaid Financial Eligibility	Individual	Married Couple One spouse receiving services	Married Couple Two spouse receiving services
Income	$2,199	$ 2,199	$2,199 each
Assets	$1,600	$25,444	$1,600 each

a. Income and asset limits are established annually.

b. A higher amount of assets may be allowed with a spousal assessment.

c. Refer to Department Form W-1530 DSS Assessment of Spousal Assets (Rev. 7/10).

B. TERM: Services related to the PCA Waiver will begin on January 1, 2015 and terminate on June 30, 2016 and services related to Care Management will begin on April 1, 2015 and will terminate June 30, 2016.

C. DEFINED TERMS**.** Defined terms used but not defined in this agreement are as defined in Part I, SECTION ONE. B.1. labeled DEFINITIONS of the Original Contract.

D. SCOPE OF WORK

1. Effective January 1, 2015 the Department will initiate the transitions of assessments, reassessments and status reviews for the Personal Care Assistance Waiver to the Contractor.

2. Effective April 1, 2015 the Contractor will provide and be reimbursed for quality Care Management services within specified HCBS Region(s) to Clients.

3. **Processes for Contractor Eligibility and Client Eligibility**

a. Designation and Role of an "Access Agency" and Medical Assistance Program Provider Enrollment - The Contractor has been designated by the Department as an Access Agency as defined herein and must be enrolled with the Department as a Medical Assistance Program Provider specific to this waiver program and Care Management services. Such enrollment throughout the entire Contract period is required for the Contractor to be reimbursed for services.

b. PCA Applicants and Clients with Special Needs - The PCA waiver program may have Applicants applying and/or Clients with special needs including but not limited to some whose primary language is not English and some who are hearing and/or visually impaired. The Contractor shall employ staff or implement and facilitate an effective strategy that will provide the Department with confirmation that the Contractor has the ability to serve Connecticut Home Care Programs' (CHCP) Applicants and Clients with special needs.

4. **PCA Care Plan Cost Limits** - The Contractor shall develop, monitor, and be responsible for the Client's individual plan of care adhering to the Department's plan of care cost limits and shall be required to do the following:

a. Complete the Care Plan Cost Worksheet, (Rev 1/13) to determine the monthly or annual cost of services identified in the plan of care and ensure plan of care costs are at or below the allowed amount.

b. If an Applicant's or Client's plan of care cost exceeds the cost limits, the Client and/or family shall be given the option of paying the difference between the limit and the care plan cost.

c. If the Contractor does not have information on the actual cost of services on the plan of care being paid for by other state administered programs, the Contractor shall estimate the cost based upon payments made for similar services.

1) If the rate(s) for a home care service covered by the CHCPs is modified, the Contractor shall update the plan of care to reflect those changes at the next scheduled monthly monitoring activity or at the six month visit (whichever occurs first) following receipt of the new and/or modified rate(s).

2) Client Contribution: The contribution of Clients whose services are funded by Medicaid will be an "applied income" amount calculated by the Department. The Department's Regional Office determines the exact amount of a Client's applied income. The Department's Regional Office is responsible for all financial matters related to Medicaid eligibility. The Department allows Clients to protect an amount equal to 200% of the federal poverty level. This means that Clients with income at or below that amount whose services are funded by Medicaid will have no contribution.

5. **Plan of Care -** The Contractor's Care Managers are responsible for the development and monitoring of Clients plan of care.

   a. The Department shall review the initial plan of care and care plan cost worksheet to determine the appropriateness of services and to assure that the plan of care is complete and within Department plan of care cost limits.

   b. The Contractor shall develop and monitor Client's individualized plans of care adhering to the following requirements:

      1) Plan of Care Format and Content:

         a) Use the Department's format and content as the standard design for Client's individualized plan of care.

         b) The plan of care shall have at least one waiver covered service in addition to care management.

         c) The plan of care shall be complete, dated, and signed by the Care Manager and the Client/Client representative at initial assessment, at each reassessment and any time there is a significant Revision to the plan of care.

         d) Use new plan of care forms for care plans developed at reassessments and any time significant changes have been made to the care plan.

         e) Document all formal and informal home care services regardless of the provider, source of reimbursement or whether the services are compensated or uncompensated.

         f) Specify the frequency, type of service(s), and monthly cost of service. (Services expressed in weeks on the plan of care are multiplied by 4.3 to ascertain the monthly units. The monthly units multiplied by the rate per unit equals the monthly cost of the service.)

         g) Reflect all Client need(s) identified and documented on the most recent assessment tool

         h) Document Care Management on the plan of care.

      2) Development of plan of care with a person-centered approach.

         a) Confirm that a cost effective plan of care that meets the Client's home care needs can be developed.

b) When the Client agrees, utilize the least costly provider when a choice of providers of the same Community Based service with the same quality of service is available.

c) Provide information to the Client so they can select the most appropriate services to meet the Client's needs offering a choice of providers.

d) Plan services in close cooperation with the family and other involved members of the informal support system. The Client shall direct the process, concerns and decisions throughout his/her program participation and be involved, to the extent possible, in the entire process.

e) Document the risks of Home and Community Based services and the Client's understanding of the risks and the Client's choice to accept the risks or mitigate the risks.

f) Establish and ensure an appropriate, non-duplicative or overlapping service mix.

g) Plans of care shall not unnecessarily provide similar services at the same time, such as the overlapping of companion and homemaker services.

h) Collaborate with other health care professionals providing services to the Client to avoid duplication and to obtain input regarding the development of the plan of care.

i) Review the plan of care and determine whether or not there is the need for a back-up plan for each service listed on the plan of care. A back-up plan is required for all PCA Waiver Clients whose day and/or time of service(s) are necessary to ensure the Client's health and/or safety:

   (1) Evaluate each service in the plan of care to determine whether the schedule may vary without risk to the Client.

   (2) Review for the need of a back-up plan at the time of initial assessment, at the time of reassessment, at any time the Client's status changes to the extent that a back-up plan becomes necessary or is no longer necessary.

   (3) Document in the plan of care the Review for the need of a back-up plan and the results of that Review.

   (4) Note the back-up plan in the plan of care and include:

      (a) The specificity of day and/or time needed to ensure the Client's health and safety.

      (b) The identification of a Client as the back-up and the Client's contact information.

      (c) Notify the provider(s) when a Client's health and/or safety are jeopardized if services are either not delivered or not delivered at the day and/or time indicated on the plan of care.

   (5) Submit to the Department a copy of the initial plan of care and upon request any subsequent plans of care.

   (6) Ensure that the Client is given a copy of the most current care plan signed and dated by both the Client and Care Manager.

(7) Obtain the Department's authorization for all home care services for PCA waiver participants prior to the delivery of the service(s).

(8) For PCA services when the provider is requested to be a Client's family member, utilize the Intra Referral DSS ACU Access Agency/Provider/DDS/DMHAS memorandum to request the Department's approval and to explain why the utilization of a Client's family member is in the best interest of the Client.

6. **Contractor Service/Applicant and Client Assessment** - The Initial Assessment is a process by which a PCA Waiver Applicant is evaluated for functional and financial eligibility. The initial assessment involves a comprehensive evaluation of an Applicant's medical, psychosocial and economic status, degree of functional impairment, risks, unmet needs, related service needs and identification of the appropriate category of service. The initial assessment process also includes conducting all administrative requirements associated with the application process, assisting the Applicant with the completion and submission of Title 19 Application, if applicable. The Applicant's representative is educated about all relevant aspects of the programs by the Care Manager.

   a. The Contractor shall conduct assessments adhering to specific requirements:

      1) Require a registered nurse licensed in the State of Connecticut or social worker to conduct the initial assessments.

      2) Contact the PCA waiver Applicant/Applicant's representative within one working day of receiving the referral from the Department to schedule a face-to-face interview with the Applicant.

      3) Inform the CHCPs Applicant/Applicant's representative at the time the Applicant contact is made that Clients who require nursing facility care have the right to decide whether or not to live in the community or an institution.

      4) Utilize the following Department Assessment/Outcome forms for the PCA Waiver program:
         a) W1507A – Modified Community Care Assessment or other tool as directed by the Department
         b) W1153 - PCA and ABI Medicaid Waiver Submission for Approval/Case Disposition Form
         c) W1510 part I - Uniform Client Care Plan
         d) W1510 part II – Care Plan Cost Worksheet
         e) W1527 – Outcome Form
         f) W951 (optional) – Care Plan Summary
         g) W1528 (first page only from Access Agency to Allied) – Connecticut Home Care Program for Elders (CHCPE PCA-Routing Slip)

7. **Client Reassessment**- The Client reassessment is very similar to the initial assessment except that it involves a comprehensive reexamination of a Client's medical, psychosocial, and economic status, degree of functional impairment, related service needs, and category of service. The reassessment identifies whether or not circumstances have changed that affect the Client's program eligibility or service needs. The reassessment also serves to identify changes in the availability of services that would affect the Client's plan of care or program participation status. Revision to the plan of care is made when appropriate and the plan of care resulting from the reassessment is implemented. The reassessment is a person-centered approach to care plan development recognizing the needs and preferences of the Client and allowing for the maximization of the Client's choice.

8. **Client Status Review** - The Contractor shall conduct Status Reviews adhering to specific requirements:

    a. Require a registered nurse licensed in the State of Connecticut or social worker to conduct the Status Reviews.

    b. Conduct Status Reviews during a Client's hospital or nursing facility stay according to the following:
        1) No more than one time during a hospital stay.

        2) No more than one time during a nursing facility stay.

        3) Upon obtaining prior authorization from the Department for a second status Review conducted during a Client's hospital or nursing facility stay.

    c. Conduct Status Reviews when the Client's plan of care needs to be adjusted and the Client is not yet known to the Access Agency.
    d. Include an evaluation of the appropriateness of the plan of care, including an evaluation of the need for a back-up plan, and making any necessary revisions to the plan of care.
    e. If during a status review visit, the Contractor has to complete a more in depth evaluation to determine service needs, the Contractor may perform a full reassessment and notify the Department that the reassessment was conducted prior to the scheduled due date. The Contractor shall request in writing that the Department change the reassessment date via the web based client data base

9. **Authorization of Services** - As referenced in Section Two, A.2. Authorization of Services, the Department must authorize the services to be provided by the Contractor. The Department shall reimburse the Contractor for only those assessments that have been conducted of Applicants who were referred to the Contractor by the Department and for whom the Contractor has obtained a signed consent form authorizing the assessment. The Contractor may not bill the Department and the Department will not reimburse the Contractor for Applicant contacts that were made to explain the program but did not result in the Applicant consent to conduct an assessment.
    a. Department shall reimburse the Contractor at the same assessment rate when:
        1) The Applicant consents to an assessment. From 1/1/15 through 12/31/15, the Department will reimburse the Contractor the assessment rate for all reassessments because in every case, the Contractor is meeting the Client for the first time and is required to establish their own data base for the client.
        2) A face-to-face interview is conducted.
        3) The Applicant is determined to be ineligible or inappropriate for community placement.
    b. The Department shall reimburse the Contractor for a Status Review conducted on a hospitalized Client or a Client admitted to a nursing facility for a short-term placement. The Status Review rate shall be 33% of the Contractor's assessment rate. From 1/1/15 through 12/31/15, for clients who require a change to their service plan but their manual reassessment has not yet been conducted, the Contractor may bill the Department for a status review.
        1) Effective 4/1/15, the Contractor may begin billing the Department for Care Management services for any Clients for whom they have done face to face assessment, reassessment or status review visits. Thereafter, billing for Care Management can begin the day after the face to face visit.

        2) Tiered care management: The Department in collaboration with the Access Agencies has developed a tiered approach to Care Management based on the frequency and intensity of Care Management interventions presented in the following hyperlinks: CHCPE Tiered Case Management Rates, Criteria, Process & Methodology and Tiered Case Management Criteria and Process and Intervention Leveling Criteria.

3) The Department shall reimburse the Contractor for annual reassessments of only self-directed or private assisted living Clients when requested to do so by the Department. The reassessment rate shall be 75% of the Contractor's assessment rate.

4) Community Based services - The Department shall authorize all initial delivery of Community-Based services prior to the delivery of the service. This includes Care Management services provided to Medicaid Clients as well as Home Health services.

5) The Contractor shall maintain documentation of the authorization for Community-Based services in the Client records.

6) Direct service providers shall not change the plan of care without approval from the Contractor. Changes and approvals shall be recorded in the case record and conform to all program requirements.

10. **Privacy and Confidentiality** - In addition to Part II, Section B.2., Safeguarding Client Information, Confidentiality and Safeguarding of Client Information, Section C.19., Protection of Personal Information, and Section E.1. Statutory and Regulatory Compliance, Health Insurance Portability and Accountability Act of 1996 of the Original Contract, the Contractor shall be responsible for protecting PCA waiver Client confidentiality and implementing Client information safeguards. The Contractor shall:

    a. Maintain the confidentiality of all Client case records.

    b. Implement a confidentiality policy.

    c. Provide the Department, its designees and/or the federal government access to Client case records.

    d. Require written consent by the Client or legal representative to release medical information to other providers.

    e. Develop a standard release form.

    f. Conduct all other release activity in accordance with written policy on the protection and release of information as specified in the Federal and State Regulations (e.g. Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended).

    g. Make aware to the Department of subpoenas and any court orders for Client records. It is up to the Contractor to handle any necessary proceedings relating to a subpoena.

11. **Customer Service, Training and Education Requirements** - The Contractor shall provide training and education activities with Clients and the public at large.

12. **Quality Assurance Program** - The Contractor shall implement a Quality Assurance Program .for monitoring adherence to PCA Waiver policies and procedures including the provision of quality Care Management services.

    a. The Quality Assurance Program shall be reviewed and approved by the Department prior to implementation.

    b. The Contractor shall utilize the system of Critical Incident Reporting to the Department utilizing the Department's web based critical incident reporting system.

    c. Review of Contractor's PCA Waiver Client Records - The Contractor shall be responsible for monitoring adherence to the Department's requirements for maintaining Client records including documentation of quality Care Management activities. The Contractor shall submit to the Department for approval a quality assurance procedure to review the Contractor's CHCPs.

Client records that includes:

1) An explanation of the sampling methodology.

2) A description of the factors used to determine the appropriate management of a Client.

3) Review for adherence to PCA Waiver program requirements for Client records.

4) A description of the Review process.

5) A requirement that the Contractor will:

a) Review a sample of cases quarterly.

b) Conduct an annual review of a minimum of 1% of active PCA Client records.

c) Commit to take effective and appropriate corrective action.

d) Implement the Contractor's approved procedure for internal Client record reviews.

13. **Monitoring of CHCPs Client Satisfaction** - The Contractor shall be responsible for the monitoring of Client satisfaction among CHCPs Clients and implementing appropriate and timely corrective action when indicated. The Contractor will assure the quality of services provided, and assure that the Client feels empowered to choose from a full range of services that meet their needs and preferences. The Contractor will assure that the Client feels respected in the care planning process, embracing person-centered approach to care plan development. The Contractor will encourage Client comfort to freely report concerns of retaliation from a provider. The Contractor shall:

a. Develop and implement a strategy for measuring Client satisfaction with PCA waiver program services. The strategy for measuring Client satisfaction shall include the use of Client surveys that are conducted for new Clients within 60 days of admission to the PCA waiver and randomly thereafter.

b. Conduct random Client satisfaction surveys at least annually.

c. Conduct the random Client satisfaction process through a randomly selected sample size that shall be at least 15% of the total Client population which results in an average reported sampling size of no less than 10% of the total Client population per year/per region.

d. Use both telephone and print surveys to gather information.

e. Address all CHCPs services, availability of providers and service delivery, intake procedures, and on-going Contractor contact.

f. Conduct the survey with a Client representative when the Client is unavailable or unable to participate.

g. Commit to the Department that appropriate and effective corrective action will be taken based on survey results.

h. Report the Contractor's processes to measure Client satisfaction to the Department annually. The report shall:

1) Provide the specifics of the administration of the survey(s) including:

a) Number and percentage of the Client population who were sent surveys or contacted for survey participation.

b) Date(s) survey(s) sent or conducted.

c) Methodology used to select survey Clients.

d) A copy of the survey instrument.

2) Provide the results of the survey including:

a) Number of and percent of surveys completed.

b) Results for each question on the survey instrument.

c) Description of any corrective action taken as a result of the surveys.

d) Results that the Contractor is in compliance with Department's requirements for measuring Client satisfaction.

(1) Use Client satisfaction survey tools approved by the Department that include measures that reflect Client experience with care, Client choice, quality of life, self-determination, perception of a person-centered approach to care plan development and coordination of care.

(2) Following the Department's approval, implement the approved procedure for measuring Client satisfaction.

14. **Department's Client Record and Administrative Review** - The Department reserves the right to conduct Client record and administrative reviews encompassing an evaluation of the assessment, Care Management, and community based services provided under the program, as well as adherence to PCA Waiver program policies and procedures. The Contractor shall:

a. Cooperate fully with the Department or its designees with the evaluation including providing access to all requested program forms, records, documents, and reports.

b. Ensure timely reporting of required statistical information to the Department as required to satisfy Medicaid waiver commitments.

c. Take corrective action(s) based on the results of Department's' Client record and administrative Reviews within an established timeframe deemed appropriate by the Department.

d. Respond, in writing, to the Department's recommendations resulting from the Client record and administrative reviews and the corrective action taken by the Contractor.

e. Perform internal supervisory record reviews utilizing an audit tool approved by the Department.

f. Report results of the audit in a summary format on a quarterly basis.

15. **Hearings and Appeals** - An Applicant/Client/representative may appeal Department or Contractor decisions. It is the responsibility of the Contractor to ensure that the Applicant / Client / representative is provided with written notification of their appeal rights according to Department policy including but not limited to:

a. A list of Department or Contractor decisions that may be appealed and how these decisions are appealable to: Level of care determination (appealed directly to the Department).

1) Denial of assessment (appealed directly to the Department).

2) Denial of Home Care upon completion of the assessment and Plan of Care development (initial appeal to the Contractor).

3) Content of the Plan of Care including type and frequency of service(s) and designated provider (initial appeal to the Contractor).

4) Provision of community based services such as dissatisfaction with a provider (initial appeal to the Contractor).

5) Client applied income (initial appeal to the Department).

b. A requirement that appeals be submitted in writing to the Contractor or the Department as applicable.

1) A procedure for determining whether the appeal has merit based on program regulations.

2) A procedure for correcting errors in cases where the appeal is ruled to be justified;

3) A procedure for negotiating disputes.

4) The right of a Client to further appeal PCA Waiver Program related decisions through the Department fair hearing process, if the Contractor does not resolve the issue.

c. The Contractor shall document in the Client record:

1) The Contractor's verbal review of the Client's grievance and appeal rights.

2) The Client's/Client's representative's receipt of written description of the grievance and appeals process.

3) The Client's/Client's representative's acknowledgement of understanding the Client's grievance and appeal rights.

d. The Contractor shall work with the Department regarding Client grievances and appeals:

1) Attend hearings at the request of the Department.

2) Document all grievances filed and their outcomes.

3) Assist the Department in the preparation of summaries for Fair Hearings when an appeal is made to DSS including conducting a Client reevaluation upon Department request.

e. The Contractor shall maintain a grievance/complaint log that outlines the grievance or complaint and the resolution.

16. **PCA Program Staffing** - The Contractor shall determine the appropriate staffing levels to ensure timely completion of the assessment, reassessment and care management activities. The staffing pattern should be similar to the staffing for the CHCPE. The Contractor shall be responsible for providing adequate orientation and training to new employees, appropriate and ongoing in-service training programs for existing staff and adequate supervision of staff to ensure adherence to PCA Waiver policies and procedures.

17. **Care Management Staffing Requirements** - The requirements for employees who conduct care management activities and those who supervise the Care Managers for this program are the same

requirements as those specified for Care Managers for the CHCPE. The Contractor shall employ Care Managers who conduct quality Care Management services that meet or exceed the following specified requirements.

The Contractor's Care Managers shall:

a. Be the primary contact with the Client and the Client's family unless other arrangements are specified in the plan of care.

b. Cooperate with the Client's legal representatives or other individuals for which consent has been given by the Client/Client's representative.

c. Provide Client advocacy, crisis intervention, and referral services to the Client and the Client's family.

d. Provide program information that explains the options under the programs and answers Client questions.

e. Direct efforts to maximize the potential of the informal support system and encourage better community independent living capability.

f. Conduct initial assessments, reassessments, reevaluations and status reviews that adhere to the principles of person-centered approach to care plan development and negotiated risk.

g. Assist the Client with the completion and submittal of any required forms including but not limited to the Department's W1-LTC.

h. Authorize the start of service delivery for enrolled service providers.

i. Ensure the timely discontinuance of a service(s) when appropriate.

j. Collaborate with and involve all providers that serve a particular Client at all points of the Care Management process.

k. Coordinate the delivery of all services in the plan of care regardless of the provider or source of reimbursement, if any, to avoid duplication and overlapping of services, to monitor service quality and quantity, and to maintain the informal network.

l. Develop working relationships with nursing facilities and/or hospitals to develop policies and procedures in order to access necessary information (such as facility or hospital records) as allowed under federal regulation (e.g. Health Insurance Portability and Accountability Act (HIPAA)).

m. Document Care Management in the plan of care and all activities in the Client's record.

n. Provide Care Management only to Clients who are not living in an institutional setting such as a hospital or nursing facility unless they are institutionalized for respite care.

o. Ensure that community-based services are not continued during a period of institutionalization unless transition services are subsequently authorized.

p. Ensure Care Management is not provided to people living in an institutional setting.

q. Provide information and service referral or access to appropriate resources on a 24 hour per day basis, including responding to emergencies.

18. **Clinical Client Record** - The Contractor shall maintain a written or electronic Clinical Client Record for each care managed Client in accordance with the requirements specified in this contract for the CHCPE.

19. **Client Discontinuance from CHCPs Services** - The Contractor shall:

    a. Conduct and document Client discontinuance activities in accordance with PCA Waiver process of discontinuance.

    b. Recommend to the Department the discontinuance of services when appropriate. Circumstances in which discontinuation of services may been recommended include, but are not limited to:

        1) The Client voluntarily chooses not to participate.

        2) The Client is no longer a resident of the State of Connecticut.

        3) The Client is no longer functionally eligible.

        4) The Client is no longer financially eligible.

        5) The Client is institutionalized for more than 90 days.

        6) The Client enters a nursing facility and does not intend to return to the community.

        7) The lack of available services to meet the Client's needs.

        8) The cost of the plan of care exceeds the Department's established cost limits.

        9) The Client entered a nursing facility.

        10) The Client does not comply with the mandatory fee agreement.

        11) The Client fails to comply with the mandatory Medicaid requirement.

        12) The death of a Client.

        13) The client transitions to the Community First Choice State Plan option to receive PCA services.

    c. Initiate the Department's approval process for the discontinuance of services by completing and submitting to the HCBS unit clinical staff, a discontinuance recommendation utilizing the Department's web based client data. When services are being discontinued due to the Client's or Client representative's request, obtain the request for discontinuance in writing from the Client or Client representative. If the Client or Client representative refuses to provide the request in writing, the Contractor shall document in the Client record the date the verbal request was made.

    d. Document in the Client record that the Client/Client representative is informed of the plan to discontinue services, the reason(s) for the discontinuance, and the Client's right to appeal.

    e. Provide pre-discontinuance planning to the Client, provider agencies and all other sources of service.

    f. Discontinuance from the PCA Waiver is the sole authority of the Department. The Contractor cannot discharge a Client prior to receiving written approval from the Department. Upon receiving written Department approval for a Client's discontinuance from the PCA Waiver, make sure that all providers are notified in a timely manner that services are to be discontinued.

20. **Reporting Requirements and Data Collection** - The Contractor shall submit the following reports to the Department:

a. Annual Audited Financial Report - The "Annual Audited Financial Report" is due within 30 days of completion of the audit report, but no later than six months after the end of the audit period.
b. Annual Grievance and Appeals Report - The "Annual Grievance and Appeals" Report is due within 90 days after the end of each fiscal year. This report is a listing of grievances filed by PCA Waiver Clients including a description of the grievance(s) filed, the action(s) taken by the Contractor, and the final resolution(s).
c. Semi-Annual Client List - The "Semi-Annual Client List" is due by December 31st and June 30th of each Contract year. This report is to be prepared for each region being served.
d. Bi-Annual Quantitative Assessment Data Report - The Bi-Annual Quantitative Assessment Data report is due February 15 and by August 15 of each Contract year. This report is a computerized data transfer as detailed in the Department's Data Specifications for Contractor File Transfer. The data file includes comprehensive, Client specific information on assessment data, care plans; Client fees and such other information as may be required by the Department. This report will not be required once the core standardized assessment is fully operational.
e. Quarterly Assessment and Care Management Activities Report - The "Quarterly Assessment and Care Management Activities Report" is due on October 31st, January 31st, April 30th, and July 31st of each Contract year. This report is to be prepared for each region being served with a total page for all regions.
f. Quarterly Cost Report - The Quarterly Cost Reports are due on April 30 for January - March, due on July 31 for April - June, due on October 31 for July - September, and due on January 31 for October - December of each Contract year. This report is to be prepared by Client funding source by region with a total page for all regions.
g. Quarterly Report of Supervisory Record Reviews - Report results of the internal supervisory record audits, in a summary format, on a quarterly basis.
h. Monthly Activity Report - The Monthly Activity Report is due on the last day of the month after the report month. Example: January report is due no later than February 28, etc. of each Contract year. This report is to be prepared on the DSS standardized monthly activity report form. Required reporting is by region and a total for all regions.
i Miscellaneous Reports - The Contractor is responsible for submitting unscheduled reports requested by the Department about any aspect of PCA Waiver operations and in a timeframe determined by the Department.
j. The Department shall require the Contractor to submit complete and accurate data files within the designated timeframe. Contractor failure to submit accurate and complete reports as defined above is subject to financial withholding to be determined by the Department. Consistent failure to meet these requirements may result in the termination of the Contract.

21. **Accounting System** - The Contractor shall:
a. Implement and maintain a uniform accounting system that, budgets, accounts for, and reports all actual program Revenues and expenditures and units of service provided. This system shall reflect the application of generally accepted accounting principles (GAAP), principles and practices that are approved by the American Institute of Certified Public Accountants.
b. Implement the accrual method of accounting.
c. Maintain records in sufficient detail to support all financial and statistical information provided to the Department, and provide a clear audit trail.
d. Differentiate between DSS and non-DSS funding sources in income and expenditure reports.
e. Allocate the costs by services, administrative, and general categories.
f. Segregate and report this information by PCA Waiver region if the Contractor is under Contract with more than one region

g. Allocate costs directly attributable to each of the primary Contractor functions (Care Management and assessments) performed for each program region directly to an account for that region. Allocate costs that cannot be directly related to a specific regional operation on the

basis of Care Management time. The Contractor shall demonstrate that a cost cannot reasonably be attributed to PCA Waiver operations before the cost may be allocated.

22. **Web-Based Communication System and Portal** - The Contractor shall utilize a web-based plan of care portal for the purpose of the Department and Contractor to communicate PCA Waiver Client information.
23. **Department Responsibilities**- To assist the Contractor in the performance of the duties herein, the Department shall:

    a. Monitor the Contractor's performance and request updates, as appropriate.

    b. Respond to written requests for policy interpretations.

    c. Provide technical assistance to the Contractor, as needed, to accomplish the expected outcomes.

    d. Schedule and hold regular program meetings with the Contractor.

    e. Provide a process for and facilitate open discussions with Department Staff and Contractor personnel to gather information regarding recommendations and suggestions for improvement.

    f. Make Department staff available to assist with training regarding the program policies and procedures to provide ongoing technical assistance in all aspects of the waiver program.

    g. Provide both an application and a provider participation agreement that shall be completed, signed, and filed with the Department prior to enrollment as a Medical Service Provider.

    h. Provide billing instructions and be available to provide assistance with the billing process including completion of claim forms and corrections.

    i. Designate a liaison to facilitate a cooperative working relationship with the Contractor in the performance and administration of this Contract.

    j. Program Management: A Program Director will be appointed by the Department. The Program Director will be responsible for monitoring program progress and will have final authority to approve/disapprove program deliverables.

    k. Staff Coordination: The Program Director will coordinate all necessary contacts between the Contractor and Department staff.

    l. Approval of Deliverables: The Program Director will Review, evaluate, and approve all deliverables prior to the Contractor being released from further responsibility.

    m. The Department retains the ultimate decision-making authority required to ensure PCA Waiver tasks are completed.

    n. The Department will provide quarterly and annual claims-based services utilization to plan of care reports.

24. Part II Section E.1, labeled HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 in the Original Contract shall be amended by deleting the part in its entirety and replace the terms with the following:

Health Insurance Portability and Accountability Act of 1996.

(a) If the Contactor is a Business Associate under the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as noted in this Contract, the Contractor must comply with all terms and conditions of this Section of the Contract. If the

Contractor is not a Business Associate under HIPAA, this Section of the Contract does not apply to the Contractor for this Contract.

(b) The Contractor is required to safeguard the use, publication and disclosure of information on all applicants for, and all clients who receive, services under the Contract in accordance with all applicable federal and state law regarding confidentiality, which includes but is not limited to HIPAA, more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E; and

(c) The State of Connecticut Agency named on page 1 of this Contract ("Agency") is a "covered entity" as that term is defined in 45 C.F.R. § 160.103; and

(d) The Contractor is a "business associate" of the Agency, as that term is defined in 45 C.F.R. § 160.103; and

(e) The Contractor and the Agency agree to the following in order to secure compliance with the HIPAA, the requirements of Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), (Pub. L. 111-5, §§ 13400 to 13423) , and more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, D and E (collectively referred to herein as the "HIPAA Standards").

(f) Definitions

(1) "Breach" shall have the same meaning as the term is defined in section 45 C.F.R. 164.402 and shall also include a use or disclosure of PHI that violates the HIPAA Standards.

(2) "Business Associate" shall mean the Contractor.

(3) "Covered Entity" shall mean the Agency of the State of Connecticut named on page 1 of this Contract.

(4) "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 C.F.R. § 164.501.

(5) "Electronic Health Record" shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. §17921(5).

(6) "Individual" shall have the same meaning as the term "individual"' in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative as defined in 45 C.F.R. § 164.502(g).

(7) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

(8) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, and includes electronic PHI, as defined in 45 C.F.R. 160.103, limited to information created, maintained, transmitted or received by the Business Associate from or on behalf of the Covered Entity or from another Business Associate of the Covered Entity.

(9) "Required by Law"' shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

(10) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

(11) "More stringent" shall have the same meaning as the term "more stringent" in 45 C.F.R. § 160.202.

(12) "This Section of the Contract" refers to the HIPAA Provisions stated herein, in their entirety.

(13) "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. § 164.304.

(14) "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. part 160 and part 164, subpart A and C.

(15) "Unsecured protected health information" shall have the same meaning as the term as defined in 45 C.F.R. 164.402.

(g) Obligations and Activities of Business Associates.

(1) Business Associate agrees not to use or disclose PHI other than as permitted or required by this Section of the Contract or as Required by Law.

(2) Business Associate agrees to use and maintain appropriate safeguards and comply with applicable HIPAA Standards with respect to all PHI and to prevent use or disclosure of PHI other than as provided for in this Section of the Contract and in accordance with HIPAA standards.

(3) Business Associate agrees to use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

(4) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by Business Associate in violation of this Section of the Contract.

(5) Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Section of the Contract or any security incident of which it becomes aware.

(6) Business Associate agrees, in accordance with 45 C.F.R. 502(e)(1)(ii) and 164.308(d)(2), if applicable, to ensure that any subcontractors that create, receive, maintain or transmit protected health information on behalf of the business associate, agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;.

(7) Business Associate agrees to provide access (including inspection, obtaining a copy or both), at the request of the Covered Entity, and in the time and manner designated by the Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. Business Associate shall not charge any fees greater than the lesser of the amount charged by the Covered Entity to an Individual for such records; the amount permitted by state law; or the Business Associate's actual cost of postage, labor and supplies for complying with the request.

(8) Business Associate agrees to make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of the Covered Entity, and in the time and manner designated by the Covered Entity.

(9) Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created, maintained, transmitted or received by, Business Associate on behalf of Covered Entity, available to Covered Entity or to the Secretary in a time and manner agreed to by the parties or designated by the Secretary, for purposes of the Secretary investigating or determining Covered Entity's compliance with the HIPAA Standards.

(10) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.

(11) Business Associate agrees to provide to Covered Entity, in a time and manner designated by the Covered Entity, information collected in accordance with subsection (g)(10) of this Section of the Contract, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder. Business Associate agrees at the Covered Entity's direction to provide an accounting of disclosures of PHI directly to an individual in accordance with 45 C.F.R. §

164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.

(12) Business Associate agrees to comply with any state or federal law that is more stringent than the Privacy Rule.

(13) Business Associate agrees to comply with the requirements of the HITECH Act relating to privacy and security that are applicable to the Covered Entity and with the requirements of 45 C.F.R. §§ 164.504(e), 164.308, 164.310, 164.312, and 164.316.

(14) In the event that an individual requests that the Business Associate

(A) restrict disclosures of PHI;

(B) provide an accounting of disclosures of the individual's PHI;

(C) provide a copy of the individual's PHI in an electronic health record; or

(D) amend PHI in the individual's designated record set,

the Business Associate agrees to notify the Covered Entity, in writing, within five business days of the request.

(15) Business Associate agrees that it shall not, and shall ensure that its subcontractors do not, directly or indirectly, receive any remuneration in exchange for PHI of an Individual without

(A) the written approval of the covered entity, unless receipt of remuneration in exchange for PHI is expressly authorized by this Contract and

(B) the valid authorization of the individual, except for the purposes provided under section 13405(d)(2) of the HITECH Act, (42 U.S.C. § 17935(d)(2)) and in any accompanying regulations

(16) Obligations in the Event of a Breach.

(A) The Business Associate agrees that, following the discovery by the Business Associate or by a subcontractor of the Business Associate of any use or disclosure not provided for by this section of the Contract, any breach of unsecured protected health information, or any Security Incident, it shall notify the Covered Entity of such breach in accordance with Subpart D of Part 164 of Title 45 of the Code of Federal Regulations and this Section of the Contract.

(B) Such notification shall be provided by the Business Associate to the Covered Entity without unreasonable delay, and in no case later than 30 days after the breach is discovered by the Business Associate, or a subcontractor of the Business Associate, except as otherwise instructed in writing by a law enforcement official pursuant to 45 C.F.R. 164.412. . A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate or its subcontractor. The notification shall include the identification and last known address, phone number and email address of each individual (or the next of kin of the individual if the individual is deceased) whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

(C) The Business Associate agrees to include in the notification to the Covered Entity at least the following information:

1. A description of what happened, including the date of the breach; the date of the discovery of the breach; the unauthorized person, if known, who used the PHI or to whom it was disclosed; and whether the PHI was actually acquired or viewed.

2. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).

3. The steps the Business Associate recommends that Individual(s) take to protect themselves from potential harm resulting from the breach.

4. A detailed description of what the Business Associate is doing or has done to investigate the breach, to mitigate losses, and to protect against any further breaches.

5. Whether a law enforcement official has advised the Business Associate, either verbally or in writing, that he or she has determined that notification or notice to Individuals or the posting required under 45 C.F.R. 164.412 would impede a criminal investigation or cause damage to national security and; if so, contact information for said official.

(D) If directed by the Covered Entity, the Business Associate agrees to conduct a risk assessment using at least the information in subparagraphs 1 to 4, inclusive of (g) (16) (C) of this Section and determine whether, in its opinion, there is a low probability that the PHI has been compromised. Such recommendation shall be transmitted to the Covered Entity within 20 business days of the Business Associate's notification to the Covered Entity.

(E) If the Covered Entity determines that there has been a breach, as defined in 45 C.F.R. 164.402, by the Business Associate or a subcontractor of the Business Associate, the Business Associate, if directed by the Covered Entity, shall provide all notifications required by 45 C.F.R. 164.404 and 45 C.F.R. 164.406.

(F) Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed of a breach have the opportunity to ask questions and contact the Business Associate for additional information regarding the breach. Such procedures shall include a toll-free telephone number, an e-mail address, a posting on its Web site and a postal address. Business Associate agrees to include in the notification of a breach by the Business Associate to the Covered Entity, a written description of the procedures that have been established to meet these requirements. Costs of such contact procedures will be borne by the Contractor.

(G) Business Associate agrees that, in the event of a breach, it has the burden to demonstrate that it has complied with all notifications requirements set forth above, including evidence demonstrating the necessity of a delay in notification to the Covered Entity.

(h) Permitted Uses and Disclosure by Business Associate.

(1) General Use and Disclosure Provisions Except as otherwise limited in this Section of the Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract, provided that such use or disclosure would not violate the HIPAA Standards if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(2) Specific Use and Disclosure Provisions

(A) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(B) Except as otherwise limited in this Section of the Contract, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains

reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(i) Obligations of Covered Entity.

(1) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity, in accordance with 45 C.F.R. § 164.520, or to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

(2) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual(s) to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

(3) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(j) Permissible Requests by Covered Entity. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Standards if done by the Covered Entity, except that Business Associate may use and disclose PHI for data aggregation, and management and administrative activities of Business Associate, as permitted under this Section of the Contract.

(k) Term and Termination.

(1) Term. The Term of this Section of the Contract shall be effective as of the date the Contract is effective and shall terminate when the information collected in accordance with provision (g)(10) of this Section of the Contract is provided to the Covered Entity and all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(2) Termination for Cause Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

(A) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity; or

(B) Immediately terminate the Contract if Business Associate has breached a material term of this Section of the Contract and cure is not possible; or

(C) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(3) Effect of Termination.

(A) Except as provided in (k)(2) of this Section of the Contract, upon termination of this Contract, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity.

Business Associate shall also provide the information collected in accordance with section (g)(10) of this Section of the Contract to the

Covered Entity within ten business days of the notice of termination. This section shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(B) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon documentation by Business Associate that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Section of the Contract to such PHI and limit further uses and disclosures of PHI to those purposes that make return or destruction infeasible, for as long as Business Associate maintains such PHI. Infeasibility of the return or destruction of PHI includes, but is not limited to, requirements under state or federal law that the Business Associate maintains or preserves the PHI or copies thereof.

(l) Miscellaneous Sections.

(1) Regulatory References. A reference in this Section of the Contract to a section in the Privacy Rule means the section as in effect or as amended.

(2) Amendment. The Parties agree to take such action as in necessary to amend this Section of the Contract from time to time as is necessary for Covered Entity to comply with requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104 191.

(3) Survival. The respective rights and obligations of Business Associate shall survive the termination of this Contract.

(4) Effect on Contract. Except as specifically required to implement the purposes of this Section of the Contract, all other terms of the Contract shall remain in force and effect.

(5) Construction. This Section of the Contract shall be construed as broadly as necessary to implement and comply with the Privacy Standard. Any ambiguity in this Section of the Contract shall be resolved in favor of a meaning that complies, and is consistent with, the Privacy Standard.

(6) Disclaimer. Covered Entity makes no warranty or representation that compliance with this Section of the Contract will be adequate or satisfactory for Business Associate's own purposes. Covered Entity shall not be liable to Business Associate for any claim, civil or criminal penalty, loss or damage related to or arising from the unauthorized use or disclosure of PHI by Business Associate or any of its officers, directors, employees, contractors or agents, or any third party to whom Business Associate has disclosed PHI contrary to the sections of this Contract or applicable law. Business Associate is solely responsible for all decisions made, and actions taken, by Business Associate regarding the safeguarding, use and disclosure of PHI within its possession, custody or control.

(7) Indemnification. The Business Associate shall indemnify and hold the Covered Entity harmless from and against any and all claims, liabilities, judgments, fines, assessments, penalties, awards and any statutory damages that may be imposed or assessed pursuant to HIPAA, as amended or the HITECH Act, including, without limitation, attorney's fees, expert witness fees, costs of investigation, litigation or dispute resolution, and costs awarded thereunder, relating to or arising out of any violation by the Business Associate and its agents, including subcontractors, of any obligation of Business Associate and its agents, including subcontractors, under this section of the contract, under HIPAA, the HITECH Act, and the HIPAA Standards.

E. BUDGET AND PAYMENT

1. **Budget Variance** - This is a Fee for Service Contract and budget variances with be reviewed by the DSS Program Director.

2. **Rates for Care Management -** Billing for Care Management will begin on 4/1/15 following a face to face visit whether an assessment, reassessment or status review. Rates are as follows:

   Tier A: $4.40

   Tier B: $4.75

   Tier C: $4.95

3. **Rates per task:** - An Initial Assessment one-time only, per Client, rate is $284.55. A Status Review, as required, per Client, rate is $94.12. For clients for whom care management service has been initiated, payment for the reassessment is included in the care management per diem rate. For the first year of this Contract Amendment 1/1/15-12/31/15, all reassessments may be billed at the initial assessment rate.

4. **Billing and Payment Information** - The Contractor shall:

   a. Invoice Care Management services to the Department's MMIS Contractor, HP, in accordance with Department procedures. Home and community based services and medical services provided to Clients are to be billed directly by the enrolled Medicaid provider in accordance with Department procedures.

   b. Submit bills to the Department within the time specified for the filing of Medicaid claims of one year. Invoices for Care Management services shall be received within 12 months of the services being delivered or within 12 months of the date a Client is granted retroactive eligibility.

   c. Invoice for Care Management services provided to each PCA Waiver Client. The Department shall reimburse on a two times per month financial cycle. The Department shall pay all valid and proper claims within 30 days after receipt of said claims. A valid and proper bill for services is one that has no defects and requires no additional information for processing.

   d. Electronic claims are the preferred method of billing.

   e. Submit HIPAA compliant electronic claims when the Contractor has the computer capability and when authorized in advance to do so by the Department. The Contractor shall follow all current HIPAA procedures including signed Trading Partner Agreement Reimbursements. The Contractor shall adhere to the Department's Policies and Procedures relative to the Access Agency's billing procedures to receive reimbursement for Care Management services performed.

5. **Reimbursement Denial Information** - The Department shall not reimburse:

   a. If Contractor fails to meet the terms of this Contract.

   b. For Care Management while a Client is institutionalized.

   c. Invoices for services after the death of a Client. The count of Client days for purposes of billing for Care Management services begins on the effective date of a written plan of care. The effective date shall be subsequent to the completion of an assessment performed by the Contractor. The date of death, the end date for self-directed Clients, or the date of institutionalization may be billed, but no date(s) of service may be billed after these dates.

   d. Services that are not provided or not provided in accordance with PCA Waiver procedures, including prior authorization when appropriate.

   e. Services not included as part of the plan of care or not included under the PCA Waiver regulations or Medicaid program and incorrect, incomplete, or duplicative claims or when the Client is no longer eligible for the Waiver program.

6. **Access Agency Fee Schedule** – Listed below are the access agency fee schedules for the CT Home Care Program for Elders reflecting a 1% increase effective January 1, 2015. This Access

Agency Fee Schedule supersedes Section Three-Budget and Payment A. Contract Amount 4. Care Management Rate and 5. Rates per Task and Frequency found on page 51 of the Original Contract.

CCCI - Eastern Region #4071700

Procedure Code	Service	Rate
1286Z	Case Management	$ 4.75
1288Z	Initial Assessment	$ 284.55
1291Z	Status Review	$ 94.12
1292Z	Status Review - Hospital	$ 94.12
1293Z	Status Review – Nursing Home	$ 94.12
1295Z	Claims Processing Fee – SDC	$ 30.29
1300Z	Reassessment on SDC or PAL clients	$ 213.41

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CCCI – North Central #4096229

Procedure Code	Service	Rate
1286Z	Case Management	$ 4.75
1288Z	Initial Assessment	$ 284.55
1291Z	Status Review	$ 94.12
1292Z	Status Review - Hospital	$ 94.12
1293Z	Status Review – Nursing Home	$ 94.12
1295Z	Claims Processing Fee – SDC	$ 30.29
1300Z	Reassessment on SDC or PAL clients	$ 213.41

CCCI- North Western # 4071718

Procedure Code	Service	Rate
1286Z	Case Management	$ 4.75
1288Z	Initial Assessment	$ 284.55
1291Z	Status Review	$ 94.12
1292Z	Status Review - Hospital	$ 94.12
1293Z	Status Review – Nursing Home	$ 94.12
1295Z	Claims Processing Fee – SDC	$ 30.29
1300Z	Reassessment on SDC or PAL clients	$ 213.41

All terms and conditions of the Original Contract, and any subsequent amendments thereto, which were not modified by this Amendment remain in full force and effect.

BUDGET

PROGRAM NAME:	**Connecticut Home Care Program**
	PCA
Eastern	***Connecticut Community Care, Inc.***
	Year 1
Line # *Item/Total*	**Budget Year1**

		12 months
1	**CONTRACTUAL SERVICES**	
	TOTAL CONTRACTUAL SERVICES	$0.00
2	**ADMINISTRATION**	
	Staff	$24,210.00
	Fringe Benefits	$8,285.00
	Non-Personnel	$5,953.00
	TOTAL ADMINISTRATION	$38,448.00
3	**DIRECT PROGRAM STAFF**	
	Staff	$148,616.00
	Fringe Benefits	$49,791.00
	TOTAL DIRECT PROGRAM	$198,407.00
4	**OTHER COSTS**	
	Direct Non-Personnel	$19,446.00
	TOTAL OTHER COSTS	$19,446.00
5	**EQUIPMENT**	
		$0.00
6	**PROGRAM INCOME**	
		$0.00
	TOTAL PROGRAM INCOME	$0.00
7	**TOTAL NET PROGRAM COST**	$256,301.00
	(Sum of 1 through 5, minus Line 6)	

PROGRAM NAME:	**Connecticut Home Care Program**
	PCA
North Central	***Connecticut Community Care, Inc.***
	Year 1
Line # *Item/Total*	**Budget Year1**
	12 months

1	**CONTRACTUAL SERVICES**	
	TOTAL CONTRACTUAL SERVICES	$0.00
2	**ADMINISTRATION**	
	Staff	$51,525.00
	Fringe Benefits	$17,729.00
	Non-Personnel	$19,730.00
	TOTAL ADMINISTRATION	$88,984.00
3	**DIRECT PROGRAM STAFF**	
	Staff	$339,363.00
	Fringe Benefits	$114,632.00
	TOTAL DIRECT PROGRAM	$453,995.00
4	**OTHER COSTS**	
	Direct Non-Personnel	$49,912.00
	TOTAL OTHER COSTS	$49,912.00
5	**EQUIPMENT**	
		$0.00
6	**PROGRAM INCOME**	
		$0.00
	TOTAL PROGRAM INCOME	$0.00
7	**TOTAL NET PROGRAM COST**	$592,891.00
	(Sum of 1 through 5, minus Line 6)	

PROGRAM NAME:	**Connecticut Home Care Program**
	PCA
Northwest	*Connecticut Community Care, Inc.*
	Year 1
Line # *Item/Total*	**Budget Year1**
	12 months

1	**CONTRACTUAL SERVICES**	
	TOTAL CONTRACTUAL SERVICES	$0.00
2	**ADMINISTRATION**	
	Staff	$25,846.00
	Fringe Benefits	$8,814.00
	Non-Personnel	$8,334.00
	TOTAL ADMINISTRATION	$42,994.00
3	**DIRECT PROGRAM STAFF**	
	Staff	$158,807.00
	Fringe Benefits	$53,828.00
	TOTAL DIRECT PROGRAM	$212,635.00
4	**OTHER COSTS**	
	Direct Non-Personnel	$30,731.00
	TOTAL OTHER COSTS	$30,731.00
5	**EQUIPMENT**	
		$0.00
6	**PROGRAM INCOME**	
		$0.00
	TOTAL PROGRAM INCOME	$0.00
7	**TOTAL NET PROGRAM COST**	$286,360.00
	(Sum of 1 through 5, minus Line 6)	

SIGNATURES AND APPROVALS

017CCC-CHC-04/13DSS6501FO A2

The Contractor IS NOT a Business Associate under the Health Insurance Portability and Accountability Act of 1996 as amended.

Documentation necessary to demonstrate the authorization to sign must be attached.

SIGNATURES AND APPROVALS

017CCC-CHC-04/13DSS6501FO A2

The Contractor IS NOT a Business Associate under the Health Insurance Portability and Accountability Act of 1996 as amended.

Documentation necessary to demonstrate the authorization to sign must be attached.

CONTRACTOR - CONNECTICUT COMMUNITY CARE, INC.

Molly Rees Gavin

Molly Rees Gavin, *President*

6/12/15

Date

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner*

6/17/15

Date

OFFICE OF THE ATTORNEY GENERAL

ASSOC. ATTY. GENERAL

Joseph Rubin

ASST. / ASSOC. ATTORNEY GENERAL *(Approved as to form)*

7/2/15

Date