_X_ Original Contract Number:	11DSS1202GQ
____ Amendment Number:	_____
Maximum Contract Value:	$409,387,566.00
Contractor Contact Person:	Sylvia Kelly
DSS Contact - Program:	Dr. Mark Schaefer
Fiscal:	Uma Ganesan and Lee Voghel

STATE OF CONNECTICUT
PURCHASE OF SERVICE CONTRACT
("POS", "Contract" and/or "contract")
Revised September 2011

The State of Connecticut DEPARTMENT OF SOCIAL SERVICES

Street: 25 SIGOURNEY STREET

City: HARTFORD **State:** CT **Zip:** 06106

Tel#: (800) 842-1508 **("Agency" and/or "Department"), hereby enters into a Contract with:**

Contractor's Name: **Community Health Network of Connecticut, Inc.**

Street: **11 Fairfield Boulevard**

City: **Wallingford** **State:** **CT** **Zip:** **06492**

Tel#: **203-949-4000** **FEIN/SS#:** **06-1429341**

("Contractor"), for the provision of services outlined in Part I and for the compliance with Part II. The Agency and the Contractor shall collectively be referred to as "Parties". The Contractor shall comply with the terms and conditions set forth in this Contract as follows:

Contract Term	This Contract is in effect from 10/14/2011 through 12/31/2016.
Statutory Authority	The Agency is authorized to enter into this Contract pursuant to § 4-8, 17b-3 and 17b-261m of the Connecticut General Statutes ("C.G.S.").
Set-Aside Status	Contractor ☐ IS or ☒ IS NOT a set aside Contractor pursuant to C.G.S. § 4a-60g.
Effective Date	This Contract shall become effective only as of the date of signature by the Agency's authorized official(s) and, where applicable, the date of approval by the Office of the Attorney General ("OAG"). Upon such execution, this Contract shall be deemed effective for the entire term specified above.
Contract Amendment	Part I of this Contract may be amended only be means of a written instrument signed by the Agency, the Contractor, and, if required, the OAG. Part II of this Contract may be amended only in consultation with, and with the approval of, the OAG and the State of Connecticut, Office of Policy and Management ("OPM").

All notices, demands, requests, consents, approvals or other communications required or permitted to be given or which are given with respect to this Contract (collectively called "Notices") shall be deemed to have been effected at such time as the Notice is hand-delivered, placed in the U.S. mail, first class and postage prepaid, return receipt requested, or placed with a recognized, overnight express delivery service that provides for a return receipt. All such Notices shall be in writing and shall be addressed as follows:

If to the Agency:	STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES 25 SIGOURNEY STREET HARTFORD, CT 06106 Attention: Dr. Mark Schaefer	If to the Contractor:	Community Health Network of CT, Inc. 11 Fairfield Boulevard Wallingford, CT 06492 Attention: Sylvia Kelly

A party may modify the addressee or address for Notices by providing fourteen (14) days' prior written Notice to the other party. No formal amendment is required.

PART I – SCOPE OF SERVICES

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PART I – SCOPE OF SERVICES

A. DEFINITIONS

As used throughout this Contract, the following terms shall have the meanings set forth below:

A.1. Abuse: Provider and/or Contractor practices inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the State of Connecticut, or a pattern of failing to provide medically necessary services required by this Contract. Member practices that result in unnecessary cost to the State of Connecticut also constitute abuse.

A.2. Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service in specific circumstances; the failure to provide services in a timely manner, as defined by the Department; and the failure to act within the timeframes for authorization decisions set forth in this contract.

A.3. Acute Services: Medical or behavioral health services needed for an illness, episode, or injury that requires intense care, and hospitalization.

A.4. Ad-hoc Report: A report that has not been previously produced and which may require specifications to be written, developed and tested prior to production to complete.

A.5. Administrative Hearing: Also called Fair Hearing. A proceeding during which a Medicaid client presents his or her claim to an impartial hearing officer at the Department of Social Services that the Department failed to take action within a required period of time or acted erroneously with regard to coverage of services. Claims relating to coverage of service include the Department's or Contractor's decision to deny, reduce, suspend or terminate services or to authorize a level of care that the member believes is inappropriate.

A.6. Administrative Services Organization (ASO): an organization or organizations providing utilization management benefit information and intensive care management services within a centralized information system framework.

A.7. Adult: Person 18 years of age or older.

A.8. Advanced Practice Registered Nurse (APRN): A nurse licensed pursuant to the provisions of Conn. Gen. Stat. Sec. 20-94a.

A.9. Agent: An entity with the authority to act on behalf of the Department.

A.10. Automated Eligibility Verification System (AEVS): The sole comprehensive source of the Department of Social Services' client eligibility information. The following electronic methods can be used to verify client eligibility: Automated Voice Response System (AVRS), HP's Provider Electronic Solutions (PES) software, and vendor software utilizing the ASC X12N 270/271: Health Care Eligibility/Benefit Inquiry and Information Response transaction.

A.11. Behavioral Health Partnership ("CT BHP"): An integrated behavioral health service system developed and managed by the Commissioners of Social Services, Children and Families, and Mental Health and Addition Services. The BHP has served HUSKY Part A and HUSKY Part B members, children enrolled in the Voluntary Services Program operated by the Department of Children and Families and, at the discretion of the Commissioners of Children and Families and Social Services, other children, adolescents, and families served by the Department of Children and Families. Effective April 1, 2011, the CT BHP was expanded to include, Medicaid clients in the aged, blind and disabled coverage groups, Medicaid for Low-Income Adults clients and Charter Oak Health Plan members.

A.12. Behavioral Health Services: Services that are necessary to diagnose, correct or diminish the adverse effects of a psychiatric or substance use disorder.

A.13. Bypass Program: A program for high performing providers that enables them to bypass the usual utilization management requirements and instead fulfill prior authorization requirements through a notification process.

A.14. Care Coordinator: A licensed health care clinician employed by the Contractor, who works with providers and members to facilitate organization of care, and facilitates the exchanging of information among participants in a member's care plan.

A.15. Care Manager: An independently licensed clinician employed by the Contractor to perform utilization review on services that require prior authorization and concurrent review.

A.16. Case Management: Services whose primary aim is assessment, evaluation, planning, linkage, support and advocacy to assist individuals

in gaining access to needed medical, social, educational or other services.

A.17. Case Managers: Clinicians or paraprofessionals typically funded by DDS or DMHAS whose responsibilities include outreach, engagement, linkage, advocacy, and monitoring of assigned cases.

A.18. Centers for Medicare and Medicaid Services (CMS): The Centers for Medicare and Medicaid Services (CMS) is a division within the United States Department of Health and Human Services. CMS oversees Medicaid and the Children's Health Insurance Program (CHIP).

A.19. The Charter Oak Health Plan: A publicly-funded program that, pursuant to Connecticut General Statutes § 17b-311, provides access to health insurance coverage for Connecticut residents who have been uninsured for at least six (6) months and who are ineligible for Medicare, HUSKY A, HUSKY B, HUSKY C, HUSKY D and most other publicly-funded health insurance.

A.20. Children: Individuals under eighteen (18) years of age.

A.21. Children and Youth With Special Healthcare Needs: Children who have or who are at an increased risk of chronic physical, developmental, behavioral, or emotional conditions and require health and related (not educational or recreational) services beyond those required for children in general (U.S. Maternal and Child Health Bureau).

A.22. CHIP (Children's Health Insurance Program): Services provided in accordance with Title XXI of the federal Social Security Act. Formerly called "SCHIP" (State Children's Health Insurance Program).

A.23. Chronic Disease Hospital: Per Conn. Agencies Reg. § 19-13-D1(b)(2), a chronic disease hospital is defined as a "long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of a wide range of chronic diseases."

A.24. Clinical Management: The process of evaluating and determining the appropriateness of the utilization of health services as well as providing assistance to clinicians or members to ensure appropriate use of resources. This may include, but is not limited to, prior authorization, concurrent review, and retroactive medical necessity review; discharge review; retrospective utilization review; quality management; provider certification; and provider performance enhancements.

A.25. Clinician: Unless otherwise designated by the Department, a person who is licensed to practice medicine independently in the State of Connecticut.

A.26. Committed: Placed under the custody of the Commissioner of the Department of Children and Families (DCF), pursuant to a valid court order issued by a court of competent jurisdiction.

A.27. Complaint: A written or oral communication to the Contractor from an individual expressing dissatisfaction with some aspect of the Contractor's services.

A.28. Concurrent Review: Review of the medical necessity of medical services on a periodic basis during the course of treatment.

A.29. Connecticut Medical Assistance Program (CMAP): The Connecticut Medical Assistance Program consists of several medical programs administered by the Department of Social Services and the provider network that serves these programs. The programs include: Medicaid (also known as Title XIX), several Medicaid waiver programs, the Connecticut Behavioral Health Partnership (CT BHP), Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE), Health Insurance for Uninsured Kids and Youth (HUSKY) A & B, Connecticut AIDS Drug Assistance Program (CADAP), Connecticut Dental Health Partnership, and the Charter Oak Health Plan.

A.30. Connecticut Medical Assistance Program (CMAP) Network: A network of providers available to Members that are enrolled with the Department for the purpose of serving members. A provider in the CMAP Network does not include providers of services that are enrolled with the Department solely for the purpose of obtaining reimbursement for emergency services or through a Limited Provider Agreements.

A.31. Consultant: A corporation, company, organization or person or their affiliates retained by the Department to provide assistance in this project or any other project; not the Contractor or subcontractor.

A.32. Contract Administrator: The State of Connecticut employee designated by the Department to fulfill the administrative responsibilities associated with this Contract.

A.33. Contract Services: Those services that the Contractor is required to provide under this Contract.

A.34. Contractor: An Administrative Services Organization providing case management, benefit information, member services, quality management, and other administrative services outlined in this Contract within a centralized information system framework.

A.35. Critical Incident/Significant Event: Any action or inaction by an employee or agent of the Department, the Contractor or their subcontractors or

vendors, provider or client that creates a significant risk of substantial or serious harm to the health, safety or well-being of a HUSKYHEALTH or Charter Oak Member or CMAP Provider.

A.36. Current Procedural Terminology (CPT): The most recent edition of a listing, published by the American Medical Association, of descriptive terms and identifying codes for reporting medical services performed by providers.

A.37. Data Warehouse: A data storage system or systems constructed by consolidating information currently being tracked on different systems by different contractors of the Department.

A.38. Date of Application: The date on which a completed Medical Assistance application is received by the Department of Social Services, or its agent, containing the applicant's signature.

A.39. Day: Except where the term "business days" is expressly used, all references in this Contract will be construed as calendar days.

A.40. Denial of Authorization: Any rejection, in whole or in part, of a request for authorization from a provider on behalf of a member.

A.41. Dental Health Partnership ("CT DHP"): An integrated dental health service system developed and managed by the Commissioner of Social Services.

A.42. Department: The Department of Social Services (DSS) or its agents.

A.43. Department of Children and Families (or DCF): Pursuant to Conn. Gen. Stat. § 17a-2, the Connecticut Department of Children and Families (DCF) offers child protection, behavioral health, juvenile justice and prevention services to (i) abused and neglected children, (ii) children committed to DCF by the juvenile justice system; and (iii) families of these and other at-risk children. Additional information is available online at www.ct.gov/dcf/site/default.asp

A.44. Department of Developmental Services (DDS): Department of Developmental Services or "DDS" means the state agency responsible for the planning, development and administration of complete, comprehensive and integrated state-wide services for persons with developmental impairments, including the operation of the Home and Community Based Service waivers for individuals with mental retardation or who are otherwise eligible for such services.

A.45. Department of Mental Health and Addiction Services (DMHAS): Pursuant to Conn. Gen. Stat. § 17a-450, Department of Mental Health and

Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut.

A.46. Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition): The American Psychiatric Association's current listing of descriptive terms and identifying codes for reporting a classification of mental and substance abuse disorders.

A.47. Discharge Planning: Activities that facilitate a patient's movement from one health care setting to another or to home. Discharge planning is a multidisciplinary process, involving the patient and his or her family, physicians, nurses, social workers and possibly other health care professionals. The process begins on admission and is aimed at enhancing continuity of care.

A.48. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Comprehensive child health care services to Medicaid members under twenty-one (21) years of age, including all medically necessary prevention, screening, diagnosis and treatment services listed in Section 1905 (r) of the Social Security Act.

A.49. EPSDT Case Management Services: Services such as making and facilitating referrals and development and coordination of a plan of services that will assist members under twenty-one (21) years of age in gaining access to needed medical, social, educational, and other services.

A.50. EPSDT Diagnostic and Treatment Services: All health care, diagnostic services, and treatment necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by an interperiodic or periodic EPSDT screening examination.

A.51. EPSDT Screening Services: Comprehensive, periodic health examinations for members under the age of twenty-one (21) provided in accordance with the requirements of the federal Medicaid statute at 42 U.S.C. § 1396d(r) (1).

A.52. EPSDT Special Services: As required by 42 U.S.C. § 1396(r)(5), other health care, diagnostic services, preventive services, rehabilitative services, treatment, or other measures described in 42 U.S.C. 1396d(a), that are not otherwise covered under the Connecticut Medicaid Program and that are medically necessary.

A.53. Eligible: Eligible means that the individual has been approved or is entitled to services under one of the Department's Medical Assistance programs.

A.54. Eligibility Management System (EMS): An automated system operated by the Department of Social Services (DSS) for maintaining eligibility information regarding Medicaid, Medicaid for Low Income Adults, CADAP, HUSKY A, Waiver Programs, DCF funded clients or Voluntary Services members. It also provides fully integrated data processing support for benefit calculation and issuance, financial accounting, and management reporting.

A.55. Emergency or Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part.

A.56. Emergency Services: Inpatient and outpatient services needed to evaluate or stabilize an emergency medical condition.

A.57. Enrollment Broker: An entity contracted by the Department of Social Services to perform certain administrative and operational functions for the Charter Oak Health Plan, HUSKY A and HUSKY B programs that may include HUSKY application processing, HUSKY B eligibility determinations or other functions as required by the Department.

A.58. Explanation of Benefits (EOB): The remittance advice received by the provider, which details how the service was adjudicated.

A.59. Family: Family means a member together with (A) one or more biological or adoptive parents, except for a parent whose parental rights have been terminated, (B) one or more persons to whom legal custody or guardianship has been given, or (C) one or more adults, including foster parents, who have a primary responsibility for providing continuous care to such child or youth; or the close relatives of an adult including but not limited to parents, children, spouse or domestic partner. For adults, family is considered an individual or individuals who are part of the member's immediate or extended family.

A.60. Federal Poverty Level: The poverty guidelines updated annually in the Federal Register by the U.S. Department of Health & Human Services under authority of 42 U.S.C. § 9902.

A.61. Fraud: Intentional deception or misrepresentation, or reckless disregard or willful blindness, by a person or entity with the knowledge that the deception, misrepresentation, disregard or blindness could result in some unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable federal or state law.

A.62. Healthcare Common Procedure Coding System (HCPCS): A system of national health care codes that includes the following: Level I is the American Medical Association Physician's Common Procedural Terminology (CPT codes). Level II covers services and supplies not covered in CPT. Level III includes local codes used by state Medicare carriers.

A.63. Healthcare Effectiveness Data and Information Set (HEDIS): A standardized performance measurement tool promulgated by the National Committee for Quality Assurance (NCQA) that enables users to evaluate quality of health care services based on the following categories: effectiveness of care; contractor stability; use of services; cost of care; informed health care choices; and contractor descriptive information.

A.64. Home Health Care Services: Services provided by a home health care agency (as defined in Subsection d of section 19a-490 of Connecticut General Statutes) that is licensed by the Department of Public Health, meets the requirements for participation in Medicare and meets all of the Department's enrollment requirements.

A.65. HP Enterprise Services (HP) formerly EDS: The Department of Social Service's fiscal agent contracted to operate a Medicaid Management Information System (MMIS) which adjudicates and processes claims, includes an eligibility verification system, and supports other related functions, and to provide related support services such as enrollment of providers, client and provider call centers, and other ancillary services to support the Connecticut Medical Assistance Program

A.66. HUSKY, Part A or HUSKY A: Connecticut's implementation of health insurance under the federal Medicaid program (Title XIX) for children, parents or relative caretakers. Eligibility is for families earning below 185% as well as pregnant women under 250% of the federal poverty level and other groups pursuant to Section 17b-266 of the Connecticut General Statutes.

A.67. HUSKY, Part B or HUSKY B: The health insurance plan for children and youth, up to the age of nineteen, established pursuant to Title XXI (CHIP) of the Social Security Act, the provisions of Sections 17b-289 to 17b-303, inclusive, of the Connecticut General Statutes, and Section 16 of Public

Act 97-1 of the October special session. This program provides subsidized health insurance for uninsured children in families earning from 185% to 300% of the federal poverty level. Unsubsidized coverage is available under HUSKY B for families earning more than 300% of the federal poverty level.

A.68. HUSKY Plus Physical Program (or HUSKY Plus Program): A supplemental physical health program pursuant to Conn. Gen. Stat. § 17b-294, for medically eligible members of HUSKY B in Income Bands 1 and 2, whose intensive physical health needs cannot be accommodated within the HUSKY Plan, Part B.

A.69. HUSKY, Part C or HUSKY C: Connecticut's implementation of health insurance under the federal Medicaid program (Title XIX) for individuals who are aged, blind or disabled (ABD) and certain other groups such as refugees.

A.70. HUSKY, Part D or HUSKY D: Connecticut's implementation of health insurance under the federal Medicaid program (Title XIX) for low income adults age 19 to 64, also known as Medicaid for Low Income Adults (LIA).

A.71. HUSKY Limited Benefit Program or HUSKY, LBP: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.

A.72. Implementation: The date on which the Contractor assumes responsibility for the management of medical benefits for members.

A.73. Implementation Review: An on-site review to determine whether the Contractor has achieved sufficient implementation progress to operate its administrative services by such time as indicated in the Contractor's approved Implementation Plan.

A.74. Income Bands: For the purposes of the HUSKY B or Charter Oak Programs, members who are in families with the following countable incomes:

A.75. Income Band 1: For purposes of HUSKY B, members who are in families with countable incomes over 185% and up to and including 235% of the federal poverty level.

A.76. Income Band 2: For purposes of HUSKY B, members who are in families with countable incomes over 235% and up to and including 300% of the federal poverty level.

A.77. Income Band 3: For purposes of HUSKY B, members who are in families with countable incomes over 300% of the federal poverty level.

A.78. Income Band C1: For purposes of Charter Oak, members who are in families with countable incomes up to and including 150% of the federal poverty level.

A.79. Income Band C2: For purposes of Charter Oak, members who are in families with countable incomes over 150% and up to and including 185% of the federal poverty level.

A.80. Income Band C3: For purposes of Charter Oak, members who are in families with countable incomes over 185% and up to and including 235% of the federal poverty level.

A.81. Income Band C4: For purposes of Charter Oak, members who are in families with countable incomes over 235% and up to and including 300% of the federal poverty level.

A.82. Income Band C5: For purposes of Charter Oak, members who are in families with countable incomes over 300% of the federal poverty level.

A.83. Inpatient: Inpatient refers to a level of care including medical services provided in a 24-hour medically managed setting.

A.84. Intensive Care Management (ICM): Intensive care management refers to activities related to assessing the needs of an individual with significant clinical problems or circumstances that prevents him or her from effectively utilizing medically necessary care, and consistent with his/her preferences, facilitating access to and monitoring the effectiveness of that care over time.

A.85. Intensive Care Manager: An independently licensed clinician employed by the Contractor who is responsible for managing and coordinating the care of individuals who are eligible for intensive care management.

A.86. Level of Care (LOC) Guidelines: Guidelines that are used by the Contractor to conduct utilization management and which help to determine whether a service is medically necessary.

A.87. Medicaid: One of the Connecticut Medical Assistance Programs, operated by the Connecticut Department of Social Services under Title XIX of the federal Social Security Act, and related State and Federal rules and regulations.

A.88. Medicaid Management Information System (MMIS): The Department's automated claims processing and information retrieval system certified

by CMS. It is organized into several function areas- Recipient (Member), Provider, Claims, Reference, Financial, Buy-In and Internet. Management and Administrative Reporting subsystem (MAR) and Surveillance and Utilization Review subsystem (SUR) are certified as part of the MMIS but are contained in the Data Warehouse.

A.89. Medicaid Program Provider Manuals: Service-specific documents created or issued by the Department to describe policies and procedures applicable to the Medicaid program generally and that service specifically.

A.90. Medical Assistance: For the purposes of this Contract, Medical Assistance will mean all of the healthcare and related programs administered by the Department of Social Services, including but not limited to Medicaid, CHIP, and the Charter Oak Program.

A.91. Medically Necessary or Medical Necessity: Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

A.92. Member: An individual eligible for coverage under any of the Department's medical assistance programs included in the scope of this Contract and whose medical benefits are managed by the Contractor.

A.93. Money Follows the Person: A Connecticut initiative designed to promote personal independence and achieve fiscal efficiencies. It is funded by CMS and the State of Connecticut as part of a national effort to "rebalance" long-term care systems, according to the individual needs of persons with disabilities of all ages.

A.94. National Committee on Quality Assurance (NCQA): A not-for-profit organization that develops and defines quality and performance measures for managed care, thereby providing an external standard of accountability.

A.95. National Provider Identifier: A standard, unique identifier for health care providers and health plans developed as a component of HIPAA Administrative Simplification. CMS developed the National Plan and Provider Enumeration System to assign these identifiers.

A.96. Network Manager: An employee of the Contractor who supports provider network development by providing profiling analyses and results, developing continuous quality improvement plans, and supporting providers and communities in the execution of the plans.

A.97. Network Provider: Means a CMAP Network Provider.

A.98. Normal Business Hours: The normal business hours for the Contractor will be 9 AM through 7 PM, Monday through Friday except for eight (8) holidays: New Years Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving Day, the day after Thanksgiving Day, and Christmas Day.

A.99. Operational: Performance by the Contractor of all of the major functions and requirements of this Contract for all members.

A.100. Outlier Management: Utilization management protocols geared toward client- or provider-based utilization levels that fall below or exceed established thresholds.

A.101. Person-Centered Medical Home (PCMH): A Person-Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The provider is required to provide this coordination and is encouraged to improve practice infrastructure in order to qualify as a medical home.

A.102. Peer Advisor: Doctor- level licensed health professionals employed by the Contractor who are qualified, as determined by the medical director, to render a clinical opinion about the medical condition, procedures, and treatment under review.

A.103. Peer Desk Review: A review of available clinical documentation conducted by an appropriate peer advisor when a request for

authorization was not approved during the initial clinical review conducted by a care manager.

A.104. Peer Review: A telephonic conversation between the Contractor's peer advisor and a provider requesting authorization when the request does not appear to meet the medical necessity guidelines and either the provider or the peer advisor believes that additional information needs to be presented in order to make an appropriate medical necessity determination. Peer review also includes a review of available clinical documentation.

A.105. Peer Review Organization (PRO): (See Quality Improvement Organization.)

A.106. Performance Review: An on-site review by the Department for the purpose of determining whether and to what extent the Contractor is operating its administrative services in accordance with the terms of this Contract.

A.107. Post-Stabilization Services: Services that a treating physician views as medically necessary after an emergency medical condition has been stabilized during an emergency department visit.

A.108. Preferred Practice: Designation given by the Department to recommended clinical/intervention practices.

A.109. Presumptive Eligibility: A method of determining temporary Medicaid eligibility for individuals under the age of nineteen (19) and pregnant women, or temporary CHIP eligibility for children. The determination is made by organizations authorized under federal and State law and approved by the Department to make presumptive eligibility determinations. These organizations are called Qualified Entities or Qualified Providers. Individuals and pregnant women who are given presumptive eligibility become entitled to Medicaid, CHIP or HUSKY Limited Benefit Family Planning benefits on the date the Qualified Entity or Qualified Provider makes the determination.

A.110. Primary Care Provider (PCP): A licensed health care professional, including licensed Obstetrician/Gynecologists, Advanced Practice Registered Nurses (APRN) and Certified Nurse Midwives, responsible for performing or directly supervising the primary care services of members.

A.111. Primary Care Services: Services provided by health professionals specifically trained in comprehensive first contact and continuing care for persons with any health concern. Primary care includes health

promotion, disease prevention, health maintenance counseling, patient education, diagnosis and treatment of acute and chronic illnesses, in a variety of health care settings (e.g. office, inpatient, home, etc.).

A.112. Prior Authorization: Refers to the Contractor's process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by the Contractor as to whether the requested service is medically necessary.

A.113. Procedure Codes: A broad term to identify systematic numeric or alphanumeric designations used by healthcare providers and medical suppliers to report professional services, procedures and supplies. Among the procedure codes used in this document are Healthcare Common Procedure Coding System (HCPCS, which include CPT codes) and Revenue Center Codes (RCCs).

A.114. Professional: A practitioner licensed or certified by the Connecticut Department of Public Health to provide health care services.

A.115. Provider: A person or entity, other than a Network Provider, that is enrolled with the Department solely for the purpose of obtaining reimbursement for emergency services provided to Members or through a Limited Provider Agreement.

A.116. Qualified Entity: An entity that is permitted under federal and state law to determine presumptive eligibility for Medicaid.

A.117. Qualified Provider: A medical provider who is eligible for Medicaid payments; provides the type of services provided by outpatient hospitals, rural health clinics, or other physician directed clinics; has been determined by the Department to be capable of making presumptive eligibility determinations; and receives funds under either the federal Public Health Service Act's Migrant Health Center or Community Health Center programs, the Maternal and Child Health Services block grant programs or Title V of the Indian Health Care Improvement Act.

A.118. Quality Improvement Organization (QIO) or QIO-like entity: An organization designated by CMS as a QIO or QIO-like entity (formerly PRO or PRO-like entity), with which a state can contract to perform medical and utilization review functions required by law.

A.119. Quality Management (QM): The process of reviewing, measuring and continually improving the processes and outcomes of care delivered.

A.120. Random Retrospective Audit: Audits conducted for the purpose of determining a provider's continued qualification as a high performing provider for the purpose of the bypass program.

A.121. Recovery: A process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.

A.122. Registration: The process of notifying the Department or its agent of the initiation of a medical service, to include information regarding the evaluation findings and plan of treatment, which may serve in lieu of authorization if a service is designated by the Department as requiring notification only.

A.123. Requestor: The provider that is requesting authorization of a service on behalf of a member.

A.124. Retroactive Medical Necessity Review: Refers to the Contractor's process for approving payment for covered services after the delivery of the service or initiation of the plan of care based on a determination by the Contractor as to whether the requested service is medically necessary. Such reviews typically occur when a service is rendered to an individual who is retroactively granted eligibility, when the effective date of eligibility spans the date of service and the service requires authorization.

A.125. Retrospective Chart Review: A review of provider's charts to ensure that the provider's chart documentation supports the utilization management practices, for example, that the documentation is consistent with the provider's verbal report and corresponding authorization decision. The charts selected for review may be random or targeted based on information available secondary to the utilization management process.

A.126. Retrospective Utilization Review: A component of utilization management that involves the analysis of historical utilization data and patterns of utilization in order to inform the ongoing development of the utilization management program.

A.127. Revenue Center Codes (RCC): A national coding system used to define specific medical services used by hospitals and certain other providers.

A.128. Standard Report: A report that once developed and approved will be placed into production on a routine basis as defined in the Contract.

A.129. State Fiscal Year (SFY): July 1st through June 30th of the following year.

A.130. Subcontract: Any written agreement between the Contractor and a third party that obligates the third party to perform any of the services required to be provided by the Contractor under this Contract.

A.131. Subcontractor: A third party that, pursuant to the terms of a written agreement with the Contractor, is obligated to perform any of the services required to be provided by the Contractor under this Contract.

A.132. Tax identification number (TIN): The federal identification number, either Social Security number or employer identification number, that is used by a provider for tax filing, billing and reporting purposes.

A.133. Third Party: Any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services for a Member.

A.134. Title XIX: The provisions of 42 United States Code Section 1396 et seq., including any amendments thereto, which established the Medicaid program. (See Medicaid).

A.135. Title XXI: The provisions of 42 U.S.C. § 1397aa et seq., providing funds to enable states to initiate and expand the provision of child health assistance to uninsured, low-income children (see CHIP).

A.136. Transitional Care Management: A person-centered, interdisciplinary process to plan for and facilitate preparation for discharge of members from inpatient acute care and chronic disease hospital care.

A.137. Unique Client Identifier (UCI): A single number or code assigned to each person in a data system and used to individually identify that person.

A.138. Urgent Cases: Illnesses or injuries of a less serious nature than those constituting emergencies but for which treatment is required to prevent a serious deterioration in the individual's health and for which treatment cannot be delayed without imposing undue risk to the individual's' well-being until the individual is able to secure services from his/her regular physician(s).

A.139. Utilization Management (UM): The prospective, retrospective or concurrent assessment of the medical necessity of the allocation of health care resources and services given, or proposed to be given, to a member.

A.140. Utilization Management (UM) Protocol: Guidelines approved by the Department and used by the Contractor in performing UM responsibilities.

A.141. Utilization Management (UM) Staff: Contractor's clinicians and care managers.

A.142. Vendor: Any party with which the Contractor has contracted to provide services to support its business, other than the clinical and administrative services that are required under this Contract.

A.143. Warm transfer: A process that allows the Contractor to transfer the caller directly to the individual who can assist the caller and, when such individual is available, to introduce the call in advance of executing the transfer and remain on the call as a participant. For example, if a member calls the Contractor regarding transportation, it would be expected that the Contractor would contact the appropriate Department transportation broker and transfer the caller directly to the transportation broker.

A.144. Well-Care Visits: Routine physical examinations, immunizations and other preventive services.

A.145. WIC or Women, Infant, Children Program: The federal Special Supplemental Food Program for Women, Infants and Children administered by the Department of Public Health, State of Connecticut as defined in Conn. Gen. Stat. § 17b-290.

B. CONTRACT MANAGEMENT AND ADMINISTRATION

B.1. Contract Oversight

B.1.1. The Department shall designate a Contract Manager (hereinafter referred to as "Contract Manager") to oversee management of this contract including the performance of the Contractor.

B.1.1.1. The Contract Manager will be the Contractor's first contact regarding issues that arise related to Contract implementation, operations, and program management. The Contract Manager will be responsible for overseeing and managing the Contractor's performance according to the terms and conditions of the Contract; responding to all Contractor inquiries and other communications related to implementation, operations, and program management; and rendering opinions or determinations with respect to applicable state and federal regulations and policies as the need arises and upon request of the Contractor.

B.1.1.2. The Department may, at its discretion, station one or more of its employees on-site at the Contractor's place(s) of business to provide consultation, guidance and monitoring regarding the administration of the contract.

B.2. Key Person

B.2.1. The Contractor shall designate a key person to be responsible for all aspects of the Contract and the Contractor's performance with respect to said Contract. This key person shall be responsible solely for all Connecticut-based operations with authority to reallocate staff and resources to ensure contract compliance. Contractor's corporate resources shall also be provided to assist the Contractor in complying with contractual requirements.

B.2.1.1. The Contractor's key person must be approved by the Department. Such designation shall be made in writing to the Contract Administrator within five (5) working days of execution of the contract and notification of any subsequent change of the key person shall be made in writing to the Contract Administrator for approval prior to such change.

B.2.1.2. The Contractor's key person shall immediately notify the Contract Manager of the discharge of any personnel assigned to the contract and such personnel shall be immediately relieved of any further work under the contract. The Contractor's key person or designee shall be the first contact for the Department regarding any questions, problems, and any other issues that arise during implementation and operation of the Contract.

B.3. Key Positions and Personnel

B.3.1. Key positions shall mean executive or managerial positions. Key personnel shall mean people in the key positions. The Contractor's key positions and key personnel must be approved by the Department. Such designations shall be made in writing to the Contract Manager by November 1, 2011. No changes, substitutions, additions or deletions, whether temporary or permanent shall be made unless approved in advance by the Department, whose approval shall not be unreasonably withheld.

B.3.2. In the event of resignation, death or approved substitution of personnel filling the key positions, substitute personnel shall be named by the Contractor on a permanent or interim basis and approved by the Department. The Contractor shall, upon request, provide the Department with a resume for any member of its personnel or of a subcontractor's personnel assigned to or proposed to be assigned to fill a key position under the Contract. Substitutions shall be made within ten (10) Business Days of the resignation or death of personnel filling a key position, unless otherwise agreed to in writing by the Department and the Contractor

B.3.3. The Department reserves the right to approve or reject the Contractor's or any subcontractor's personnel assigned to the Contract, to approve or reject any proposed changes in personnel, or to require the removal or reassignment of any Contractor personnel or subcontractor personnel assigned to this contract found unacceptable by the Department. A requirement for removal shall be based on grounds which are specified in writing to the Contractor and which are not discriminatory.

B.3.4. The Contractor shall notify the Department in the event of any unplanned absences longer than seven days of key personnel and provide a coverage plan.

B.4. Subcontracts: The Contractor may subcontract for any function, excluding Telephone Call Management and Member Services. The following provisions of this section apply to those subcontractors retained by the Contractor for the purposes of providing the contractor's requirements. For each subcontract arrangement the Contractor shall be required to comply with following contractual conditions in addition to those Terms and Conditions approved by the Attorney General.

B.4.1. The Contractor shall be held directly accountable and liable for all contractual provisions regardless of whether the Contractor chooses to subcontract its responsibilities to a third party.

B.4.2. No subcontract shall negate the legal responsibilities of the Contractor including those responsibilities that require the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of the Contractor's contract with the Department.

B.4.3. All subcontracts shall be written and incorporate the following conditions:

B.4.3.1. All subcontracts shall include any general requirements of this Contract that are appropriate to the services provided by the subcontractor;

B.4.3.2. All subcontracts shall provide for the right of either of the Department or other governmental entity to enter the subcontractor's premises to inspect, monitor or otherwise evaluate the work being performed as a delegated duty by the Contractor.

B.4.4. The Contractor and its subcontractors shall cooperate in the performance of financial, quality or other audits conducted by the Department or its agent(s).

B.4.5. The Contractor shall provide upon the Department's request a copy of any subcontract.

B.5. Contract Administration

B.5.1. The Contractor shall raise technical matters associated with the administration of the Contract including matters of Contract interpretation and the performance of the State and Contractor in meeting the obligations and requirements of the Contract with the Contract Manager.

B.5.2. When responding to written correspondence by the Department or when otherwise requested by the Department, the Contractor shall provide written response.

B.5.3. The Contractor shall address all written correspondence regarding the administration of the Contract and the Contractor's performance according to the terms and conditions of the Contract to the Contract Manager.

B.5.4. The Contractor shall coordinate directly with the appropriate Department representatives as directed by the Contract Manager when issues arise involving clinical care, quality of care, or safety of a member and reporting privacy or security incidents.

B.5.5. The Contractor's key person or designee shall respond to telephone calls from the Department within one (1) business day.

B.6. Deliverables – Submission and Acceptance Process

B.6.1. The Contractor shall submit to the Department certain materials for its review and approval. For purposes of this section, any and all materials required to be submitted to the Department for review and approval shall be considered a "Deliverable".

B.6.2. The Contractor shall submit each Deliverable to the Department's Contract Manager. As soon as possible, but in no event later than 30 Business Days or such other date as agreed to by the parties in writing, after receipt (not counting the date of receipt) of a Deliverable, the Department's Contract Manager shall give written notice of the Department's unconditional approval, conditional approval or outright disapproval. Notice of conditional approval shall state the conditions necessary to qualify the Deliverable for approval.

B.6.3. As soon as possible, but in no event later than 10 Business Days or such other date as agreed to by the parties in writing, after receipt (not counting the date of receipt) of a Notice of conditional approval

or outright disapproval, the Contractor shall make the corrections and resubmit the corrected Deliverable.

B.6.4. As soon as possible, but in no event later than 10 Business Days or such other date as agreed to by the parties in writing, following resubmission of any Deliverable conditionally approved or outright disapproved, the Department's Contract Manager shall give written notice of the Department's unconditional approval, conditional approval or outright disapproval.

B.6.5. In the event that the Department's Contract Manager fails to respond to a Deliverable (such as, to give notice of unconditional approval, conditional approval or outright disapproval) within the applicable time period, the Deliverable shall be deemed unconditionally approved.

B.6.6. Whenever the due date for any Deliverable, or the final day on which an act is permitted or required by this Contract to be performed by either party falls on a day other than a Business Day, such due date shall be the first Business Day following such day.

B.7. Committee Structure

B.7.1. The Contractor shall establish committees with family, consumer, and provider representation to provide advice and guidance to the Department and the Contractor regarding the scope of clinical and administrative services under the contract. The Contractor shall submit an initial plan for the establishment or use of such committees to the Department for approval by November 1, 2011. The Contractor's initial plan shall include, but not be limited to the following committees:

B.7.1.1. Quality Committee

B.7.1.2. Clinical Quality Subcommittee

B.7.1.3. Service Quality Subcommittee

B.7.1.4. Member Advisory Workgroup and

B.7.1.5. Provider Advisory Workgroup.

B.7.2. Following the Department's approval of the initial plan the Contractor shall submit any proposed changes to the approved plan or committee structures to the Department for their review and approval.

B.8. Participation at Public Meetings

B.8.1. The Contractor shall ensure that the Contractor's key person attends, unless excused by the Department, all of the meetings of any body established to provide legislative oversight of this initiative. The Contractor shall make available appropriate Contractor Key Personnel, as directed by the Department, to attend the meetings of various bodies established to provide input into this initiative or related services, including legislative and other public committees with responsibility for monitoring the budget of the Department.

B.9. Cooperation with External Evaluations

B.9.1. The Contractor shall cooperate with any external evaluations or studies as required by the Department including, but not limited to providing data, reports, and making Contractor staff and records available to the outside evaluators.

B.10. Policy Manual

B.10.1. The Contractor shall produce a single integrated manual of all of the policies and procedures pertaining to services provided under the Contract. The manual shall include, but is not limited to the specific policies and procedures provided for in subsequent sections of the Contract, and which may require review and approval of the Department. The Contractor shall post the manual on a website accessible to staff of the Department. The website shall include the current version of the manual and all archived versions of the manual that contain policies in effect at any time following implementation. Certain policies and procedures may be exempt from this requirement with the approval of the Department. The Policy Manual shall be submitted for the Department's approval by February 1, 2012; or within thirty (30) days of approval for policies and procedures submitted after that date.

C. ELIGIBILITY

C.1. Eligibility Determination and File Production and Transmission

C.1.1. The Department shall, in accordance with the Department's individual eligibility policies, determine the initial and ongoing eligibility of each individual enrolled in the Medical Assistance programs that are part of this Contract in accordance with the Department's eligibility policies.

C.1.2. The Contractor will be responsible for maintaining a methodology to verify Member eligibility for the purpose of performing service authorization requests for Medical Assistance clients.

C.1.2.1. Eligibility for most Members will be effective on the first of the month.

C.1.2.2. Eligibility for members in a spenddown coverage group will be effective on the day of the month in which the member absorbs the excess income.

C.1.2.3. Eligibility for newborns will be effective on the first day of the month of the newborn's birth.

C.1.2.4. Eligibility for Members will terminate on the last day of the month.

C.1.2.5. Loss of eligibility results in termination of coverage.

C.1.2.6. Coverage for members can be terminated any day of the month. However, coverage for most members will terminate on the last day of the month.

C.2. The Department and its agent will generate and transmit eligibility files to the Contractor.

C.2.1. For Medicaid, the Contractor will begin with a weekly file of all eligible members for the ongoing month.

C.2.1.1. Daily files will be sent to the Contractor, which will include transactions for "adds" (retroactive, current and ongoing) and deletes (retro, current, and ongoing).

C.2.2. For HUSKY B and Charter Oak the Contractor will begin with a month-end file of all eligible members for the ongoing month.

C.2.2.1. Daily files will be sent to the Contractor, which will include transactions for "adds" (retroactive, current and ongoing) and "deletes" (retroactive, current and ongoing).

C.2.3. The Contractor shall load all daily files on a daily basis and shall reconcile their membership with the weekly file for Medicaid and the monthly file for HUSKY B and Charter Oak.

C.3. Eligibility Verification and Authorization Requests:

C.3.1. The Contractor shall for each authorization request received:

C.3.1.1. Maintain a methodology to verify Member eligibility for the purpose of performing service authorization requests for Members.

C.3.1.2. Receive requests for the authorization of medical goods and services and shall, for each authorization request received, determine whether the individual is eligible for coverage of the good or service using the most recent eligibility file supplied by the Department or its agent.

C.3.1.3. Validate eligibility through the web-based interface with the Department's Automated Eligibility Verification System (AEVS) if the Contractor is unable to validate eligibility by accessing the file.

C.3.1.3.1. If eligibility is verified the Contractor shall obtain third party coverage information pertaining to eligible Medicaid members and shall:

C.3.1.3.1.1. notify the Department and/or its agent within seven (7) business days of any inconsistencies between the third party information obtained by the Contractor and the information reflected in the eligibility files or AEVS.

C.3.1.4. Implement one of the following applicable steps when the individual has third party coverage:

C.3.1.4.1. In situations where the services requested are covered by another insurance carrier, the Contractor shall follow the appropriate protocol for determining service authorization, which is further described in the Utilization Management Section. At a minimum, the Contractor shall:

C.3.1.4.1.1. Inform the provider that the Member has other coverage and Medicaid is the payor of last resort;

C.3.1.4.1.2. Require the requestor to bill other known carriers first, before billing the Department or its designated agent;

C.3.1.4.1.3. Direct the provider to submit a claim to the MMIS vendor only after the other insurance carrier(s) has processed the claim and to follow all applicable Connecticut Medical Assistance Program Provider Manual instructions.

C.3.1.4.1.4. In situations where the Member is also Medicare eligible and authorization is sought for a service, the Contractor shall determine whether Medicare covers the requested services and take action as follows:

C.3.1.4.1.5. If Medicare covers the service, the Contractor shall inform the provider that no authorization is necessary since it is a Medicare covered service. The Contractor shall inform the provider to have the claim electronically crossed over from Medicare to Medicaid or submit a claim to the Department's MMIS vendor only after Medicare has processed the claim and to include the applicable Explanation of Medicare Benefits (EOMB) with the claim.

C.3.1.4.1.6. If the service is not a Medicare covered service, the Contractor shall follow the appropriate protocol for determining service authorizations, which is further described in the Utilization Management Section.

C.3.1.5. The Contractor shall report, in a format and timeframe to be determined by the Department when any HUSKY B or Charter Oak member appears to have other insurance.

C.3.1.6. The Contractor shall use the Unique Client Identification Number assigned by EMS (Eligibility Management System) to identify each eligible person. EMS will assign a unique identification number for all individuals covered by this contract.

D. UTILIZATION MANAGEMENT

D.1. General Provisions

D.1.1. Utilization Management (UM) is a set of Contractor processes that seek to ensure that eligible members receive medically necessary treatment to meet their identified medical needs.

D.1.2. UM includes practices such as Registration, Prior Authorization, Concurrent Review, Retroactive Medical Necessity Review and Retrospective Utilization Review.

D.1.3. UM shall serve as a primary source of information for providers about the availability of services and the identification of new or alternative services.

D.2. Medical Necessity: All decisions made by the Contractor to authorize goods or services shall conform to the statutory definition of medical necessity as follows:

D.2.1. Medical necessity: Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. Conn. Gen. Stat. § 17b-259b.

D.2.2. The Contractor may use InterQual or Milliman care guidelines, other evidence-based utilization guidelines or criteria, clinical guidelines or recommendations of professional societies or specialty organizations to support medically necessary review. If the medical necessity definition conflicts with any such criteria or guideline, the medical necessity definition shall prevail.

D.2.3. Upon denial of a request for authorization of services based on medical necessity, the member shall be notified that, upon request, the Contractor shall provide a copy of the specific guidelines or criteria, or portion thereof, other than the medical necessity definition provided in D.2.1 of this section that was considered by the Department or an entity acting on behalf of the Department in making the determination of medical necessity.

D.3. Contractor's UM Program

D.3.1. The Contractor shall phase in evidence-based, automated systems to support UM functions to be completed by July 31, 2012. The key software to support the UM system shall include evidence-based criteria and an automated provider authorization system; which shall

allow Providers to submit authorization requests on-line and receive automated determinations.

D.3.2. The Department shall review for approval and implementation the Contractor's UM Program. Components of the UM Program shall include, but may not be limited to:

D.3.2.1. Prior authorization for selected services, procedures/equipment and services through both Network Providers and Providers Identification of the selected services for prior authorization shall be determined jointly by the Department and the Contractor. However final approval of the selected services for prior authorization shall be at the discretion of the Department.

D.3.2.2. Preadmission review, concurrent review, discharge planning and retrospective review.

D.3.2.3. Identification of members for ICM services.

D.3.2.4. Verification of eligibility, benefits coverage and physician/hospital contract status.

D.3.2.5. Review utilization data identifying over and under utilization practices.

D.3.2.6. Identify and implement programmatic improvements.

D.3.2.7. Retrospective review of claims for determination of medical necessity.

D.3.2.8. Analysis of utilization data.

D.3.2.9. Bypass Program.

D.3.2.10. A Radiology Benefit Management Program;

D.3.2.11. A specialty drug management program for palivizumab (Synagis®);

D.3.2.12. Evaluation of satisfaction with UM Program with Member and practitioner input; and

D.3.2.13. Identification of members for specific Disease Management programs.

D.3.3. The Contractor shall provide the Department, for its review and approval, the proposed UM Program by November 1, 2011. The Department shall reject or approve the proposed UM Program within 30 days of the Department's receipt of the UM Program. Once the UM Program is approved by the Department, the Contractor shall implement and follow the approved UM Program unless and until such approved program is revised with the approval of the Department. The Contractor shall revise and resubmit the UM Program to the Department for review and approval at least annually and no later than October 1st of each year.

D.4. Design and Conduct of the Utilization Management Program

D.4.1. The Contractor shall design and conduct a UM Program that shall:

D.4.1.1. Be minimally burdensome to the provider;

D.4.1.2. Effectively monitor and manage the utilization of specified treatment services;

D.4.1.3. Utilize state-of-the-art technologies including web-based applications for registration, prior authorization, concurrent review, and retrospective review; and

D.4.1.4. Promote person centered treatment, recovery and maintenance of overall health and wellbeing.

D.5. Clinical Review Process

D.5.1. The Contractor's UM Program shall, at a minimum, require the Contractor to conduct reviews of health care services requested on behalf of Members in accordance with best, evidence-based clinical practices.

D.5.2. The Contractor shall provide to the Department the methods it proposes to use to identify what are currently considered to be the best evidence-based practices, and when such evidence is lacking or in conflict to support the efficacy of requested health care services, its approach to reviewing and determining whether such requests are medically necessary:

D.5.3. For members receiving services pursuant to an order of the court, requested services shall be authorized if they are determined to be medically necessary.

D.5.4. The Contractor shall conduct periodic reviews of authorized health services for timely and coordinated discharge planning.

D.5.5. The Contractor shall review the Member's current and open authorizations when a new request for authorization is received to determine whether the requested service is duplication of, or in conflict with, an existing service authorization.

D.5.6. The Contractor shall verify that the services to be authorized are covered under, and the provider to whom payment would be made is enrolled as an active provider in, the program from which the provider/member is seeking coverage, prior to completing an authorization for service.

D.5.7. The Contractor shall conduct retroactive medical necessity reviews resulting in a retroactive authorization or denial of service for individuals who are retroactively granted eligibility, when the effective date of eligibility spans the date of service and the service requires authorization. The provider shall be responsible for initiating this retroactive medical necessity review to enable authorization and payment for services.

D.5.8. The Contractor shall assist hospital emergency departments with the coordination of care, when requested by the emergency department. For the purposes of this Contract, hospital shall mean general acute care hospital including children's hospitals.

D.5.9. The Contractor shall implement a systems-based protocol for checking each service request against Intensive Care Management (ICM) thresholds that might trigger the involvement of ICM staff and shall refer to ICM staff, notifying the member of the referral, if a threshold is triggered.

D.6. Clinical Review Availability and Timelines

D.6.1. The Contractor shall perform admission reviews for acute general hospital, general children's hospital, and chronic disease hospital inpatient services.

D.6.2. Acute inpatient services in a general hospital are payable under Medicaid at a per discharge case rate. The Contractor shall only be required to conduct an admission authorization and discharge review for admissions to general hospitals. Additional contacts may be necessary to facilitate timely discharge and to support transitional care coordination. Should the acute hospital reimbursement methodology change from a per case to a per diem payment structure, the Contractor and the Department shall negotiate the staffing needs required to conduct the concurrent reviews.

D.6.3. The Contractor shall propose information content requirements for provider requests for authorization of admission to acute care and chronic disease hospitals for the Department's approval.

D.6.4. The Contractor shall perform prior authorization reviews within the following time frames:

D.6.4.1. The Contractor shall render a decision concerning an elective hospital admission within five (5) business days; an emergency hospital inpatient admission within two (2) business days.

D.6.4.2. The Contractor shall render decisions concerning admission to a chronic disease hospital within two (2) business days.

D.6.4.3. The Contractor shall render a decision on requests for readmission to a chronic disease hospital from an acute care hospital within one business day. Such notice may also be communicated by telephone or electronically.

D.6.4.4. The Contractor shall authorize or deny requests for continued stay in a chronic disease hospital for clients who have exhausted third party insurance. The Contractor shall render such an authorization decision within two (2) business days from notification by the chronic disease hospital of the exhaustion of the other benefits.

D.6.4.5. The Contractor shall render a decision concerning a radiology service; a request for palivizumab (Synagis®); outpatient surgery and home care within two (2) business days.

D.6.4.6. The Contractor shall render a decision concerning a reauthorization of a request for radiology service; for palivizumab (Synagis®); and for home care within fourteen (14) calendar days.

D.6.4.7. The Contractor shall authorize decisions concerning durable medical equipment within fourteen (14) calendar days.

D.6.4.8. The Contractor shall authorize decisions concerning therapies (speech, physical, occupational) within two (2) business days of a new request for authorization.

D.6.4.9. For all other non-emergent services subject to a prior authorization request, the Contractor shall render a decision within fourteen (14) calendar days of the request.

D.6.5. The times listed in D.6.4. shall be measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision. In no event, however, shall the Contractor render a decision on a request for prior authorization more than twenty (20) calendar days following the request.

D.7. Peer Review Requirements

D.7.1. The Contractor shall offer to conduct peer reviews on any request for authorization that fails to meet authorization criteria in the judgment of the first level review clinician. A physician or clinician with appropriate expertise will conduct all peer reviews.

D.7.2. If a peer review is requested the Contractor shall allow the provider to designate an appropriate clinician to represent the provider in the peer review process. The provider shall not be required to submit additional written documentation for this peer review.

D.7.3. The Contractor shall base its determination on peer desk review if the provider does not request a peer review. Except as provided in D.7.4 when a peer review is requested, the Contractor shall schedule the peer review to occur within two (2) business days, or such other time as agreed with by the provider, of the initial determination that the request for authorization does not meet the authorization criteria. If reasonable attempts to schedule the peer review are unsuccessful, the Contractor may make the determination based on a peer desk review.

D.7.4. The Contractor shall complete such decisions that result from the peer review within the timeframes set forth in Subsection D.6 above.

D.8. Out-of-State Providers

D.8.1. The Contractor shall allow an out-of-state provider who is not enrolled in the Connecticut Medical Assistance Program Provider Network to submit an authorization request to the Contractor when an eligible member is temporarily out-of-state and requires services. This allowance shall apply to clients who are out of state and does not apply to in-state providers or to members located within ten (10) miles outside of the state line as these members can access services from a provider already enrolled in the Connecticut Medical Assistance Program ("CMAP") Provider Network. For purposes of this section an Out-of-State Provider is a Provider that is not a Network Provider but shall, for the sole purpose of obtaining reimbursement for the provision of services, enroll with the Department.

D.8.2. The Contractor shall render a decision in accordance with the timeframes set forth in the timeliness standards set forth in Sections D6 and D7. For authorization requests meeting these parameters, the Contractor shall:

D.8.2.1. Review the request for services for medical necessity.

D.8.2.1.1. If deemed medically necessary, provide an authorization number to the non-enrolled out-of-state provider seeking to authorize services to an eligible member. This authorization cannot be included in the transmission of authorizations to the Department's MMIS contractor until the provider is enrolled but it shall be transmitted within fifteen (15) business days of receipt of a provider file that indicates that the provider is enrolled.

D.8.2.1.2. Provide provider enrollment instructions to non-enrolled out-of-state providers.

D.9. Written Notice

D.9.1. The Contractor shall send written notice to providers regarding all decisions made on their requests for service authorization, registration or continued stay. Such notices shall be sent within three (3) business days of the decision.

D.9.2. All notices must reference the provider's CMAP identification number when the provider has enrolled with CMAP. The written notice of a favorable decision must include an authorization number and statement notifying the provider that although the services have been authorized, the authorization does not confer a guarantee of payment.

D.9.3. The Contractor shall send to members written notice in English, or in Spanish for members for whom Spanish is the primary language, regarding service authorization denials, in accordance with Section U of this Contract "Notice of Action, Denials, Appeals and Administrative Hearings".

D.10. Web-Based Automation

D.10.1. The Contractor shall establish a secure automated, web-based system to receive, screen, and respond to service registration and authorization requests for services as defined by the Department. The web-based system must:

D.10.1.1. Verify the eligibility of the intended Member for health services.

D.10.1.2. Issue an immediate on-screen notice that informs the requesting provider that a clinical review and authorization are required and that the provider must contact the provider line to complete the review with a clinician if any of the following are true:

D.10.1.2.1. The provider is registering a member for a service for which an authorization already exists;

D.10.1.2.2. The provider is registering a member for a service that cannot be simultaneously authorized with an existing service without a clinical review; or

D.10.1.2.3. The provider is registering a member for a service that otherwise requires clinical review.

D.10.1.3. Provide a real-time electronic authorization response including provider number, service location, authorization number, units authorized, begin and end dates, service class and billable codes, as well as notify providers when the information submitted for an authorization of service is incomplete and that describes what required information is missing.

D.10.1.4. Permit providers to obtain information regarding the status of services for which they have been authorized, including units authorized, begin and end dates, and units remaining, through a look-up function in the automated web-based system.

D.10.2. The Contractor shall provide to the Department secure access to the Contractor's web-based application.

D.11. Staff Credentials, Training and Monitoring

D.11.1. The Contractor shall utilize clinicians with the following relevant training and experience to conduct reviews for requests for medical services. The Contractor shall ensure that the clinicians:

D.11.1.1. Are individually licensed health care professionals.

D.11.1.2. Have, at a minimum, five (5) years direct service experience in the delivery of medical services.

D.11.1.3. Have appropriate State of Connecticut licensure in good - standing.

D.11.1.4. Have experience and a demonstrated competency with performing UM.

D.11.1.5. The Contractor shall employ a full time, on-site Chief Medical Officer who will devote 100% of their time to the Clinical Management area, including the ICM program. The CMO's responsibilities will include, but not be limited to: providing daily clinical program oversight; consulting to UM personnel; actively participating in staff development; conducting individual case reviews; offering peer reviews to practitioners on potential denials; determining medical necessity and making denial decisions; participating in new technology and pharmaceutical evaluations; and, reviewing the UM Program annually. In addition there will be two (2) part-time Medical Directors onsite.

D.11.1.6. The Contractor shall require and ensure that the Medical Directors are physicians, board certified or eligible in their clinical specialty with experience in managed care and the clinical treatment and management of individual clients enrolled in a public sector health care program. The Contractor may split this position between part-time physicians subject to the Department's review and approval. However the Contractor must demonstrate and certify to the Department that the split position retains full time equivalency and adequacy of coverage for the population.

D.11.1.7. The Contractor shall employ three levels of review including Clinical Reviewers; Peer Reviewers; and, Independent Peer Clinical Reviewers. Denials will be thoroughly reviewed by the appropriate level of reviewer.

D.11.1.7.1. The Contractor's CMO will ultimately be responsible for denials that require a medical necessity review, ensuring that a fair and reasonable process will be applied across all decisions regarding care delivery.

D.11.1.7.2. The Contractor's CMO is not responsible for denials that do not require a medical necessity review - e.g. administrative denials such as lack of eligibility.

D.11.2. The Contractor may use clinical assistants or liaisons to gather and prepare materials to support review by licensed clinicians.

D.11.3. The Contractor shall conduct, no less frequently than quarterly, reviews of authorizations issued by each staff member. The reviews shall monitor the timeliness, completeness, and consistency with UM criteria of the authorizations and shall be reported by the Contractor to the Department annually. The Contractor shall:

D.11.3.1. Require individual staff performing at less than 90% proficiency in any UM criteria during any month, as demonstrated through the review, to receive additional coaching and be monitored monthly, until they show consistent (i.e. at least two (2) months in a row) proficiency at the 90% level.

D.11.3.2. Require the removal of the staff person from UM responsibilities if the monthly reviews of that staff person demonstrate three (3) consecutive months of audits at below 90% proficiency.

D.11.4. The Contractor shall, throughout the term of this Contract retain or contract with specific specialists, including but not limited to a geriatrician, physiatrist, general pediatrician, general internist or family physician, if the Contractor's Medical Director does not have this experience. These specialists shall have experience in the clinical treatment and management of individual clients enrolled in a public sector health care program.

D.12. Records

D.12.1. The Contractor shall, at a minimum, include the following data elements in the service authorization process:

D.12.1.1. Member name, EMS issued ID number, race, ethnicity, age, date of birth, gender and address;

D.12.1.2. Date and time the request for authorization or registration was made;

D.12.1.3. Type of good or service, including level of care and units of service/length of stay requested;

D.12.1.4. Type of good or service and level of care authorized, denied or partially denied, including diagnosis and procedure codes;

D.12.1.5. Start and stop dates of authorization;

D.12.1.6. Number of visits, days, units of service, and/or dollar limit (as appropriate) authorized;

D.12.1.7. Reason for referral or admission (including diagnostic information);

D.12.1.8. Reason for denial, reported according to the specific section of the definition of medical necessity used to justify the denial;

D.12.1.9. Authorized rendering provider name, CMAP (Medicaid) number, and group or facility name and Medicaid number and contact information;

D.12.1.10. Location where service will be provided (if provider has more than one location);

D.12.1.11. Authorization number, date and time;

D.12.1.12. The name of the individual and their credentials that authorized or denied the requested service and/or the CMO;

D.12.1.13. The tracking status of any requested documentation;

D.12.1.14. The program under which coverage is provided for each service request; which will in turn indicate whether or not an NOA or denial is required to be sent for adverse decision;

D.12.1.15. An indicator for when a member is receiving ICM or, by virtue of obtaining the requested service, has triggered an ICM threshold;

D.12.1.16. An indicator of court involvement and/or mandated activity by type related to the service authorization in question; and

D.12.1.17. An indicator for individuals eligible for ICM, which would include an ICM start and end date.

D.12.1.18. Additional elements may be requested in order to meet MMIS requirements.

D.12.2. The Contractor shall maintain internal records of all UM decisions, member clinical status, and service utilization in a manner consistent with company policy, as approved by the Department.

D.12.3. The Contractor shall maintain a UM system that has the capacity to enter and maintain text for the following:

D.12.3.1. The member's presenting symptoms, history, other services tried;

D.12.3.2. Clinical review notes;

D.12.3.3. Any inpatient admission request information for which an admission is not approved;

D.12.3.4. Notes from discussions with other medical professionals employed by or contracted by the Contractor;

D.12.3.5. Citation of review criteria for approval or denial; and

D.12.3.6. Any other information or call tracking related to a member's care including indication of need for coordination with behavioral health or Medicaid Waiver programs.

D.13. Inpatient Census Report

D.13.1. The Department shall require all inpatient general and chronic disease hospitals to notify the Contractor of all inpatient admissions of individuals dually-eligible for Medicare and Medicaid.

D.13.2. The Contractor shall develop and present to the Department for review and approval by April 1, 2012, a process to provide the primary care provider or medical home with a daily census report as indicated in Exhibit E, which shall include all individuals admitted to general hospitals and chronic disease hospitals. The Department shall accept or reject the process within 30 days of the receipt of the proposed process.

D.13.3. Once approved by the Department the Contractor shall implement the inpatient census process and maintain the same throughout the term of the contract unless revised with the approval of the Department.

D.13.4. The Contractor will notify the appropriate waiver staff members of all inpatient admissions to general acute and chronic disease hospitals of individuals who are enrolled in waiver programs. Responsibility for ICM for these individuals may be transferred to the waiver at the discretion of the waiver staff members.

D.14. Discharge Planning and Transitional Care Management

D.14.1. The Contractor shall provide transitional care management for members with authorized acute inpatient care and chronic disease hospital care, including individuals about whom the Contractor received notification, but who are dual eligible and whose inpatient care did not require authorization by the Contractor.

D.14.2. Discharge planning shall be conducted as a person-centered, interdisciplinary process that includes member and family participation in all phases of the planning process. Participation activities shall include but not be limited to:

D.14.2.1. Discussion of anticipated discharge plans with inpatient providers within two days of admission;

D.14.2.2. Ongoing collaboration between the member, family and the interdisciplinary care team, including the provision of verbal and written information on the range of support and service and available options in the member's community.

D.14.2.3. Identification of the cause(s) where the discharge may be impeded or impacted by barriers or issues including, but not limited to, a) the need for housing, foster care or living arrangement; b) availability of an appropriate service provider; or c) emergency back-up. Confirm that DCF, DDS, DMHAS, or waiver case management staff are, as appropriate, notified regarding the discharge.

D.14.2.4. Assisting providers as necessary with discharge planning and overseeing the coordination of care and medication reconciliation with the aftercare facility or provider(s).

D.14.2.5. Obtaining complete information describing the aftercare plan including providers' names, dates of follow-up visits with PCP and specialists, referrals for waiver services or case management, if necessary, medication regimen, home health care and transportation arrangements.

D.14.2.6. Discussion of plans for completeness prior to discharge especially to assure that initial visits for essential services have been arranged prior to discharge and post-discharge shall review with the Member whether the provider discussed the plan with the Member or legal guardian and provided him or her with a written copy.

D.14.2.7. Transitional coordination shall ensure that necessary member education regarding the care plan has occurred post-discharge, and include condition specific self-management education. When necessary for the success of the aftercare plan, the Contractor will be expected to meet with the member to educate them about their care plan upon request by the hospital.

D.14.3. Transitional Care Management - The Contractor shall monitor follow up care for members discharged from inpatient care by:

D.14.3.1. Contacting the lead clinical provider as designated in the discharge plan within seven (7) business days after discharge to ensure that the members have obtained follow-up care. This shall include, but not be limited to, arrangements for medication, home health care, durable medical equipment, and skilled nursing facility, as needed.

D.14.3.2. Offering assistance with appointment scheduling for members who have not obtained follow-up care.

D.14.3.3. Identifying reasons for unsuccessful follow-up care and communicating this to the Contractor's Quality Management unit.

D.14.3.4. Identifying inpatients who would qualify for Intensive Care Management (using the criteria in Section E below) and referring them for enrollment in ICM.

D.14.3.5. The Contractor shall coordinate with the appropriate waiver personnel to augment any necessary medical or disease management identified as the individual transitions from a skilled nursing facility to a community setting or placement.

D.14.3.6. The Contractor shall not be required to monitor follow up care for members discharged from inpatient care following a brief stay, routine hospitalizations or uncomplicated minor surgical procedures.

D.15. Special Retrospective Reviews

D.15.1. On an annual basis, the Department shall determine the number of special retrospective reviews it will allow for each acute hospital in Connecticut to request on a hospital admission where it failed to follow procedures in obtaining a prior authorization as specified in State Regulation Sec 17-134d-80. The Department shall provide this list to the Contractor each year.

D.15.2. The Department shall define criteria for the Contractor to determine if a special retrospective review meets "good cause" requirements, which would enable the Contractor to perform the review.

D.15.3. Hospitals shall submit requests for special retrospective reviews to the Contractor along with a check made payable to the

Department in an amount as determined by the Department for such review.

D.15.3.1. If the Contractor determines the request meets the Department's requirements for good cause, the Contractor shall complete the retrospective review.

D.15.3.2. The Contractor shall forward the Hospital's payment for the retrospective review to the appropriate Department contact, as defined by the Department.

D.15.3.3. If the Contractor determines the request does not meet the Department's requirements for good cause, the Contractor shall notify the hospital in writing and return the Hospital's payment for the review.

D.15.4. The contractor shall complete all special retrospective reviews within 60 days from the receipt of complete information.

E. INTENSIVE CARE MANAGEMENT

E.1. General Provisions:

E.1.1. Intensive Care Management is the organization and implementation of activities to assess needs, maximize coordination of resources and improve the health and outcomes for individuals with significant clinical conditions that severely impact their daily lives. These members may have one or more chronic conditions with or without co-occurring behavioral health conditions, or environmental and social circumstances which prevent an efficient utilization of medically necessary care and resources.

E.1.2. The goal of the Intensive Care Management (ICM) Program is to promote the overall care experience, wellness and health outcomes of high-risk members by leveraging the delivery of person-centered ICM services. A successful ICM Program will:

E.1.2.1. Identify high risk members with potential for improved management of their conditions, and improved outcomes through a predictive modeling system;

E.1.2.2. Require that a member consent to receive ICM services and opt-out to terminate ICM services. A member or member's legal representative may provide either verbal or written consent for the member to participate or terminate their participation in ICM. The Contractor's ICM staff shall document the consent in the care management system;

E.1.2.3. Engage members in their own care through education and self-help coaching;

E.1.2.4. Increase use of preventive care services;

E.1.2.5. Integrate the delivery of physical health and BH services;

E.1.2.6. Mitigate poor outcomes and high costs at the individual and system levels.

E.1.3. To ensure the appropriate delivery of health care services through an ICM program the Contractor shall:

E.1.3.1. Organize care using a person-centered, multidisciplinary primary care and specialty practice team,

E.1.3.2. Identify community supports and other resources required to support the individual and to address their needs,

E.1.3.3. Exchange information among those responsible for different aspects of the member's care, including the member, family and circles of support. If required by the HIPAA Privacy standards or Department policies the Contractor shall obtain the written approval of the member or member's legal representative prior to the to exchange of any information with other individuals responsible for the member's care; and

E.1.3.4. Delineate and inform participants about each others' roles in the member's care and the available resources to fulfill the care plan.

E.1.4. The Contractor shall comply with the ICM standards included in its ICM policies and procedures, as approved by the Department.

E.1.5. For each member requiring ICM services the Contractor's ICM staff shall collaborate with a multi-disciplinary care team made up of clinicians, service providers, and the member or the member's designee, to develop a personal plan of care, as defined in the ICM policies and procedures in order to improve individual outcomes.

E.1.5.1. The Contractor shall enroll a member into ICM when the Contractor has received notification from the member or member's guardian that the member has consented to receive ICM services.

E.1.5.2. The Contractor shall complete an initial assessment, as defined in the ICM policies and procedures, within thirty (30)

days of a member's enrollment into ICM. The initial assessment shall determine the member's health status and environmental and social circumstances which may prevent the efficient utilization of medically necessary care and resources. The member will be engaged into the ICM program once the initial assessment has been completed.

E.1.5.3. The Contractor shall develop a personal care plan as defined in the ICM policies and procedures for each enrolled member within the fourteen (14) calendar days of completing the initial assessment.

E.1.5.4. The Contractor shall update the care plans of those members identified through the initial assessment as moderate or high need, upon every encounter, but not less frequently than every ninety (90) days, and shall monitor the effectiveness of the care plans ongoing.

E.1.5.5. The Contractor shall conduct a formal reassessment, as defined in the ICM policies and procedures, of a member every six (6) months, beginning from the date of the initial assessment.

E.1.6. In the first year of this Contract, the Contractor's ICM Program shall provide intensive care management for the following special populations and in addition to those populations identified through the Contractor's predictive modeling and health risk stratification methods:

E.1.6.1. Pregnancies at high risk of adverse outcomes,

E.1.6.2. Newborns at high risk of poor developmental, behavioral or medical outcomes, and

E.1.6.3. Members with untreated conditions causing chronic pain for which they are at risk of overusing addictive pain medications.

E.2. ICM – Service Delivery:

E.2.1. The Contractor shall provide ICM within the State of Connecticut , with the regional deployment of Intensive Care Managers in the field assigned to five (5) regional teams as defined by and agreed to by the parties in the Contractor's ICM Program Plan, sized to correspond to the level of membership and provider presence in each of the five regions.

E.2.2. The Contractor shall provide ICM services for specified number of members across all member populations identified in the ICM

Program Description as approved by the Department. The average monthly caseload requirements shall be included in the ICM Program Description and approved by the Department.

E.2.3. Each of the five (5) ICM regional teams will include ICM nurses who will support provider practices and their patients in each geographic area of the State.

E.2.4. Social Workers and Human Services Specialists will support all five (5) ICM regional teams.

E.2.5. Behavioral Health (BH) nurses will also participate on the regional teams to serve members with co-morbid BH conditions.

E.3. ICM Team Roles and Credentials:

E.3.1. The Contractor's ICM program shall include staff members with experience in the care of members from diverse cultural and socioeconomic backgrounds.

E.3.2. The Contractor shall engage a variety of expertise on the ICM team to ensure that each member receives the services they personally need. The Contractor shall ensure that the individuals who provide ICM services to members possess the following minimum credentials:

Title and Role on the Team	Minimum Credentials
ICM Nurses: Each of the ICM Nurses shall be responsible for developing and executing person-centered integrated care plans in collaboration with the interdisciplinary care team. They shall work directly with the member telephonically and, when appropriate, face to face. The ICM Nurses shall integrate with provider staff to support practices to achieve member-specific care planning goals; integrate BH care with BH Specialists and, using electronic view capabilities to see BH care plans; and shall integrate with the CTBHP ICM when appropriate.	R.N. with 3-5 years of clinical experience. Managed care and case management experience preferred.
ICM Social Services Coordinator: Shall provide psychosocial support across Regional teams; establish linkages to community-based specialists and support waiver programs.	B.S. or M.S.W. or licensed behavioral health therapist; and 3-5 years clinical experience. Managed care and case management

	experience preferred
ICM Human Services Specialists: Shall identify community-based resources for members and for providers for referral; shall address member psychosocial issues in the community with a primary focus on linking members (and providers) with community-based social supports; and shall provide non clinical face-to-face contact as needed to assist members with identifying and accessing needed community resources.	B.A. or B.S. desired; and a minimum of 2 years of experience w/ community-based human or social services
ICM BH Nurse: shall educate the Contractor's Regional team members on BH care delivery issues and needs.	R.N., with 3-5 years of behavioral health clinical experience. Managed care and case management experience preferred

E.4. The Contractor shall provide Health Informatics Analysts and Quality Data Analysts resources to the ICM regional teams. The ICM regional teams shall be required to further integrate services with other clinical areas including UM, QM and Network Management among others.

E.5. ICM Training: The Contractor shall train all current staff who will transition to the ASO (including sub-contractor staff) and any new hires.

E.5.1. Comprehensive ASO Orientation services will be provided on an ongoing basis, including a mixture of in-person classroom learning, mentoring, monitoring and web-based learning. The Contractor shall participate in cross-training efforts to maximize knowledge of ICM strategies and functions across the Regional Teams. ICM training will include the following components:

E.5.1.1. Core Training: staff orientation will include strategies and content on: engagement and building member rapport, active listening, motivational coaching, use of ASO technology, client-specific management strategies, care integration, chronic condition management and ASO services and benefits among other topics.

E.5.1.2. Cultural Competency: All ICM staff will be trained to enhance cultural awareness and knowledge of cultural and ethnic influences. Cultural sensitivity training will include exercises in empathy, interpersonal communication, appropriateness, and

respect as well as assessment, diagnostic and clinical skills. A cultural competency self-study and testing will be required for staff.

E.5.1.3. Preceptor and Mentoring program. Preceptors will actively train staff telephonically and at providers' offices. The Contractor shall have senior staff as mentors for work-related issues or questions and demonstrate coaching techniques for more junior staff.

E.5.1.4. The Contractor shall ensure that its ICM staff receive training in person-centered care planning as part of its mentoring program.

E.5.1.5. Integrated care management approaches to manage patients who have interacting physical and psychological health multimorbidities; inadequate social networks and limited or poorly coordinated access to needed health services

E.5.2. Continuing Education: Post-core continuing education will be an integral component of the ICM program for all staff. The Contractor shall, throughout the term of this contract provide distance learning opportunities as well as a library of online and classroom-based learning opportunities in chronic care and medical home among other issues.

E.6. Data Analytics to Support Intensive Care Management.

E.6.1. The Contractor shall use a predictive modeling decision-support tool that has the ability to meet or exceed the following requirements:

E.6.1.1. Production of predictive modeling reports to inform the Contractor, the Department and individual providers of the highest risk members who require ICM program outreach;

E.6.1.2. Identification of frequent Emergency Department utilizers which will require the Contractor to conduct telephonic and/or in-person outreach;

E.6.1.3. Stratification of identified members to further define member needs and prioritize level of care management required

E.6.1.4. Ability for Contractor to drill down to member- and provider-specific care delivery patterns; and allow the user to configure data including annual and ad hoc provider-and member-centric compliance reports;

E.6.1.5. Ability to connect the Department, the Contractor and participating Network Providers through a provider portal allowing providers to access their own performance metrics, including utilization, quality scores and gaps in care.

E.7. Intensive Care Management Program Plan

E.7.1. Development and Approval : The Contractor shall, on or before March 1, 2012, develop and submit to the Department for its review and approval an ICM Program including a program description, policies, procedures, workflows, and qualifying criteria for children, adolescents and adults. The plan must include but shall not be limited to:

E.7.1.1. Organizational structure with reporting and supervisory relationships.

E.7.1.2. ICM staff credentials and orientation and training procedures

E.7.1.3. A description of proposed data analytics for population health management and/or health risk stratification that support intensive care management.

E.7.1.4. ICM process including identification of members requiring ICM, enrollment processes, intervention strategies for ICM, use of a care plan, coordination with primary care and other providers, and local services and supports.

E.7.1.5. A process for individuals to opt out of the ICM process.

E.7.1.6. A strategy for identifying individuals excessively seeking care in inappropriate care settings and developing mechanisms to facilitate care in more appropriate settings.

E.7.1.7. A strategy for communication with the member, service and support providers, local social and community service agencies, and the member's family and key supports.

E.7.1.8. The role of the Contractor's information systems in supporting the ICM process and fidelity to the proposed ICM model.

E.7.1.9. Plan for coordination, communication and integration of the work of the ICM staff with the local service system such as establishing local or regional outstations and building collaborative relationships with providers.

E.7.1.10. A description of the Contractor's analyses using claims or encounter data to develop care management or ICM priorities.

E.7.1.11. A description of the ICM approach that would be used for members who are attributed to medical homes.

E.7.1.12. A description of the process utilized to capture data related to care plans.

E.7.1.13. A description of the process for ICM unit communication with other units including the UM, QM, and Provider Relations Department.

E.7.1.14. The process by which the ICM unit will communicate and coordinate care with the Behavioral Health Partnership and the Dental Health Partnership.

E.7.1.15. The process to establish lead ICM responsibility for individuals with serious medical and behavioral health co-morbidities,

E.7.1.16. A description of how the Contractor's ICM resources will be modified or reduced in coordination with the emergence of PCMH providers.

E.7.1.17. A description of how the Contractor's proposed ICM program takes into consideration cultural diversity and poverty.

E.7.1.18. A description of the plan to collaboratively work with community-based organizations, other government and non-government agencies, and community-based advocacy groups to create innovative approaches to health care delivery in the context of poverty and cultural diversity.

E.7.1.19. Description of processes to comply with reporting requirements as identified in Exhibit E and internal reporting necessary to monitor program performance and outcomes.

E.8. The Department shall review and comment, approve or reject the submission. Once approved by the Department, the Contractor shall implement the approved ICM Program to be effective as of the implementation date and shall utilize the approved criteria unless and until revisions to the qualifying criteria are approved by the Department.

E.9. The Contractor shall propose to the Department modifications to the Program including qualifying criteria at least annually and no later than

October 1st of each subsequent year of the contract for implementation as of January 1 of the following year.

F. PRIMARY CARE PROVIDER ASSIGNMENT

F.1. General Provisions: Primary Care is the basis of high quality and affordable health care. Adequate access to primary care is associated with greater use of preventive care and in improvements in patient satisfaction, patient outcomes and health service value.

F.2. Requirements of the Contractor.

F.2.1. The Contractor shall develop for the Department's review and approval a PCP assignment plan that provides for welcome calls, PCP selection, and PCP/ PCMH attribution.

F.2.2. The Department and the Contractor shall mutually agree upon the specific submission date within the month of January, 2012. Specifically, the plan shall provide for:

F.2.2.1. With respect to welcome packets, welcome calls and PCP selection, the contractor shall:

F.2.2.1.1. Send a welcome packet and place an automated welcome call to all members eligible in January 2012 within sixty (60) days of implementation.

F.2.2.1.2. Effective with the February 2012 eligibility month, send a welcome packet and place an automated welcome call to all new members within fifteen (15) days of receiving an eligibility file from the Department.

F.2.2.1.3. Provide automated welcome calls that are both linguistically and culturally appropriate and shall encourage members to select a PCP.

F.2.3. With respect to attribution, the Contractor shall:

F.2.3.1. Implement procedures to allow members to be attributed to a primary care provider based on service history. The circumstances under which the Contractor shall use attribution shall be specified in the PCP/ PCMH assignment plan.

F.2.3.2. The Contractor shall utilize the Department's claims history file for members to identify member relationships with PCPs based on the claims history over a prior period to be specified in the plan.

F.2.3.3. If a member's claim history includes PCP visits with a Network PCP, the Contractor will assign the member to that Network PCP;

F.2.4. On a monthly basis, monitor primary care and other service utilization measures, based on claims data, to ensure that members have access to and are regularly receiving primary care services.

F.2.4.1. Contact members who have not received primary care services to determine why they have not visited their PCP.

F.2.4.2. Educate the member about the importance of primary and preventive care;

F.2.4.3. Reinforce the selection of the PCP and the value of PCP visits at recommended intervals;

F.2.4.4. Determine and provide assistance to the member in scheduling an appointment or choosing a new PCP.

F.2.5. Allow members to change PCPs at any time by contacting the call center or by making the change through a secure Member portal on the Contractor's website.

F.2.6. Monitor member complaints on a monthly basis to ensure PCPs have the capacity to offer access to the assigned members.

F.2.7. Make patient attribution reports, including additions and deletions, available through a secure Provider portal on the ASO website.

F.2.8. The Provider portal shall allow Providers to log in securely and view their patient attribution report and other service utilization reports for their patients, such as gaps in care and ED utilization.

F.2.9. Report to the Department all member attributions to PCMH providers to trigger the PCMH payment process, in a format and frequency determined by the Department.

G. General Supports to PCMH Practices

G.1. General Provisions: The Contractor's Transformation Specialists shall:

G.1.1. provide support to practices and clinics for transformation to a Person-Centered Medical Homes model;

G.1.2. deliver and educate practices on tools to manage the Contractor's population (e.g. predictive modeling, provider portal, screening tools, evidence-based protocols, etc.);

G.1.3. work closely with Contractor's ICM Nurses to inform them of the process for medical home transformation; and

G.1.4. monitors certified PCMH practices continued compliance with certification standards.

G.2. The Contractor shall provide the Department and Person-Centered Medical Home (PCMH) practices and clinics with the following services and supports. The Contractor shall:

G.2.1. Have staff that have received training from professionals with expertise in PCMH and practice transformation to execute all activities described in this section of the Agreement;

G.2.2. Seek approval from the Department regarding training and development resources for PCMH-related activities including other written curricula; educational evaluation materials and reference tools;

G.2.3. Identify and develop strategies to share care coordination resources among practices;

G.2.4. Meet with potential PCMH practices to discuss options and obtain resources that will satisfy the Department's PCMH requirements including, but not limited to NCQA requirements;

G.2.5. identify and make available tools for assessment of current PCMH capability, identification of practice gaps requiring change and action plans for practice specific transformation;

G.2.6. Facilitate partnerships between practices that wish to share resources, to the extent that the Contractor is aware of such resources;

G.2.7. Develop an outreach strategy that involves community supports for informing Members and Providers and engaging in the PCMH transformation to include orientation to the "medical home" concept;

G.2.8. Work with the Department to develop and implement a set of initiatives to decrease health disparities. Based on Department guidelines and direction, the Contractor shall collaborate with the Department or its agent to:

G.2.8.1. Develop strategies to sensitize and educate practices regarding racial disparities in care delivery among HUSKY Health and Charter Oak Health Plan populations.

G.2.9. On an annual basis, help produce at least two educational events for PCMH practices to be delivered in specified geographic regions as agreed to by the Department.

G.2.9.1. The Department would be responsible for costs associated with producing educational events (space, speaker, food) for such activities.

G.2.9.2. The Contractor shall evaluate participant satisfaction and impact of such forums as part of the production and implementation process.

G.2.10. Review data to identify and prioritize racial and ethnic disparities among specific PCMH (and other CMAP) providers.

G.2.11. Develop, implement and monitor strategies to help practices implement data-driven interventions to decrease disparities;

G.2.12. Identify EHR (electronic health records) data and reports and develop strategies based on such data and reports.

G.2.13. Assist practices in interpreting EHR data to develop data-driven interventions to decrease racial and ethnic disparities; and,

G.2.14. Maintain an inventory of local and state community-based resources for use by PCMH practices and recipients. At a minimum, the Contractor shall, upon request, make the following information available to Providers and Members:

G.2.14.1. The name of the agency that provides the community-based resource;

G.2.14.2. A description of the type of available resource and applicability for specific conditions and populations; and

G.2.14.3. Contact information to access the available resource.

G.2.15. Include a provider's PCMH designation by the Department in the Contractor's searchable CMAP provider directory in addition to the data elements identified in Section O – Provider Relations, subsection 8 – Web-based Communication Solution;

G.2.16. Develop and publish, electronically, policy and procedure models required by the NCQA to operate a PCMH based on the NCQA application and standards for Level 3 PCMH no later than May 1, 2012.

G.2.17. Make available electronic evidence-based disease management protocols available for download by CMAP Providers including PCMH providers. At a minimum the Contractor shall provide protocols for the treatment of asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure (CHF); high-risk pregnancy and for serving recipients with co-morbid behavioral health conditions.

G.2.18. Create a provider web-page for the PCMH initiative accessible through the HUSKY Health Program and Charter Oak Health Plan websites. The Contractor shall collaborate with the Department or its designee to develop and implement the PCMH provider web-page no later than March 1, 2012.

G.2.19. Develop and implement a minimum of four PCMH educational efforts annually for qualified PCMH practices.

G.2.19.1. The curriculum, approved by the Department on an annual basis, to support PCMH practices in continuously improving PCMH services for Members shall include, but not be limited to instruction in:

G.2.19.1.1. developing and maintaining quality improvement efforts to support practice efficiency across clinical and non-clinical functions;

G.2.19.1.2. performance measurement initiatives that target measures associated with Incentive Payments;

G.2.19.1.3. strategies to address racial and ethnic disparities; and

G.2.19.1.4. additional topics requested by PCMH practices;

G.2.20. Provide training to PCMH practices to assist them in using all data on the provider portal.

G.2.21. Administer a questionnaire to practitioners who participate in educational PCMH activities to assess their level of satisfaction with PCMH technical and educational support.

G.3. The Contractor shall utilize data from the PCMH provider satisfaction survey to continuously improve PCMH provider services.

G.4. The Contractor shall incorporate efforts to continuously review and improve care delivered through PCMH practices and clinics as part of the Contractor's overall quality management and improvement program as required in Section N – Quality Management.

G.5. The Contractor shall review, and report to the Department, annually for each qualified PCMH, the ongoing ability of PCMH practices to comply with NCQA requirements including, but not limited to:

G.5.1. The ability of PCMH practices to meet, on an ongoing basis, NCQA "Must Pass" elements.

G.6. The Contractor shall develop indicators of ongoing PCMH performance in collaboration with the Department, to include:

G.6.1. Conducting a systematic review and analysis of data available through the Contractor to identify performance outliers and suggest improvement strategies.

G.6.2. Reporting such outliers and plans to the Department in conjunction with their on-site reviews of PCMH practices.

G.7. The Contractor shall identify and implement processes to ensure PCMH practices have access to:

G.7.1. analytic capabilities to identify and stratify Members for care coordination and intensive care management

G.7.2. decision–support tools to assist with clinical decision-making and assignment of appropriate interventions

G.7.3. processes to allow for comprehensive clinical/care management documentation and exchange of information; and

G.7.4. data collection and analysis for performance monitoring and outcome reporting.

G.8. Perform PCMH data analysis and reporting activities. The Contractor shall:

G.8.1. Include performance measures designated by the Department on the Contractor's provider data portal. Such measures shall be updated monthly beginning in June 2012;

G.8.2. Calculate baseline results for PCMH performance measures based on the first year of PCMH operation from 1/1/12 through 12/31/12.

Such data will be available to PCMH practitioners, the Department and other stakeholders on or before 6/30/13;

G.8.3. Conduct a PCMH CAHPS survey annually within three months of the end of each calendar year unless otherwise specified by the Department.

G.8.3.1. The Contractor shall oversample participating PCMH practices in order to obtain statistically significant results regarding consumer experience.

G.8.3.2. The Contractor shall make CAHPS results available to PCMH providers and clinics on the provider portal of the ASO website.

G.9. Collaborate with the Department and the Regional Extension Center to assist PCMH Glide Path and fully qualified practices in activities related to EHR management. The Contractor shall:

G.9.1. Confirm the ability of individual practices to meet EHR-based reporting requirements;

G.9.2. Develop reporting formats for providers to support EHR submissions for both ongoing reporting and performance measurement activities;

G.9.3. Ensure the provision of key reports to PCMH practices on the web-based portal including, but not limited to all standard reports available to other practitioners through the Contractor. Such reports shall be provided to PCMH practices and clinics in a matter that facilitates comparison of results between individual PCMH practices and clinics, the complete PCMH network and the CMAP network overall

G.9.4. Calculate performance measurement results for Incentive and Improvement payments for each PCMH practice. The Contractor shall further calculate PCMH incentive and improvement payments annually for the PCMH network by July 1 of each year beginning in 2013. Issuance of payments is the responsibility of the Department.

G.9.5. Prepare documentation to send to practices and clinics that explains the methodology and results for Incentive Payments and Improvement Payments, including but not limited to: the measurement methodology; results relative to other providers in the network; performance results by measure for all Department-designated measures; and, the payment amount.

G.10. The Contractor shall collaborate with the Department in the design of PCMH reports.

G.11. PCMH Application Support

G.11.1. The Contractor shall assist practices that wish to submit an application to the Department to participate in the PCMH program. For such practices, the Contractor shall:

G.11.1.1. Provide consultation regarding PCMH requirements and the application process,

G.11.1.2. Maintain a link on the provider portal of the ASO website for providers to obtain:

G.11.1.2.1. information on the PCMH program,

G.11.1.2.2. instructions on how to complete and submit a PCMH application; and

G.11.1.2.3. the PCMH application for participation.

G.11.1.3. Respond to provider inquiries regarding PCMH participation and application-related requirements either telephonically or, in person;

G.11.1.4. In consultation with the Department develop and maintain a PCMH database with information, provided through the PCMH application process, as specified by the Department;

G.11.2. Prior to Contractor forwarding a completed PCMH application to the Department, the Contractor shall:

G.11.2.1. Review the application for completeness and;

G.11.2.2. If applicable, review provider practice Medicaid and NPI ID numbers for accuracy.

G.11.3. The Contractor shall forward complete and accurate PCMH applications to the Department in the form of a scanned copy of the application and a data file of the application elements, as maintained in the PCMH database.

G.12. Glide Path Application Support

G.12.1. The Glide Path option provides financial and technical support for practices that are preparing to seek PCMH qualification to

serve HUSKY Health and Charter Oak Health plan recipients. To qualify for Glide Path status a practice must demonstrate in its application that it has initiated activities to achieve NCQA PCMH recognition. The Contractor shall administer the Glide Path application process. The Contractor shall:

G.12.1.1. Accept completed glide path applications submitted by practices.

G.12.1.2. Review applications for completeness and accuracy and respond to practices with necessary adjustments to the application to achieve completeness.

G.12.1.3. Review initial applications and re-submissions and notify practices of the results within ten (10) business days.

G.12.1.4. Provide monthly reports to the Department regarding the number of new applications received, applications in process, and applications recommended for approval.

G.12.1.4.1. The monthly reports shall also include a report on the status of the Glide Path practices including, for example, number that progress within six months, number that request extensions, status of extensions, cumulative extension total.

G.12.1.5. The Department shall be responsible for the notification to practices of their approval to participate in the Glide Path program, any communications related to potential disqualification from participation due to non-performance and final approval of successful qualification as a PCMH.

G.12.1.6. The Department shall administer reimbursement adjustments for practices in accordance with their level of qualification.

G.13. Glide Path Practice Support

G.13.1. The Contractor shall provide support for practices that wish to apply for and maintain Glide Path status. The Contractor shall:

G.13.1.1. Assist practices in preparing their Glide Path applications to the Department.

G.13.1.2. Provide consultation per practice or clinic to support self-assessment and work plan development activities associated with achieving Glide Path status;

G.13.1.3. Develop a curriculum associated with each Glide Path task consistent with Department requirements as transmitted to the Contractor that supports practices and clinics in efforts to achieve Glide Path milestones;

G.13.1.4. Develop and implement PCMH learning communities for Glide Path practices and clinics to join at six-month intervals;

G.13.1.5. Develop a schedule of webinars and/or in-person technical support sessions for practices and clinics and their office staff. At such sessions, the Contractor shall deliver the Glide Path curriculum to providers and clinics, consistent with the schedule for PCMH learning communities.

G.13.2. The Contractor shall make at least four sessions per year (two per phase) available to Glide Path providers. In-person sessions shall be provided on a regional basis at locations and, at times of the day, that are convenient for the practices and clinics;

G.13.3. The Contractor may propose the use of Webinars, subject to the Department's prior approval.

G.13.4. The Contractor shall develop a Glide Path "Blog" to help learning communities share PCMH development experiences;

G.13.5. The Contractor shall provide a PCMH web-page that includes information on the Department's goals and objectives and on key literature as well as tips on development and implementation strategies for PCMH practices and clinics;

G.13.6. The Contractor shall provide in-person consultation to PCMH practices and clinics regarding strategies to meet Glide Path requirements for each phase of the Glide Path. This may include, but not be limited to support on: work flow re-design, achievement of Glide Path tasks, and care coordination strategies;

G.13.7. The Contractor shall maintain trained resources to provide care coordination and care management to PCMH patients prior to practice-based supports being available (Phase 1 and 2 of the Glide Path Only).

G.13.8. The Contractor shall survey practices to determine their level of satisfaction with Glide Path supports provided by the Contractor.

G.13.9. The Contractor shall report provider and clinic satisfaction results to the Department.

G.13.10. The Contractor shall report to the Department, at least twice annually, on opportunities to improve Glide Path support to practices and clinics based on such feedback.

G.13.11. The Contractor shall provide support for smaller practices implementing their EHRs to include:

G.13.11.1. Information about the Regional Extension Center and all available services;

G.13.11.2. Summary information on EHR standards (meaningful use, ICD-10, HIT/HIE requirements, etc.); and

G.13.11.3. Strategies to review data based on racial and ethnic stratifications in order to design interventions to decrease racial disparities.

G.13.12. The Contractor shall monitor, on an ongoing basis and report to the Department the progress of each practice or clinic toward Glide Path deliverables.

G.13.13. The Contractor shall provide the Department with recommendations as to whether a practice or clinic has completed the Glide Path.

G.13.14. The Contractor shall not be responsible for making the final determination regarding whether or not a Glide Path practice has completed a Glide Path phase or not. The Department shall provide oversight of the Glide Path process.

H. EARLY AND PERIODIC, SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) SERVICES

H.1. The Contractor shall ensure that all Medicaid-eligible individuals under twenty-one (21) years of age receive EPSDT services.

H.1.1. EPSDT services consist of comprehensive child health care services, including all medically necessary prevention, screening, diagnosis and treatment services listed in Section 1905 (r) of the Social Security Act. The Contractor shall:

H.1.1.1. Utilize written and oral methods to inform all EPSDT eligible clients about the program including the benefits of preventive health care and the services available under EPSDT, including transportation and scheduling assistance.

H.1.1.1.1. Oral informing techniques may include face-to-face contact, public service announcements, community campaigns and other media.

H.1.1.2. Ensure that clients and their families who have limited English proficiency or are hearing or vision impaired are advised of the EPSDT services. The Contractor shall:

H.1.1.2.1. Produce all EPSDT written materials at a seventh-grade reading level:

H.1.1.2.1.1. in English and Spanish;

H.1.1.2.1.2. in other languages as may be directed by the Department;

H.1.1.2.1.3. in Braille or in font 16 or larger for visually impaired members, if requested by the Department.

H.1.1.3. The Contractor shall also provide telephonic and face to face translation services, including sign language at CMAP provider sites when requested to facilitate the provision of EPSDT services.

H.1.2. The Contractor shall collaborate with community and service organizations that assist members with limited English proficiency, visual and hearing impairments on other effective ways of distributing EPSDT information to its Members.

H.1.3. The Contractor shall provide EPSDT Case Management Services such as making and facilitating referrals and development and coordination of a plan of services that will assist Members under twenty-one (21) years of age in gaining access to needed medical, social, educational, and other services.

H.1.4. The Contractor shall identify health care, diagnostic services, and treatment necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the Contractor through an interperiodic or periodic EPSDT screening examination.

H.1.5. The Contractor shall facilitate access to EPSDT Special Services as required by 42 U.S.C. § 1396(r)(5), other health care, diagnostic services, preventive services, rehabilitative services, treatment, or other measures described in 42 U.S.C. 1396d(a), that are not otherwise covered under the Connecticut Medicaid Program and that are medically necessary.

H.2. The Contractor shall authorize all medically necessary medical services that may be recommended or ordered pursuant to an EPSDT periodic or interperiodic examination including medically necessary services that are not otherwise covered under the Connecticut Medicaid Program.

H.3. The Contractor shall facilitate access to medically necessary health services recommended pursuant to an EPSDT examination when requested by the member or designated representative or when the Contractor otherwise determines that it is necessary and appropriate as follows:

H.3.1. Provide families with information about how to obtain health care services for their children and where these services can be obtained.

H.3.2. Assist families with scheduling appointments with health service providers. The Contractor's Call Center representatives shall assist with appointment scheduling while the Member is on the phone and shall conduct a conference call with the Provider to arrange for an appointment.

H.3.3. Assist with transportation for children and their families to appointments for health services. Assistance includes providing the member and/or their family with the information necessary to arrange for transportation to the appointments through the Department's transportation services broker(s) and/or providing assistance in coordinating such transportation if the member and/or their family encounters barriers.

H.3.4. Arrange for the provision of those medically necessary health services that are not covered under the Connecticut Medicaid Program or can only be provided through a Provider, other than a Provider in the CMAP Network, by working with the Department to implement special provider service agreements.

H.4. The Contractor shall implement policies and procedures to maintain and improve upon EPSDT participation and screening ratios for all age groups, including those to improve screening rates for adolescents and other hard to reach populations. The Contractor shall:

H.4.1. Expand the Contractor's VAX N8: Shield Your Health Campaign, to include brochures, posters for School Based Health Centers, PCMHs, FQHCs, providers of adolescent medicine, OB/GYN practices and family planning clinics throughout the CMAP network and work with the CTBHP and CTDHP to distribute material to Behavioral Health and Dental Providers;

H.4.2. With the Department's approval, utilize social media to broadcast messages to adolescents about EPSDT services;

H.4.3. Conduct surveys and focus groups with adolescents to query members and providers on their strategies for improving EPSDT scores.

I. REQUIREMENTS FOR THE HUSKY B PROGRAM

I.1. The Contractor shall:

I.1.1. Ensure that the families of all HUSKY B enrolled individuals receive benefit information about CHIP services; and

I.1.2. Inform families with Children and Youth with Special Health Care Needs (whose family income is within Bands 1 and 2) about the HUSKY Plus Physical benefit package and coordinate administration of this benefit with HUSKY B Plus Physical benefit subcontractor.

I.2. The Contractor shall, using written and oral methods, inform the families of all CHIP eligible clients including those with special health care needs about the HUSKY Plus program within sixty (60) days of the client's eligibility, and for clients who have not used CHIP services, annually thereafter. The Contractor shall:

I.2.1. Provide families with information about the eligibility requirements for HUSKY Plus Physical;

I.2.2. Provide families with information about how to obtain health care services for their children and where these services can be obtained;

I.2.3. Assist families with scheduling appointments with health service providers. The Contractor's Call Center representatives shall assist with appointment scheduling while the Member is on the phone and shall conduct a conference call with the Provider to arrange for an appointment.

I.3. Coordination of HUSKY PLUS Benefits

I.3.1. The Contractor shall work to coordinate benefits with the appropriate Department agent.

I.3.2. The Contractor shall coordinate care for Children and Youth with Special Health Care Needs with the subcontractor managing this benefit.

J. PRENATAL CARE

J.1. In order to promote healthy birth outcomes, the Contractor shall:

J.1.1. Identify pregnant Members as early as possible in the pregnancy. To do so the Contractor shall:

J.1.1.1. Utilize the Medicaid eligibility groups on the eligibility and pharmacy claims files from the Department to identify Members who are pregnant;

J.1.1.2. Educate participating providers on the availability of the Prenatal Care Registration Forms (PCRF), available in the provider portal of the Contractor's website for providers to submit a PCRF for pregnant Members treated by the provider;

J.1.1.3. Require call center staff to notify ICM staff when they speak with a Member who indicates that she is pregnant;

J.1.1.4. Require UM Nurses that process an authorization request for a diagnosis or procedure indicating pregnancy to refer the Member to ICM staff; and

J.1.1.5. Require the UM Nurses, on-site at hospitals to review ED visit and inpatient admissions to identify and refer Members with a diagnosis or procedure indicating pregnancy to the ICM staff;

J.1.1.6. Expand its relationships with Healthy Start programs and Women, Infant and Children (WIC) offices and develop reciprocal referral processes; and

J.1.1.7. Include a Health Risk Assessment (HRA) for Members on the member portal of the Contractor's website which asks Members to identify if they are pregnant.

J.1.2. Conduct prenatal risk assessments to identify high risk pregnant Members. The Contractor shall stratify Members into low, moderate or high-risk categories for pregnancy complications.

J.1.2.1. Members identified as moderate and high-risk will be contacted by the Contractor's ICM to complete a more comprehensive assessment to create an agreed upon care plan.

J.1.2.2. Members identified as low-risk shall be followed by healthy beginnings Licensed Practical Nurse Care coordinators. The LPN care coordinators shall conduct telephonic outreach to ensure that:

J.1.2.2.1. Members have a physician that they see regularly;

J.1.2.2.2. Prenatal visits are scheduled and timely;

J.1.2.2.3. Routine dental care is received;

J.1.2.2.4. Community resources are provided, if needed; and

J.1.2.2.5. Learning needs are identified and educational resources are provided by mail.

J.1.2.3. Continue care coordination efforts throughout the pregnancy and early postpartum weeks.

J.1.3. Refer pregnant Members to the WIC program;

J.1.4. Assess the Member's ability to access community resources. The Contractor shall:

J.1.4.1. Facilitate interpreter or translation services to address any language barriers that may limit the Member's ability to effectively communicate with their healthcare providers;

J.1.4.2. Assist the Member with scheduling prenatal appointments and transportation if needed; and

J.1.4.3. Provide care coordination services through the Contractor's Human Service Specialists who will meet face to face with Members in their homes and/or at group forums to help the Member access community resources.

J.1.4.3.1. The Contractor shall collaborate with other home visitation programs, including Healthy Start and Nurturing Families to improve outcomes and prevent duplication of services.

J.1.5. Provide culturally and linguistically appropriate education material on the importance of prenatal and postpartum care and well-child visits. Specifically, the Contractor shall:

J.1.5.1. Provide to every pregnant Member enrolled in the Contractor's Healthy Beginnings Program a booklet such as "My 9 Months", from the March of Dimes or such other comparable publication approved in advance by the Department;

J.1.5.2. Conduct calls as part of a post-partum education campaign ;

J.1.5.3. Make materials available through the Contractor's ICM programs for asthma care, diabetes and other complex care co-morbid disease processes; and

J.1.5.4. Have materials available in written form and on the Member portal on the Contractor's website.

J.1.6. Offer information about HIV and other sexually-transmitted disease (STD) testing and counseling and all appropriate treatment to pregnant Members;

J.1.6.1. If, during the initial assessment, the Contractor's ICM staff determines that a pregnant Member is at risk for HIV or other STD, the ICM Nurse shall work collaboratively with the Member and the member's Provider to facilitate adherence to recommended screening and care, including testing and counseling.

J.1.7. Refer pregnant Members who are actively abusing drugs or alcohol to CT BHP ASO;

J.1.8. Identify pregnant members who are smoking and inform them of all available resources for smoking cessation, such as DPH Quitline, coverage of smoking cessation medications to be discussed with the Member's OB Provider and other educational materials.

J.1.8.1. If the Member is associated with an iQuit Provider, the Contractor shall educate the Member on the iQuit program and encourage participation; and

J.1.8.2. If the Member is not associated with an iQuit provider, the Contractor shall inform the Member of participating iQuit practices and the benefits of the iQuit program.

J.1.9. Educate Members who are new mothers about the importance of the postpartum visit and well-baby care.

J.2. The Contractor shall comply with requirements of the Newborns' and Mothers' Health Protection Act of 1996 regarding requirements for minimum hospital stays for mothers and newborns in accordance with 45 CFR §§ 146.130 and 148.170.

K. COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH CARE

K.1. Except as otherwise provided herein, care management for behavioral health services for all members will be managed by the CTBHP ASO.

K.1.1. The Contractor shall promote coordination of physical health and behavioral health care and shall be responsible for coordination with the CT BHP.

K.1.2. The Contractor shall promote communication between primary care providers (PCPs) and behavioral health providers and shall support primary care based management of psychiatric medications as medically appropriate.

K.1.3. For individuals who access health services and who also have special behavioral health care needs, the Contractor shall help ensure that services are coordinated, that duplication is eliminated, and that lead management is established in cases where medical and behavioral needs are serious or complex. Coordination of physical and behavioral health care shall be included in the Contractor's clinical management program.

K.1.4. If there is a conflict between the Contractor and the CTBHP regarding whether a member's medical or behavioral health condition is primary, the Contractor's medical director shall work with the CTBHP's medical director to reach a timely and mutually agreeable resolution. If the two entities are not able to reach a resolution, the Department will make a binding determination.

K.1.4.1. Issues related to whether a Member's medical or behavioral health condition is primary must not delay timely medical necessity determinations. In these circumstances, the Contractor shall render a determination within the standard timeframe required under the contract.

K.1.5. The Contractor shall be responsible for primary care and other services provided by primary care providers in hospitals regardless of diagnosis.

K.1.6. The Contractor shall be responsible for primary care and other services provided by primary care solo and group practitioners and medical clinics not affiliated with a hospital, regardless of diagnosis with the following exception.

K.1.6.1. Contractor shall not be responsible for managing behavioral health evaluation and treatment services provided in these settings and billed under CPT codes 90801-90806, 90853, 90846, 90847 and 90862, when the member has a primary behavioral health diagnosis and the services are provided by a licensed behavioral health professional.

K.2. Behavioral Health-related Responsibilities of the Contractor. The Contractor shall:

K.2.1. Utilize a predictive modeling technology to identify those at greatest risk for poor outcomes and high costs due to the presence of multiple co-morbid conditions.

K.2.1.1. High-risk individuals with behavioral health needs and a co-morbid chronic condition shall be assigned by the Contractor to ICM staff who will collaborate with co-located BH staff. ICM Nurses shall facilitate multi-disciplinary care management meetings with the members' PCP and BH Providers.

K.2.2. Be responsible for the following behavioral health related activities provided in primary care settings:

K.2.2.1. Behavioral health related prevention and anticipatory guidance;

K.2.2.2. Screening for behavioral health disorders;

K.2.2.3. Training on behavioral health screening methods.

K.2.2.3.1. Initial trainings will focus on the behavioral health screening process and use of screening tools, subsequent trainings will cover topics and issues requested by PCPs or the Department.

K.2.2.4. Treatment of behavioral health disorders that the PCP concludes can be safely and appropriately treated in a primary care setting; and

K.2.2.5. Management of psychotropic medications in conjunction with treatment by a non-medical behavioral health specialist, when necessary.

K.2.3. The Contractor shall support the provision of medication management by primary care providers for persons with behavioral disorders when such care can be provided safely and appropriately by such providers.

K.2.4. The Contractor shall, as directed by the Department, work with the CTBHP to identify and manage individuals over utilizing emergency department services for complaints not clearly just medical or behavioral in nature, such as frequent complaints of pain and pain-related symptoms.

K.2.5. The Department shall require the CTBHP to collaborate with the Contractor to coordinate services for individuals with both behavioral health and special physical health care needs.

K.2.6. The Contractor shall assume responsibility for management of home health services when the home health service is for medical diagnoses alone and when the home health services are required for medical and behavioral diagnoses, but the medical diagnosis is primary or the member's medical treatment needs cannot be safely and effectively managed by the psychiatric nurse or aide with exceptions approved by the Department.

K.2.7. The Contractor shall manage all ancillary services such as laboratory, radiology, and medical equipment, devices and supplies regardless of diagnosis.

K.3. Coordination with CT BHP. The Contractor shall:

K.3.1. Communicate and coordinate with the CT BHP as necessary to ensure the effective coordination of medical and behavioral health for individuals with both behavioral health and special physical health care needs.

K.3.2. Provide for all necessary aspects of coordination between the Contractor and the CTBHP. The details of such coordination shall be set forth by the Contractor in its Behavioral and Physical Health Coordination Program, which shall be submitted to the Department by April 1, 2012 for their review and approval. Specifically the Contractor shall:

K.3.2.1. Contact the appropriate CTBHP staff when co-management of a member is indicated, such as for persons with special physical health and behavioral health care needs;

K.3.2.2. Respond to inquiries by the CTBHP regarding the presence of behavioral co-morbidities;

K.3.2.3. Coordinate management activities and services with the CTBHP when requested by the CTBHP;

K.3.2.4. Promote and support coordination between medical providers and the behavioral health providers as appropriate; and

K.3.2.5. Participate with the CTBHP in the development of policies pertaining to coordination between the Contractor and the

CTBHP and shall adhere to such policies as approved by all parties, and as they may be revised from time to time.

L. COORDINATION WITH THE DENTAL HEALTH PARTNERSHIP

L.1. The Contractor shall coordinate the health care needs of individuals with the Dental Health Partnership (DHP). Except as otherwise identified in this section, care management for dental health services for all members will be managed by the dental health ASO and dental services shall be managed by the dental health ASO. The Contractor shall:

L.1.1. Communicate and coordinate with the DHP as necessary to ensure the effective coordination of medical and dental health benefits;

L.1.2. Work with the CTDHP to identify dental providers willing and able to present at one or more of the provider orientation forums to educate and guide primary care providers on special considerations in dentistry for those with special health care needs;

L.1.3. Work with the CTDHP to identify a dental consultant available to aid in the referral and management of members identified by the Contractor as having special physical health care needs; and

L.1.4. In coordination with the Department or the DHP, develop guidelines for primary care based screening and treatment of dental health disorders including indications for referral to a dental health specialist, and procedures for referrals.

L.2. The Department shall require the DHP to collaborate with the Contractor to coordinate services for individuals with both dental health and special health care needs.

M. COORDINATION WITH OTHER STATE AGENCIES; AND HOME AND COMMUNITY BASED WAIVER PROGRAMS

M.1. The Contractor, when directed by the Department, shall develop coordination agreements with the following agencies:

M.1.1. The Department of Children and Families (DCF) with respect to children involved in the care and custody of DCF; and

M.1.2. The Departments of Developmental Services (DDS) and Mental Health and Addiction Services (DMHAS) with respect to the management of services for individuals participating in DDS or

DMHAS administered Home and Community Based Waiver (HCBW) programs.

M.2. The Contractor shall be required to coordinate with HCBW programs administered by the Department including the Acquired Brain Injury waiver program, the Connecticut Home Care Program for Elders, the Personal Care Assistance waiver, the Money Follows the Person project, and any other HCBW waiver programs that may be established by the Department during the period of this Contract. This shall include, but not be limited to referral of potential clients to these programs in order to maximize community-based care.

M.3. The Contractor shall be required to track clients who could potentially benefit from waiver participation, but are not able to due to waiting list and capacity.

M.4. The Contractor shall submit policies and procedures explaining the coordination process as it pertains to waiver programs administered by the Department and other state agencies and the Money Follows the Person Program by April 1, 2012.

N. QUALITY MANAGEMENT

N.1. Quality Management (QM) refers to a comprehensive program of quality and cost measurement, quality improvement and quality assurance activities responsive to the Department's objectives. The Department seeks to ensure that all individuals receive appropriate, effective, medically necessary, and cost effective treatment in order to maximize health outcomes. The Contractor shall systematically and objectively measure access to care, demand for services, quality of care, and outcomes and analyze utilization data, satisfaction surveys, complaints, and other sources of quality information. This information will support the development of continuous quality improvement strategies by the bidder and by providers that are consistent with the vision and mission of the Department. The Contractor's quality management activities shall include:

N.1.1. Statewide quality initiatives focused on improving access to well visits, health screens, prenatal care, and care for common illnesses such as diabetes and asthma;

N.1.2. Provider profiling to support quality improvement and pay for performance initiatives;

N.1.3. Performance measurement of PCMH providers, and regional provider consortia such as health neighborhoods with respect to access, quality and cost; and

N.1.4. Statewide performance measurement with respect to access, quality and cost.

N.2. The Contractor shall:

N.2.1. No later than February 1, 2012, provide the Department, for its review and approval, a written description of the QM Program including the program structure and processes that explain the accountability of each committee or organizational unit; functional relationships between each committee and organizational unit; policies and procedures and the mechanisms for obtaining input from member and provider groups;

N.2.2. In consultation with the Department, develop performance measures and indicators of a person-centered care system and approach, as further defined in Section N 12;

N.2.3. In consultation with the Department, monitor the effectiveness of the established performance measures and indicators of a person-centered medical home as further defined in Section N 11;

N.2.4. Track and monitor access and quality indicators and PMPM claims cost experience as set forth in Exhibit E;

N.2.5. Employ a full-time qualified QM Director responsible for the operation and success of the QM program. The QM Director must possess an advanced degree in a field of study relevant to human services and demonstrate at least 5 (five) years of experience in the development and implementation of quality management programs, including participating in audited HEDIS surveys; and

N.2.6. Participate in the Department's QM Committee as requested by the Department to report on all QM activities that are part of the Annual Quality Management Program Plan or to review other issues identified by the Department or the Contractor.

N.3. Annual Quality Management Project Plan and Program Evaluation: The Contractor shall:

N.3.1. By May 1, 2012 and annually thereafter, propose to the Department for its review and approval an Annual Quality Management Project Plan that outlines the objectives and scope of planned projects. The Annual Quality Management Project Plan shall describe how the Contractor will conduct:

N.3.1.1. Member satisfaction surveys (program wide and specific to an individual's PCMH);

N.3.1.2. Provider satisfaction surveys;

N.3.1.3. Measurement of access, quality, care experience and outcomes (program wide and specific to an individual's PCMH), including PMPM claims experience and medical cost on a program wide basis;

N.3.1.4. Clinical Issue Studies; Ongoing Quality Management Activities; and

N.3.1.5. Quality Improvement Initiatives (beginning in year two).

N.3.2. The Contractor shall by April 1, 2013 and annually thereafter, provide a Quality Management Program Evaluation.

N.4. Member Satisfaction Surveys

N.4.1. The Contractor shall conduct annual Member Satisfaction Surveys.

N.4.2. The Contractor shall conduct Satisfaction Surveys within the following guidelines:

N.4.2.1. Measurement by the following levels of aggregation:

N.4.2.1.1. The Contractor shall measure and report to the Department on the satisfaction of members once during each contract year using the CAHPS or similar instrument approved by the Department and using a stratified sample of HUSKY Health Members statewide.

N.4.2.1.2. The Contractor shall also measure the satisfaction of Members enrolled in or attributed to each PCMH once during each contract year using the CAHPS or similar instrument approved by the Department.

N.4.2.1.3. For the first year of this Contract the Contractor shall commence the collection of member satisfaction survey data at the direction of the Department. Annually, thereafter the Contractor shall commence the collection of member satisfaction survey data in accordance with the NCQA/ HEDIS cycle.

N.4.2.1.4. For the first year of this Contract the Contractor shall complete the data collection, analysis, interpretation, final reporting and any proposed action plan to the Department by January 15, 2013. Annually thereafter the Contractor shall complete the data collection, analysis, interpretation

and final reporting and any proposed action plan to the Department by August 15 of each year or by such other date as directed by the Department.

N.4.2.1.5. The implementation of the action plan proposed by the Contractor shall be directed by the Department.

N.4.2.1.6. The data collection methodology utilized by the Contractor shall be based on generally recognized and accepted research methods that ensure an adequate sample size and statistically valid and reliable data collection practices.

N.5. Provider Satisfaction Surveys

N.5.1. The Contractor shall conduct, and report to the Department the results of, an annual provider satisfaction survey using a provider survey instrument approved by the Department. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the state or its agents including but not limited to authorization procedures, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing as administered by the Department's MMIS) and overall administrative burden. The first survey will be conducted by October 1, 2012 and annually thereafter.

N.5.2. For the first year of this Contract the Contractor shall complete the data collection, analysis, interpretation, final reporting and any proposed action plan to the Department by January 31, 2013 and annually thereafter.

N.5.3. The implementation of the action plan proposed by the Contractor shall be directed by the Department.

N.6. Clinical Issue Studies

N.6.1. The Contractor shall propose to the Department for its approval at least three (3) annual clinical issue studies beginning in year one of the contract.

N.6.2. The Contractor shall during each year of the contract:

N.6.2.1. Propose to the Department the scope of the clinical issue studies by June 1 or such other date as agreed to by the parties.

N.6.2.2. Submit to the Department, for their review and approval, a draft of the study report for each clinical issue study. The study report shall be submitted to the Department by August 1 of each calendar year or such other date as agreed to by the parties and shall, at a minimum, include recommendations for intervention;

N.6.2.3. Implement the report recommendations upon approval by and as directed by the Department.

N.6.3. The Contractor shall use a methodology based on accepted research practices ensuring an adequate sample size and statistically valid and reliable data collection practices.

N.6.4. The Contractor shall use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

N.7. Ongoing Quality Management Activities

N.7.1. The Contractor shall prioritize, monitor, analyze and document problems identified by the UM, ICM, Provider Relations, and Member Services Units, as well as problems identified through the complaints process.

N.7.2. Complaints related to access (lack of access or delays in access) must be categorized at a minimum as to service type and/or specialty (e.g., primary care, cardiology, orthopedics); client age (pediatric, adult, geriatric); and locality.

N.7.3. The Contractor shall advise the Department of innovative strategies related to Utilization Management and Intensive Care Management based on national trends and evidence-based practice.

N.7.4. The Contractor shall investigate and address access and quality of care issues. On-site reviews of quality of care issues conducted by the Contractor must take place during normal business hours with at least 24 hours advance notice to the Provider.

N.7.5. As requested by and on behalf of the Department, the Contractor shall:

N.7.5.1. Review the quality of care rendered by a Provider, including but not limited to chart audits;

N.7.5.2. Conduct visits at the Provider's service site;

N.7.5.3. Require corrective action plans of the Provider;

N.7.5.4. Recommend to the Department to suspend referrals, registration, or authorizations from the Provider; and

N.7.5.5. Report to the Department when issues are of a serious nature or remain unresolved.

N.8. Quality Improvement Initiatives

N.8.1. The Contractor shall identify, prioritize and submit for the Department's review and approval, as part of its Annual Quality Management Project Plan, quality initiatives based on:

N.8.1.1. Data and experience available through the Department and the Contractor's experience in Connecticut and other states, if applicable;

N.8.1.2. The results of the member and provider satisfaction surveys;

N.8.1.3. The results of the clinical issues studies; and

N.8.1.4. Recommendations derived from the analysis of problems identified by the UM, ICM, Network Management, Provider Relations, Member Services Units, and through the complaints process.

N.8.2. The Contractor shall emphasize reduction of ethnic and racial health disparities in all quality improvement initiatives.

N.8.3. The Contractor shall implement quality improvement initiatives starting in year one of the contract in coordination with and with the approval of the Department. Initial quality improvement initiatives will be in the areas of:

N.8.3.1. Chronic pain management;

N.8.3.2. Breast, cervical, and colon cancer screening;

N.8.3.3. Tobacco cessation;

N.8.3.4. Depression screening;

N.8.3.5. EPSDT well visits;

N.8.3.6. Adult well visits;

N.8.3.7. Comprehensive diabetes care;

N.8.3.8. Asthma care;

N.8.3.9. Prenatal and postnatal care.

N.9. Provider Profiling

N.9.1. The Contractor shall, by March 31, 2012, and annually thereafter, produce for the Department a provider profiling strategy and methodology for review and approval.

N.9.2. The Contractor shall work collaboratively with the provider and consumer stakeholders to inform them of the provider profiling methodology.

N.9.3. The Contractor shall, at a minimum, develop provider profiles in two categories of care each contract year.

N.9.4. The Contractor's Network Managers shall share profiling results with providers, advise on the provider's development of continuous quality improvement plans and support providers and communities in the execution of the plans.

N.9.5. The profiling system shall enable the Department to profile provider performance including for the purpose of pay for performance and shall also support provider self-profiling.

N.10. Person Centered Medical Home Performance Measurement

N.10.1. The Contractor shall, by March 31, 2012, and annually thereafter, produce for the Department a PCMH performance measurement strategy and methodology for review and approval.

N.10.2. The performance measurement strategy shall encompass the range of PCMH performance measures established by the Department in consultation with the Medical Assistance Program Oversight Council (MAPOC).

N.10.3. The Contractor shall work collaboratively with the PCMH providers and consumer stakeholders to inform the performance measurement methodology.

N.10.4. The Contractor's Network Managers shall share profiling results with providers to support providers and communities continuous quality improvement activities.

N.10.5. The profiling system shall enable the Department to profile PCMH performance and shall also support PCMH self-profiling.

N.11. Statewide Performance Measurement

N.11.1. The Contractor shall, by February 1, 2012, and annually thereafter, produce for the Department a statewide profiling strategy and methodology for review and approval.

N.11.1.1. The profiling strategy shall encompass the range of performance measures contained in Exhibit E: Reporting Matrix as amended by the Department in consultation with the MAPOC.

N.11.2. The Contractor will be required to carry out the full complement of audited HEDIS Medicaid measures including hybrid measures, as agreed upon by the Department, in accordance with NCQA standards.

N.11.3. The Contractor shall use claims data provided by the Department and shall contract with an NCQA accredited auditor.

N.11.4. The Contractor shall contract for or use the Contractor's quality management staff to undertake all field-based chart reviews and other document reviews as necessary to meet the HEDIS requirements.

N.12. Network Managers

N.12.1. The Contractor shall employ sufficient Network Managers to conduct the provider and PCMH profiling activities outlined in N.10 and N.11.

N.12.2. The Contractor shall provide the Network Managers with training and ongoing supervision to support their role in analyzing network information, developing quality improvement plans, monitoring of critical incidents, and promoting the development of best practices within provider organizations.

N.12.3. The Contractor shall ensure that applicants for the Network Manager positions have:

N.12.3.1. Significant experience in the field of health and care management;

N.12.3.2. Demonstrated leadership and accomplishments in the management of health services;

N.12.3.3. Expertise in basic data analysis and reporting;

N.12.3.4. Demonstrated experience in helping to develop a continua of health systems;

N.12.3.5. Demonstrated experience in quality management;

N.12.3.6. The ability to develop and implement performance improvement plans; and

N.12.3.7. Experience in organizing and coordinating meetings while promoting communication and collaboration among stakeholders.

N.13. Annual Quality Management Project Plan Evaluation

N.13.1. The Contractor shall submit to the Department according to the schedule provided in the Reporting Matrix at Exhibit E, a comprehensive QM Program Evaluation Report utilizing the performance measures detailed in the Contractor's QM Plan. The evaluation components shall correspond to the components and to the schedule outlined in the approved Annual Quality Management Program Plan.

N.13.2. At a minimum the evaluation report shall include the following:

N.13.2.1. description of completed and ongoing Provider and Member Surveys, Clinical Issue Studies, Ongoing QM Activities and annual QM Initiatives;

N.13.2.2. Summary of improvements in access, quality of care, coordination of physical and behavioral healthcare, and performance in other areas as a result of Ongoing QM Activities and QM Initiatives and evaluation of the overall effectiveness of the Annual Quality Management Program Plan;

N.13.2.3. Summary of other trends in access, utilization, and quality of care including but not limited to measures contained in the Reporting Matrix - Exhibit E that provide an overall illustration of the health system's performance;

N.13.2.4. Assessment of utilization and other indicators that suggest patterns of potential inappropriate utilization and other types of utilization problems;

N.13.2.5. Assessment of provider network adequacy including instances of delayed service and transfers to higher or lower levels of care due to network inadequacy, adequacy of linguistic capacity, and cultural capacity of specialized outpatient services,

N.13.2.6. Assessment of provider network access based on standards defined by the Department. Access standards apply to life threatening and non-life threatening emergency care services, urgent care services and routine care services;

N.13.2.7. Evaluation of the Contractor's performance with respect to targets and standards described in Exhibit E - Reporting Matrix with corrective action plans including proposed interventions to improve performance and proposed intervention measures;

N.13.2.8. Proposed QM initiatives and corrective actions including proactive action to improve member clinical functioning, sustain recovery, minimize crises and avert adverse outcomes and to remediate utilization problems; and Overall impression of the ASO's system operations and functioning with recommendations for remediation.

N.14. Critical Incidents

N.14.1. The Contractor shall report to the Department any critical incident or significant event within one (1) hour of determining the incident is critical.

N.14.2. The Contractor shall report to the Department, on an annual basis, critical incidents and significant events in the aggregate. Reports shall be submitted in accordance with timeframes outlined in the Reporting Matrix (Exhibit E).

O. PROVIDER RELATIONS

O.1. Throughout the term of the contract the Contractor shall develop and maintain positive Contractor-Provider Relations; communicate with all providers in a professional and respectful manner; promote positive provider practices through communication and mutual education and provide administrative services in the most efficient manner possible in an effort to pose minimal burden on providers.

O.2. The Contractor shall promote on-going and seamless communication between providers and the Contractor. The Contractor shall:

O.2.1.1. Include providers in the Contractor's committee structure, to give providers a direct voice in developing and monitoring clinical policies;

O.2.1.2. Offer providers' on-site consultation with respect to both clinical and administrative issues;

O.2.1.3. Work with providers to reduce administrative responsibilities through the use of the Contractor's bypass program, automated voice response (AVR) system, Web-enabled registration systems, and other technologies;

O.2.1.4. Provide encryption software upon request from a provider to provide for the exchange of member data via e-mail;

O.2.1.5. Post all policies and procedures, handbooks and other material, produced as a requirement under this Contract and as determined by the Department, on the Contractor's Website.

O.2.1.6. Make all policies and procedures, handbooks and other material produced as a requirement under this Contract and as determined by the Department, available to providers in electronic and written hard copy, if requested;

O.2.1.6.1. Notify providers of impending policy or procedural changes at least 30 days prior to implementation or such other time period as agreed to, in advance, by the Department ;

O.2.1.7. Monitor Provider complaints and if, in the opinion of the Contractor, the complaints are of sufficient severity or frequency to warrant consideration for disenrollment from the CMAP network, notify the Department.

O.2.1.8. Conduct provider satisfaction surveys at least once per year, sharing findings with provider advisors and involve the provider advisors in implementing corrective action as indicated;

O.2.1.9. Beginning February 1, 2012, provide the Department with a publication-ready newsletter for review and approval twice a year.

O.2.1.9.1. The newsletter shall include articles covering health topics of interest for providers who work both with children and adults, that appropriate medical professionals are involved in writing the assigned articles, and that the newsletters are posted to the ASO website once approved by the Department; and

O.2.1.10. Assist the Department with monitoring and training the provider community by offering individualized training to providers, targeting high volume providers or those providers with specific needs identified through monitoring reports, and

tracking and monitoring all complaints, and inform the Department if intervention is required in an urgent situation.

O.3. Provider Handbook

O.3.1. The Contractor shall, by April 1, 2012, produce a Provider Handbook for the Department's review and approval prior to its distribution, and shall make this handbook available on the website.

O.3.2. The Contractor shall make the printed form of this handbook available for distribution upon request.

O.3.3. The Provider Handbook shall include but may not be limited to the following:

O.3.3.1. Contractor corporate information;

O.3.3.2. Confidentiality provisions;

O.3.3.3. Mission statements of the Department and the Contractor;

O.3.3.4. Descriptive process for accessing services including but not limited to ICM services under the Contractor;

O.3.3.5. Procedures for communicating with the Department and the Contractor;

O.3.3.6. Summary of service and benefit structure;

O.3.3.7. Description of formularies or preferred drug lists for enrolled members;

O.3.3.8. Procedures for submitting complaints and appeals;

O.3.3.9. Procedures for service authorization and registration;

O.3.3.10. Procedures for using web-based provider services;

O.3.3.11. Summary of UM requirements;

O.3.3.12. Summary of claims procedures and the Department's MMIS Contractor contact information;

O.3.3.13. Names and contact information of Provider Relations staff; and

O.3.3.14. Information on how members may access pharmacy, transportation, behavioral and dental services.

O.4. Provider Notification

O.4.1. Throughout the term of this Contract the Contractor shall be required to alert providers to modifications in the Provider Handbook and to changes in provider requirements that are not otherwise communicated by the Department or its MMIS Contractor. The Contractor shall:

O.4.1.1. Request and obtain from providers an e-mail address, so they can be alerted to access the Contractor's ASO Website to download updates to the provider handbook, provider bulletins, and provider requirements;

O.4.1.2. E-mail to providers and publish on the Contractor's ASO Website any clarification or direction on matters not otherwise communicated by the Department; and

O.4.1.3. Post notification of policy changes on the Contractor's ASO Website.

O.5. Provider Orientation

O.5.1. During the first year of this Contract, the Contractor shall conduct an initial statewide provider orientation initiative and at least two subsequent rounds of provider orientation sessions in five different geographic areas of the State. The schedule, specific locations and the use of a webinar for the orientation session shall be submitted to and approved in advance by the Department.

O.5.2. The Contractor shall work with representatives of the provider community to develop the agenda for the initial statewide provider orientation to identify the most effective ways to encourage attendance.

O.5.3. The Contractor shall alert providers to the various meetings through direct mailings, coordination with professional organizations, notices posted to the ASO website and through personal invitations issued by Contractor staff.

O.5.4. The Contractor shall, following the initial statewide and local provider orientation sessions, determine in conjunction with the Department, whether the initial orientation sessions should be repeated at one or more locations to further encourage provider participation.

O.6. Provider Training and Targeted Technical Assistance

O.6.1. Throughout the term of the contract the Contractor shall:

O.6.1.1. Offer training and technical assistance to providers on clinical topics, including introducing evidence-based and emerging best practices, as approved by the Department,

O.6.1.2. Offer training and technical assistance to providers on a person-centered approach to care, as approved by the Department;

O.6.1.3. Develop and implement an ongoing program of provider workshops and training sessions designed to meet the specialized needs and interests of providers; and

O.6.1.4. Have available both clinical and administrative staff to provide targeted technical assistance onsite at the request of network providers and also non-network providers seeking to become network providers.

O.7. Provider Inquiries and Complaints

O.7.1. Throughout the term of the Contract the Contractor shall:

O.7.1.1. Track and manage all provider inquiries and complaints related to clinical and administrative services covered under this Contract and direct all complaints related to enrollment, claims, behavioral health, pharmacy, dental and transportation services to the responsible Department vendor.

O.7.1.2. Ensure that all Provider inquiries and complaints are addressed and resolved in compliance with the Contractor's approved QM Plan and no later than 30 days from receipt.

O.7.1.3. Provide the Department with a regular report outlining the Contractor's compliance with required timeframes and notifications related to inquiries and complaints. The Department and the Contractor shall agree to the form, content and frequency of the report in advance.

O.7.1.4. Utilize the Contractor's management information system(s) (MIS) to track complaint related information and provide this data to the Department upon request. Such data shall include, but may not be limited to the following:

O.7.1.4.1. Caller Name;

O.7.1.4.2. Date and Time of complaint;

O.7.1.4.3. The nature of the complaint;

O.7.1.4.4. Category/type of complaint including information regarding location and specific professional service type if complaints relate to access;

O.7.1.4.5. Actions taken to address complaint;

O.7.1.4.6. Complaint resolution outcome, date and time; and

O.7.1.4.7. Narrative details regarding complaint.

O.8. Web-based Communication Solution

O.8.1. By January 1, 2012 the Contractor shall develop and implement a Website specifically to serve ASO providers and members (hereinafter referred to as the "ASO Website").

O.8.2. The Contractor shall ensure that the ASO Website provides information about the Contractor's services, a link to the Department's primary websites and ASO related websites (e.g., www.ctdssmap.com). Coordination of this for the Department's website should be done through the Department's Webmaster.

O.8.3. The Contractor shall, in collaboration with the Department, determine the program content to be published on the ASO Website,

O.8.4. The Contractor shall provide the following Web-enabled transactional capabilities through the ASO Website by January 1, 2012, subject to the Department's approval:

O.8.4.1. Provider/member inquiries;

O.8.4.2. A Web-based referral search system that will allow Contractor's and Department's staff, providers, members and any other interested persons to locate network providers through an online searchable database.

O.8.4.2.1. The searchable database shall include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and program types.

O.8.4.2.2. The system shall permit searches using any combination of the following criteria: provider category (e.g., hospital, clinic, physician and others as determined by the Department); service type (e.g., physician, laboratory, clinic,

home health care, durable medical equipment, optometrist); zip code; population served; languages spoken; sex of provider; ethnicity of provider; clinical specialty; last name; and first name.

O.8.4.2.3. Persons accessing the referral search system shall be able to sort provider search results by driving distance, list the details available on each provider (e.g., specialties and languages), and include a map showing locations of provider offices in relation to a specified location; and

O.8.4.2.4. The Contractor's secure provider portal shall have the ability for providers to securely initiate updates of certain provider's information as determined by the Department in the searchable database if requested by the Department.

O.8.4.3. The Contractor shall ensure that the Website includes an internet "library" of health information for providers, ASO members, families and the Department's staff. The library shall provide comprehensive information and practical recommendations related to health conditions, wellness, and services in both English and Spanish.

O.8.5. The Contractor shall begin to provide the following Web-enabled transactional capabilities through the ASO Website by April 1, 2012 and complete the same by July 1, subject to the Department's approval:

O.8.5.1. Submission of initial request for authorization, registration and re-registration;

O.8.5.2. Authorization/registration provider look-up capability including authorization/registration number, authorization status indicator for pending authorizations, begin and end dates, number of units authorized, units available (or used), and payable codes under authorization;

O.8.5.3. Contractor's Online Provider Services application to allow providers to register care and verify eligibility online and to submit requests for continued care beyond the initially authorized/registered services;

P. PROVIDER AND MEDICAL HOME NETWORK DEVELOPMENT

P.1. Throughout the term of the Contract, the Contractor shall provide network management and development functions including the development of a provider file, PCMH qualifications review, assess demand, network

adequacy analysis, and network development assistance. The Contractor shall:

P.1.1. Facilitate the expansion of the CMAP provider network to support adequate client access to a complete range of provider types and specialties;

P.1.2. Provide technical assistance in the field and data to support the emergence and ongoing operations of person-centered medical homes and other service delivery innovations, such as Health Neighborhoods;

P.1.3. Interact with the providers as an administrative agent on behalf of the Department.

P.1.3.1. The Contractor shall assist the Department in developing and maintaining the provider and PCMH network sufficient to ensure the delivery of all covered services to all members.

P.1.4. Receive provider network data from the Department and shall build and maintain a provider file as specified in Section T of this Contract, "Information Systems".

P.2. Access to Provider Files

P.2.1. Throughout the term of the Contract the Contractor shall:

P.2.1.1. Ensure that Contractor's staff have immediate access to all provider files through an integrated management information system to allow staff to search for a provider appropriate to a member's needs, preferences, and location; and

P.2.1.2. Ensure that Contractor's clinical staff and Member/Provider Services staff, both in the Service Center and in the field, have wireless, real-time access to the provider file via their computers.

P.3. Provider Search Function

P.3.1. The Contractor shall ensure that the Provider Search Function in the Contractor's MIS allows the Contractor staff to conduct provider searches utilizing any combination of the following criteria:

P.3.1.1. Provider type;

P.3.1.2. Service type/level of care;

P.3.1.3. Zip Code;

P.3.1.4. Population Served;

P.3.1.5. Language;

P.3.1.6. Gender;

P.3.1.7. Race/Ethnicity of Provider (when available);

P.3.1.8. Specialty, using the CMAP provider specialties

P.3.1.9. Provider Last Name;

P.3.1.10. Provider First Name;

P.3.1.11. Provider Medicaid Number;

P.3.1.12. Provider Number; and

P.3.1.13. Whether the provider is accepting new patients.

P.4. Network Assessment

P.4.1. The Contractor shall assess the size and scope of the current CMAP contracted provider network to assist the Department in determining the need for provider recruitment. The Contractor shall:

P.4.1.1. Implement data verification process as directed by the Department; and

P.4.1.2. Establish and update provider file information with respect to whether providers are accepting new members.

P.4.2. The Contractor shall:

P.4.2.1. Perform a gap analysis regularly (GeoAccess study) and density report at least quarterly including only those providers who are accepting new patients. Closed panel providers and the members attributed to those providers should be excluded from GeoAccess reporting.

P.4.2.2. Implement ongoing provider monitoring processes to assure network PCPs adhere to timely scheduling of appointments through the Department defined methodology for random appointment call/audit;

P.4.2.3. Work with PCP practices to offer expanded hours (i.e. evenings, weekends); and

P.4.2.4. Determine which PCP practices utilize 24/7 nurseline services or 24 hour physician lines and evaluate utilization effectiveness.

P.4.3. Throughout the term of the Contract, the Contractor shall identify service gaps in a variety of other ways using a variety of data sources including:

P.4.3.1. Tracking and trending information on member complaints and services requested but not available;

P.4.3.2. Requesting the Contractor's advisory committees to identify services that are needed but unavailable;

P.4.3.3. Monitoring services for which authorization is continued for administrative reasons (e.g., lack of essential aftercare services);

P.4.3.4. Monitoring penetration rates by age, location and ethnic/minority;

P.4.3.5. Monitoring consumer-reported satisfaction with access to services;

P.4.3.6. Monitoring population growth; and

P.4.3.7. Utilizing findings of other local research.

P.5. Network Development

P.5.1. The Contractor shall assist the Department in addressing deficiencies in the Connecticut Medical Assistance Program Provider Network by developing the provider network in geographic areas that do not provide adequate access to sufficient providers in a range of types and specialties to support adequate access to covered services. Specifically, the Contractor shall

P.5.1.1. Encourage the use of provider outreach activities, such as scheduled office visits, recruiting and information stations at professional meetings, sponsoring of evidence-based continuing education activities;

P.5.1.2. Work with trade organizations and licensing boards to actively recruit providers;

P.5.1.3. Work with existing CMAP providers to expand existing capacity and add new services;

P.5.1.4. Identify potential providers and provide them with information and technical assistance regarding the provider enrollment process and provider service and performance standards to support participation as a network provider; and

P.5.1.5. Coordinate with the Department's MMIS Contractor and the Department as necessary to facilitate enrollment of new providers, identify impediments to enrollment, and develop new services for existing network providers.

P.6. Limited Provider Agreements

P.6.1. The Contractor shall negotiate and facilitate the execution of limited provider agreements between a provider and the Department on a case-by-case basis to address critical access issues.

P.6.2. If instructed by the Department, the terms of such agreements may be negotiated without the participation of the Department but the final terms of the agreement shall be subject to approval by the Department.

P.6.3. Such agreements are allowed to address access issues including, but not limited to:

P.6.3.1. Provision of a service to address continuity of care during the transition period or for new members;

P.6.3.2. Provision of a service that is covered, but unavailable in network or in the client's geographic area, or provided out of state when the service is not performed by a Connecticut provider;

P.6.3.3. Provision of a service to eligible members who are temporarily out-of-state and in need of services; and

P.6.3.4. Provision of a service that is not available within the network, but is covered under Medicaid EPSDT.

P.6.4. The Contractor shall coordinate with the Department and its MMIS contractor to enroll providers with whom a limited provider agreement has been negotiated that will be payable through the MMIS.

P.7. Payment Related Troubleshooting and Technical Assistance

P.7.1. The Contractor shall facilitate the identification and resolution of provider payment problems. The Contractor shall:

P.7.1.1. Attend regular meetings hosted by the Department and attended by the Department's fiscal agent to address operational issues that are or may impact providers.

P.7.1.2. Use overall and provider specific payment monitoring reports in coordination with the Department's MMIS Contractor to identify payment problems and diagnose the nature of those problems (i.e., authorization related vs. claims adjudication related).

P.7.1.3. Participate in a rapid response team consisting of the Department's MMIS Contractor personnel and Contractor personnel to resolve issues related to timely and accurate claims payment.

P.7.2. The Contractor shall, by 12/5/2011, present to the Department for its review and approval, a plan for coordinating problem assessment and intervention.

P.7.3. The plan shall include provisions for on-site assistance by a rapid response team when problems persist for more than 60 days.

Q. MEMBER SERVICES

Q.1. Throughout the term of the Contract the Contractor's member services staff shall provide non-clinical information to members and when appropriate provide immediate access to clinical staff for care related assistance. The Contractor shall:

Q.1.1. Staff member services with competent, diverse professionals including Spanish-speaking individuals in order to best serve the needs of members;

Q.1.2. Make special provisions for clients and their families who have limited English proficiency, or are hearing or vision impaired. Oral informing techniques may include face-to-face contact, public service announcements, community campaigns and other media, including TDD/TTY and sign language services;

Q.1.3. Ensure that member information is clearly communicated in a manner that is culturally sensitive;

Q.1.4. Provide sufficient information to members to allow members to facilitate access to covered services and allows successful navigation of the health service system;

Q.1.5. Ensure that all member services staff demonstrate professionalism and respect and that they communicate in a culturally appropriate manner with members;

Q.1.6. Develop, plan and assist members with information related to community based, free care initiatives and support groups;

Q.1.7. Respond to member clinical care decision inquiries in a manner that promotes member self-direction and involvement;

Q.1.8. Initiate a warm transfer for callers who require behavioral or dental services to the appropriate ASO, or instruct individuals who are not enrolled how they can apply for medical assistance (regional office, 211); and

Q.1.9. Have written policies regarding member rights and responsibilities, once such rights and responsibilities are determined by the Department in collaboration with the Medical Assistance Program Oversight Council and/or its applicable subcommittee; and

Q.1.10. Refer more complex access to care requests requiring additional research and referral to Contractor's Member Services Escalation Unit. The Escalation Unit shall research options available within appropriate timeframe's for a member's condition.

Q.2. The Contractor shall ensure that its employees and subcontractors consider and respect member rights.

Q.3. The Contractor shall develop and implement:

Q.3.1. A reference manual for member service representatives to use during daily operations and a formal training program and curriculum for staff that respond to member inquiries.

Q.3.1.1. The training program shall include training in how to recognize members that may need ICM and to make referrals as appropriate.

Q.4. The Contractor's data base of providers shall identify the linguistic capabilities of providers. The Contractor shall use this information to refer Members to health services that are culturally and linguistically responsive to the preferences of the Members.

Q.4.1. When requested, the Contractor shall identify participating providers, facilitate access, and assist with appointment scheduling when necessary.

Q.5. The Contractor shall, no later than January 1, 2012, develop and submit to the Department for their review and approval a Member Inquiry Process including policies and procedures for resolving and responding to member inquiries. The policies and procedures shall include tracking and reporting of the following:

Q.5.1.1. Complaints regarding the Contractor's performance;

Q.5.1.2. Complaints related to the service delivery system;

Q.5.1.3. Complaints related to specific providers;

Q.5.1.4. Resolution of complaints not later than 30 days from receipt;

Q.5.1.5. Routine, urgent and emergent (crisis) calls;

Q.5.1.6. Inquiries regarding the status of any denial, reduction, suspension or termination of services;

Q.5.1.7. Inquiries related to the status of authorization requests;

Q.5.1.8. Inquiries regarding member rights and responsibilities including those related to complaints and appeals;

Q.5.1.9. Forms and instructions for filing a written complaint;

Q.5.1.10. Requests for referral, taking into consideration linguistic and cultural preferences when requested;

Q.5.1.11. Request to facilitate access and assist with appointment scheduling when necessary;

Q.5.1.12. Requests for coverage information including benefits and eligibility;

Q.5.1.13. Inquiries related to community based free care initiatives and support groups; and

Q.5.1.14. Inquiries regarding information related to the Behavioral Health or Dental Partnerships.

Q.6. Throughout the term of the contract the Contractor, through its member services staff shall facilitate and coordinate access to transportation services. The Contractor shall:

Q.6.1.1. Facilitate and coordinate access to transportation services for any Medicaid eligible individual by referring the Member to the NEMT contractor.

Q.6.1.2. Offer to provide a warm transfer to the NEMT contractor; and

Q.6.1.3. Ask the caller to call the Contractor back if problems are encountered in accessing transportation.

Q.7. The Contractor shall coordinate with staff from the Department in the conduct of semi-annual community meetings. The purpose of the community meetings shall be to share information and feedback with members, family members, advocacy groups and providers.

Q.7.1. The community meetings shall be conducted in at least five (5) locations throughout the State, as proposed by the Contractor and approved by the Department.

Q.7.2. The first series of community meetings shall be conducted between November 1, 2011 and February 29, 2012 and shall focus on orienting members of the community to the new ASO initiative.

Q.7.3. The Contractor shall:

Q.7.3.1. Develop agendas with common topics across all regions as well as specific local topics suggested by local stakeholders;

Q.7.3.2. Select sites and times that will encourage the largest number of participants;

Q.7.3.3. Publicize the event throughout the region and across the State;

Q.7.3.4. Arrange for a keynote speaker panel presentation or main focus; and

Q.7.3.5. Provide a mechanism for all attendees to evaluate the meeting and offer suggestions for future regional committee meetings.

Q.8. The Contractor shall propose an informational member brochure by November 1, 2011 to be written at no higher than a seventh grade reading level, in both English and Spanish. The contents of the brochure shall:

Q.8.1.1. Explain benefits for members;

Q.8.1.2. Describe how to access providers;

Q.8.1.3. Describe how to contact the Contractor for assistance; and Describe member rights and responsibilities, including complaints and appeals.

Q.8.2. The Contractor shall produce, print, and distribute the informational member brochure to the FQHCs and larger provider groups and mail a brochure to any member or provider upon request.

Q.8.3. The Contractor shall supply the Department with brochures to be distributed by the Department at the time that eligibility is granted.

Q.8.4. The Contractor shall revise and update the brochure as required by the Department but not more often than annually and distribute the revised brochures according to the distribution plan approved by the Department. The Contractor shall post the Member Brochure to the ASO website.

Q.9. The Contractor shall, by April 1, 2012, develop a Member Handbook for review and approval by the Department. The Member Handbook shall include:

Q.9.1.1. The benefits available to members;

Q.9.1.2. The procedures for accessing services covered by the Contractor and related services such as transportation and pharmacy for which services may be accessed through the Contractor;

Q.9.1.3. Member rights and responsibilities; and

Q.9.1.4. Notices of Action, appeals and complaints rights.

Q.9.2. The Contractor shall post the Member Handbook on the ASO Website and shall print and mail or otherwise arrange delivery of this handbook to members upon request.

Q.9.3. The Contractor's ASO Website shall include a member services section and such section shall:

Q.9.3.1. Contain information for members and their families concerning health information for members;

Q.9.3.2. Ensure that the website has the capability of exchanging Contractor information and member information with providers and members;

Q.9.3.3. Include the text of the Member Handbook; and

Q.9.3.4. Include security provisions approved in advance and required by the Department.

Q.10. Member Cards

Q.10.1. The Contractor shall be required to produce and disseminate member ID cards for all eligible members. The Contractor shall be required to produce and disseminate member ID cards for all eligible members.

Q.10.2. The Contractor shall produce four (4) types of member ID cards: one for HUSKY A, C and D; one for HUSKY B; one for HUSKY Limited Benefit members; and one for Charter Oak members.

Q.10.2.1. Each card, regardless of program, must have contact information printed on the back of the card that will enable recipients to access Non-Emergency Medical Transportation benefits, Behavioral Health benefits, Dental Health benefits and Pharmacy benefits, as applicable.

Q.10.2.2. The cards for HUSKY B and Charter Oak Members must also include copayment information specific to the applicable program.

Q.10.2.3. The Contractor shall produce and disseminate replacement cards if a member loses their card or changes programs.

Q.10.2.4. Each card shall have a blank area for the member or the member's primary care provider to affix a sticker identifying the primary care provider's name and phone number. It will be the responsibility of the primary care provider to provide a new primary care assignment sticker if the member changes primary care providers.

R. TELEPHONE CALL MANAGEMENT

R.1. Throughout the term of the Contract, the Contractor shall provide Telephone Call Management Services in a manner that facilitates member and provider access to information and services in an efficient, convenient, and user-friendly manner. This shall include the use of both automatic response system (ARS) and staffed lines, the use of industry standard technology to monitor and distribute call volume and the ability to provide detailed and timely reporting for both day-to-day operational management and ongoing service quality monitoring.

R.1.1. The Contractor shall provide and operate call management services through a location in Connecticut.

R.1.2. The Contractor shall include up to (3) nationwide toll free lines, at least one of which shall be dedicated to toll-free fax communications.

R.1.3. The Contractor shall develop, implement and maintain operational procedures, manuals, forms, and reports necessary for the smooth operation of the Telephone Call Management Services.

R.2. The Contractor shall establish and maintain a toll free telephone line for members and providers with the following specifications:

R.2.1. Access to a limited menu automated response (ARS) system. Speech recognition is optional;

R.2.2. Ability to receive transferred calls from other automated Systems;

R.2.3. Ability to transfer calls to local departmental offices, as specified by the Department;

R.2.4. Ability to warm transfer to the Department and the Department's agents for eligibility/ enrollment, dental, behavioral health, pharmacy, transportation, and claims services;

R.2.5. Ability to immediately transfer calls to a direct contact with a service representative on a priority basis without the caller having to listen to AVR menu options;

R.2.6. Conferencing capability;

R.2.7. TDD/TTY capability for hearing-impaired;

R.2.8. Multi-lingual Capabilities;

R.2.9. Overflow capability; and

R.2.10. Voicemail capability.

R.3. The Contractor shall establish and maintain the following menu options for members who call the main toll free telephone line:

R.3.1. Crisis Calls. Crisis calls are calls from members seeking immediate medical assistance. Crisis calls that are received during normal business hours shall be routed to clinical staff as appropriate.

R.3.2. Member Services. The Member Services Line shall enable members to call with questions, information and clinical requests during normal business hours.

R.4. The Contractor shall establish and maintain the following menu options for providers who call the main toll free telephone line:

R.4.1. Authorization and/or verification requests twenty-four (24) hours a day and seven (7) days per week; and

R.4.2. Provider Services during normal business hours.

R.5. Performance Specifications

R.5.1. Throughout the term of the Contract the Contractor shall meet or exceed the following Performance Specifications for Telephone Call Management. The Contractor shall:

R.5.1.1. Ensure that the AVR system provides the options menu to all callers within two (2) rings;

R.5.1.2. Ensure that the member and provider call-in lines never have a busy signal;

R.5.1.3. During normal business hours, provide sufficient and appropriate staff to answer all ARS transferred crisis calls and answer 100% of such calls within fifteen (15) seconds with a live person, and maintain an abandonment rate of less than 5%.

R.5.1.3.1. When crisis calls are not answered within the first fifteen (15) seconds, the ARS shall initiate a recorded message encouraging a caller to remain on the line and assuring a caller that a qualified staff person will answer the call momentarily;

R.5.1.4. Provide sufficient and appropriate staff to answer all AVR transferred calls from the member services menu and shall answer 90% of calls with a live person within sixty (60) seconds and maintain an abandonment rate under 5% during Normal Business Hours.

R.5.1.5. During non-business hours when a staff person is not available for routine calls, the ARS shall respond with a recording within ten (10) seconds of the ARS call activation, instructing the caller to call back during normal business hours;

R.5.1.6. Provide sufficient and appropriate staff to answer all ARS transferred calls to the Authorization Line 24 hours a day, seven (7) days a week for providers, who shall answer 90% of such calls with a live person within (sixty) 60 seconds and maintain an abandonment rate of less than 5%.

R.5.1.6.1. When a staff person is not available, a recording shall respond every thirty (30) seconds instructing the caller to wait for the next available agent;

R.5.2. Provide sufficient and appropriate staff to answer all ARS transferred calls to "Provider Services" who shall answer 90% of calls with a live person within sixty (60) seconds and maintain an abandonment rate under 5% during Normal Business Hours.

R.5.2.1. During non-business hours when a staff person is not available, the ARS shall respond with a recording within ten (10) seconds of the ARS call activation instructing the caller to call back during normal business hours;

R.5.3. Ensure that Contractor's staff and ARS can communicate in English and Spanish on an as needed basis and that access is provided to a language line during normal business hours; and

R.5.4. Ensure that Contractor's telephone staff greets all callers, identify themselves by first name when answering and always treat the caller in a responsive and courteous manner.

R.6. Automatic Call Distribution Reporting

R.6.1. Throughout the term of the Contract the Contractor shall establish and maintain a functioning automatic call distribution (ACD) call reporting system that, at a minimum, has the capacity to record and aggregate the following information by AVR line:

R.6.1.1. Number of incoming calls;

R.6.1.2. Total number of answered calls by Contractor staff;

R.6.1.3. Average number of calls answered by each Contractor staff member;

R.6.1.4. Average call wait time by staff member;

R.6.1.5. Average talk time by staff member;

R.6.1.6. Percent of crisis calls answered by staff in less than fifteen (15) seconds during normal business hours after the selection of a menu option;

R.6.1.7. Percent of crisis calls answered by staff in less than fifteen (15) seconds or the systematic transfer within ten (10) seconds during after hours after the selection of a menu option;

R.6.1.8. Percent of routine Member Services calls answered by staff in less than sixty (60) seconds after the selection of a menu option;

R.6.1.9. Percent of provider Authorization calls answered by staff in less than sixty (60) seconds after the selection of a menu option;

R.6.1.10. Percent of Provider Services calls answered by staff in less than sixty (60) seconds after the selection of a menu option;

R.6.1.11. Number of calls placed on hold and length of time on hold; and

R.6.1.12. Number and percent of abandoned calls. (For purposes of this section abandonment refers to those calls abandoned 60 seconds after the entire menu selection has been played and the caller has entered into the cue). The call abandonment rate shall be measured by each hour of the day and averaged for each month.

R.6.2. The Contractor shall maintain phone statistics daily and shall tally and submit the statistics to the Department in accordance with the reporting schedule and format outlined in Exhibit E, Reporting Matrix. The Department reserves the right to change the reporting timeframe for these reports; however, any revised timeframes must be mutually agreed upon by the Department and the Contractor.

S. DATA REPORTING REQUIREMENTS

S.1. The Contractor shall store all operational data collected in an information system that is compliant with Open Database Connectivity Standards (ODBC) and allows for easy data capture;

S.2. The Contractor shall ensure that the information system's reporting capacity is flexible and able to use data elements from different functions or processes as required to meet the program reporting specifications described in this Contract.

S.3. The Contractor shall provide the Department with a mutually agreeable electronic or Web-based file format of the MIS data dictionary of all data elements in all databases maintained pursuant to the terms of this Contract.

S.4. The Contractor shall ensure that any database used in association with their performance under this Contract can execute ANSI SQL.

S.5. The Contractor shall respond to questions or issues regarding data and/or reports presented to the Contractor within five (5) business days unless otherwise specified.

S.6. The Contractor shall provide access to detailed and summary information that the Contractor maintains regarding UM decisions, information on other registration services, UM staff coverage, appeals and complaints, and related data in conjunction with the authorization process.

S.7. Report Production, Integrity and Timeliness

S.7.1. The Contractor shall be required to submit to the Department reports regarding the Contractor's activities under this Contract. The required reports, including due dates and prescribed format and medium are memorialized in Exhibit E - Reporting Matrix. The Department and Contractor agree that throughout the term of this contract the parties may through mutual agreement, revise Exhibit E – Reporting Matrix and that such revisions will not require a formal amendment to the contract.

S.7.2. The Department shall provide the Contractor with final specifications for submitting reports. The Contractor shall not be required to begin submitting reports to the Department until report specifications have been defined by the Department. If requested by the Department, the Contractor shall provide suggested report specifications for the Department's review and approval. After final report specifications have been defined and/or approved by the Department, the Contractor shall have thirty (30) days to program the report(s) against the specifications unless the Contractor demonstrates to the Department's satisfaction the need for additional time. The reporting schedule defined in Exhibit E will begin after this thirty (30) day period or other timeframe as mutually agreed to by the parties.

S.7.3. The Contractor shall be responsible for the production of all HEDIS designated reports listed in Exhibit E - Reporting Matrix including the use of HEDIS certified software and independent audit requirements.

For the 2012 reporting year for CY 2011 data, the Department shall permit unaudited HEDIS reporting.

S.7.4. Whenever the due date for any report falls on a day other than a Business Day, such due date shall be the first Business Day following such day.

S.7.5. The Contractor and the Department agree that the parties may desire to change Exhibit E - Reporting Matrix. Such changes may include the addition of new reports the deletion of existing reports and/or changes to due dates, prescribed formats and medium.

S.7.5.1. Agreed upon changes to Exhibit E shall only be effective as of the date that the Department and the Contractor agree, in writing, to the change.

S.7.5.2. The Contractor shall comply with the Department's requests to modify or add to the reporting requirements set forth in Exhibit E unless the Contractor demonstrates to the Department that to meet such requirements, there must be a modification to the functional design of the information systems or increased staffing which will result in additional costs to the Contractor.

S.7.6. The Contractor shall produce all reports timely and accurately with minimal revisions following submission.

S.7.7. If the submission date for a report will not be met, the Contractor shall request in writing an extension for submission. Such request must be received by the Department no later than one business day before the scheduled due date of the report.

S.7.7.1. The Department shall approve or reject the request for the extension. The Department's approval shall not be unreasonably withheld.

S.7.8. The Contractor shall advise the Department, within one (1) business day, when the Contractor identifies an error in a report and shall submit a corrected report within five (5) business days of becoming aware of the error.

S.7.8.1. The Contractor shall specify on the corrected report the element that changed, the cause of the error and the guidelines that the Contractor shall implement to prevent future occurrences.

S.7.9. The Contractor shall provide the Department on or before February 15, 2012 for its review and approval the processes and controls

implemented by the Contractor to ensure "data integrity", defined as the ability to ensure data presented in reports are accurate (e.g. "reporting accuracy").

S.8. Data Storage and Elements

S.8.1. In addition to the data elements necessary to complete the reports in Exhibit E and as described in the "Utilization Management" and "Quality Management" Sections, the Contractor shall store data with report programming flexibility to produce, sort and summarize reports that include one or more of the following data elements:

S.8.1.1. EMS Unique Client Identifier;

S.8.1.2. Age (including summarization by age bands and or focus on a specific age, including those age bands specified in Exhibit E);

S.8.1.3. Gender;

S.8.1.4. Diagnoses;

S.8.1.5. Significant co-morbidities, including pregnancy;

S.8.1.6. ICM Indicators

S.8.1.7. BHP ICM co-management;

S.8.1.8. Local areas as defined by the Department;

S.8.1.9. Program (ABD, LIA, Family, CHIP, Charter Oak) and special population identifier if any;

S.8.1.10. PCP assignment

S.8.1.11. PCMH attribution;

S.8.1.12. Health Neighborhood attribution;

S.8.1.13. Waiver/MFP enrollment;

S.8.1.14. Court involvement/mandate type;

S.8.1.15. DCF identifier, if applicable;

S.8.1.16. Ethnicity and Race;

S.8.1.17. MMIS provider type;

S.8.1.18. MMIS provider specialty;

S.8.1.19. Provider identifiers and TIN;

S.8.1.20. Service type/level of care;

S.8.1.21. Procedure code/revenue code;

S.8.1.22. Fiscal Year or Calendar Year;

S.8.1.23. Periodic Comparison (month to month, year to year);

S.8.1.24. Compilation by day, week, month, quarter, semiannually, and yearly ; and

S.8.1.25. Payment amount for each claim.

S.9. Data Aggregation

S.9.1. The Contractor shall aggregate the data collected statewide by regions;

S.9.2. The Contractor shall aggregate the data collected geographically by client's town of residence and provider service location. Geographic aggregation of provider data shall be based upon the provider's type, specialty and service location;

S.9.3. The Contractor shall aggregate data collected by client/medical home attribution; or client/health neighborhood attribution as such attribution methodologies are established.

S.9.4. The Contractor shall ensure that authorization data includes units denied and authorized.

S.10. Ad-hoc Reports

S.10.1. The Contractor shall produce Ad-hoc reports upon request of the Department. Ad-hoc reports may require data from any or all of the Contractor's databases associated with this Contract, including but not limited to the provider database and authorization database.

S.10.2. The Contractor shall provide a request form that structures the Ad-hoc report request process such as by identifying report criteria, data necessary, priority, resources, and turnaround time. If the requested report exceeds staff resources, the Contractor shall

work with the Department to prioritize requests in order to accommodate requested reports within available resources. If requested reports cannot be so accommodated, the Contractor and the Department shall negotiate the cost of accommodating the request.

S.10.3. The Contractor shall produce and deliver such Ad-hoc reports to the Department within five (5) business days of the Contractor's receipt of the Department's written request.

S.10.3.1. If the Contractor will not be able to make the Ad-hoc report available within the requisite five (5) business days, then the Contractor shall, within three (3) business days from its receipt of the initial request, notify the Department of the estimated production date. The Contractor's response shall include reporting specifications, report development and resource requirements, and the expected delivery date of the information.

T. INFORMATION SYSTEM

T.1. System Requirements

T.1.1. The Contractor shall transmit authorization data to the Department's MMIS Contractor, integrate claims and authorization data and if requested by the Department, produce extracts for the Department data warehouse

T.1.2. The Contractor shall establish and maintain a HIPAA compliant computer system to accommodate all operational and reporting functions required through this Contract.

T.1.3. The Contractor shall establish and maintain connectivity between the Contractor's information system and the Department's systems and support the required eligibility data exchanges based upon the Department's standards for the exchange of data.

T.2. Eligibility Data

T.2.1. The Contractor shall accept eligibility, membership and enrollment data (eligibility data) from the Department and the Department's contractors electronically.

T.2.2. Upon receipt of the eligibility data from the Department and/or its contractors, the Contractor shall conduct a quality assurance or data integrity check of the eligibility data.

T.2.2.1. Any eligibility audit report that results in an error rate below two percent shall be loaded into the Contractor's information system within two (2) business days of receipt.

T.2.3. The Contractor shall, in a format specified by the Department, notify the Department of any eligibility record that errors out due to missing or incorrect data and post corrected data to the Contractor's eligibility system.

T.2.4. The Contractor shall generate an update report that includes the number of eligibility records that have been read and the percentage of records loaded.

T.2.5. The Contractor shall provide all authorized staff with on-line access to the Contractor's comprehensive eligibility database to serve Members and Providers.

T.2.6. The Contractor shall verify the eligibility of persons not yet showing in the weekly eligibility file utilizing PC-based software, Provider Electronic Solutions (PES), to query the Department's Automated Eligibility Verification System (AEVS).

T.2.7. The Contractor shall add a missing member to the Contractor's eligibility database as a "temporary" member if services are requested by or for an individual who is not listed on the weekly eligibility file but who is listed on AEVS.

T.3. Build and Maintain the Provider File

T.3.1. Initial Provider File Information and Updates

T.3.1.1. The Contractor shall receive an initial provider extract from the Department's MMIS contractor in a file layout and media determined by Department's MMIS and load the information into the Contractor's MIS;

T.3.1.2. The Contractor shall accept from the Department's MMIS contractor a full file replacement at a frequency agreeable to the Contractor and the Department in a format and media determined by the Department and update the Contractor's MIS provider file accordingly within (3) three business days of receipt;

T.3.1.3. The Contractor shall accept from the Department additional source provider data that it may otherwise obtain from providers and use such information to build a more comprehensive provider file;

T.3.1.4. The Contractor shall build the provider file locally and such file shall reside on a server located in the Contractor's Service Center.

T.3.2. Supplemental Information

T.3.2.1. The Contractor shall customize the Contractor's MIS provider file to accommodate supplemental information required by the Department;

T.3.2.2. The Contractor shall update the Contractor's provider file to include the supplemental data elements obtained through the provider re-enrollment process and the uniform provider application developed by the Department.

T.3.3. Provider Identification

T.3.3.1. The Contractor shall propose and implement a provider identification solution in its provider file that shall permit all authorizations to be correctly linked to the provider's CMAP ID, provider type and specialty and that will enable reporting and external provider searches by service location (address) regardless of provider type.

T.3.3.2. The Contractor shall utilize the provider's CMAP ID, assignment type, provider type and specialty in the authorization or denial of services.

T.3.4. Data Elements

T.3.4.1. The Contractor shall store the minimum provider data elements in the table below in the Contractor's MIS provider file.

Data Elements	
Assignment Type	
Provider Type	Clinical Specialties
Service Types	Discipline License Level
Provider ID	Provider Specialty
Location ID	Primary service location address
CMAP ID	Alternate service location address

CMAP Provider type	Service City (Primary and alternates)
CMAP Provider specialty	Service State (Primary and alternates)
Last Name	Service Zip (Primary and alternates)
First Name	Service Phone (Primary and alternates)
Middle Initial	Service Contact Name
Mailing Address 1	TIN
Mailing Address 2	Billing Address 2
Mailing City	Billing State
Mailing State	Languages Spoken
Mailing Zip	Race/Ethnicity
E-mail address	Populations served
Gender	Enrollment status
Billing Address 1	NPI
Billing City	NPI Taxonomy (Primary and 5 additional)
Billing Zip	License number

T.3.5. Other Requirements

T.3.5.1. The Contractor's provider database shall have the ability to identify where services reside by location, provider type and specialty.

T.3.5.2. The Contractor shall ensure that provider searches can also be conducted in the Provider Subsystem, Care Management module, and the Inquiry Tracking module.

T.3.5.3. The Contractor shall ensure that the provider subsystem supports processes involving provider entry, reports, inquiry, and other fields to meet Department requirements.

T.4. Data Extracts from the Department to the Contractor

T.4.1. The Contractor shall receive paid and denied claims extract files for their member population from the Department's MMIS Contractor.

T.4.2. The Department shall provide the Contractor with claims extracts from its MMIS contractor for each scheduled financial cycle, typically on a bi-monthly basis.

T.4.3. The claims extracts shall be used to produce claims based reports as designed by the Department including the full complement of HEDIS Medicaid measures.

T.5. Batch Authorization Files

T.5.1. The Contractor shall provide to the Department's MMIS contractor a daily Prior Authorization (PA) Transaction batch file of all authorized services and authorization updates indicating service member ID, provider group (billing) CMAP ID, procedure/revenue code, units, span dates, diagnosis, and any other information specified by the Department's MMIS contractor. The batch file layout will be in a custom (i.e., non-HIPAA compliant) format specified by the Department's MMIS contractor.

T.5.2. The Department shall require that its MMIS contractor provide a Daily Error file to the Contractor in response to each PA Transaction file that is received from the Contractor. The Daily Error file will be sent to the Contractor on the same day that the corresponding PA Transaction file is received.

T.5.3. The PA Transaction file from the Contractor and the Daily Error file to the Contractor from the Department's MMIS contractor shall be transferred electronically via File Transfer Protocol (FTP) or other mutually agreeable and secure means of transmission.

T.5.4. The Department shall produce a "units used" file at after each financial cycle, typically on a bi-monthly basis. The Contractor shall receive and upload the units used file thus retaining a complete record in its care management system of units used against total units authorized.

T.5.5. The Department shall grant Contractor on-line access to interChange to look up authorizations resident in the interChange (iC)

system, whether authorized by the Contractor, the Department or a previous contractor.

T.6. Data Extracts from Contractor to the Department

T.6.1. The Contractor shall provide the Department with the complete provider file and authorization file as required by the Department in a format specified by the Department.

T.7. Access by the Contractor to Department's Data Warehouse

T.7.1. The Department shall train the Contractor staff to use the Department's data warehouse for inquiry and reporting. If requested by DSS the Contractor shall use the Department data warehouse to generate required ad-hoc reports directed by the Department.

T.8. Access by Department to Contractor's Databases/Data Warehouse

T.8.1. The Contractor shall provide a secure and mutually agreeable mechanism by which Department personnel can access the Contractor's reporting databases and/or data warehouse which may include but shall not be limited to access to the authorization file, the network provider file, and other information in the Contractor's MIS.

T.8.2. The Contractor shall develop procedures for granting the Department secure access through terminals at the Contractor's Connecticut service center and for training an adequate number of Department personnel in report generation and ad hoc querying. At the Department's request, the Contractor shall provide training in any ODBC compliant reporting tools used by the Contractor's reporting staff to provide reports to the Department.

T.8.3. The Contractor shall provide for the Department's use, a workstation at the Connecticut service center. The workstation shall include a personal computer with access rights to the Contractor's reporting software tools, databases and data warehouse related to this Contract.

T.9. Telecommunications and IT Systems Outage

T.9.1. The Contractor shall notify the Department's Contract Manager when the Contractor experiences a telecommunications outage during normal business hours that exceeds 15 minutes.

T.9.2. The Contractor shall track all outages including date, outage duration, and outage reason of any mission critical part of its IT or

telecommunications system and make this report available to the Department upon request.

T.10. Disaster Recovery and Business Continuity

T.10.1. The Contractor shall, by May 4, 2012, provide to the Department a Disaster Recovery and Business Continuity plan that will, at a minimum, prevent the loss of historical data and ensure continuous operations, meaning no break in member and provider telecommunications and authorization services of more than thirty (30) minutes in the event of a system failure and no more than five (5) business days for all other administrative functions.

T.10.2. The plan shall include a backup schedule and the Contractor's plan for responding to phone calls seamlessly in the event of local power failures, phone system failures or other emergencies.

T.10.3. During such period as the disaster recovery plan is in effect, the Contractor shall be responsible for all costs and expenses related to provision of the alternate services under its normal Administration fee. The Contractor shall notify the Department's Contract Manager prior to the initiation of alternate services as to the extent of the disaster and/or emergency and the expected duration of the alternate services within twenty-four (24) hours of onset of the problem.

T.10.4. The Department shall review and approve the Disaster Recovery Plan or provide the Contractor with comments and changes. The Contractor is required to advise the Department, in writing of any anticipated changes to those sections of the Contractor's Disaster Recovery Plan that have been approved by the Department.

T.10.5. The Contractor shall maintain and execute the Disaster Recovery and Business Continuity plan to ensure compliance with the Department's IT requirements even if a disaster interrupts normal business and IT operations. The Disaster Recovery or "IT Business Continuity" plan shall include:

T.10.5.1. Daily Backups

T.10.5.1.1. Traditional daily system backups shall be done on all servers to ensure that the content of all of both host and local area network systems can be recovered in the event of a disaster. Software and production data files are copied to digital tape or other suitable media. A verification and audit

program shall be used to confirm that the system backup tapes are complete and accurate and can be properly restored. Copies of the tapes shall be created and stored in a secure off-site location to be used to reload the production systems. System backup tapes shall be rotated regularly to ensure physical integrity of the tapes and to minimize tape parity error problems;

T.10.5.2. Backup Power

T.10.5.2.1. A backup power generator shall support the Contractor's information systems wherever such systems shall reside and restore power to the systems within minutes in the event of a power failure. The service center computer room shall be supported with its own uninterruptible power supply to continue operations while the building backup power generator is activated;

T.10.5.3. Recovery

T.10.5.3.1. The Contractor shall be able to have the Contractor's IT system back online within 45 minutes and operating in a secure environment; and

T.10.5.4. Testing

T.10.5.4.1. Testing of the disaster recovery process, at a minimum shall be provided for bi-annually with preparation and delivery of a report to the Department within one month of the test.

U. NOTICES OF ACTION, DENIAL NOTICES, APPEALS AND ADMINISTRATIVE HEARINGS

U.1. The requirements for the content and issuance of Notices of Action and Denial Notices and the processes for Appeals to the Contractor and Administrative Hearings heard by the Department vary by program (Medicaid, CHIP and Charter Oak) and may change.

U.1.1. To the extent that there are changes in state or federal laws that affect these requirements or policies, the Contractor shall be required to modify the processes at the direction of and with the approval of the Department.

U.2. Notices of Action and Denial Notices

U.2.1. The Contractor shall meet or exceed the Notice of Action and Denial notice requirements as specified for each program and set forth in this Section. The Contractor shall, no later than January 15, 2012, submit to the Department for its review and approval, a Member Appeals Process including policies and procedures related to the administration of Notices of Action, Denial Notices, and internal appeals processes in accordance with this section.

U.2.2. In order to ensure that the Contractor responds to every request for authorization, the Contractor shall automatically generate authorization letters from its computer system whenever a request for authorization is entered.

U.2.2.1. If the Contractor denies, partially denies, terminates, suspends or reduces services, the corresponding Notice of Action or Denial Notice must be completed on an individualized basis. The explanation of and reason for the Contractor's action must be specific to the client. A specific legal citation for the action must be specified on the notice.

U.2.3. The Contractor shall generate Notices of Action and Denial Notices specific to each program and each type of action. All Notices of Action and Denial Notices based on Medical Necessity shall be consistent with the requirements of Connecticut General Statutes Section 17b-259b concerning the definition of "medical necessity" and the application of the definition.

U.2.3.1. For all programs, the Contractor shall issue notices for both denials and partial denials of covered services on the approved notice, as applicable.

U.2.3.1.1. A partial denial includes approval of a good or service that is not the same type, amount, duration, frequency or intensity that is requested by the provider.

U.2.3.2. For HUSKY A, C and D, the Contractor shall also issue notices of action if a provider requests a good or service that is not covered.

U.2.3.3. For all programs, Notices of Action and Denial Notices shall be communicated in writing and sent out as expeditiously as possible, but no later than three (3) business days following the date of the decision.

U.2.4. For all programs, the Contractor shall issue notices for terminations, suspensions and reductions of previously authorized services, on the approved notice, as applicable.

U.2.4.1. Termination/Suspension/Reduction notices related to previously authorized covered services shall be communicated in writing ten days in advance of the effective date. For HUSKY A, C and D Members, if the client requests an administrative hearing, services must be continued as described in Section U.3.

U.2.4.2. The ten (10) day advance notice requirements do not apply, and the Contractor may send a Notice of Action no later than the date of action in any of the circumstances described in 42 C.F.R. § 431.213. To the extent these exceptions apply, they will also excuse the Contractor from issuing ten day advance notice to HUSKY B and Charter Oak Members.

U.2.4.3. The Contractor may shorten the 10-day advance notice in the circumstances described in 42 C.F.R. § 431.214. To the extent these circumstances apply, the Contractor may also shorten the 10-day advance notice issued to HUSKY B and Charter Oak Members.

U.2.5. If additional information is needed for the Contractor's consideration of a request for approval of covered services for any Member and the provider does not wish to participate in a peer review or is not available for peer review within the decision timeframe required of the Contractor for the pending request in accordance with subsections D.6 and D.7, then the Contractor shall issue an NOA or Denial Notice, as applicable. The notice shall state that the reason for the action is the lack of sufficient information from the provider to demonstrate medical necessity.

U.2.6. The Department shall provide the Contractor with templates for the following:

U.2.6.1. Notice of Action pertaining to Denials/Partial Denials for HUSKY A, C and D;

U.2.6.2. Notice of Action pertaining to Termination, Suspension, Reduction for HUSKY A, C and D;

U.2.6.3. Denial Notice pertaining to non-coverage for HUSKY A, C, and D.

U.2.6.4. Termination, Suspension, Reduction Notice for HUSKY B and Charter Oak;

U.2.6.5. Denial/Partial Denial Notice for HUSKY B and Charter Oak:

U.2.6.6. Appeal/Administrative Request form for HUSKY A, C, and D.;

U.2.6.7. Appeal Form for HUSKY B and Charter Oak.

U.2.7. The Contractor shall submit final standardized Notices of Action and Denial Notices to the Department for review and approval, the format and content of which may not be altered without the prior written approval of the Department. All notices shall include the specific reason for denial in English and in Spanish, if the Member's primary language is Spanish.

U.2.8. The Contractor shall mail the applicable notice to one of the following individuals:

U.2.8.1. The Member, if the Member is 18 years of age or older and, if applicable, the Member's conservator or guardian;

U.2.8.2. The Member's head of household or Member's parent or guardian if the Member is under the age of 18; or

U.2.8.3. The identified person at DCF's central office for a child who is committed to or under the custody of the Department of Children and Families.

U.2.9. The Contractor shall be required to advise Members that the Member may file an appeal in writing within sixty (60) days of the date of the notice on a form provided by the Department.

U.2.9.1. Appeals may be filed by the Member; the Member's authorized representative, a conservator or guardian, or the Member's parent or guardian if the Member is under the age of 18.

U.2.9.2. A provider may initiate a medical necessity appeal through the Provider Appeal process described in Section W.

U.2.10. The Contractor shall track in a database all cases sent to a Peer Advisor for review, as well as the outcomes of each review.

U.2.10.1. Each case sent to a Peer Advisor shall contain the clinical information the Care Manager has obtained as well as the appropriate level of care criteria and the definition of medical necessity.

U.2.10.2. Daily reports shall be run from this database.

U.2.11. Decisions to deny, partially deny, terminate, suspend or reduce services shall be entered into a database.

U.2.11.1. All Notices of Action and Denial Notices, with appropriate appeals rights, shall be generated from this database.

U.2.11.2. All letters shall be generated within three (3) business days of complete PA request.

U.2.11.3. The notices shall follow the verbal notification of the decision to the provider in instances when the clinical circumstances require immediate response back to the provider.

U.2.12. The Contractor shall complete a quality control check on 100 percent of all Notices of Action and Denial Notices.

U.2.12.1. The Quality Control Check must be performed by an individual(s) with specific training on the contractual and legal requirements for notices and processes for each of the programs.

U.2.12.2. Letters generated shall be compared with the report of all cases that have been sent to a Peer Advisor to assure that letters are generated for all denials, partial denials, terminations, suspensions and reductions, within one business day of the decision.

U.2.12.3. A member of the Clinical Operations management team shall review denial letters before they are mailed. Letters shall be reviewed for accuracy in format and for content against a checklist.

U.3. Continuation of Benefits Pending Appeal

U.3.1. If the Contractor terminates, suspends or reduces an existing authorization for services being provided to HUSKY A, C or D Members, the Member has a right to continuation of the services previously authorized, provided that the Member files an appeal/hearing request within ten (10) calendar days of the date the NOA is mailed to the Member, or the effective date of the intended action, whichever is later.

U.3.1.1. The right to continuation of services does not apply to subsequent requests for approval that result in denial of the

additional request or re-authorization of the request at a different level than requested.

U.4. Contractor Appeals Process – Routine

U.4.1. The Contractor shall develop and implement timely and organized policies and procedures for appeals to resolve disputes between the Contractor and Members concerning the Contractor's denial/partial denial, termination, suspension, or reduction of services for all Members and disputes concerning coverage of goods and services for HUSKY A, C and D Members.

U.4.2. The Contractor shall maintain a record keeping system for appeals, which shall include a copy of the appeal, the response, the final resolution and supporting documentation.

U.4.3. The Contractor shall designate one primary and one back up contact person for its appeal/administrative hearing process.

U.4.4. The Contractor shall implement a single process for any HUSKY A, C and D Members pursuing an appeal and requesting an administrative hearing. The Contractor and the Department shall treat the filing of a Medicaid appeal as a simultaneous request for an administrative hearing.

U.4.5. Appeals by HUSKY A, C and D Members shall be mailed or faxed to a single address within the Department. The Department will

U.4.5.1. schedule an administrative hearing within thirty (30) calendar days of receipt of the appeal and notify the Member and Contractor of the hearing date and location. If a Member is disabled, the hearing may be scheduled at the Member's home, if requested by the Member.

U.4.5.2. date stamp and forward the appeal by fax to the Contractor within two (2) business days of receipt. The fax to the Contractor will include the date the Member mailed the appeal to the Department. The postmark on the envelope will be used to determine the date the appeal was mailed.

U.4.5.3. fax a request for expedited review to the Contractor within one business day of receipt by the Department when the Member's appeal contains a request for expedited review. The fax will include the date the Member mailed the appeal. If the Contractor receives an appeal form, the Contractor shall date stamp and fax the appeal to the appropriate fax number at the Department within two (2) business days.

U.4.6. Appeals for HUSKY B or Charter Oak Members shall be mailed or faxed to a single address at the Contractor. The Contractor shall date stamp the appeal upon receipt, which date shall be used to determine whether an appeal was timely filed.

U.4.7. An individual(s) having final decision-making authority shall render the Contractor's appeal decision. Any appeal arising from an action based on a determination of medical necessity shall be decided by one or more Peer Reviewers who were not involved in making the medical decision related to the denial or other action. The Peer Reviewers shall have the appropriate training or clinical experience to be able to render an expert opinion on the subject of the appeal.

U.4.8. An appeal may be decided on the basis of the written documentation available unless the Member requests an opportunity to meet with the individual or individuals making that determination on behalf of the Contractor and/or requests the opportunity to submit additional documentation or other written material.

U.4.9. If the Member wishes to meet with the Contractor's decision-maker, the meeting can be held via telephone or at a location accessible to the Member. Subject to approval of the Department's regional Offices, any of the Department office locations may be available for video conferencing.

U.4.10. The Contractor shall

U.4.10.1. attempt to resolve the appeal at the earliest point possible, but no later than thirty (30) days following the filing of the appeal.

U.4.10.2. resolve all HUSKY A, C and D appeals no later than the date of the administrative hearing or within thirty (30) days of the filing of the appeal, whichever is earlier.

U.4.10.3. mail to the Member, the Member's conservator, the Member's parent or guardian if the Member is under the age of 18 and/or the DCF central office contact person for any child who is committed to or in the custody of DCF, by certified mail, a written appeal determination described below, with a copy to Department, by the date of the Department's administrative hearing for Medicaid Members or within thirty (30) days of receipt of the appeal for HUSKY B and Charter Oak Members.

U.4.10.3.1. The Contractor's written appeal determination shall include the Member's name and address; the provider's name and address; the Contractor's name and address; a

complete description of the information or documents reviewed by the Contractor in rendering its decision; a complete statement of the Contractor's findings and conclusions, including a citation to the legal authority that is the basis of the appeal determination; a clear statement of the Contractor's disposition of the appeal; and a statement that the Member has exhausted the Contractor's internal appeal procedure.

U.4.10.4. The appeal determination shall be responded to in the language that the appeal was submitted. For HUSKY B and Charter Oak Members, the Contractor shall send information on how to request an External Appeal at the Department, if the Member is dissatisfied with the Contractor's denial, partial denial, reduction, suspension, or termination of goods or services.

U.4.10.5. For HUSKY A, C and D Members, the appeal determination shall state that the Department has already reserved a time to hold an administrative hearing concerning that determination.

U.4.10.6. HUSKY A, C and D appeal determinations shall inform the Member that that if the Member fails to appear at the administrative hearing without good cause for failure to appeal, the Member's reserved hearing time will be cancelled and any disputed services that were maintained will be suspended, reduced, or terminated in accordance with the Contractor's appeal determination. If the Member is entitled to continuation of services, the Contractor shall indicate that the services will be continued for the duration of the existing authorization until the result of the Administrative hearing.

U.5. Contractor Appeals Process – Expedited

U.5.1. The Contractor shall conduct an appeal on an expedited basis if the 30-day appeal timeframe could jeopardize the life or health of the Member or the Member's ability to regain maximum function.

U.5.2. The postmark on the envelope or the date stamp of the fax will be used to determine the date the appeal was filed.

U.5.3. The Contractor shall determine, within one business day of receipt of an appeal that contains a request for an expedited review, whether to expedite the review or whether to perform a review according to the standard timeframes.

U.5.4. The Contractor shall expedite its review in all cases in which such a review is requested by the Member's treating provider, functioning within his or her scope of practice as defined under state law, or requested by the Department.

U.5.5. An expedited review shall be completed and an appeal decision shall be issued within a timeframe appropriate to the condition or situation of the Member, but no more than two days from the Contractor's receipt of the appeal from the Department or from the Member. In total, the internal review may take no more than seventy-two hours from request, unless the Member asks to meet with the decision maker or to submit additional information.

U.5.6. If the Member asks to meet with the decision maker and/or submit additional information, the decision maker shall offer to meet with the Member within three (3) business days of receipt of the appeal from the Department, and the Contractor shall issue its determination not later than five (5) business days after receipt of the appeal.

U.5.7. The meeting with the Member may be held via the telephone or at a location accessible to the Member; subject to approval of the Department's Regional Offices any of the Department's office locations may be available for video conferencing.

U.6. Administrative Hearings-Medicaid (HUSKY A, C and D)

U.6.1. If a Member is dissatisfied with the results of the appeal determination or the Contractor has not issued the appeal determination, the Department shall conduct the Administrative hearing as scheduled.

U.6.2. If a Member proceeds to a hearing, the Contractor shall make its entire file concerning the Member and the appeal, including any materials considered in making its determination, available to the Department.

U.6.3. The Contractor shall make available staff who are familiar with the case to attend the hearing.

U.6.4. The Contractor's file shall include a summary of the clinical justification supporting the original decision and subsequent appeal determination.

U.6.5. The Contractor shall prepare a summary for the administrative hearing, subject to approval by the Department. The Contractor shall submit a draft hearing summary seven (7) business days prior to the scheduled hearing date and a final, signed hearing summary to the

DEPARTMENT and the Member no later than five (5) business days prior to the scheduled hearing date, and shall present proof of all facts supporting its initial action.

U.6.6. The Contractor shall comply with any requests for additional information made by the hearing officer during the hearing. The Contractor shall be bound by the Department's hearing decision.

U.6.7. If the Department reverses the Contractor's decision to deny, terminate, suspend or reduce services, the Contractor shall promptly authorize the disputed services, as expeditiously as the Member's health requires. The Contractor shall document compliance with the hearing decision, as directed by the Department.

U.7. External Review - Charter Oak and HUSKY B

U.7.1. The Department operates a program specific review process for an external review of appeals conducted by the Contractor. If a HUSKY B or Charter Oak Member has exhausted the Contractor's internal appeals process and has received a final written determination from the Contractor upholding the Contractor's original denial of the service, the Member may file an external appeal with the Department of Social Services within thirty (30) days of the receipt of the final written appeal determination.

U.7.2. The Department will assign the appeal to the appropriate clinician within the agency who had no involvement in the underlying appeal or determination.

U.7.3 The Contractor will provide copies of its determination and all clinical documentation necessary to the Department's consideration of the External Appeal.

U.7.4 The Department will complete its External Appeal in no more than thirty days from the date it was requested by the Member.

U.7.5 The Contractor shall comply with the Department's External Appeal determination and issue notification of same to the Department.

U.7.6 The Department shall conduct expedited External Appeals.

U.7.6.1 If the Contractor conducts the internal appeal on an expedited basis, the Contractor will scan and e-mail its final determination along with the supporting clinical information to the Department on the same day the Contractor makes its determination.

U.7.6.2 If the Contractor did not conduct an expedited internal appeal, but the Department determines that an expedited external appeal is warranted, or the client's provider certifies that an expedited external appeal is warranted, the Contractor shall provide the clinical/supporting information electronically on the same day that the Department requests this information.

U.7.6.3 The Department will issue a determination within 48 hours. If the Department reverses the Contractor's internal decision, the determination will direct the Contractor to authorize or otherwise implement the decision as timely basis and may specify a date for implementation.

V. PROVIDER APPEALS

V.1. General Provisions

V.1.1. A provider may lodge medical necessity and administrative appeals with the Contractor.

V.1.2. The Contractor shall, no later than December 15, 2011, submit to the Department for review and approval a Provider Appeals Process including policies and procedures related to the administration of denial, and internal appeals processes.

V.2. Medical Necessity Appeals

V.2.1. Level One

V.2.1.1. Upon receipt of the decision from the Contractor, a provider may initiate the appeals process by notifying the Contractor verbally or in writing. The provider shall be required to initiate the appeal no later than seven (7) calendar days after receipt of the decision to deny, partially deny, reduce, suspend or terminate a health service.

V.2.1.2. The Contractor shall complete arrangements for peer review within one (1) business day upon notification of an appeal, to be conducted at a mutually agreed upon time. A peer desk review will be conducted if the provider peer is unavailable or is accepting of the alternative. The Contractor shall render a determination of the appeal and notify the provider telephonically no later than one (1) business day following completion of the peer review or peer desk review. The Contractor shall mail notice of the appeal determination to the provider within two (2) business days.

V.2.2. Level Two

V.2.2.1. If the provider is dissatisfied with the first level appeal determination, the provider may initiate a second level appeal by sending written notice to the Contractor no later than fourteen (14) calendar days after the first level appeal denial. The provider may submit additional documentation in support of the appeal including the medical record within thirty (30) calendar days of the request for the appeal.

V.2.2.2. The Contractor shall send the provider notice of the determination of the second level of appeal no later than five (5) business days after receipt of information deemed necessary and sufficient to render a determination.

V.3. Administrative Appeals

V.3.1. A provider may appeal a determination by the Contractor based on non-compliance by the provider with policies and procedures pertaining to utilization management.

V.3.2. The provider may, no later than seven (7) calendar days after receipt of the determination from the Contractor, initiate an administrative appeal by providing the Contractor with a rebuttal with additional information or good cause.

V.3.3. The Contractor shall mail a notice of the determination to the provider within seven (7) business days following receipt of the appeal. The notification shall include the principal reason for the determination and instructions for requesting a further appeal, if applicable.

V.4. Outcome of Appeal

V.4.1. If the appeals process is followed and the denial determination is overturned, the Contractor shall authorize services to allow for provider payment for covered services rendered to a member.

V.4.2. If the appeals process is not followed or if the appeals process is followed and the appeal is denied, the Contractor shall not authorize provider payment for the services that are the subject of appeal.

W. SECURITY AND CONFIDENTIALITY

W.1. Compliance with State and Federal Law

W.1.1. The Department is required by state and federal law to protect the privacy and security of all applicant and client information, including, but not limited to, protected health information, as defined in 45 C.F.R. § 160.103.

W.1.2. The Department is a "covered entity," as defined in 45 C.F.R. § 160.103, which means that it is subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), more specifically with the requirements of the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C and E and Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Pub. L. 111-5 sections 13400 to 13423, inclusive. The Contractor must comply with all terms and conditions in the business associate section of the Contract.

W.1.3. The Contractor is a "business associate" of the Department, as defined in 45 C.F.R. § 160.103. The Contractor shall be required to comply with all state and federal laws concerning privacy and security of all applicant and client information that is provided to the Contractor by the Department or acquired by the Contractor in performance of the contract. This includes all applicant and client information, whether maintained or transmitted verbally, in writing, by recording, by magnetic tape, electronically or otherwise.

W.1.4. Compliance with privacy and security laws includes, but is not limited to, compliance with the HIPAA Privacy and Security Rules, the HITECH Act and all other federal and state statutes, regulations and policies that apply to the Department. The Department also requires the Contractor to continually update and improve its privacy and security measures as applicant and client data become more vulnerable to external technological developments.

W.1.5. The Contractor shall store and maintain information and records concerning applicants and clients in accordance with state and federal laws, policies and record retention schedules.

W.2. Staff Designation

W.2.1. The Contractor shall designate a Security Officer and a Privacy Officer, who shall be responsible for implementation and monitoring of compliance with privacy and security policies and procedures and for reporting any improper disclosures or security or privacy breaches.

W.2.2. The Department shall designate and notify the Contractor of the specific staff authorized by the Department to access and request

applicant and client information from the Contractor in order to maintain the security and privacy of applicant and client information.

W.2.3. The Department shall review and approve the names and qualifications of all Contractor staff who will have access to the Department's data warehouse, on either a routine, periodic, or ad hoc basis.

W.3. Security and Privacy Plan

W.3.1. The Contractor shall develop a Security and Privacy Plan with policies and procedures that comply with state and federal laws concerning the use, disclosure, and security of applicant and client data in order to maintain the security and privacy of applicant and client information.

W.3.2. The Contractor shall submit the Security and Privacy Plan to the Department for review and approval by November 15, 2011.

W.3.3. The Contractor's Security and Privacy Plan shall be consistent with all applicable state and federal laws that pertain to the Department and shall address, at a minimum, the following topics:

W.3.3.1. Preventing privacy and security breaches by:

W.3.3.2. Implementing steps to prevent the improper use or disclosure of information about clients;

W.3.3.3. Training all employees, directors, and officers concerning state and federal privacy and security laws;

W.3.3.4. Requiring that each employee or any other person to whom the Contractor grants access to applicant and client information under the Contract sign a statement indicating that he or she is informed of, understands, and will abide by, all state and federal statutes, regulations and policies concerning confidentiality, privacy and security;

W.3.3.5. Limiting access to applicant and client information held in its possession to those individuals who need such information for the performance of their job functions and ensuring that those individuals have access to only such information that is the minimum necessary for performance of their job functions;

W.3.3.6. Implementing steps to ensure the physical safety of data under its control by using appropriate devices and methods, including, but not limited to, alarm systems, locked files, guards

or other devices reasonably expected to prevent loss or unauthorized removal of data;

W.3.3.7. Implementing security provisions to prevent unauthorized changes to applicant and client eligibility files;

W.3.3.8. Implementing steps to prevent unauthorized use of passwords, access logs, badges or other methods designed to prevent loss of, or unauthorized access to, electronically or mechanically held data. Methods used shall include, but are not be limited to, restricting system and/or terminal access at various levels; assigning personal IDs and passwords that are tied to pre-assigned access rights to enter the system; and restricting access to input and output documents, including a "view-only" access and other restrictions designed to protect data;

W.3.3.9. Complying with all security and use requirements provided by the Department for parties using EMS, AEVS, or any other system, if applicable, including the signing of confidentiality forms by all employees and personnel working for subcontractors who have access to client eligibility data;

W.3.3.10. Complying with the requirement of the HIPAA privacy and security regulations that apply to the Department's business associates, including, but not limited to, returning or destroying all client information created or received by the Contractor on behalf of the Department, as directed by the Department;

W.3.3.11. Monitoring privacy and security practices to determine whether improper disclosures or breaches are likely to or have occurred;

W.3.3.12. Developing systems for managing what happens in the event of a breach of unsecured protected health information, as defined in 45 C.F.R. § 164.402 ("breach"), including, but not limited to:

W.3.3.12.1. Reviewing all improper disclosures and breaches in privacy and security that have been reported to Contractor's Privacy or Security officer by Contractor's staff;

W.3.3.12.2. Implementing a system of sanctions for any employee, subcontractor, officer, or director who violates the privacy and security laws or policies;

W.3.3.12.3. Developing a system to ensure that corrective action occurs and mechanisms are established to avoid the reoccurrence of an improper disclosure or breach; and

W.3.3.12.4. Establishing practices to recover data that has been released without authorization.

W.4. Security or Privacy Improper Disclosures and Breaches

W.4.1. The Contractor shall comply with the terms and conditions of the section of the Contract governing Business Associates under the requirements of HIPAA, including but not limited to, the Contractor's obligations in the event of a breach.

W.4.2. The Contractor shall notify the Department in writing and by the next business day, when it has knowledge of and confirms that an employee, director, officer or subcontractor has:

W.4.2.1. Improperly disclosed applicant or client information or improperly used, copied or removed any applicant or client data; or

W.4.2.2. Misused or used without proper authorization, an operator password or authorization number, whether or not such use has resulted in fraud or abuse.

W.5. Subpoenas and Requests for Information Under the Freedom of Information Act

W.5.1. The Contractor shall notify the Department, in writing, and consult with the Department, by the next business day after receiving

W.5.1.1. A subpoena that was served on the Contractor related to the Contract; or

W.5.1.2. A request made pursuant to the state Freedom of Information Act (Conn. Gen. Stat. 1-200, et seq.) received by the Contractor concerning material held by the Contractor related to the Contract.

X. CONTRACT COMPLIANCE, PERFORMANCE STANDARDS, AND SANCTIONS

X.1. General Requirements

X.1.1. In an effort to ensure continued quality service, the Department has established specific Performance Standards that shall be met by the

Contractor. All provisions for Performance Standards described under this section shall also constitute independent requirements under this Contract in addition to operating as standards for the purpose of determining whether the Contractor may be subject to penalties. In addition to sanctions related to specific Performance Standards, the Department reserves the right to impose sanctions for other conduct of the Contractor, including monetary sanctions for: failure to adhere to Medicaid or other applicable program requirements, acts or omissions that could result in harm to a Member, and other conduct the constitutes noncompliance with the Contractor or state or federal regulatory requirements.

X.1.2. Failure to meet these Performance Standards will result in a sanction against the Contractor for each occurrence per Performance Standard not met. If the Contractor's Performance Reports or Audits by the Department indicate that the Contractor failed to meet these Standards within the specifications under consideration, the Department shall adjust the Contractor's payment by a predetermined dollar amount set for each Performance Standard.

X.1.3. The Reporting Matrix in Exhibit E and deliverable due dates specified in Exhibit B comprise all Performance Standards and corresponding measures and the dollar amount to be deducted from the Contractor's payment each time the Performance Standard is not met.

X.1.4. The Contractor shall not be penalized for reporting delays that are a consequence of delays that are the fault of the Department or their agents.

X.2. Responsibilities of the Department

X.2.1. The Department shall regularly review the Performance Standard reports to determine if the Contractor is meeting these Standards and issue a written sanction notification for each occurrence in which the Contractor fails to meet a Performance Standard. The Department shall have the sole authority to determine whether the Contractor has met, exceeded or fallen below any or all of the Performance Standards.

X.2.2. The Department shall adjust the Contractor's payment for each sanction to be paid within thirty (30) business days of the postmark date of the written sanction notification from the Department to the Contractor.

X.2.3. The Department shall review and approve the development of, modification to and implementation of corrective action plans.

X.3. Responsibilities of the Contractor

X.3.1. The Contractor shall provide the required reports as indicated in Exhibit E. Failure to provide the Department with these reports may, at the Department's discretion, be considered a failure to meet the corresponding standard.

X.3.2. Within fifteen (15) business days of the date of the Department's written sanction notification to the Contractor for failure to meet a specified standard, the Contractor shall submit to the Department a corrective action plan to avoid the reoccurrence of non-compliance and possible additional penalties and a timetable for implementation of the corrective action plan to the Department for review.

X.3.3. In determining the Contractor's compliance and achievement against the Performance Standards, performance measures shall not be rounded. For example, if the Contractor is required to achieve a performance level of 95%, the target will not be achieved if the performance is 94.9%. Where applicable all times are measured as of Contractor's receipt of complete, legible, and accurate information.

X.3.4. Implementation of any sanction provision or the decision of the Department to refrain from implementation shall not be construed as anything other than as a means of further encouraging the Contractor to perform in accordance with the terms of the contract.

X.3.5. Implementation of a sanction provision is not to be construed as the Department's sole remedy or as an alternative remedy to the specific performance of the contract requirement and/or injunctive relief.

X.4. Alternative Effort Determination

X.4.1. The Department may provide or procure the services reasonably necessary to cure a default by the Contractor if, in the reasonable judgment of the Department:

X.4.1.1. A default by the Contractor is not so substantial as to require termination;

X.4.1.2. Reasonable efforts to induce the Contractor to cure the default are unavailing; and

X.4.1.3. The default is capable of being cured by the Department or by another resource without unduly interfering with continued performance by the Contractor.

X.5. Alternative Effort Implementation

X.5.1. If the Department exercises its right to procure services to cure the default, the Contractor's next payment will be adjusted to recover the reasonable cost of the procured services and the costs associated with the procurement of the services. If the Department exercises this right, the Contractor shall:

X.5.1.1. Cooperate with such entities the Department may obtain to cure the default and shall allow those entities access to the facility, documentation, software, utilities and equipment.

X.5.1.2. Remain liable for all system support and administration performance criteria, maintenance of and further enhancements to any applications developed by these resources to the extent that it constitutes the Contractor's work product whether impacted by the work of the other resource or not.

Y. PERFORMANCE TARGETS AND WITHHOLD ALLOCATION

Y.1. The Department shall withhold 7.5% of each quarterly administrative payment during each year of the contract to be paid to the Contractor, in whole or in part, at the end of each contract year contingent upon the Contractor's success in meeting established Performance Targets as set forth in Exhibit A.

Y.2. The established Performance Targets are tied to objectives such as access, quality, and expenditures. Each Performance Target has a separate value and, in some cases, separate values have been established for domains within each Performance Target. The Contractor shall have the opportunity to separately earn the amount associated with each Performance Target and, wherever specified in Exhibit A, each domain within each Performance Target. The established Performance Targets shall be reviewed on an annual basis before the start of the new contract year and may be revised.

Y.3. The Department shall measure the Contractor's success in meeting the Performance Targets. The Department shall establish specifications mutually agreeable to the Department and the Contractor for measurement of the Contractor's performance and shall calculate the Contractor's performance or base its calculation on reports or data submitted by the Contractor.

Y.4. The Contractor's failure to provide the Department with the requisite data or reports in accordance with the reporting frequency identified in Exhibit E shall result in the Contractor's forfeiting of the specified percentage of withhold attached to the corresponding Performance Target(s), if any.

Y.5. The Department shall determine whether the Contractor has met, exceeded or fallen below any or all of the required Performance Targets set forth in this subsection. The decision of the Department shall be final.

Y.5.1. In determining the Contractor's success in meeting the agreed upon Performance Targets, performance measures will not be rounded. For example, if the Contractor is required to achieve a performance level of 95%, the target will not be achieved if the performance is 94.9%.

Y.5.2. When a Performance Target includes the performance of a random sample, the sample size will be mutually agreed upon by the Department and the Contractor and will be based on the size of the population relevant to the Performance Target. The measure will be calculated and planned to enable statistically valid survey results at a 95% confidence interval with a margin of error of five (5) percentage points unless otherwise mutually agreed upon by the Department and the Contractor.

Y.5.3. The reporting period for purpose of calculation of Contractor's success in meeting the Performance Targets shall be by calendar year unless otherwise noted. Claim based reports will not be completed until (9) months following the close of the calendar year to allow for claims run out, although a preliminary calculation will be done with (3) months of run out for an initial assessment of whether the Contractor has met the claims based performance targets.

Y.5.4. The Department shall notify the Contractor of its success or failure in meeting the Performance Targets.

Y.5.5. If the Contractor has failed to meet a Performance Target the Contractor shall, within fifteen (15) business days of the date of the Department's notification of the Contractor's failure to meet a specified Performance Target(s), submit a written report to the Department that shall explain why specific Performance Targets were not met and describe a plan of action to be implemented in an effort to meet these Performance Targets.

Y.5.6. If the Contractor has met or exceeded the Performance Targets the Department shall return the specified portion of the withhold no later

than the end of the second quarter following the end of the calendar year unless otherwise agreed to by the parties.

Y.5.7. In the case of the Contractor's success in meeting a Performance Target for claims based reporting, the Department shall also return the portion of the withhold no later than the second quarter after the close of the calendar year if the preliminary calculation of the Contractor's performance suggests that the target will be met. However, the Department shall provide a reconciliation and adjust the withhold allocation as necessary within twelve (12) months after the close of the calendar year based on the completed claims based reports.

Z. CONTRACT IMPLEMENTATION, REVIEW AND TERMINATION PROVISIONS

Z.1. Implementation Plan

Z.1.1. The Contractor shall develop and provide to the Department by November 1, 2011 for review and approval an Implementation Plan using software such as Microsoft Project, GANTT chart, or equivalent, which shall at a minimum include the designated individuals responsible for the execution of the Implementation Plan, the date by which the Contractor will begin operation of its administrative services and be responsible for managing health services for all eligible members.

Z.1.2. The Department shall review the Contractor's Implementation Plan and periodic updates and not unreasonably withhold approval of the Plan and updates.

Z.1.3. The Contractor shall perform administrative services and become operational as defined in the detailed and negotiated Implementation Plan by the date indicated in the Contractor's approved Implementation Plan, or on such other date as the Contractor and the Department may agree in writing.

Z.1.4. The Department requires a fully operational health administrative system in accordance with the implementation plan as of 12:01 am on January 1, 2012 and for each day of the contract period thereafter. The failure of the Contractor to pass the "Implementation Review" or the failure of the Contractor to provide an operational system as of 12:01 am on January 1, 2012, as agreed by the Department, in accordance with the Contractor's Implementation Plan, or the failure of the Contractor to maintain a fully operational system thereafter will

cause considerable harm to the Department and their eligible members.

Z.1.5. The Department requires the timely completion of key deliverables summarized in Exhibit B and elsewhere in the contract. Failure by the Contractor to deliver each deliverable to the Department by the required due date shall results in a $1,000 sanction per late deliverable per day.

Z.2. Performance Bond or Statutory Deposit

Z.2.1. The Contractor shall be liable to the Department for resulting harm if the Contractor is not operational by the date specified in the Contractor's approved Implementation Plan. The Contractor shall not be liable for such harm if the Department has failed to meet its obligations under this Contract and that failure of the Department was a material cause of a delay of the Contractor's ability to perform its administrative services by the date specified in the Contractor's approved Implementation Plan.

Z.2.2. To mitigate such harm the Department requires the Contractor to obtain either a Performance Bond or a Statutory Deposit as further described below.

Z.2.3. The Contractor shall obtain a Performance Bond or Statutory Deposit Account in the amount of $1,000,000 no later than ten (10) calendar days after the execution of the Contract in accordance with the following:

Z.2.3.1. The purpose of the bond or Statutory Deposit amount is to mitigate harm caused by any failure of the Contractor to perform services required in the resultant contract.

Z.2.3.2. The bond shall be provided by an insurer, which has been previously approved by the Department.

Z.2.3.3. The bond shall name the State of Connecticut as the Obligee.

Z.2.3.4. The bond or Statutory Deposit amount shall remain in effect until the latter of:

Z.2.3.4.1. The duration of the contract and any extensions to the contract.

Z.2.3.4.2. The work to be performed under the contract has been fully completed to the satisfaction of the Department.

Z.3. Implementation Review

Z.3.1. The Department shall conduct an Implementation Review the purpose of which will be to determine whether the Contractor has achieved sufficient implementation progress to operate its administrative services by such time as indicated in the Contractor's approved Implementation Plan.

Z.3.2. The Department shall begin this Implementation Review at least 30 days prior to the date by which the Contractor will begin to operate its administrative services as indicated in the Contractor's approved Implementation Plan. The Implementation Review will extend beyond the January 1 implementation date in order to assess readiness for subsequent phases of the Implementation Plan.

Z.3.3. The Department shall notify the Contractor in writing of the results of its review. The Department may approve the Contractor's progress without comment, conditionally approve the Contractor's progress with additional requirements, or may determine that the Contractor has not made sufficient progress to operate its administrative services by the date indicated in the Contractor's approved Implementation Plan.

Z.3.4. If the Department determines that the Contractor has failed to make sufficient progress to become operational and to perform administrative services by the date established in the Contractor's approved Implementation Plan, the Contractor shall have five (5) business days from the date of such notice to propose a corrective action plan to the Department's satisfaction.

Z.3.5. In addition and irrespective of the Contractor's corrective action, the Department at its option may take such additional steps as they deem necessary to provide seamless delivery of health administrative services for its clients including, but not limited to, calling for execution of the Performance Bond and terminating the Contract for the Contractor's failure to pass the Implementation Review.

Z.4. Annual Performance Review

Z.4.1. The Department shall objectively evaluate the on-going performance of the Contractor during the term of the contract through annual Performance Reviews, the first of which shall be conducted within 180 days of implementation.

Z.4.2. The Department shall exercise their right to invoke the provisions of Termination subsection, when it determines the Contractor has failed to perform.

Z.5. Termination Provisions

Z.5.1. All terminations shall be effective at the end of a month, unless otherwise specified in this Article. The Contractor may be terminated under the following circumstances:

Z.5.1.1. By mutual written agreement of the Department and the Contractor upon such terms and conditions as they may agree;

Z.5.1.2. By the Department for convenience, upon not less than one hundred-eighty (180) days written notice to the Contractor;

Z.5.1.3. By the Department, for cause, upon failure of the Contractor to materially comply with the terms and conditions of this Contract. The Department shall give the Contractor written notice specifying the Contractor's failure to comply and shall provide Contractor a period of thirty (30) days to cure such breach. If the Contractor fails to comply, the Department may serve written notice stating the date of termination and work stoppage arrangements, not otherwise specified in this Contract. Such date of termination shall be no less than thirty (30) days following the date on which notice is provided to the Contractor.

Z.5.1.4. By the Department, in the event of default by the Contractor, defined as the inability of the Contractor to provide services, where such inability is not otherwise excused pursuant to this Contract. With the exception of termination due to insolvency, the Department shall require the Contractor to cure the default within thirty (30) days or to submit a plan of correction acceptable to the Department unless such opportunity would result in immediate harm to members, or the improper diversion of Medicaid program funds;

Z.5.1.5. By the Department, in the event of notification by the Connecticut Insurance Department or other applicable regulatory body that the certificate of authority under which the Contractor operates has been revoked, or that it has expired and shall not be renewed;

Z.5.1.6. By the Department, in the event of notification that the owners or managers of the Contractor, or other entities with substantial contractual relationship with the Contractor, have

been convicted of Medicare or Medicaid fraud or abuse or received certain sanctions as specified in Section 1128 of the Social Security Act;

Z.5.1.7. By the Department, in the event it determines that the health or welfare of consumers is in jeopardy should the contract continue.

Z.5.1.7.1. Termination of the contract requires a written finding by the Department that a substantial number of members face the threat of immediate and serious harm;

Z.5.1.8. By the Department, in the event of the Contractor's failure to comply with the Scope of Work. The Contractor shall be given fourteen (14) days to cure any such failure, unless such opportunity would violate any federal law or regulation;

Z.5.1.9. By the Department, in the event a petition for bankruptcy is filed by or against the Contractor;

Z.5.1.10. By the Department, if the Contractor fails substantially to authorize medically necessary items and services that are required under this Contract;

Z.5.1.11. By the Department, if the Contractor intentionally misrepresents or falsifies information that is furnished to the Secretary of Health and Human Services, the Department or Medicaid clients, potential clients or health care providers under the Social Security Act or pursuant to this Contract;

Z.5.1.12. By the Contractor, on at least thirty (30) days prior written notice in the event the Department fails to pay any amount due the Contractor hereunder within thirty (30) days of the date such payments are due; and

Z.5.1.13. By the Contractor, on sixty (60) days' written notice with cause, or one hundred eighty (180) days written notice without cause.

Z.5.2. Unless termination occurs pursuant to any of the above conditions, this Contract shall terminate on the Expiration date. The Contractor shall be paid solely for covered services provided prior to the Expiration or Termination date. The Contractor is obligated to cooperate fully with the closeout or transition of any activities so as to permit continuity in the administration of the Department's programs. This includes, but is not limited to, allowing the Department's full access to the Contractor's facilities and records to the extent

necessary to arrange for the orderly transfer of contracted activities (including information for the reimbursement of any outstanding Medicaid claims) and any other provisions specifically defined in the termination agreement.

Z.5.3. If the Department terminates this Contract pursuant to this Article and unless otherwise specified in this Article, the Department shall provide the Contractor written notice of such termination at least sixty (60) days prior to the effective date of the termination, unless the Department itself receives less than sixty (60) days notice, in which case the Department shall provide the Contractor with as much notice as possible. If the Department determines a reduction in the scope of work is necessary, it shall notify the Contractor and the parties shall proceed to amend this Contract pursuant to its provisions. By termination pursuant to this Article, neither party may nullify obligations already incurred for performance of services prior to the date of notice or, unless specifically stated in the notice, required to be performed through the effective date of termination. Any agreement or notice of termination shall incorporate necessary transition arrangements if such arrangements are not otherwise specified in this Contract.

Z.5.4. In the event that either party seeks early termination of this agreement, the Contractor and the Department shall negotiate an early termination agreement that may include transition activities, the status of the Contractor during the termination/transition period, cost recovery, payment terms, and any other matter that is necessary for the orderly termination and transfer of activities to a new Contractor or the Department. Such agreement shall be concluded within thirty (30) days of the notice of termination or the contract shall terminate thirty (30) days thereafter. If, despite the best efforts of the parties an agreement is not reached regarding the termination agreement within the specified thirty (30)-day period, the contract may be further extended in thirty-day increments to allow the Contractor and the Department to reach an agreement regarding the termination agreement.

AA. STAFFING, RESOURCES AND PROJECT MANAGEMENT

AA.1. Project Management

AA.1.1. From the time of the Department's approval of and throughout the term of the contract, the Project Manager will be responsible for the implementation and management of the project, for ensuring the performance of duties and obligations under the contract, the day to day oversight of the project and be available to

attend all project meetings at the request of the Department. The Project Manager shall be permanently located in the Contractor's Connecticut office and shall respond to requests by the Department for status updates and ad hoc and interim reports.

AA.2. Implementation Team

AA.2.1. The Implementation Team shall:

AA.2.1.1. Organize initial and subsequent planning meetings with the Department;

AA.2.1.2. Facilitate communications between the Contractor and the Department;

AA.2.1.3. Meet with providers;

AA.2.1.4. Participate in the initial account operations following the completion of the implementation until responsibilities have been transitioned to the Project Manager and staff;

AA.2.1.5. Oversee site selection, build-out, furnishing and equipping for operation of the Connecticut Service Center; and

AA.2.1.6. Remain primarily responsible for the conduct of the implementation until such time as the Department approves the Project Manager and the transition of the implementation team's responsibilities to the Project Manager and staff.

AA.3. Staffing Levels – Ongoing Operations

AA.3.1. By November 1, 2011 the Contractor shall provide the Department with an organizational chart for the Connecticut Service Center identifying the number and type of personnel in each department and personnel category. The Contractor shall provide the Department with an updated organizational chart each time changes are made to the number, type and/or category of personnel.

AA.3.2. The Contractor certifies that the Connecticut Service Center shall staff to conduct UM for services designated by the Department, notwithstanding subcontracted utilization management services as approved by the Department.

AA.3.3. For the first year of operations the Contractor's budget, approved by the Department, includes UM staffing necessary to comply with the terms of this Contract. The number of prior authorizations, concurrent reviews and associated level of staffing

shall be reviewed by the Contractor and the Department and, if necessary, adjusted in subsequent years in accordance with Section BB. 5.5 for changes to actual enrollment.

AA.3.4. The Contractor shall ensure that the Contractor's staff participating in the conduct of UM, including but not necessarily limited to Care Managers and Intensive Care Managers, on average meet the following minimum productivity and efficiency standards at the Connecticut Service Center:

AA.3.4.1. That clinical support staff shall perform a variety of non-clinical functions to increase the productivity of Care Managers and Intensive Care Managers;

AA.3.4.2. That the Contractor's MIS accepts and processes registrations via the Web portal and automatically, therefore staff time is not required;

AA.3.4.3. That authorization letters are generated automatically and therefore, limited staff time is required to perform this function;

AA.3.4.4. That prior authorizations for all levels of care will take approximately 20 minutes each and that on average an office-based Care Manager can conduct 18 prior authorizations in an average workday. An average work day assumes that 6 hours of each work day is allocated to telephonic reviews and the balance to clinical rounds, staff meetings, directing the work of clinical support staff and related administrative responsibilities;

AA.3.4.5. That Care Managers can, on average, conduct approximately 24 concurrent reviews per day, assuming an average duration of ten to fifteen minutes per call and an average of 6 hours per day in telephonic reviews; and

AA.3.4.6. That Intensive Care Managers will spend a significant amount of their time traveling and working in their assigned local areas, which will reduce the number of cases they manage.

AA.3.5. ICM clinicians will serve a defined caseload. At any given time the needs of the network or membership may dictate the necessity to change from a facility, systems focus to a member specific focus, or a combination of both. The department and the Contractor shall review and, if necessary adjust the number of Intensive Care Managers and/or the number of members served, however, such review and adjustment shall continue to require compliance with the following productivity assumptions:

AA.3.5.1. Total individuals served on an annual basis shall be no less than the number identified in the ICM Program Description as approved by the Department; and

AA.3.5.2. The Contractor certifies that the staffing for quality management shall be sufficient to ensure that the Quality Management Department can continuously meet the requirements established in the Quality Management section of the Contract.

AA.3.6. The Contractor certifies that the staffing levels for Management Information Systems (MIS) functions include at least two (2) full time programmers who will be dedicated to customizing the Contractor's MIS for designing and producing reports for this Contract.

AA.3.6.1. The Contractor certifies that the staffing levels for the Telephone Call Management Center functions shall be based on the following assumptions:

AA.3.6.1.1. That upon implementation, the Contractor shall be staffed to handle call volumes based on member numbers referenced adjusted in subsequent months and years for increases in actual enrollment;

AA.3.6.1.2. That the Contractor has provided for hiring and training temporary staff as necessary to meet the increased demand during the early weeks of the program;

AA.3.6.1.3. That Telephone Call Center staff shall not be responsible for responding to inquiries related to claims issues that are outside of the scope of their obligations under the Contract but shall transfer those calls to the Department's fiscal agent;

AA.3.6.1.4. That, based on average talk time, the Call Center service representatives can on average respond to a minimum of eight (8) calls per hour; and

AA.3.6.1.5. That the crisis line is set up as a separate call distribution queue with several layers of backup to ensure that there are no delays or abandoned calls.

AA.3.7. Staff and Infrastructure Location

AA.3.7.1. The Contractor agrees to locate and maintain its Connecticut Service Center including staff and infrastructure used to carry out

the program/operations/services authorized by this contract within a twenty (20) mile radius of the city of Hartford, Connecticut.

AA.3.8. Utilization of Minority Business Enterprises

AA.3.8.1. Pursuant to Section 4a-60g(b) of the Connecticut General Statutes, the Department is required to set-aside at least twenty-five percent (25%) of all contracts for small contractors and/or minority business enterprises. To assist the Department the Contractor agrees to use its best efforts consistent with Section 45 CFR 74.161 and Section 4a-60g of the Connecticut General Statutes to utilize a small Contractor and/or minority business enterprise as defined in Sections 4a-60(g)(1) and (3) of the Connecticut General Statutes as a supplier of goods and services or in the award of any subcontracts which may be permitted by this contract. The Contractor shall report the status of these efforts, including but not limited to the actual dollar value and payments to small contractors and/or minority business enterprises, in a form and frequency agreed to by the Department and the Contractor.

BB. BUDGET AND PAYMENT PROVISIONS

BB.1. Overview: This section sets forth the payment provisions and conditions for goods and services provided or performed pursuant to this contract.

BB.2. Contractor Reimbursement – Start Up

BB.2.1. Total maximum budget for start-up activities is set forth in Exhibit F. The start-up period is October 14, 2011 through the Contractor's successful completion of the post-implementation review as determined by the Department.

BB.2.2. Following the Contractor's successful loading of a complete eligibility file with Contractor-assigned local area field and the successful loading of an authorization test file with the Department's MMIS contractor and the successful completion of the first phase of the pre-implementation readiness review as determined by the Department, the Contractor shall submit an invoice for actual expenditures supported by a budget to actual report of start-up expenditures;

BB.2.3. Following the Contractor's successful completion of the second phase of the pre-implementation readiness review and the successful completion of the post-implementation review as

determined by the Department, the Contractor shall submit an invoice for actual expenditures supported by a budget to actual report of start-up expenditures.

BB.2.4. Payments to the Contractor shall be made by the Department within thirty (30) days of the date of the receipt of the invoice and budget to actual report for implementation activities.

BB.2.5. All invoices and payment of invoices for implementation activities completed by the Contractor and accepted by the Department shall be submitted and processed no later than December 31, 2012.

BB.3. Budget Provisions – Operating Years

BB.3.1. The maximum value of this contract for the performance of the administrative services required to meet the requirements of this contract on an annual basis for each of the five years of full contract operations are set forth in Exhibit F to this contract.

BB.3.2. The Contractor shall utilize the funds paid under this contract by the Department for the administrative services provided under this contract in accordance with the corresponding budgets set forth in Exhibit F.

BB.3.3. The Contractor certifies that "Total Salary and Fringe" and "Total Other Direct Costs" in Exhibit F represent expenses to be incurred by the Contractor solely for their performance under the terms of this Contract. Such "Total Salary and Fringe" expenses are limited to expenses incurred by full or part-time staff, whose time is 100% dedicated to the Contractor's performance under the terms of this Contract. "Total Other Direct Costs" are limited to those expenses incurred by the Contractor through the use of services, equipment and supplies purchased or contracted for by the Contractor solely for the operation of this Contract.

BB.3.4. The Contractor may transfer funds from "Total Salary and Fringe" to "Total Other Direct Costs" or from "Total Other Direct Costs" to "Total Salary and Fringe" without prior notification to or approval of the Department so long as such transfer(s) do not result in a re-allocation in the annual budget between "Total Salary and Fringe" and "Total Other Direct Costs" of greater than $500,000. Such limit shall be reviewed on an annual basis and based on that review may be revised to either increase or decrease the budget flexibility.

BB.3.5. The Contractor must submit and the Department must approve, in advance, a written request for a budget revision if the transfer will result in a re-allocation in the annual budget between "Total Salary and Fringe" and "Total Other Direct Costs" of greater than $500,000.

BB.3.6. The Department shall respond to a written request for a budget revision within a reasonable time frame not to exceed thirty (30) calendar days after the receipt of the request.

BB.4. Payment Provisions – Operating Years

BB.4.1. The Contractor shall be paid prospectively on a monthly basis for monthly operating expenses. Monthly payments shall equal $1/12^{th}$ of the approved budget in Exhibit F for the contract year less the 7.5% profit withhold. Requests for payments shall be submitted on a **DSS W-1270 Form** to the DSS Contract Manager on or after the first of the month prior to the month billed. Such payment shall be processed by the Department and paid on or after the 15th day of the month prior to the month billed, but not later than the first of the month billed. Each Request for Payment must be signed and dated by the Contractor and submitted to the Contract Manager for review and approval.

BB.4.2. Request for payment will be honored and funds released based on submission of the Request for Payment by the Contractor, with review and acceptance by the Department and the Contractor's satisfactory compliance with the terms of the contract. If the Contractor complies with the request for payment process and the Department fails to make payments in a timely manner for two consecutive months, the Contractor may demand and the Department shall revert to prospective payments on a quarterly basis.

BB.4.3. The Contractor shall be paid the profit withhold, in whole or in part, after the end of each contract year contingent upon the Contractor's success in meeting established Performance Targets as set forth in Exhibit A and in accordance with the requirements set forth in section Y.5.6.

BB.4.4. The profit withhold eligible to be earned by the Contractor through its success in meeting established Performance Targets as set forth in Exhibit A shall equal 7.5% of the approved budget in Exhibit F for each contract year. If, however, the actual expenditures for the contract year are less than the approved budget for the contract year such that the calculated withhold exceeds 9% of actual

expenditures, then the withhold, eligible to be paid to the Contractor, shall be held at 9% of actual expenditures.

BB.5. Financial Reporting and Reconciliation Provisions

BB.5.1. As set forth in Exhibit E – Reporting Matrix, the Contractor shall submit to the Department a budget to actual report within 45 days of the close of each calendar quarter. The budget to actual report shall show actual expenditures for each line item in the budget set forth in Exhibit F. The budget to actual reports shall be directed to the Department's Contract Manager and the Department's Director of the Division of Financial Management and Analysis.

BB.5.2. When the Department's review of any financial report submitted pursuant to Exhibit E, including the budget to actual report listed in B.5.1, quarterly or final reconciliation or on-site examination of the Contractor's financial records indicate that under expenditure or under utilization of contract funds has or is likely to occur by the end of each contract year, the Department may, with advance notice to and in consultation with the Contractor, reduce the next prospective payment due to the Contractor; or demand the return to the Department, in whole or in part, any unexpended funds, or; alter the payment schedule for the balance of the contract period, or; direct the Contractor to reinvest the under expended funds in the program so long as the reinvestment tasks are within the agreed to scope of work, or; authorize that the unexpended funds be carried over and used as part of a new contract period if a new similar contract is executed.

BB.5.3. The Contractor shall submit for the Department's review a final reconciliation of all payments received by the Contractor, including payments for implementation activities, against actual expenditures as reported in the audited financial statements for each contract year, no later than May 31 of the year following the contract year. The Department and the Contractor may agree to alternate or additional procedures. The Department shall require the return of any disallowed expenditures and may require the Contractor to return unexpended funds to the Department or reinvest any unexpended funds into the scope of work in the Contract.

BB.5.4. Beginning with the second operating year, the 7.5% profit performance target will be reallocated such that 3.75% shall be awarded based on the Contractor's ability to meet PMPM claims targets for the HUSKY A/B, HUSKY C, and HUSKY D populations. In addition, the Contractor agrees to enter into good faith discussions with the Department for additional and/or alternative performance

standards related to meeting established PMPM claims targets. As an example, the Department has suggested placing a percentage of the Contractor's operating budget at risk for meeting PMPM claims targets. If the discussions result in a mutual agreement the amount at risk and the methodology for calculating these targets will be set forth in writing by the Contractor and DSS for the year in which they would be effective.

BB.5.5. The Contractor and/or the Department may re-open the contract to negotiate agreed upon terms if, for a period of three (3) consecutive months during any of the full contract implementation years, the enrollment levels are less than the minimum stated or greater than the maximum stated enrollment levels in the enrollment corridor summary set forth in Exhibit F. Such negotiations shall be based upon an approved methodology that takes into account fixed versus variable costs and does not consider costs not affected by enrollment levels, such as PCMH development activities. The Department may also re-open the contract to negotiate Exhibit F at any point during the contract period based on changes in anticipated costs and deliverables, as well as adjustments to the number of FTEs or other productivity or efficiency standards or analyses conducted that indicate a need for increased operational efficiency during the contract period. Any such adjustments shall not be applied retroactively.

BB.6. Optional Tasks/Change Orders

BB.6.1. The Department may request minor modifications to the Contractor's scope of work within this Contract. If the requested changes pertain to an existing task but the specific changes are outside of the scope of work for the specific task, the Contractor shall submit to the Department a Change Order request documenting the scope of the change, the staffing levels and/or direct charges required to address the change, the cost to the Department and the impact of the cost on the approved budget. The Contractor shall not be authorized to work on any Change Order unless and until the Department provides the Contractor with their written approval. Significant Change Order work may require authorization from the State of Connecticut Office of Policy and Management in order to amend the contract to allocate additional funds to this project.

BB.6.2. If the requested changes do not pertain to an existing task and are therefore outside the Scope of Work in this contract the Department shall issue a request to the Contractor identifying the

scope of the optional task to be performed. Within ten (10) business days of the Contractor's receipt of the task request or such other date as agreed to by the Department, the Contractor shall provide the Department with a work plan including start and end dates, staffing plan, total cost for the task and payment schedule. The Department will review the materials and approve, reject or revise the task request. The Contractor shall not be authorized to work on any optional tasks unless and until the Department provides the Contractor with an approved task order. Significant task requests may require authorization from the State of Connecticut Office of Policy and Management in order to amend the contract to allocate additional funds to this project.

BB.7. Capital Purchases

BB.7.1. The Contractor shall be responsible for all capital expenditures within the approved amount for "Total Other Direct Costs". If, during the term of the contract, the Department or the Contractor identifies a need to purchase additional capital equipment to address special requirements outside of the scope of work imposed by the Department, the Contractor shall provide the Department with a written request for the purchase. The request shall identify the equipment to be purchased with a written justification for the purchase, the per unit cost and maximum total cost. The Department shall within thirty (30) calendar days of the receipt of the request, deny or approve the request up to the total maximum cost. If approved by the Department the Contractor shall be reimbursed for the actual cost, not to exceed the maximum total cost set forth in the Department's approval, incurred through the purchase of the requested equipment.

BB.8. Withholding of Payment

BB.8.1. The Department and the Contractor acknowledge that there will be certain administrative requirements throughout this contract, for which there are no penalties assessed in this Contract with respect to Contractor's failure to perform or provide in the manner and within the timeframe agreed to by the Department and Contractor. With respect to such requirements, the Department shall have the discretion to withhold payment in the event Contractor fails to perform or provide the administrative requirements as agreed to with the Department. The withholding of payment shall be subject to the requirements set forth in subsection B.8.2, below.

BB.8.2. If the Department determines that Contractor is not performing or providing or has not performed or provided the

administrative requirements set forth herein in the manner agreed to by the Department and Contractor, the Department shall notify Contractor of that fact in writing. Such written notice shall include a description of the deficiency and any suggestions or recommendations the Department may have for addressing the deficiency. The Contractor shall have ten (10) calendar days, or such other time as the parties may agree in writing, from the date it receives such notice to correct the deficiency or agree with the Department upon a plan for correcting such deficiency. If the Contractor fails to correct the deficiency or agree with the Department upon a plan for correcting the deficiency within the ten (10) calendar day time period, or such other time period as the parties have agreed, then the Department may withhold payment to the Contractor. The Department may withhold up to 10 percent of the monthly payment as set forth in Exhibit F of this contract owed to the Contractor for each month during which the Department determine that the deficiency has not been cured as agreed upon by the parties. No withhold of payment shall be imposed upon the Contractor pursuant to this Section if the alleged deficiency is being disputed by Contractor pursuant to Part II, Section C.13 of this Contract. The Departments shall release the withheld payment to the Contractor immediately upon the Department's determination that the deficiency has been corrected as agreed or the Contractor has prevailed in its dispute of the alleged deficiency.

PART II. TERMS AND CONDITIONS

The Contractor shall comply with the following terms and conditions.

A. Definitions. Unless otherwise indicated, the following terms shall have the following corresponding definitions:

1. **"Bid"** shall mean a bid submitted in response to a solicitation.

2. **"Breach"** shall mean a party's failure to perform some contracted-for or agreed-upon act, or his failure to comply with a duty imposed by law which is owed to another or to society.

3. **"Cancellation"** shall mean an end to the Contract affected pursuant to a right which the Contract creates due to a Breach.

4. **"Claims"** shall mean all actions, suits, claims, demands, investigations and proceedings of any kind, open, pending or threatened, whether mature, unmatured, contingent, known or unknown, at law or in equity, in any forum.

5. **"Client"** shall mean a recipient of the Contractor's Services.

6. **"Contract"** shall mean this agreement, as of its effective date, between the Contractor and the State for Services.

7. **"Contractor Parties"** shall mean a Contractor's members, directors, officers, shareholders, partners, managers, principal officers, representatives, agents, servants, consultants, employees or any one of them or any other person or entity with whom the Contractor is in privity of oral or written contract (e.g. subcontractor) and the Contractor intends for such other person or entity to perform under the Contract in any capacity. For the purpose of this Contract, vendors of support services, not otherwise known as human service providers or educators, shall not be considered subcontractors, e.g. lawn care, unless such activity is considered part of a training, vocational or educational program.

8. **"Data"** shall mean all results, technical information and materials developed and/or obtained in the performance of the Services hereunder, including but not limited to all reports, survey and evaluation tools, surveys and evaluations, plans, charts, recordings (video and/or sound), pictures, curricula, electronically prepared presentations, public awareness or prevention campaign materials, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents, whether finished or unfinished, which result from or are prepared in connection with the Services performed hereunder.

9. **"Day"** shall mean all calendar days, other than Saturdays, Sundays and days designated as national or State of Connecticut holidays upon which banks in Connecticut are closed.

10. **"Expiration"** shall mean an end to the Contract due to the completion in full of the mutual performances of the parties or due to the Contract's term being completed.

11. **"Force Majeure"** shall mean events that materially affect the Services or the time schedule within which to perform and are outside the control of the party asserting that such an event has occurred, including, but not limited to, labor troubles unrelated to the Contractor, failure of or inadequate permanent power, unavoidable casualties, fire not caused by the Contractor, extraordinary weather conditions, disasters, riots, acts of God, insurrection or war.

12. **"Personal Information"** shall mean any name, number or other information that may be used, alone or in conjunction with any other information, to identify a specific individual including, but not limited to, such individual's name, date of birth, mother's maiden name, motor vehicle operator's license number, Social Security number, employee identification number, employer or taxpayer identification number, alien registration number, government passport number, health insurance identification number, demand deposit account number, savings account number, credit card number, debit card number or unique biometric data such as fingerprint, voice print, retina or iris image, or other unique physical representation. Without limiting the foregoing, Personal Information shall also include any information regarding clients that the Department classifies as "confidential" or "restricted." Personal Information shall not include information that may be lawfully obtained from publicly available sources or from federal, state, or local government records which are lawfully made available to the general public.

13. **"Personal Information Breach"** shall mean an instance where an unauthorized person or entity accesses Personal Information in any manner, including but not limited to the following occurrences: (1) any Personal Information that is not encrypted or protected is misplaced, lost, stolen or in any way compromised; (2) one or more third parties have had access to or taken control or possession of any Personal Information that is not encrypted or protected without prior written authorization from the State; (3) the unauthorized acquisition of encrypted or protected Personal Information together with the confidential process or key that is capable of compromising the integrity of the Personal Information; or (4) if there is a substantial risk of identity theft or fraud to the client, the Contractor, the Department or State.

14. **"Records"** shall mean all working papers and such other information and materials as may have been accumulated and/or produced by the Contractor in performing the Contract, including but not limited to, documents, data, plans, books, computations, drawings, specifications, notes, reports, records, estimates, summaries and correspondence, kept or stored in any form.

15. **"Services"** shall mean the performance of Services as stated in Part I of this Contract.

16. **"State"** shall mean the State of Connecticut, including any agency, office, department, board, council, commission, institution or other executive branch agency of State Government.

17. **"Termination"** shall mean an end to the Contract affected pursuant to a right which the Contract creates, other than for a Breach.

B. Client-Related Safeguards.

1. Inspection of Work Performed.

(a) The Agency or its authorized representative shall at all times have the right to enter into the Contractor or Contractor Parties' premises, or such other places where duties under the Contract are being performed, to inspect, to monitor or to evaluate the work being performed in accordance with Conn. Gen. Stat. § 4e-29 to ensure compliance with this Contract. The Contractor and all subcontractors must provide all reasonable facilities and assistance to Agency representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. The Contractor shall disclose information on clients, applicants and their families as requested unless otherwise prohibited by federal or state law. Written evaluations pursuant to this Section shall be made available to the Contractor.

(b) The Contractor must incorporate this section verbatim into any Contract it enters into with any subcontractor providing services under this Contract.

2. **Safeguarding Client Information.** The Agency and the Contractor shall safeguard the use, publication and disclosure of information on all applicants for and all Clients who receive Services under this Contract

with all applicable federal and state law concerning confidentiality and as may be further provided under the Contract.

3. **Reporting of Client Abuse or Neglect.** The Contractor shall comply with all reporting requirements relative to Client abuse and neglect, including but not limited to requirements as specified in C.G.S.§§ 17a-101 through 103, 19a-216, 46b-120 (related to children); C.G.S.§ 46a-11b (relative to persons with mental retardation); and C.G.S.§ 17b-407 (relative to elderly persons).

4. **Background Checks.** The State may require that the Contractor and Contractor Parties undergo criminal background checks as provided for in the State of Connecticut Department of Public Safety Administration and Operations Manual or such other State document as governs procedures for background checks. The Contractor and Contractor Parties shall cooperate fully as necessary or reasonably requested with the State and its agents in connection with such background checks.

C. Contractor Obligations

1. Fraud and Abuse

a) The Contractor shall not knowingly take any action or fail to take action that could result in an unauthorized Benefit to the Contractor, its employees, or its subcontractors or to a member.

b) The Contractor commits to preventing, detecting, investigating, and reporting potential fraud and abuse occurrences, and shall assist the Department and the Department of Health and Human Services (HHS) in preventing and prosecuting fraud and abuse in the Connecticut Medical Assistance Programs.

c) The Contractor acknowledges that the HHS, Office of the Inspector General has the authority to impose civil monetary penalties on individuals and entities that submit false and fraudulent claims to DSS.

d) The Contractor shall within five (5) business days immediately notify the Department when it detects a situation of suspected fraud or abuse, including, but not limited to, the following:

1. False statements, misrepresentation, concealment, failure to disclose, and conversion of benefits;
2. Any giving or seeking of kickbacks, rebates, or similar remuneration;
3. Charging or receiving reimbursement in excess of that provided by the Department; and
4. False statements or misrepresentation made by a provider, subcontractor, or Member in order to qualify for a Connecticut Medical Assistance Program.

e) Upon receipt of written notification from the Department, the Contractor shall cease any conduct that the Department deems to be abusive of the HUSKY or Charter Oak programs, and to take any corrective actions requested by the Department.

f)The Contractor attests to the truthfulness, accuracy, and completeness of all data submitted to the Department, based on the Department's best knowledge, information, and belief. This data certification requirement applies to the Contractor's subcontractors, if applicable.

g) The Contractor shall comply with all applicable provisions of Medicaid fraud and abuse regulations, including, but not limited to 42 CFR 455.100 through 106, inclusive.

h) The Contractor shall have administrative and management procedures and a mandatory compliance plan to guard against fraud and abuse. The Contractor's compliance plan shall include but not necessarily be limited to, the following efforts:

1. Designating a compliance officer and a compliance committee, responsible to senior management;
2. Establishing written policies, procedures and standards that demonstrate compliance with all applicable federal and state fraud and abuse requirements. These include but are not limited to the following:
   i) Regs., Conn. State Agencies § 17b-262-770 through 773, which relate to federal and state requirements regarding false claims and whistleblower protections and the Connecticut False Claims Act, Conn. Gen. Stat. Section 17b-301a to 17b-301p, inclusive (2001 Supp.); and
   ii) Sections 1128, 1156, and 1902(a)(68) of the federal Social Security Act.
3. Establishing effective lines of communication between the compliance officer and Contractor's employees and subcontractors;
4. Conducting regular reviews and audits of operations to guard against fraud and abuse;
5. Effectively training and educating employees and subcontractors about fraud and abuse and how to report it;
6. Effectively organizing resources to respond to allegations of fraud and abuse;
7. Establishing procedures to process allegations of fraud and abuse; and
8. Establishing procedures for prompt responses to potential offenses and reporting information to the Department.

i) On a monthly basis, the Contractor shall examine publicly available data, including but not limited to the OIG's List of Excluded Individuals/Entities (LEIE) database to determine whether any potential or current employees or subcontractor have been suspended or excluded or terminated from the Medicare, Medicaid, or other federal health care program. For reference, the LEIE database is available online at http://www.oig.hhs.gov. The Contractor shall comply with, and give effect to, any such suspension, exclusion, or termination in accordance with the requirements of state and federal law. The Contractor shall further comply with the provisions of State Medicaid Director Letter #09-001, issued by CMS on January 16, 2009.

j) The Contractor shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest, five percent (5%) or more, in the organization, or any subcontractor in which the Contractor has a five percent (5%) or more ownership interest.

k) The Contractor shall immediately provide full and complete information when it becomes aware of any employee or subcontractor who has been convicted of a civil or criminal offense related to that person's involvement under Medicare, Medicaid, or any other federal or state assistance program prior to entering into or renewing this contract.

l) The Contractor shall not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations or from participating in non-procurement activities under regulations or guidelines implementing Executive Order 12549.

2. **Credits and Rights in Data.** Unless expressly waived in writing by the Agency, all Records and publications intended for public distribution during or resulting from the performances of this Contract shall include a statement acknowledging the financial support of the State and the Agency and, where applicable, the federal government. All such publications shall be released in conformance with applicable federal and state law and all regulations regarding confidentiality. Any liability arising from such a release by the Contractor shall be the

sole responsibility of the Contractor and the Contractor shall indemnify and hold harmless the Agency, unless the Agency or its agents co-authored said publication and said release is done with the prior written approval of the Agency Head. All publications shall contain the following statement: "This publication does not express the views of the [insert Agency name] or the State of Connecticut. The views and opinions expressed are those of the authors." Neither the Contractor nor any of its agents shall copyright Data and information obtained under this Contract, unless expressly previously authorized in writing by the Agency. The Agency shall have the right to publish, duplicate, use and disclose all such Data in any manner, and may authorize others to do so. The Agency may copyright any Data without prior Notice to the Contractor. The Contractor does not assume any responsibility for the use, publication or disclosure solely by the Agency of such Data.

3. **Organizational Information, Conflict of Interest, IRS Form 990.** During the term of this Contract and for the one hundred eighty (180) days following its date of Termination and/or Cancellation, the Contractor shall upon the Agency's request provide copies of the following documents within ten (10) Days after receipt of the request:

   (a) its most recent IRS Form 990 submitted to the Internal Revenue Service, and

   (b) its most recent Annual Report filed with the Connecticut Secretary of the State's Office or such other information that the Agency deems appropriate with respect to the organization and affiliation of the Contractor and related entities.

   This provision shall continue to be binding upon the Contractor for one hundred and eighty (180) Days following the termination or cancellation of the Contract.

4. **Federal Funds.**

   (a) The Contractor shall comply with requirements relating to the receipt or use of federal funds. The Agency shall specify all such requirements in Part I of this Contract.

   (b) The Contractor acknowledges that the Agency has established a policy, as mandated by section 6032 of the Deficit Reduction Act (DRA) of 2005, P.L. 109-171, that provides detailed information about the Federal False Claims Act, 31 U.S.C. §§ 3729-3733, and other laws supporting the detection and prevention of fraud and abuse.

      (1) Contractor acknowledges that it has received a copy of said policy and shall comply with its terms, as amended, and with all applicable state and federal laws, regulations and rules. Contractor shall provide said policy to subcontractors and shall require compliance with the terms of the policy. Failure to abide by the terms of the policy, as determined by the Agency, shall constitute a Breach of this Contract and may result in cancellation or termination of this Contract.

      (2) This section applies if, under this Contract, the Contractor or Contractor Parties furnishes, or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the Agency.

   (c) Contractor represents that it is not excluded, debarred, suspended or otherwise ineligible to participate in federal health care programs.

   (d) Contractor shall not, for purposes of performing the Contract with the Agency, knowingly employ or contract with, with or without compensation: (A) any individual or entity listed by a federal agency as excluded, debarred, suspended or otherwise ineligible to participate in federal health care programs; or (B) any person or entity who is excluded from contracting with the State of Connecticut or the federal government (as reflected in the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, Department of Health and Human

Services, Office of Inspector General (HHS/OIG) Excluded Parties list and the Office of Foreign Assets Control (OFAC) list of Specially Designated Nationals and Blocked Persons List). Contractor shall immediately notify the Agency should it become subject to an investigation or inquiry involving items or services reimbursable under a federal health care program or be listed as ineligible for participation in or to perform Services in connection with such program. The Agency may cancel or terminate this Contract immediately if at any point the Contractor, subcontractor or any of their employees are sanctioned, suspended, excluded from or otherwise become ineligible to participate in federal health care programs.

5. **Audit Requirements.**

(a) The State Auditors of Public Accounts shall have access to all Records for the fiscal year(s) in which the award was made. The Contractor shall provide for an annual financial audit acceptable to the Agency for any expenditure of state-awarded funds made by the Contractor. Such audit shall include management letters and audit recommendations. The Contractor shall comply with federal and state single audit standards as applicable.

(b) The Contractor shall make all of its and the Contractor Parties' Records available at all reasonable hours for audit and inspection by the State, including, but not limited to, the Agency, the Connecticut Auditors of Public Accounts, Attorney General and State's Attorney and their respective agents. Requests for any audit or inspection shall be in writing, at least ten (10) days prior to the requested date. All audits and inspections shall be at the requester's expense. The State may request an audit or inspection at any time during the Contract term and for three (3) years after Termination, Cancellation or Expiration of the Contract. The Contractor shall cooperate fully with the State and its agents in connection with an audit or inspection. Following any audit or inspection, the State may conduct and the Contractor shall cooperate with an exit conference.

(c) For purposes of this subsection as it relates to State grants, the word "Contractor" shall be read to mean "nonstate entity," as that term is defined in C.G.S. § 4-230.

(d) The Contractor must incorporate this section verbatim into any Contract it enters into with any subcontractor providing services under this Contract.

6. **Related Party Transactions.** The Contractor shall report all related party transactions, as defined in this section, to the Agency on an annual basis in the appropriate fiscal report as specified in Part I of this Contract. "Related party" means a person or organization related through marriage, ability to control, ownership, family or business association. Past exercise of influence or control need not be shown, only the potential or ability to directly or indirectly exercise influence or control. "Related party transactions" between a Contractor or Contractor Party and a related party include, but are not limited to:

(a) Real estate sales or leases;

(b) leases for equipment, vehicles or household furnishings;

(c) Mortgages, loans and working capital loans; and

(d) Contracts for management, consultant and professional services as well as for materials, supplies and other services purchased by the Contractor or Contractor Party.

7. **Suspension or Debarment.** In addition to the representations and requirements set forth in Section D.4:

(a) The Contractor certifies for itself and Contractor Parties involved in the administration of federal or state funds that they:

(1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any governmental agency (federal, state or local);

(2) within a three year period preceding the effective date of this Contract, have not been convicted or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract under a public transaction; for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the above offenses; and

(4) Have not within a three year period preceding the effective date of this Contract had one or more public transactions terminated for cause or fault.

(b) Any change in the above status shall be immediately reported to the Agency.

8. **Liaison.** Each Party shall designate a liaison to facilitate a cooperative working relationship between the Contractor and the Agency in the performance and administration of this Contract.

9. **Subcontracts.** Each Contractor Party's identity, services to be rendered and costs shall be detailed in Part I of this Contract. Absent compliance with this requirement, no Contractor Party may be used or expense paid under this Contract unless expressly otherwise provided in Part I of this Contract. No Contractor Party shall acquire any direct right of payment from the Agency by virtue of this section or any other section of this Contract. The use of Contractor Parties shall not relieve the Contractor of any responsibility or liability under this Contract. The Contractor shall make available copies of all subcontracts to the Agency upon request.

10. **Independent Capacity of Contractor.** The Contractor and Contractor Parties shall act in an independent capacity and not as officers or employees of the state of Connecticut or of the Agency.

11. **Indemnification.**

(a) The Contractor shall indemnify, defend and hold harmless the state of Connecticut and its officers, representatives, agents, servants, employees, successors and assigns from and against any and all:

(1) claims arising directly or indirectly, in connection with the Contract, including the acts of commission or omission (collectively the "Acts") of the Contractor or Contractor Parties; and

(2) liabilities, damages, losses, costs and expenses, including but not limited to attorneys' and other professionals' fees, arising, directly or indirectly, in connection with Claims, Acts or the Contract. The Contractor shall use counsel reasonably acceptable to the State in carrying out its indemnification and hold-harmless obligations under this Contract. The Contractor's obligations under this section to indemnify, defend and hold harmless against Claims includes Claims concerning confidentiality of any part of or all of the bid or any records, and intellectual property rights, other propriety rights of any person or entity, copyrighted or uncopyrighted compositions, secret processes, patented or unpatented inventions, articles or appliances furnished or used in the performance of the Contract.

(b) The Contractor shall reimburse the State for any and all damages to the real or personal property of the State caused by the Acts of the Contractor or any Contractor Parties. The State shall give the Contractor reasonable notice of any such Claims.

(c) The Contractor's duties under this Section shall remain fully in effect and binding in accordance with the terms and conditions of the Contract, without being lessened or compromised in any way, even where the Contractor is alleged or is found to have merely contributed in part to the Acts giving rise to the Claims and/or where the State is alleged or is found to have contributed to the Acts giving rise to the Claims.

(d) The Contractor shall carry and maintain at all times during the term of the Contract, and during the time that any sections survive the term of the Contract, sufficient general liability insurance to satisfy its obligations under this Contract. The Contractor shall name the State as an additional insured on the policy and shall provide a copy of the policy to the Agency prior to the effective date of the Contract. The Contractor shall not begin performance until the delivery of the policy to the Agency.

(e) The rights provided in this section for the benefit of the State shall encompass the recovery of attorneys' and other professionals' fees expended in pursuing a Claim against a third party.

(f) This section shall survive the Termination, Cancellation or Expiration of the Contract, and shall not be limited by reason of any insurance coverage.

12. **Insurance.** Before commencing performance, the Agency may require the Contractor to obtain and maintain specified insurance coverage. In the absence of specific Agency requirements, the Contractor shall obtain and maintain the following insurance coverage at its own cost and expense for the duration of the Contract:

(a) Commercial General Liability. $1,000,000 combined single limit per occurrence for bodily injury, personal injury and property damage. Coverage shall include Premises and Operations, Independent Contractors, Products and Completed Operations, Contractual Liability, and Broad Form Property Damage coverage. If a general aggregate is used, the general aggregate limit shall apply separately to the services to be performed under this Contract or the general aggregate limit shall be twice the occurrence limit;

(b) Automobile Liability. $1,000,000 combined single limit per accident for bodily injury. Coverage extends to owned, hired and non-owned automobiles. If the vendor/contractor does not own an automobile, but one is used in the execution of this Contract, then only hired and non-owned coverage is required. If a vehicle is not used in the execution of this Contract then automobile coverage is not required.

(c) Professional Liability. $1,000,000 limit of liability, if applicable; and/or

(d) Workers' Compensation and Employers Liability. Statutory coverage in compliance with the Compensation laws of the State of Connecticut. Coverage shall include Employer's Liability with minimum limits of $100,000 each accident, $500,000 Disease – Policy limit, $100,000 each employee.

13. **Choice of Law/Choice of Forum, Settlement of Disputes, Claims Against the State.**

(a) The Contract shall be deemed to have been made in the City of Hartford, State of Connecticut. Both Parties agree that it is fair and reasonable for the validity and construction of the Contract to be, and it shall be, governed by the laws and court decisions of the State of Connecticut, without giving effect to its principles of conflicts of laws. To the extent that any immunities provided by federal law or the laws of the State of Connecticut do not bar an action against the State, and to the extent that these courts are courts of competent jurisdiction, for the purpose of venue, the complaint shall be made returnable to the Judicial District of Hartford only or shall be brought in the United States District Court for the District of Connecticut only, and shall not be transferred to any other court,

provided, however, that nothing here constitutes a waiver or compromise of the sovereign immunity of the State of Connecticut. The Contractor waives any objection which it may now have or will have to the laying of venue of any Claims in any forum and further irrevocably submits to such jurisdiction in any suit, action or proceeding.

(b) Any dispute concerning the interpretation or application of this Contract shall be decided by the Agency Head or his/her designee whose decision shall be final, subject to any rights the Contractor may have pursuant to state law. In appealing a dispute to the Agency Head pursuant to this section, the Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its appeal. Pending final resolution of a dispute, the Contractor and the Agency shall proceed diligently with the performance of the Contract.

(c) The Contractor agrees that the sole and exclusive means for the presentation of any claim against the State arising from this Contract shall be in accordance with Title 4, Chapter 53 of the Connecticut General Statutes (Claims Against the State) and the Contractor further agrees not to initiate legal proceedings, except as authorized by that Chapter, in any state or federal court in addition to or in lieu of said Chapter 53 proceedings.

14. **Compliance with Law and Policy, Facility Standards and Licensing.** Contractor shall comply with all:

(a) pertinent local, state and federal laws and regulations as well as Agency policies and procedures applicable to contractor's programs as specified in this Contract. The Agency shall notify the Contractor of any applicable new or revised laws, regulations, policies or procedures which the Agency has responsibility to promulgate or enforce; and

(b) applicable local, state and federal licensing, zoning, building, health, fire and safety regulations or ordinances, as well as standards and criteria of pertinent state and federal authorities. Unless otherwise provided by law, the Contractor is not relieved of compliance while formally contesting the authority to require such standards, regulations, statutes, ordinance or criteria.

15. **Representations and Warranties.** Contractor shall:

(a) perform fully under the Contract;

(b) pay for and/or secure all permits, licenses and fees and give all required or appropriate notices with respect to the provision of Services as described in Part I of this Contract; and

(c) adhere to all contractual sections ensuring the confidentiality of all Records that the Contractor has access to and are exempt from disclosure under the State's Freedom of Information Act or other applicable law.

16. **Reports.** The Contractor shall provide the Agency with such statistical, financial and programmatic information necessary to monitor and evaluate compliance with the Contract. All requests for such information shall comply with all applicable state and federal confidentiality laws. The Contractor shall provide the Agency with such reports as the Agency requests as required by this Contract.

17. **Delinquent Reports.** The Contractor shall submit required reports by the designated due dates as identified in this Contract. After notice to the Contractor and an opportunity for a meeting with an Agency representative, the Agency reserves the right to withhold payments for services performed under this Contract if the Agency has not received acceptable progress reports, expenditure reports, refunds, and/or audits as required by this Contract or previous contracts for similar or equivalent services the Contractor has

entered into with the Agency. This section shall survive any Termination of the Contract or the Expiration of its term.

18. **Record Keeping and Access.** The Contractor shall maintain books, Records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of this Contract. These Records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the State or, where applicable, federal agencies. The Contractor shall retain all such Records concerning this Contract for a period of three (3) years after the completion and submission to the State of the Contractor's annual financial audit.

19. **Protection of Personal Information.**

(a) Contractor and Contractor Parties, at their own expense, have a duty to and shall protect from a Personal Information Breach any and all Personal Information which they come to possess or control, wherever and however stored or maintained, in a commercially reasonable manner in accordance with current industry standards.
http://www.ct.gov/doit/cwp/view.asp?a=1245&q=253968http://www.ct.gov/doit/cwp/view.asp?a=1245&q=253968

(b) Each Contractor or Contractor Party shall implement and maintain a comprehensive data security program for the protection of Personal Information. The safeguards contained in such program shall be consistent with and comply with the safeguards for protection of Personal Information, and information of a similar character, as set forth in all applicable federal and state law and written policy of the Department or State concerning the confidentiality of Personal Information. Such data-security program shall include, but not be limited to, the following:

(1) A security policy for employees related to the storage, access and transportation of data containing Personal Information;
(2) Reasonable restrictions on access to records containing Personal Information, including access to any locked storage where such records are kept;
(3) A process for reviewing policies and security measures at least annually;
(4) Creating secure access controls to Personal Information, including but not limited to passwords; and
(5) Encrypting of Personal Information that is stored on laptops, portable devices or being transmitted electronically.

(c) The Contractor and Contractor Parties shall notify the Department and the Connecticut Office of the Attorney General as soon as practical, but no later than twenty-four (24) hours, after they become aware of or suspect that any Personal Information which Contractor or Contractor Parties possess or control has been subject to a Personal Information Breach. If a Personal Information Breach has occurred, the Contractor shall, within three (3) business days after the notification, present a credit monitoring and protection plan to the Commissioner of Administrative Services, the Department and the Connecticut Office of the Attorney General, for review and approval. Such credit monitoring or protection plan shall be made available by the Contractor at its own cost and expense to all individuals affected by the Personal Information Breach. Such credit monitoring or protection plan shall include, but is not limited to reimbursement for the cost of placing and lifting one (1) security freeze per credit file pursuant to Connecticut General Statutes § 36a-701a. Such credit monitoring or protection plans shall be approved by the State in accordance with this Section and shall cover a length of time commensurate with the circumstances of the Personal Information Breach. The Contractors' costs and expenses for the credit monitoring and protection plan shall not be recoverable from the Department, any State of Connecticut entity or any affected individuals.

(d) The Contractor shall incorporate the requirements of this Section in all subcontracts requiring each Contractor Party to safeguard Personal Information in the same manner as provided for in this Section.

(e) Nothing in this Section shall supersede in any manner Contractor's or Contractor Party's obligations pursuant to HIPAA or the provisions of this Contract concerning the obligations of the Contractor as a Business Associate of the Department.

20. **Workforce Analysis.** The Contractor shall provide a workforce Analysis Affirmative Action report related to employment practices and procedures.

21. **Litigation.**

(a) The Contractor shall require that all Contractor Parties, as appropriate, disclose to the Contractor, to the best of their knowledge, any Claims involving the Contractor Parties that might reasonably be expected to materially adversely affect their businesses, operations, assets, properties, financial stability, business prospects or ability to perform fully under the Contract, no later than ten (10) days after becoming aware or after they should have become aware of any such Claims. Disclosure shall be in writing.

(b) The Contractor shall provide written Notice to the Agency of any final decision by any tribunal or state or federal agency or court which is adverse to the Contractor or which results in a settlement, compromise or claim or agreement of any kind for any action or proceeding brought against the Contractor or its employee or agent under the Americans with Disabilities Act of 1990 as revised or amended from time to time, Executive Orders Nos. 3 & 17 of Governor Thomas J. Meskill and any other requirements of federal or state law concerning equal employment opportunities or nondiscriminatory practices.

22. **Sovereign Immunity.** The Contractor and Contractor Parties acknowledge and agree that nothing in the Contract, or the solicitation leading up to the Contract, shall be construed as a modification, compromise or waiver by the State of any rights or defenses of any immunities provided by Federal law or the laws of the State of Connecticut to the State or any of its officers and employees, which they may have had, now have or will have with respect to all matters arising out of the Contract. To the extent that this Section conflicts with any other Section, this Section shall govern.

D. Changes to the Contract, Termination, Cancellation and Expiration.

1. **Contract Amendment.**

(a) No amendment to or modification or other alteration of this Contract shall be valid or binding upon the parties unless made in writing, signed by the parties and, if applicable, approved by the OAG.

(b) The Agency may amend this Contract to reduce the contracted amount of compensation if:

(1) the total amount budgeted by the State for the operation of the Agency or Services provided under the program is reduced or made unavailable in any way; or

(2) federal funding reduction results in reallocation of funds within the Agency.

(c) If the Agency decides to reduce the compensation, the Agency shall send written Notice to the Contractor. Within twenty (20) Days of the Contractor's receipt of the Notice, the Contractor and the Agency shall negotiate the implementation of the reduction of compensation unless the parties mutually agree that such negotiations would be futile. If the parties fail to negotiate an implementation schedule, then the Agency may terminate the Contract effective no earlier than sixty (60) Days from the date that

the Contractor receives written notification of Termination and the date that work under this Contract shall cease.

2. **Contractor Changes and Assignment.**

(a) The Contractor shall notify the Agency in writing:

(1) at least ninety (90) days prior to the effective date of any fundamental changes in the Contractor's corporate status, including merger, acquisition, transfer of assets, and any change in fiduciary responsibility;

(2) no later than ten (10) days from the effective date of any change in:

(A) its certificate of incorporation or other organizational document;

(B) more than a controlling interest in the ownership of the Contractor; or

(C) the individual(s) in charge of the performance.

(b) No such change shall relieve the Contractor of any responsibility for the accuracy and completeness of the performance. The Agency, after receiving written Notice from the Contractor of any such change, may require such contracts, releases and other instruments evidencing, to the Agency's satisfaction, that any individuals retiring or otherwise separating from the Contractor have been compensated in full or that allowance has been made for compensation in full, for all work performed under terms of the Contract. The Contractor shall deliver such documents to the Agency in accordance with the terms of the Agency's written request. The Agency may also require, and the Contractor shall deliver, a financial statement showing that solvency of the Contractor is maintained. The death of any Contractor Party, as applicable, shall not release the Contractor from the obligation to perform under the Contract; the surviving Contractor Parties, as appropriate, must continue to perform under the Contract until performance is fully completed.

(c) Assignment. The Contractor shall not assign any of its rights or obligations under the Contract, voluntarily or otherwise, in any manner without the prior written consent of the Agency.

(1) The Contractor shall comply with requests for documentation deemed to be appropriate by the Agency in considering whether to consent to such assignment.

(2) The Agency shall notify the Contractor of its decision no later than forty-five (45) Days from the date the Agency receives all requested documentation.

(3) The Agency may void any assignment made without the Agency's consent and deem such assignment to be in violation of this Section and to be in Breach of the Contract. Any cancellation of this Contract by the Agency for a Breach shall be without prejudice to the Agency's or the State's rights or possible claims against the Contractor.

3. **Breach.**

(a) If either party Breaches this Contract in any respect, the non-breaching party shall provide written notice of the Breach to the breaching party and afford the breaching party an opportunity to cure within ten (10) Days from the date that the breaching party receives the notice. In the case of a Contractor Breach, the Agency may modify the ten (10) day cure period in the notice of Breach. The right to cure period shall be extended if the non-breaching party is satisfied that the breaching party is making a good faith effort to cure, but the nature of the Breach is such that it cannot be cured within the right to cure period. The Notice may include an effective Contract cancellation date if the

Breach is not cured by the stated date and, unless otherwise modified by the non-breaching party in writing prior to the cancellation date, no further action shall be required of any party to effect the cancellation as of the stated date. If the notice does not set forth an effective Contract cancellation date, then the non-breaching party may cancel the Contract by giving the breaching party no less than twenty four (24) hours' prior written Notice after the expiration of the cure period.

(b) If the Agency believes that the Contractor bas not performed according to the Contract, the Agency may:

(1) withhold payment in whole or in part pending resolution of the performance issue, provided that the Agency notifies the Contractor in writing prior to the date that the payment would have been due in accordance with the budget;

(2) temporarily discontinue all or part of the Services to be provided under the Contract;

(3) permanently discontinue part of the Services to be provided under the Contract;

(4) assign appropriate State personnel to provide contracted for Services to assure continued performance under the Contract until such time as the contractual Breach has been corrected to the satisfaction of the Agency;

(5) require that contract funding be used to enter into a subcontract with a person or persons designated by the Agency in order to bring the program into contractual compliance;

(6) take such other actions of any nature whatsoever as may be deemed appropriate for the best interests of the State or the program(s) provided under this Contract or both; or

(7) any combination of the above actions.

(c) The Contractor shall return all unexpended funds to the Agency no later than thirty (30) calendar days after the Contractor receives a demand from the Agency.

(d) In addition to the rights and remedies granted to the Agency by this Contract, the Agency shall have all other rights and remedies granted to it by law in the event of Breach of or default by the Contractor under the terms of this Contract.

(e) The action of the Agency shall be considered final. If at any step in this process the Contractor fails to comply with the procedure and, as applicable, the mutually agreed plan of correction, the Agency may proceed with Breach remedies as listed under this section.

4. **Non-enforcement Not to Constitute Waiver.** No waiver of any Breach of the Contract shall be interpreted or deemed to be a waiver of any other or subsequent Breach. All remedies afforded in the Contract shall be taken and construed as cumulative, that is, in addition to every other remedy provided in the Contract or at law or in equity. A party's failure to insist on strict performance of any section of the Contract shall only be deemed to be a waiver of rights and remedies concerning that specific instance of performance and shall not be deemed to be a waiver of any subsequent rights, remedies or Breach.

5. **Suspension.** If the Agency determines in its sole discretion that the health and welfare of the Clients or public safety is being adversely affected, the Agency may immediately suspend in whole or in part the Contract without prior notice and take any action that it deems to be necessary or appropriate for the benefit of the Clients. The Agency shall notify the Contractor of the specific reasons for taking such action in writing within five (5) Days of immediate suspension. Within five (5) Days of receipt of this notice, the Contractor may request in writing a meeting with the Agency Head or designee. Any such meeting shall be held within five (5) Days of the written request, or such later time as is mutually agreeable to the parties. At

the meeting, the Contractor shall be given an opportunity to present information on why the Agency's actions should be reversed or modified. Within five (5) Days of such meeting, the Agency shall notify the Contractor in writing of his/her decision upholding, reversing or modifying the action of the Agency head or designee. This action of the Agency head or designee shall be considered final.

6. **Ending the Contractual Relationship.**

(a) This Contract shall remain in full force and effect for the duration of its entire term or until such time as it is terminated earlier by either party or cancelled. Either party may terminate this contract by providing at least sixty (60) days prior written notice pursuant to the Notice requirements of this Contract.

(b) The Agency may immediately terminate the Contract in whole or in part whenever the Agency makes a determination that such termination is in the best interest of the State. Notwithstanding Section D.2, the Agency may immediately terminate or cancel this Contract in the event that the Contractor or any subcontractors becomes financially unstable to the point of threatening its ability to conduct the services required under this Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver for its business or its assets.

(c) The Agency shall notify the Contractor in writing of Termination pursuant to subsection (b) above, which shall specify the effective date of termination and the extent to which the Contractor must complete or immediately cease performance. Such Notice of Termination shall be sent in accordance with the Notice provision contained on page 1 of this Contract. Upon receiving the Notice from the Agency, the Contractor shall immediately discontinue all Services affected in accordance with the Notice, undertake all reasonable and necessary efforts to mitigate any losses or damages, and deliver to the Agency all Records as defined in Section A.14, unless otherwise instructed by the Agency in writing, and take all actions that are necessary or appropriate, or that the Agency may reasonably direct, for the protection of Clients and preservation of any and all property. Such Records are deemed to be the property of the Agency and the Contractor shall deliver them to the Agency no later than thirty (30) days after the Termination of the Contract or fifteen (15) days after the Contractor receives a written request from the Agency for the specified records whichever is less. The Contractor shall deliver those Records that exist in electronic, magnetic or other intangible form in a non-proprietary format, such as, but not limited to ASCII or .TXT.

(d) The Agency may terminate the Contract at any time without prior notice when the funding for the Contract is no longer available.

(e) The Contractor shall deliver to the Agency any deposits, prior payment, advance payment or down payment if the Contract is terminated by either party or cancelled within thirty (30) days after receiving demand from the Agency. The Contractor shall return to the Agency any funds not expended in accordance with the terms and conditions of the Contract and, if the Contractor fails to do so upon demand, the Agency may recoup said funds from any future payments owing under this Contract or any other contract between the State and the Contractor. Allowable costs, as detailed in audit findings, incurred until the date of termination or cancellation for operation or transition of program(s) under this Contract shall not be subject to recoupment.

7. **Transition after Termination or Expiration of Contract.**

(a) If this Contract is terminated for any reason, cancelled or it expires in accordance with its term, the Contractor shall do and perform all things which the Agency determines to be necessary or appropriate to assist in the orderly transfer of Clients served under this Contract and shall assist in the orderly cessation of Services it performs under this Contract. In order to complete such transfer and wind down the performance, and only to the extent necessary or appropriate, if such activities are expected

to take place beyond the stated end of the Contract term then the Contract shall be deemed to have been automatically extended by the mutual consent of the parties prior to its expiration without any affirmative act of either party, including executing an amendment to the Contract to extend the term, but only until the transfer and winding down are complete.

(b) If this Contract is terminated, cancelled or not renewed, the Contractor shall return to the Agency any equipment, deposits or down payments made or purchased with start-up funds or other funds specifically designated for such purpose under this Contract in accordance with the written instructions from the Agency in accordance with the Notice provision of this Contract. Written instructions shall include, but not be limited to, a description of the equipment to be returned, where the equipment shall be returned to and who is responsible to pay for the delivery/shipping costs. Unless the Agency specifies a shorter time frame in the letter of instructions, the Contractor shall affect the returns to the Agency no later than sixty (60) days from the date that the Contractor receives Notice.

E. Statutory and Regulatory Compliance.

1. 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"), 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, on behalf of the Agency, performs functions that involve the use or disclosure of "individually identifiable health information," as that term is defined in 45 C.F.R. § 160.103; and

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

(f) 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, and E.

(g) Definitions

(1) "Breach" shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. § 17921(1)).

(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, limited to information created or received by the Business Associate from or on behalf 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 section 13402(h)(1)(A) of HITECH. Act. (42 U.S.C. §17932(h)(1)(A)).

(h) 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 appropriate safeguards to prevent use or disclosure of PHI other than as provided for in this Section of the Contract.

(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 to insure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate, on behalf of the Covered Entity, agrees to the same restrictions and conditions that apply through this Section of the Contract to Business Associate with respect to such information.

(7) Business Associate agrees to provide access, at the request of the Covered Entity, and in the time and manner agreed to by the parties, 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.

(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 agreed to by the parties.

(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 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 determining Covered Entity's compliance with the Privacy Rule.

(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 agreed to by the parties, information collected in accordance with subsection (h)(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; or

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

(D) the Business Associate agrees to notify the covered entity, in writing, within five (5) business days of the request.

(15) Business Associate agrees that it shall 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 of a breach of unsecured protected health information, it shall notify the Covered Entity of such breach in accordance with the requirements of section 13402 of HITECH (42 U.S.C. § 17932(b)) 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, except as otherwise instructed in writing by a law enforcement official pursuant to section 13402(g) of HITECH (42 U.S.C. § 17932(g)). A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate. 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 brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

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 individuals take to protect themselves from potential harm resulting from the breach.

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

5. Whether a law enforcement official has advised either verbally or in writing the Business Associate that he or she has determined that notification or notice to individuals or the posting required under section 13402 of the HITECH Act would impede a criminal investigation or cause damage to national security and; if so, include contact information for said official.

(D) Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed by the Covered Entity of a breach by the Business Associate 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 or a postal address. For breaches involving ten or more individuals whose contact information is insufficient or out of date to allow written notification under 45 C.F.R. § 164.404(d)(1)(i), the Business Associate shall notify the Covered Entity of such persons and maintain a toll-free telephone number for ninety (90) days after said notification is sent to the Covered Entity. 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.

(E) 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.

(i) 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 Privacy Rule 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).

(j) 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 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.

(k) 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 Privacy Rule 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.

(l) 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 (h)(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 (l)(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 or received by Business Associate on behalf of Covered Entity. Business Associate shall also provide the information collected in accordance with section (h)(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.

(m) 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, the Privacy Rule and the Security Rule.

2. **Americans with Disabilities Act.** The Contractor shall be and remain in compliance with the Americans with Disabilities Act of 1990 (http://www.ada.gov/) as amended from time to time ("Act") to the extent applicable, during the term of the Contract. The Agency may cancel or terminate this Contract if the Contractor fails to comply with the Act. The Contractor represents that it is familiar with the terms of this Act and that it is in compliance with the law. The Contractor warrants that it shall hold the State harmless from any liability which may be imposed upon the state as a result of any failure of the Contractor to be in compliance with this Act. As applicable, the Contractor shall comply with section 504 of the Federal Rehabilitation Act of 1973, as amended from time to time, 29 U.S.C. § 794 (Supp. 1993), regarding access to programs and facilities by people with disabilities.

3. **Utilization of Minority Business Enterprises.** The Contractor shall perform under this Contract in accordance with 45 C.F.R. Part 74; and, as applicable, C.G.S. §§ 4a-60 to 4a-60a and 4a-60g to carry out this policy in the award of any subcontracts.

4. **Priority Hiring.** Subject to the Contractor's exclusive right to determine the qualifications for all employment positions, the Contractor shall give priority to hiring welfare recipients who are subject to time-limited welfare and must find employment. The Contractor and the Agency shall work cooperatively to determine the number and types of positions to which this Section shall apply.

5. **Non-discrimination.**

a. For purposes of this Section, the following terms are defined as follows:

(1) "Commission" means the Commission on Human Rights and Opportunities;
(2) "Contract" and "contract" include any extension or modification of the Contract or contract;
(3) "Contractor" and "contractor" include any successors or assigns of the Contractor or contractor;
(4) "Gender identity or expression" means a person's gender-related identity, appearance or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person's physiology or assigned sex at birth, which gender-related identity can be shown by providing evidence including, but not limited to, medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the gender-related identity or any other evidence that the gender-related identity is sincerely held, part of a person's core identity or not being asserted for an improper purpose.
(5) "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations;
(6) "good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements;
(7) "marital status" means being single, married as recognized by the State of Connecticut, widowed, separated or divorced;
(8) "mental disability" means one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", or a record of or regarding a person as having one or more such disorders;
(9) "minority business enterprise" means any small contractor or supplier of materials fifty-one percent or more of the capital stock, if any, or assets of which is owned by a person or persons: (1) who are active in the daily affairs of the enterprise, (2) who have the power to direct the management and policies of the enterprise, and (3) who are members of a minority, as such term is defined in subsection (a) of Connecticut General Statutes § 32-9n; and
(10) "public works contract" means any agreement between any individual, firm or corporation and the State or any political subdivision of the State other than a municipality for construction, rehabilitation, conversion, extension, demolition or repair of a public building, highway or other changes or improvements in real property, or which is financed in whole or in part by the State, including, but not limited to, matching expenditures, grants, loans, insurance or guarantees.

For purposes of this Section, the terms "Contract" and "contract" do not include a contract where each contractor is (1) a political subdivision of the state, including, but not limited to, a municipality, (2) a quasi-public agency, as defined in Conn. Gen. Stat. Section 1-120, (3) any other state, including but not limited to any federally recognized Indian tribal governments, as defined in Conn. Gen. Stat. Section 1-267, (4) the federal government, (5) a foreign government, or (6) an agency of a subdivision, agency, state or government described in the immediately preceding enumerated items (1), (2), (3), (4) or (5).

b.

(1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, mental retardation, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents

performance of the work involved, in any manner prohibited by the laws of the United States or of the State of Connecticut; and the Contractor further agrees to take affirmative action to insure that applicants with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, mental retardation, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by the Contractor that such disability prevents performance of the work involved;

(2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that it is an "affirmative action-equal opportunity employer" in accordance with regulations adopted by the Commission;

(3) the Contractor agrees to provide each labor union or representative of workers with which the Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which the Contractor has a contract or understanding, a notice to be provided by the Commission, advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment;

(4) the Contractor agrees to comply with each provision of this Section and Connecticut General Statutes §§ 46a-68e and 46a-68f and with each regulation or relevant order issued by said Commission pursuant to Connecticut General Statutes §§ 46a-56, 46a-68e and 46a-68f; and

(5) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the provisions of this Section and Connecticut General Statutes § 46a-56. If the contract is a public works contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works projects.

(c) Determination of the Contractor's good faith efforts shall include, but shall not be limited to, the following factors: The Contractor's employment and subcontracting policies, patterns and practices; affirmative advertising, recruitment and training; technical assistance activities and such other reasonable activities or efforts as the Commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.

(d) The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the Commission, of its good faith efforts.

(e) The Contractor shall include the provisions of subsection (b) of this Section in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes §46a-56; provided if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

(f) The Contractor agrees to comply with the regulations referred to in this Section as they exist on the date of this Contract and as they may be adopted or amended from time to time during the term of this Contract and any amendments thereto.

(g)

(1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or the State of Connecticut, and that employees are treated when employed without regard to their sexual orientation;

(2) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which such Contractor has a contract or understanding, a notice to be provided by the Commission on Human Rights and Opportunities advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment;

(3) the Contractor agrees to comply with each provision of this section and with each regulation or relevant order issued by said Commission pursuant to Connecticut General Statutes § 46a-56; and

(4) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor which relate to the provisions of this Section and Connecticut General Statutes § 46a-56.

(h) The Contractor shall include the provisions of the foregoing paragraph in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes § 46a-56; provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

6. **Executive Orders.** This Contract is subject to Executive Order No. 3 of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices; Executive Order No. 17 of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings; Executive Order No. 16 of Governor John G. Rowland, promulgated August 4, 1999, concerning violence in the workplace. This Contract may also be subject to Executive Order 7C of Governor M. Jodi Rell, promulgated July 13, 2006, concerning contracting reforms and Executive Order 14 of Governor M. Jodi Rell, promulgated April 17, 2006, concerning procurement of cleaning products and services, in accordance with their respective terms and conditions. All of these Executive orders are incorporated into and made a part of the Contract as if they had been fully set forth in it. At the Contractor's request, the Agency shall provide a copy of these Orders to the Contractor.

7. **Campaign Contribution Restrictions**. For all State contracts as defined in C.G.S. § 9-612(g) the authorized signatory to this Contract expressly acknowledges receipt of the State Elections Enforcement Commission's ("SEEC") notice advising state contractors of state campaign contribution and solicitation prohibitions, and will inform its principals of the contents of the notice. See SEEC Form 11 reproduced below: www.ct.gov/seecwww.ct.gov/seec

CONNECTICUT STATE ELECTIONS ENFORCEMENT COMMISSION
Rev. 1/11
Page 1 of 2

Notice to Executive Branch State Contractors and Prospective State Contractors of Campaign Contribution and Solicitation Limitations

This notice is provided under the authority of Connecticut General Statutes §9-612(g)(2), as amended by P.A. 10-1, and is for the purpose of informing state contractors and prospective state contractors of the following law (italicized words are defined on the reverse side of this page).

CAMPAIGN CONTRIBUTION AND SOLICITATION LIMITATIONS

No *state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor*, with regard to a *state contract* or *state contract solicitation* with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall make a contribution to (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee (which includes town committees).

In addition, no holder or principal of a holder of a valid prequalification certificate, shall make a contribution to (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of State senator or State representative, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

On and after January 1, 2011, no state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor, with regard to a state contract or state contract solicitation with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall knowingly *solicit* contributions from the state contractor's or prospective state contractor's employees or from a *subcontractor* or *principals of the subcontractor* on behalf of (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

DUTY TO INFORM

State contractors and prospective state contractors are required to inform their principals of the above prohibitions, as applicable, and the possible penalties and other consequences of any violation thereof.

PENALTIES FOR VIOLATIONS

Contributions or solicitations of contributions made in violation of the above prohibitions may result in the following civil and criminal penalties:

Civil penalties—Up to $2,000 or twice the amount of the prohibited contribution, whichever is greater, against a principal or a contractor. Any state contractor or prospective state contractor which fails to make reasonable efforts to comply with the provisions requiring notice to its principals of these prohibitions and the possible consequences of their violations may also be subject to civil penalties of up to $2,000 or twice the amount of the prohibited contributions made by their principals.

Criminal penalties—Any knowing and willful violation of the prohibition is a Class D felony, which may subject the violator to imprisonment of not more than 5 years, or not more than $5,000 in fines, or both.

CONTRACT CONSEQUENCES

In the case of a state contractor, contributions made or solicited in violation of the above prohibitions may result in the contract being voided.

In the case of a prospective state contractor, contributions made or solicited in violation of the above prohibitions shall result in the contract described in the state contract solicitation not being awarded to the prospective state contractor, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

The State shall not award any other state contract to anyone found in violation of the above prohibitions for a period of one year after the election for which such contribution is made or solicited, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

Additional information may be found on the website of the State Elections Enforcement Commission, www.ct.gov/seec. Click on the link to "Lobbyist/Contractor Limitations."

DEFINITIONS

"State contractor" means a person, business entity or nonprofit organization that enters into a state contract. Such person, business entity or nonprofit organization shall be deemed to be a state contractor until December thirty-first of the year in which such contract terminates. "State contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Prospective state contractor" means a person, business entity or nonprofit organization that (i) submits a response to a state contract solicitation by the state, a state agency or a quasi-public agency, or a proposal in response to a request for proposals by the state, a state agency or a quasi-public agency, until the contract has been entered into, or (ii) holds a valid prequalification certificate issued by the Commissioner of Administrative Services under section 4a-100. "Prospective state contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a state contractor or prospective state contractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a state contractor or prospective state contractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a state contractor or prospective state contractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a state contractor or prospective state contractor, which is not a business entity, or if a state contractor or prospective state contractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any state contractor or prospective state contractor who has *managerial or discretionary responsibilities with respect to a state contract*, (v) the spouse or a *dependent child* who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the state contractor or prospective state contractor.

"State contract" means an agreement or contract with the state or any state agency or any quasi-public agency, let through a procurement process or otherwise, having a value of fifty thousand dollars or more, or a combination or series of such agreements or contracts having a value of one hundred thousand dollars or more in a calendar year, for (i) the rendition of services, (ii) the furnishing of any goods, material, supplies, equipment or any items of any kind, (iii) the construction, alteration or repair of any public building or public work, (iv) the acquisition, sale or lease of any land or building, (v) a licensing arrangement, or (vi) a grant, loan or loan guarantee. "State contract" does not include any agreement or contract with the state, any state agency or any quasi-public agency that is exclusively federally funded, an education loan, a loan to an individual for other than commercial purposes or any agreement or contract between the state or any state agency and the United States Department of the Navy or the United States Department of Defense.

"State contract solicitation" means a request by a state agency or quasi-public agency, in whatever form issued, including, but not limited to, an invitation to bid, request for proposals, request for information or request for quotes, inviting bids, quotes or other types of submittals, through a competitive procurement process or another process authorized by law waiving competitive procurement.

"Managerial or discretionary responsibilities with respect to a state contract" means having direct, extensive and substantive responsibilities with respect to the negotiation of the state contract and not peripheral, clerical or ministerial responsibilities.

"Dependent child" means a child residing in an individual's household who may legally be claimed as a dependent on the federal income tax of such individual.

"Solicit" means (A) requesting that a contribution be made, (B) participating in any fund-raising activities for a candidate committee, exploratory committee, political committee or party committee, including, but not limited to, forwarding tickets to potential contributors, receiving contributions for transmission to any such committee or bundling contributions, (C) serving as chairperson, treasurer or deputy treasurer of any such committee, or (D) establishing a political committee for the sole purpose of soliciting or receiving contributions for any committee. Solicit does not include: (i) making a contribution that is otherwise permitted by Chapter 155 of the Connecticut General Statutes; (ii) informing any person of a position taken by a candidate for public office or a public official, (iii) notifying the person of any activities of, or contact information for, any candidate for public office; or (iv) serving as a member in any party committee or as an officer of such committee that is not otherwise prohibited in this section.

"Subcontractor" means any person, business entity or nonprofit organization that contracts to perform part or all of the obligations of a state contractor's state contract. Such person, business entity or nonprofit organization shall be deemed to be a subcontractor until December thirty first of the year in which the subcontract terminates. "Subcontractor" does not include (i) a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or (ii) an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a subcontractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a subcontractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a subcontractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a subcontractor, which is not a business entity, or if a subcontractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any subcontractor who has managerial or discretionary responsibilities with respect to a subcontract with a state contractor, (v) the spouse or a dependent child who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the subcontractor.

[X] Original Contract
[ ] Amendment #____
(*For Internal Use Only*)

SIGNATURES AND APPROVALS

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 – COMMUNITY HEALTH NETWORK OF CONNECTICUT, INC.

Sylvia B. Kelly

SYLVIA B. KELLY, *PRESIDENT & CEO*

6/25/12
Date

DEPARTMENT OF SOCIAL SERVICES

RODERICK L. BREMBY, *Commissioner*

6/27/2012
Date

OFFICE OF THE ATTORNEY GENERAL

ASST. / ASSOC. ATTORNEY GENERAL Joseph Rubin
(approved as to form and legal sufficiency)

7/10/12
Date

☑ Part I of this Contract having been reviewed and approved by the OAG, it is exempt from review pursuant a Memorandum of Agreement between the Agency and the OAG dated March 19, 2009.