STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONTRACT AMENDMENT

Contractor:	VALUEOPTIONS, INC
Contractor Address:	240 CORPORATE BOULEVARD, NORFOLK, VA 23502
Contract Number:	999VOI-BHP-01 / 11DSS1206AL
Amendment Number:	A2
Amount as Amended:	$89,767,152
Contract Term as Amended:	01/01/11 - 12/31/15

The contract between **ValueOptions, Inc** (the Contractor) and the Department of Social Services (the Department), which was last executed by the parties and approved by the Office of the Attorney General on 06/04/13, is hereby further amended as follows:

1. **This document constitutes an amendment to the above numbered contract. All provisions of that contract, except those explicitly changed above by this amendment, shall remain in full force and effect.**

2. The total maximum amount payable under this contract is increased by **$36,500,000 from $53,267,152 to $89,767,152** to fund contracted services from through 12/31/15.

3. The term of the contract is extended for two additional years, and the end date is changed from 12/31/13 to 12/31/15. Changes in the scope of services shall be added in a subsequent amendment.

4. The budget for the period 1/1/13 through 12/31/15 shall be as set forth on page 9 of this amendment.

5. The Health Insurance Portability and Accountability Act of 1996 provisions as amended on pages 3 through 10 of Amendment 1 are deleted and replaced by the following HIPAA Provisions effective September 23, 2013:

Health Insurance Portability and Accountability Act of 1996.

(a) If the Contactor is a Business Associate under the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as noted in this Contract, the Contractor must comply with all terms and conditions of this Section of the Contract. If the Contractor is not a Business Associate under HIPAA, this Section of the Contract does not apply to the Contractor for this Contract.

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

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

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

(e) The Contractor and the Agency agree to the following in order to secure compliance with the HIPAA, the requirements of Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), (Pub. L. 111-5, §§ 13400 to 13423)[1], and more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, D and E (collectively referred to herein as the "HIPAA Standards").

(f) Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Obligations and Activities of Business Associates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) restrict disclosures of PHI;

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

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

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

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

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

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

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

(16) Obligations in the Event of a Breach.

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

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

believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

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

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

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

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

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

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

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

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

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

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

(h) Permitted Uses and Disclosure by Business Associate.

(1) General Use and Disclosure Provisions Except as otherwise limited in this Section of the Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract, provided that such use

or disclosure would not violate the HIPAA Standards if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(2) Specific Use and Disclosure Provisions

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

(B) Except as otherwise limited in this Section of the Contract, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

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

(i) Obligations of Covered Entity.

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

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

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

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

(k) Term and Termination.

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

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

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

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

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

(3) Effect of Termination.

(A) Except as provided in (k)(2) of this Section of the Contract, upon termination of this Contract, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity. Business Associate shall also provide the information collected in accordance with section (g)(10) of this Section of the Contract to the Covered Entity within ten business days of the notice of termination. This section shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

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

(l) Miscellaneous Sections.

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

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

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

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

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

(6) Disclaimer. Covered Entity makes no warranty or representation that compliance with this Section of the Contract will be adequate or satisfactory for Business Associate's own purposes. Covered Entity shall not be liable to Business Associate for any claim, civil or criminal penalty, loss or damage related to or arising from the unauthorized use or disclosure of PHI by Business Associate or any of its officers, directors, employees, contractors or agents, or any third party to

whom Business Associate has disclosed PHI contrary to the sections of this Contract or applicable law. Business Associate is solely responsible for all decisions made, and actions taken, by Business Associate regarding the safeguarding, use and disclosure of PHI within its possession, custody or control.

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

CTBHP Base Contract Extension

12/3/2013

Calculation of Quarterly Payments

	Exhibit F 2013		2014		2015	
Labor	12,424,461		12,129,897	80.65%	12,408,853	80.65%
Other	2,981,871		2,910,273	19.35%	2,977,202	19.35%
Sub Expenses	15,406,332		15,040,170		15,386,055	
Allocation	1,825,650	11.85%	1,782,260	11.85%	1,823,247	11.85%
Subtotal	17,231,982		16,822,430		17,209,302	
Guaranteed	430,800	2.50%	252,336	1.50%	-	0.00%
Amt to Invoice Quarterly	17,662,782		17,074,766		17,209,302	
	4		***4***		***4***	
Quarterly Payments	***4,415,695***		***4,268,692***		***4,302,326***	
Performance Target Revenue	603,119	3.50%	925,234	5.50%	1,290,698	7.50%
Revenue	18,265,901		18,000,000		18,500,000	
Quarterly Payments	4,415,695		4,268,692		4,302,326	
	4		4		4	
Costs + Allocation + Guaranteed	17,662,782		17,074,766		17,209,302	
Performance Target	603,119		925,234		1,290,698	
Total Contract Revenue	18,265,901		18,000,000		18,500,000	

SIGNATURES AND APPROVALS

999VOI-BHP-01 / 11DSS1206AL A2

The Contractor IS 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.

This amendment may be executed in counterparts.

CONTRACTOR - VALUEOPTIONS, INC

Paul M. Rosenberg, Secretary — Date: 12-17-2013

DEPARTMENT OF SOCIAL SERVICES

Kathleen M. Brennan Deputy Commissioner for
Roderick L. Bremby, *Commissioner* — Date: 12-20-13

DEPARTMENT OF CHILDREN AND FAMLIIES

Joette Katz, *Commissioner* — Date

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patricia Rehmer, *Commissioner* — Date

OFFICE OF THE ATTORNEY GENERAL

~~ASST.~~ / Assoc. Attorney General (Approved as to form & legal sufficiency) — Date: 1/5/14

Joseph Rubin

SIGNATURES AND APPROVALS

999VOI-BHP-01 / 11DSS1206AL A2

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CONTRACTOR - VALUEOPTIONS, INC

E. Paul Dunn, Jr., *CFO* — Date

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner* — Date

DEPARTMENT OF CHILDREN AND FAMLIIES

Joette Katz, *Commissioner* — Date

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patricia Rehmer, *Commissioner* — Date

OFFICE OF THE ATTORNEY GENERAL

ASST. / Assoc. Attorney General (Approved as to form & legal sufficiency) — Date ___/___/___

SIGNATURES AND APPROVALS

999VOI-BHP-01 / 11DSS1206AL A2

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E. Paul Dunn, Jr., *CFO* — Date

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner* — Date

DEPARTMENT OF CHILDREN AND FAMLIIES

Joette Katz, *Commissioner* — Date

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patricia A. Rehmer — 12/20/2013

Patricia Rehmer, *Commissioner* — Date

OFFICE OF THE ATTORNEY GENERAL

ASST. / Assoc. Attorney General (Approved as to form & legal sufficiency) — Date

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONTRACT AMENDMENT

Contractor:	VALUEOPTIONS, INC
Contractor Address:	240 CORPORATE BOULEVARD, NORFOLK, VA 23502
Contract Number:	999VOI-BHP-01 / 11DSS1206AL
Amendment Number:	A1
Amount as Amended:	$53,267,152
Contract Term as Amended:	01/01/11 - 12/31/13

The contract between **ValueOptions, Inc** (the Contractor) and the Department of Social Services (the Department), which was last executed by the parties and approved by the Office of the Attorney General on 04/15/11, is hereby amended as follows:

1. **This document constitutes an amendment to the above numbered contract. All provisions of that contract, except those explicitly changed above by this amendment, shall remain in full force and effect.**

2. **The Year Two ASO Targets shall be as set forth in Exhibit A to this amendment.**

3. The Contractor shall adhere to the Budget/Payment Provisions, negotiated with the Department of the original contract.

4. **Section F.3.1 on page 39 of the original contract is deleted in its entirety and replaced with the following section:**
   The contractor's UM Program, which shall include a program description, flow diagrams, and specific policies and procedures pertaining to UM practices, registration, prior authorization, concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, retrospective chart review, bypass programs and outlier management programs, shall be reviewed and approved by the Departments on an annual basis, no later than April 1 of each year.

5. **Subsection S.10.4.2.2 on page 110 of the original contract is deleted in its entirety and replaced by the following subsection:**
   A backup power generator shall support the Contractor's information system wherever such system shall reside and shall be able to restore power to the systems within minutes in the event of a power failure. The Connecticut Service Center computer room shall be supported with its own uninterruptable power supply to continue operations during the transition to Business Recovery.

6. **E.17 on page 10 of Exhibit E** of the original contract shall reflect the language in T.2.3 on pages 111 and 112 of the original contract, which states that "Notices shall be communicated in writing and sent out as expeditiously as possible, but no later than three business days following the date of the decision," and the Performance Standard related to the Notice of Action letters shall be changed from 100% within one business day to 98% within three business days for this indicator.

7. **Summary of State Ethics Laws.** Pursuant to the requirements of section 1-101qq of the Connecticut General Statutes, the summary of State ethics laws developed by the State Ethics Commission pursuant to section 1-81b of the Connecticut General Statutes is incorporated by reference into and made a part of the Contract as if the summary had been fully set forth in the Contract.

8. **The Encryption of Data provisions on page 154 of the original contract are deleted and replaced by the following provisions:**

Protection of Confidential Information.

a. **"Confidential 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, Confidential Information shall also include any information that the Department classifies as "confidential" or "restricted." Confidential 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.

b. **"Confidential Information Breach"** shall mean, generally, unauthorized access to or unauthorized acquisition of electronic files, media, databases or computerized data containing personal information when access to the personal information has not been secured by encryption or by any other method or technology that renders the personal information unreadable or unusable.

c. Contractor and Contractor Parties, at their own expense, have a duty to and shall protect from a Confidential Information Breach any and all Confidential 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.

d. Each Contractor or Contractor Party shall develop, implement and maintain a comprehensive data - security program for the protection of Confidential Information. The safeguards contained in such program shall be consistent with and comply with the safeguards for protection of Confidential 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 Confidential Information. Such data-security program shall include, but not be limited to, the following:

   i. A security policy for employees related to the storage, access and transportation of data containing Confidential Information;
   ii. Reasonable restrictions on access to records containing Confidential Information, including access to any locked storage where such records are kept;
   iii. A process for reviewing policies and security measures at least annually;
   iv. Creating secure access controls to Confidential Information, including but not limited to passwords; and
   v. Encrypting of Confidential Information that is stored on laptops, portable devices or being transmitted electronically.

e. 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 three (3) business days, after they become aware of or suspect that any Confidential Information which Contractor or Contractor Parties have come to possess or control has been subject to a Confidential Information Breach. If a Confidential Information Breach has occurred, the Contractor shall, within three (3) business days after the notification, promptly initiate an appropriate investigation into the circumstances of the Breach. The

Contractor shall provide details of its findings to the Department and the Department shall determine next steps. If the Department determines that noticing the breach to affected clients is necessary, the Contractor shall provide notice of the breach to any resident of the State of Connecticut whose Confidential Information was, or is reasonably believed to have been, accessed by an unauthorized person through a breach of security by the Contractor or Contractor parties. Such notice shall be made without unreasonable delay. Subject to direction from the Department, notification to affected individuals shall not be required if, after an appropriate investigation and consultation with relevant federal, state and local law enforcement agencies, it is determined that the breach will not likely result in harm to those affected individuals. Any notice required to be given may be provided by one of the methods described in Conn. Gen. Stat. § 36a-701b. Where appropriate to the nature of the breach, Contractor, at its own cost and expense, and in consultation with the Department, shall offer a credit monitoring or protection plan to all individuals affected by the 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 Confidential 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.

9. **The Health Insurance Portability and Accountability Act of 1996 provisions on pages 160 through 169 of the original contract are deleted and replaced with the following provisions:**

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 ensure 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, including, but not limited to, 42 C.F.R. § 2 ("Confidentiality of Alcohol and Drug Abuse Patient Records."

(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.

10. The Non-Discrimination provisions on pages 170 through 174 of the original contract are deleted and replaced by the following provisions:

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.

i. 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;

ii. 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;

iii. 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;

iv. 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

v. 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.

SIGNATURES AND APPROVALS

999VOI-BHP-01 / 11DSS1206AL A1

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.

This amendment may be executed in counterparts.

CONTRACTOR - VALUEOPTIONS, INC

Scott M. Tabakin, *CFO* — Date 4/29/13

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner* — Date 5/9/2013

DEPARTMENT OF CHILDREN AND FAMLIIES

Joette Katz, *Commissioner* — Date 5/14/13

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patricia Rehmer, *Commissioner* — Date

OFFICE OF THE ATTORNEY GENERAL

ASST / Assoc. Attorney General (Approved as to form & legal sufficiency) Joseph Rubin — Date 6/4/13

SIGNATURES AND APPROVALS

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CONTRACTOR - VALUEOPTIONS, INC

Scott M. Tabakin, *CFO* — Date: 4/29/13

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner* — Date: 5/9/2013

DEPARTMENT OF CHILDREN AND FAMLIES

Joette Katz, *Commissioner* — Date

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patricia Rehmer, *Commissioner* — Date: 5/24/13

OFFICE OF THE ATTORNEY GENERAL

ASST. / Assoc. Attorney General (Approved as to form & legal sufficiency) — Date: 6/4/13

Joseph Rubin

VALUEOPTIONS®
Innovative Solutions. Better Health.

RESOLUTION

I, **Paul M. Rosenberg, EVP & General Counsel** of **ValueOptions, Inc.,** a Virginia corporation (the "Contractor"), do hereby certify that the following is a true and correct copy of a resolution duly adopted at a meeting of the **FHC Health Systems, Inc. Board of Directors** of the Contractor duly held and convened on **December 12, 2012**, at which meeting a duly constituted quorum of the **FHC Health Systems, Inc. Board of Directors** was present and acting throughout and that such resolution has not been modified, rescinded, or revoked, and is at present in full force and effect:

RESOLVED that the CFO, **Scott M. Tabakin**, is empowered to enter into and amend contractual instruments in the name and on behalf of this Contractor with the Department of Social Services, and to affix the corporate seal.

IN WITNESS WHEREOF, the undersigned has affixed his signature and the corporate seal of the Contractor this 1st day of May, 2013.

Paul M Rosenberg
(Signature of Secretary or Clerk)

Exhibit A

CT Behavioral Health Partnership

Year Two ASO Performance Targets

2012

DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

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Target 1: Data Management Related to Authorization and Payment

Value: 0.5%

The ASO will continue to perform a variety of functions during the second year in order to ensure the transmission of reliable authorization data to the Departments' claims vendor. All percentages shall be calculated annually. One fifth of the applicable withhold assigned for each domain shall be returned for each domain in which the Contractor achieves the target level of performance. Fifty percent (50%) of the amount of the applicable withhold assigned for each domain shall be returned if the Contractor's performance falls within 95% to 99.99% of the target level of performance.

Table 1

Domain	Description	Target
Eligibility file	Contractor shall build and update an eligibility file.	See Note 1 below.
Provider file	Contractor shall build and maintain a comprehensive provider file.	See Note 2 below.
Authorization file timeliness	The Contractor shall provide to the DSS MMIS contractor a daily Prior Authorization (PA) Transaction batch file of all authorized services and authorization updates.	98% shall occur timely which means prior to start of business the day following production of the authorization file.
Authorization file accuracy	(same)	The error rate shall be less than 2% as a percentage of total authorization records transmitted.
Authorization file error correction	(same)	98% of errors shall be corrected within two (2) business days of date identified, excluding Home Health for the first six months post implementation.

Note 1:

Eligibility File

The contractor will up load 98% of all monthly full files within 2 business days, and all daily update files within 1 business day provided the preprocessing validation results in a client-driven (i.e. file format, missing or invalid data elements) error rate of 2% or less. The turn-around time calculation is based on the results for all files submitted and processed annually. Files received after 2:00pm will be considered received on the following business day.

Files where the client-driven error rate exceeds 2% will not be up loaded and will be reported to the applicable State agency to determine corrective action within the following 2 business days; all subsequent eligibility file processing will be suspended if appropriate, and all related files will be excluded from the calculation of the timely turn around time target.

The percent of errors resulting from conditions solely within the Contractor's control will not preclude a file from being uploaded to our system.

Records that failed to upload from each file will be processed as follows:

- Records that failed to upload due to a condition that is solely within the Contractor's ability to correct will be re-processed within the TAT requirement. If this action does not result in an error rate of less than 2% the file will not be considered processed within the required time frame. Remaining errors from full files will be resolved within 5 business days, and those from daily files will be resolved within 3 business days.

- Records that failed to upload due to a condition that is not solely within the Contractor's ability to correct will be reported to the appropriate State agency within the following 2 business days

    - records that require correction on the part of the appropriate State agency or its representative are expected to be included in a subsequent eligibility file.

    - records that require updated information to be passed from a State agency to the Contractor for updating of the Contractor's processing system will be reprocessed by the Contractor within 4 business days of receipt of the updated information.

Sample method of tracking and calculation of TAT:

	File date	File Type	Actual TAT	TAT requirement met	Comments
Starting file	1/1/2011	Full	2	Yes	
Mon	1/2/2011	Incr	1	Yes	
Tue	1/3/2011	Incr	1	Yes	
Wed	1/4/2011	Incr	1	Yes	
Thu	1/5/2011	Incr	1	Yes	
Fri	1/6/2011	Incr	1	Yes	
Mon	1/9/2011	Incr	4		
Tue	1/10/2011	Incr	1	Yes	
Wed	1/11/2011	Incr	1	Yes	
Thu	1/12/2011	Incr	1	Yes	
Fri	1/13/2011	Incr	1	Yes	
Mon	1/16/2011	Incr	4		
Tue	1/17/2011	Incr	1	Yes	
Wed	1/18/2011	Incr	1	Yes	
Thu	1/19/2011	Incr	1	Yes	
Fri	1/20/2011	Incr	1	Yes	
Mon	1/23/2011	Incr	1	Yes	
Tue	1/24/2011	Incr	1	Yes	
Wed	1/25/2011	Incr	1	Yes	
Thu	1/26/2011	Incr	1	Yes	
Fri	1/27/2011	Incr	1	Yes	
Mon	1/30/2011	Incr	1	Yes	
Tue	1/31/2011	Incr	1	Yes	
Wed	2/1/2011	Full	1	Yes	
Thu	2/2/2011	Incr	1	Yes	
Fri	2/3/2011	Incr	1	Yes	

Total # of Files	26	
# of files excluded from TAT	1	1/16 file
# of files met TAT	24	
% met TAT	96.00%	24 of 25 files were processed within the agreed upon TAT

Note 2:

Provider File

The Contractor will receive and upload from the DSS MMIS contractor an initial provider file load of information into the Contractor's MIS within 48 business hours of receipt of a clean file. The Contractor will receive subsequent weekly and monthly changes and updates files and/or reports. The Contractor will update 98% of the provider file weekly adds or changes within three business days upon receipt of clean data, and within five business days for monthly updates upon receipt of clean data, to their MIS. Files/reports received after 2:00 pm ET will be considered received on the following business day. The turn-around time calculation is based on the results for all clean data elements submitted and processed annually.

The Contractor will perform random quarterly quality audits on data elements processed from the weekly and monthly provider file/reports. The Contractor will have a 98% accuracy rate on data element (any single field in the provider file/report) processed from the monthly and weekly provider file/reports. The accuracy rate is calculated on the results for all quarterly random quality audits on an annual basis. A sample size for 95% confidence level will be determined by the number of changes sent, per quarter by the State's MMIS contractor. Quarterly random sample with 95% confidence level will be pulled from Contractor's MIS provider file and compared to monthly provider change files sent by the State's MMIS. Error analysis report will be sent to the State quarterly.

Summary

a) Initial Provider File Load - The contractor will receive and upload from the DSS MMIS contractor a load of information into the Contractor's MIS within 48 hours of receipt of a clean file.

b) Monthly and Weekly network update files - The Contractor will update 98% of the provider file weekly adds or changes within three business days and five business days for monthly updates to their MIS.

c) Quality Audits - 98% accuracy rate of monthly and weekly network update files. Quarterly random audits with a sample size having a 95% confidence level of the Contractor's MIS provider file to the States MMIS provider file data provided.

Target # 2: Develop performance and outcome claims-based reports to determine the effectiveness of the mental health and substance use Intensive Outpatient (IOP) level of care for adults 18 years of age and older.

Total Value: 1.0%

ValueOptions Connecticut (VO) will work with the Departments of Mental Health and Addiction Services (DMHAS) and Social Services (DSS) to develop outcome based reports for Intensive Outpatient (IOP) level of care for adults 18 years of age and older.

ValueOptions Connecticut will work with the Departments to establish a mutually agreed upon set of performance and outcome indicators to assist the Departments in determining client outcomes after participating in IOP.

ValueOptions Connecticut will use a combination of authorization and claims data as necessary to report on these performance and outcome indicators except as indicated below. All queries to the DSS data warehouse will be designed with and approved by the Departments.

Beginning the second (2nd) quarter of calendar year (CY) 2012 through the fourth (4^{th}) quarter of CY 2012, (April 1^{st} 2012 to Dec 31^{st} 2012), VO will collect and analyze data and develop outcome-based reports to inform and help improve quality of care for members receiving IOP services.

The Contractor shall:

By June 15, 2012:

A. Work with the Departments to design and run a query or queries of the DSS data warehouse, and then review the resulting data to identify a cohort of clients who used IOP services (that is, were admitted and discharged) between April1 – December 31, 2011.

B. Once this initial cohort of IOP users is identified via the claims data, VO will work with DMHAS to identify those members for whom DMHAS data is available.

Within four weeks of receiving DMHAS data, VO will provide the identified utilization as described in A & B directly below:

A. Using the cohort from the combination of claims and DMHAS data, VO will gather and aggregate demographic and other data for the identified cohort such as age, gender, eligibility group, mental health and substance use diagnoses, as well as identify the treating providers.

B. Identify any patterns of utilization, including but not limited to frequency of use, any differences between mental health and substance use IOP services, etc. based on what the data shows, to be used for further discussions with the Departments, and to further inform the development of outcome claims-based reporting process.

Within four weeks of receipt of deliverable above, VO will:

A. Identify follow up data measures/outcome indicators to be pre-approved by the Departments. Providers and clients of IOP services may also participate in determining outcome measures to be used for this performance target. Outcome measures may include, but not be limited to the following examples:

   i. Average Length of Stay (ALOS);
   ii. Admissions/Readmissions to same, higher or lower levels of care within 7, 30, 90, 180 days post discharge;
   iii. Days in the community (for the 6 months period post discharge from IOP) for individuals discharged between April 1 and December 31, 2011.

B. In addition, VO will work with DMHAS to incorporate DMHAS provided data into the overall analyses and outcome reporting for the cohort to further inform the following performance and outcome indicators by IOP providers:

   i. Frequency of discharge status (e.g. completed treatment, left ACA, etc.);
   ii. Percentage of clients who maintained or improved employment status 90 days post IOP admission/discharge;
   iii. Percentage of clients who maintained or improved housing status 90 days post IOP admission/discharge;
   iv. Percentage of clients who maintained or improved social connectedness 90 days post IOP admission/discharge.

By December 31, 2012:

A. Collect, aggregate and analyze follow up data measures/outcome indicators for the cohort by provider, eligibility group, diagnoses, and other categories as agreed upon at intervals of 7, 30, 90, and 180 days post discharge from IOP.

B. Deliver outcome claims-based reports to the Departments using the IOP level of care as the prototype.

Note: Replacement of a performance indicator, or edit to an existing performance indicator, as noted above, is acceptable upon mutual agreement by the Department and the Contractor

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, or the Department's priorities and direction changes prior to the completion of this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of the withhold.

If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

Target 3: Licensed Home Health Care Agency Services

Value: 1.5%

A key goal for the CT BHP is to support the movement towards Recovery for members receiving Home Health (HH) services. A key objective of this goal is to decrease the intensity of HH services (especially medication administration services) for those members who can be more autonomous; this may also decrease the duration for which members receive HH services overall.

1. Value: 0.5% - Enhancement and Implementation of a Provider Analysis and Reporting Program for Home Health Agencies

During Calendar Year (CY) 2011, multiple data analyses were conducted in order to develop the means of measuring the frequency and duration of medication administration services both in the aggregate as well as by individual HH Agency. After review and collaboration with the Departments, an alternative methodology was introduced for measuring medication administration frequency and duration that would assist in identifying whether the agencies were making progress towards decreasing the frequency of medication administration visits. This performance target will utilize the below DWH query parameters for medication administration services, per provider, by week:

- Outpatient home health- no crossovers (claim type = 'O' and provider type = '58'
- Fee for Service Only (claim indicator "F")
- Program Code = '1'
- Behavior Health indicator = 'E' or blank

A. By May 15th, 2012, ValueOptions will establish a set of business rules that allow for development of consistent measures of:
   1. Patterns of use of different frequencies of medication administration services by each provider agency, and
   2. Evidence of reduction in patterns of higher frequencies of use of medication administration services over time (i.e., % of members, aggregate and by provider, with twice per day (BID) services quarter to quarter and once per day (QD) services quarter to quarter)

   Using claims data from Q1, Q2, and Q3 of 2011 and working collaboratively with the departments, ValueOptions will develop the measures described above and report those measures for review by the Departments.

B. Following approval of the above described measures by the Departments, ValueOptions will develop a draft Provider Analysis and Reporting profile (PARs) for the HH Agencies.
   1. By June 1st 2012, ValueOptions will review the draft profiles with the Departments and incorporate their input.
   2. By August 1, 2012, ValueOptions will review the draft profiles with the HH Agencies and obtain their input. The input of the providers will be reviewed with the Departments and incorporated into the PARs profiles, as appropriate.
   3. By December 1, 2012, ValueOptions will have completed at least one cycle of PARs meetings with the Home Health providers to review their PARs profile.
   4. Beginning in April or May 2012, and then continuing throughout the year, , ValueOptions will hold state-wide HH Agency PARs meeting on at least a quarterly basis to identify barriers that are identified by the agencies as well as to share best practices. Due to the high number of HH Agencies, smaller focus workgroups to address specific issues may be developed. For instance, it may be necessary to develop a separate workgroup to address HH Agency prescriber concerns.

2. Value: 0.5% - Work with DMHAS to Develop and Implement Clinical Review Criteria for members who receive Medication Administration Services

The Contractor will work with Departments to develop and implement guidelines regarding the frequency and duration of medication administration services, the use of "medication box technology" and the use of professional/non-professional staff. These guidelines will incorporate the impact of symptoms on daily functioning, access to/lack of social supports and adherence to treatment, as well as other areas determined to influence medication administration services.

Medication administration services for the DMHAS population requires clinically sound guidelines to ensure the correct levels and types of services are delivered to members. The guidelines and their implementation must incorporate the education of physicians in regard to their prescribing patterns, the potential addition of psycho-social supports as well as the cooperation of Home Health Agencies

A. Development of Clinical Review Criteria to assist in the clinically appropriate reduction of medication administration services:

i. The Contractor will develop draft clinical review criteria to assist in the clinically appropriate reduction of medication administration services, by 7/23/12.

ii. The Contractor will meet with and educate, at least, the top 5 high volume medication administration prescribers regarding the clinical criteria by 9/30/12

iii. The Contractor will meet with and educate, at least, the top 5 high volume Home Health agencies providing medication administration services regarding the clinical criteria by 9/30/12.

iv. The Contractor will communicate and or coordinate local resources for peer/social supports by 9/30/12 for home health agencies to utilize with their members as they begin to decrease the frequency of home health services

v. The Departments and the Contractor agree to work collaboratively to organize a DMHAS communication/training with state operated and private non-profit LMHAs to establish set goals related to appropriate service intensity that encourages skills transfer and increases members' independence.

B. By 7/15/12 and in collaboration with the departments, the contractor will collect and trend data by provider regarding the rate of hospitalization for individuals receiving home health services during the baseline period (7/1/11-12/31/11). This data will need to be analyzed in an attempt to determine characteristics of members who are at higher risk for hospitalization and findings may need to be incorporated into the clinical criteria. This data will also serve as the basis for comparison of the hospitalization rate during the performance period (7/1/12- 12/31/12) and will be reported quarterly and as a PARs program quality indicator.

C. By April 30, 2013, using claims data for Q1, Q2 and Q3 2012 collect and show evidence of skills transfer toward independence, per provider, based on claims data measured in the aggregate and by provider, the number and percentage of members receiving medication administration who:

1. Moved from average $\geq$2 services per day to average of <2 services per day from quarter to quarter
2. Moved from average $\geq$7 services per week to average <7 services per week from quarter to quarter
3. Will be based on business rules established under Section 1.A of the Performance Target

3. <u>Value: 0.5% Reduce Per Utilizer Per Month (PUPM) Cost of Home Health Services</u>

The Contractor will reduce the per member (per utilizer) per month cost of Home Health services to Medicaid HUSKY C enrollees (ABD single and dual) when comparing the six month period (7/1/11-12/31/11) calendar year 2011 to the equivalent six month period (7/1/12-12/31/12) of calendar year 2012. The PUPM

equation will be based on unduplicated Medicaid HUSKY C users of home health services rather than total Medicaid HUSKY C enrollment.

The six month period (7/1/11-12/31/11) calendar year 2011 PUPM is the following:

Ave. Monthly Claims = $8,478,942 = $1,527.65
Ave. Monthly Users = 5,550

- 100%*- The contractor will receive 100% of the withhold if they decrease the per user per month amount by 4.0% from the final 2011 PUPM baseline per user per month amount. The Departments agree to a PUPM reduction of 3.5% should the use of medication administration boxes is not implemented within CY 2012.

- 75%*- The Contractor will receive 75% of the withhold if they decrease the per user per month by 3.0% from the final 2011 PUPM baseline per user per month amount. The Departments agree to a PUPM reduction of 2.5% should the use of medication administration boxes is not implemented within CY 2012.

April 15th 2013 will be considered the cut-off date for the July-Dec 2012 final claims data run (allowance for 90 days to pass following 12/31/11). Final submission of the CY2012 PUPM for this performance target will be completed by April 30th 2013.

PUPM numerator will be the average monthly HH expenditures for all members utilizing HH services that are derived from the HH claims query for CY '11 and CY '12 and for Medicaid C population only (ABD single/ABD/dual) as described in 1. above.

PUPM denominator will be the average monthly unique Medicaid HUSKY C users (ABD/single ABD/dual) of home health services. Users will be identified per month based on any billed home health services derived from the HH claims query for CY '11 and CY '12 as described in 1. above. Home health services include skilled nursing, medication administration, home health aide, occupational therapy, physical therapy, and speech therapy.

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed as having met the required target for full or partial return of the withhold.

*If the Department institutes a rate change during the performance period in 2012 for any of the following home health services (aides, skilled nursing, or medication nursing), the Contractor and State mutually agree to conduct a re-analysis of the performance period PUPM results to adjust the expenditure data to reflect the reimbursement rate under which this performance target was developed.

Target 4: Maintaining the Reduction of Discharge Delay for Children and Adolescents Receiving Inpatient Behavioral Health Treatment

Value: 1%

Over the next calendar year, the Contractor will maintain discharge delay days, at 14% or less of total inpatient days. Specifically, "Percent of Inpatient Days in Delay Status for All Members during Quarter", as reported on the 10B Part 7 report (All Members, IPF & IPM, and excluding Riverview) shall total no more than 14% in CY 2012. Acute average length of stay shall increase by no more than 3% in CY 2012 from a revised baseline of 12.05 days. The new baseline represents the midpoint between the longest Acute average length of stay that occurred during Q3 and Q4 of 2008 (12.92 days) and the shortest Acute average length of stay that occurred during 2011 (11.17 days).

For the purposes of this project, acute average length of stay will be computed via the use of the Contractor's Discharge-based Acute/Discharge Delay Average Length of Stay utilization reports (#8066 and #8076).

One hundred percent (100%) of the amount of the withhold shall be returned if the Contractor achieves a total of no more than 14% of inpatient discharge delay days in CY 2012.

Seventy five percent (75%) of the amount of the withhold shall be returned if the Contractor achieves a total of no more than 16% of inpatient discharge delay days

The State shall have discretion regarding the value of the withhold awarded by taking other key environmental factors which impact discharge delay into consideration.

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of the withhold.

If DCF experiences significant changes (i.e. Voluntary Service restrictions, reduced access to DCF funded services or constraints in access attributable to closure of State facilities, lack of access to GH 2 or a decrease in Flex Fund availability, etc.) that negatively impact total length of stay for the Discharge Delay population and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full return of the withhold.

If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

Target 5: Enhancement and Implementation of a Provider Analysis and Reporting Program for CT Hospital Emergency Departments

Value: 1%

Building on the work completed by the CT BHP during CYs 2010 and 2011 to implement a Provider Analysis and Reporting program (PAR) for CT Hospital EDs, ValueOptions will continue to shape and enhance the ED PAR program in 2012 by utilizing claims data to obtain a more meaningful understanding of connect to care from CT EDs. In order to support this work, we will complete the following actions within the following timeframes during CY 2012:

A. By August 1, 2012, use the decision rules for the methodology that were approved by the Departments for the CY 2011 PT #6 and a combination of Medicaid claims data for ED visits and inpatient hospitalizations for dates of service in CY 2011 broken out into six (6) month increments, to establish the number of behavioral health visits (as identified with a primary diagnosis of 291 - 316) to the emergency department by CT BHP [Medicaid] youth (ages 0 – <18) and adults (>18). The number of ED visits will be broken out by youth and adults in the ED. Then, by using the ED data concerning inpatient hospitalizations and continuing to follow the methodology previously approved by the departments, determine for each of the EDs the behavioral health inpatient hospital admission rate for youth and adults, broken out into six month increments. Additionally, we will determine the Average Length of Stay (ALOS) for these admissions for each ED. Finally, for the adult population, the contractor will break out the admissions by mental health and substance abuse, and, within the substance abuse category, by inpatient hospital detox and free standing residential detox.

   For ED outcomes other than behavioral health inpatient admissions, we will use Medicaid claims data (with the exception of those levels of care for which there is no claims data noted in parenthesis below) for dates of service in CY 2011 broken out into six (6) month increments, to establish the number and percentage of Medicaid youth (ages 0-18) and adults (>18) with at least one behavioral health visit (as identified with a primary diagnosis of 291 - 316) to the following levels of care with 7 and 30 days of the emergency department visit:

   - Behavioral health routine outpatient level of care rates within 7 and 30 days of the ED stay
   - Behavioral health intermediate outpatient level of care rates within 7 and 30 days of the ED stay
   - Behavioral health free-standing residential detoxification within 7 and 30 days of the ED stay (for this category, the contractor will use

authorization data for determining return to residential treatment for youth and claims data for return to adult residential treatment)

- Behavioral health group home treatment with 7 and 30 days of the ED stay (For this category the contractor will use authorization data for determining return to group home for youth and claims data for return to adult group home treatment)
- Behavioral health residential treatment within 7 and 30 days of the ED stay
- No known behavioral health service (as measured by the absence of a claim for a behavioral health service within 7 and 30 days of the ED stay)
- Readmissions to the ED (Re-ED Visits) within 7 and 30 days of the initial ED stay

Additionally, the ED data will be used to match EMPS evaluations as measured by the presence of paid claim with procedure code S9485 on the same day as the ED stay, and within 7 days of the ED stay separately for [Medicaid] youth and adults.

B. By September 14, 2012, produce draft PAR ED profiles (separately for youth and adults) that, at a minimum, will include:
   1. Each ED's volume of [Medicaid] members treated in the ED
   2. Each ED's inpatient hospital admission rate, routine outpatient rate, intermediate outpatient care rate, and no known behavioral health service rate
   3. Average Length of Stay (ALOS) for behavioral health inpatient admissions
   4. Re-ED Visits within 7 and 30 days of the initial ED visit
   5. Each ED's use of an EMPS evaluation on the same day as the ED stay, and within 7 days of the ED stay separately for [Medicaid] youth and adults.

   Please note that additional measures may be added as determined by the workgroup made up of representatives from EDs, the departments, and the contractor.

C. By October 15, 2012, the Contractor shall have the Departments' review and approval of the draft ED Profiles.

D. By December 14, 2012, the Contractor shall have completed a cycle of the ED PAR program by sharing the profiles with individual EDs in face to face meetings, via conference call, or by mail.

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under

the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed as having met the required target for full or partial return of the withhold.
If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

If DCF or their Contractor is unable to access claims data from DSS, AND all requirements of this performance target under the control of the Contractor have been successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full return of the withhold.

Target 6: Development and Implementation of a Provider Analysis and Reporting Program for In-State Residential Treatment Centers (RTC) and Therapeutic Group Homes (TGH) (Congregate Care)

Value: 1.0%

Between 2008 and 2010, the Connecticut Department of Children and Families (DCF) worked with in-state RTC providers and ValueOptions CT to establish a mutually agreed upon set of performance indicators that would allow RTC providers to understand their own performance on set indicators as well as to compare their performance and outcomes with each other. Some of these reports were based solely on RTC chart reviews conducted by DCF staff. Others were based either solely on ValueOptions authorization data or a combination of authorization data and DCF data (e.g., data from LINK regarding services paid for by DCF flex funds following an RTC stay).

During both 2009, 2010 and into early 2011, the data in the RTC outcome reports was shared with the RTC provider community during group meetings of the providers or during provider-specific meetings. These meetings were temporarily curtailed during a time of transition within DCF. ValueOptions continued to produce and share with DCF the RTC reports based solely on authorization data. The planned development of the therapeutic group home reports was placed on hold. An additional report that compared the time spent in community prior to an RTC stay with the time in community post an RTC stay was developed during the latter half of 2011 in lieu of the measures that were dependent on DCF staff (chart audit reports) that ValueOptions could no longer produce as well as the therapeutic group home measures.

Building on the work done in previous years, for CY 2012, ValueOptions will:

1. Re-establish a Provider Analysis and Reporting program (PARs) for CT in-state RTCs
2. Establish a Provider Analysis and Reporting program (PARs) for Therapeutic Group Homes

I. Congregate Care PARs Program Phase I

A. Specifically, in CY 2012, and by August 1, 2012, the Contractor shall produce a quarterly PAR profile for 1) In-State RTCs and 2) Therapeutic Group Homes. The profiles for each of the providers of these services will include the following performance indicators that are based on data collected by ValueOptions or on data supplied by DCF:

1. Average Length of Stay (ALOS) for planned discharges, ALOS for unplanned discharges, Acute Length of Stay, and Discharge Delay Length of Stay

2. Experience in Placement

a. Average length of time to achieve readiness for planned discharge to a lower level of care, also referred to as the Average Acute Length of Stay

i. This measure begins with the subset of youth discharged during the reporting period from the program to a CT BHP authorized lower level of care within 90 days and then measures the total days and average length of time for those youth to achieve readiness for discharge.

b. Number of inpatient hospitalization events during the program stay

i. This measure begins with all youth discharged during the reporting period and then determines the number of hospitalizations and percentage of those youth who had an inpatient stay during their program stay.

c. Program Discharge Delay Days

i. This measure begins with all youth discharged from the program during the reporting period and then determines the number and percentage of those youth who experienced discharge delay during their program stay.

d. Number of Suicide Attempts, AWOLS, Arrests, Restraints

i. This measure, based on data received from DCF, displays graphically the number of suicide attempts, AWOLS, Police/EMS calls, Arrests and Restraints for youth during their program stay.

3. Program Post Placement Experience

a. Lower Level of Care within 90 days
i. This measure determines the number of discharges per quarter for each program and then determines the % of those cases with an authorization for a lower level of care within 90 days.

b. Incidence of Hospitalizations Post Program Stay
i. This measure takes the subset of youth discharged during the reporting period and authorized for a lower level of care post-discharge who were subsequently admitted to a higher level of care within 180 days of discharge.

c. Number of Youth Experiencing First Hospitalization
i. This measure begins with all youth discharged from the program and then measures how many of those youth were admitted within 180 days to a higher level of care.

B. Possible Additional Measures for the RTC PARs Program

1. Comparison of Days in Community during the 180 days prior to and post RTC placement
a. This measure begins with all youth discharged from RTC during the reporting period and eligible for Medicaid services during both the six (6) month period before as well as six (6) months after the RTC stay.

b. In order to measure the "days in community", all days that the youth spent in a confined setting during both periods are totaled for the both the period before the RTC stay and following the RTC stay. These totals for each of these periods are then compared in terms of percent of change.
c. Youth that are transferred to another RTC or discharged to Connecticut Juvenile Training School (CJTS)/Detention/Correctional Facilities will be removed from this measure.
d. Levels of care that are considered to be spent in confined settings are those days spent in inpatient psychiatric facilities, medical beds boarding as they await an inpatient psychiatric facility, inpatient detoxes and psychiatric residential treatment facilities.
e. To establish the total possible days in the community, 183 days (the number of days in a six (6) month period) is multiplied by the total number of youth discharged within the cohort. The total number of days in a confined setting is then subtracted from the total number of possible days in community to obtain the actual days in community.

2. Rate of RTC disruptions

a. This is a new measure that resulted from discussions with DCF during the review of the "time in community measure" reported for the 2011 performance target. In completing that measure, we found that RTCs seem to have different rates of members who require transfer to another RTC when the original RTC is unable to safely maintain them in their treatment setting.
b. The proposed methodology for the measure begins with all youth discharged from RTC during the reporting period and then determines the number and percentage of all discharges that resulted in transfers to or readmissions to another RTC within a two week period of time.

3. Number of Referrals/Matches Accepted to RTC Program

a. This measure displays the number of RTC "match" and "admit" decisions and the reported reasons for decline of a match or admission.

C. Possible Additional Measures for the TGH PARs Program

1. By September 30, 2012, up to two (2) additional measures for the TGHs will be determined in collaboration with DCF and the TGH providers during Phase II of the establishment of the Congregate Care PARs Program
2. Once the additional measures are agreed upon, the contractor shall produce reports of those measures by November 15, 2012.

II. **Congregate Care PARs Program – Phase II**.

A. By September 15, 2012, the contractor shall have established separate RTC and a TGH workgroups made up of program staff representatives from each of the programs, as well as DSS, DCF, and ValueOptions that will review the initial profiles, and provide input into the additional measures, review and provide input into the methodology for each of the indicators, and to establish goals for performance.

B. As many workgroup meetings as necessary will be convened to allow for decisions to be made regarding the two (2) additional measures for the TGHs. Decisions regarding the choices of measures will be based in part upon the availability of the DCF resources necessary to generate any of the measures.

C. By December 14, 2012, the Contractor shall have completed the first cycle of both the RTC and the TGH PARs program by sharing the profiles with the programs. The review of the profiles with the programs may take the form of a statewide meeting, regional meetings or individual meetings; this determination will be based on provider performance level.

III. Integration of DCF and ValueOptions, CT Data

Both DCF and ValueOptions have increasingly recognized the need to move towards establishing methods for integrating the data held within our separate organizations. As part of the performance target for 2012, we would like to propose that we move the process forward by working with DCF staff to establish specific data-integration goals.

A. By June 1, 2012, specific individuals from both organizations be identified and establish a workgroup.

B. By August 1, 2012, the workgroup would have developed at least three recommendations for datasets that would benefit from integration. These recommendations will be reviewed collaboratively between our organizations and at least one chosen to have clear methodology established and reports produced by the end of 2012.

C. By December 15, 2012, the first report that demonstrates successful integration of data would be produced.

****Note: Replacement of a performance indicator, or edit to an existing performance indicator, as noted above, is acceptable upon mutual agreement by the Department and the Contractor*

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, or the department's priorities and direction changes prior to the completion of this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of the withhold.

If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

Original Contract Number:11DSS1206AL
Amendment Number:
Maximum Contract Value: $53,267,152.00
Contractor Contact Person and Telephone: Lori Szczygiel
860-263-2005

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
HUMAN SERVICE CONTRACT

CONTRACT SUMMARY

This contract is entered into by and between The State of Connecticut Department of Social Services, with the central office located at 25 Sigourney Street, Hartford, CT 06106 and the State of Connecticut Department of Children and Families with the central office located at 505 Hudson Street, Hartford, CT 06106 and the State of Connecticut Department of Mental health and Addiction Services with the central office located at 410 Capitol Avenue, Hartford, CT 06134 (hereinafter individually referred to as "DSS", "DCF" and "DMHAS" respectively and collectively referred to as the "Departments") and Value Options, Inc. with an FEIN Number of 541414194 and its headquarters located at 240 Corporate Boulevard, Norfolk, VA 23502 (hereinafter referred to as the Contractor).

The Departments and the Contractor agree to the following:

Term of Contract	This contract is in effect from January 1, 2011 through December 31, 2013 with two (2) additional one-year extensions that may be exercised by the Departments in whole or in parts.
Statutory Authority	The Department is authorized to enter into this contract pursuant to § 17a – 22a of the Connecticut General Statutes.
Set-Aside Status	Contractor ☐ IS or ☒ IS NOT a set aside Contractor pursuant to § 32-9e of the Connecticut General Statutes.
Effective Date	This contract shall become effective only as of the date of signature by the Departments' authorized official(s) and, where applicable, the date of approval by the Attorney General. Upon such execution, this contract shall be deemed effective for the entire Term specified above. This contract may be Amended subject to Part II, Section C 1 of this contract.

WHEREAS, pursuant to CGS § 17a-22h the Department of Children and Families ("DCF") and the Department of Social Services ("DSS") formed the Behavioral Health Partnership (hereinafter referred to as "the Partnership") to plan and implement an integrated public behavioral health service system for HUSKY members and children enrolled in the voluntary services program operated by DCF (the "Original Coverage Groups"); and

WHEREAS, the primary goal of the Partnership was to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes; and

WHEREAS, through a competitive procurement the Partnership selected and entered into a contract with Value Options, Inc. (hereinafter referred to as the "Contractor") to serve as the Administrative Services Organization ("ASO") for the operation of the integrated public behavioral health service system for children and families designed to meet the goals of the Partnership; and

WHEREAS, since August 17, 2005, Contractor has been operating as the ASO for the operation of an integrated public behavioral health service system for the Original Coverage Groups designed to meet the goals of the Partnership pursuant to the terms of contract number 05DSS1206AL; and

WHEREAS, the Department of Mental Health and Addiction Services (DMHAS) is the state healthcare service agency responsible for health promotion and the prevention and treatment of mental illness and substance use disorders for adults eighteen years and older in Connecticut; and

WHEREAS, DMHAS envisions a recovery-oriented system of behavioral health care that offers Connecticut citizens an array of accessible services and recovery supports from which they will be able to choose those that are effective in addressing their particular behavioral health condition or combination of conditions; and

WHEREAS, Public Act No 10-119 amended CGS § 17a-22h to add the Department of Mental Health and Addition Services ("DMHAS") to the Partnership and to expand the integrated public behavioral health service system to include Medicaid recipients who are not enrolled in HUSKY Plan Part A and Charter Oak Health Plan members (the "Expanded Coverage Groups"); and

WHEREAS, DMHAS and DSS conducted a competitive procurement to select an Administrative Services Organization ("ASO") to provide clinical management, provider network development and other administrative services to the Expanded Coverage Groups in accordance with the goals of the Partnership; and

WHEREAS, through the competitive procurement DSS and DMHAS selected Contractor to negotiate a contract to provide clinical management, provider network development and other administrative services for behavioral health services for the Expanded Coverage Groups; and

WHEREAS, as the ASO for behavioral health services for the Original Coverage Groups is also the ASO for behavioral health services for the Expanded Partnership Coverage Groups, it

is in the best interests of the Partnership and the Contractor to integrate the ASO requirements and the rights and obligations of the Partnership and the Contractor into a single system and a single contract through which the Partnership and the Contractor shall provide Integrated Services Supporting the Health and Recovery of Children, families and adults in Connecticut; and

WHEREAS to do so, DSS, DCF and the Contractor have agreed to cancel contract number 05DSS1206AL upon the effective date of this Contract and further that the terms of this Contract shall dictate and define the Contractor's rights and obligations to provide clinical management, provider network development and other administrative services for the provision of behavioral health services to both the Original and Expanded Coverage Groups; and

WHEREAS, upon the proper execution of this contract by the authorized signers and the approval of the Office of the Attorney General, as to form, the effective date of this contract shall be January 1, 2011 and the contract term shall expire on December 31, 2013.

NOW THEREFORE, the Department of Social Services ("DSS"); the Department of Mental Health and Addictions Services ("DMHAS") and the Department of Children and Families (collectively, "the Partnership") and Value Options, Inc. ("Contractor') as the Administrative Services Organization to the Partnership, for good and valuable consideration, the sufficiency of which is set forth herein, agree as follows:

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PART I: SCOPE OF WORK
A. DEFINITIONS

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

A.1.1 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.1.2 Ad-hoc Report: A report that has not been previously produced and which may require specifications to be written and development and testing prior to production to complete.

A.1.3 Administrative Hearing: Also called Fair Hearing. A proceeding during which a Medicaid fee-for-service member 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.1.4 Administrative Services Organization (ASO): an organization providing statewide utilization management, benefit information and intensive care management services within a centralized information system framework.

A.1.5 Adult: Person 18 years of age or older.

A.1.6 Agent: An entity with the authority to act on behalf of DMHAS or DSS or DCF.

A.1.7 Appeal: A procedure through which members or providers can request a re-determination of an ASO decision concerning, but not limited to service authorization.

A.1.8 Automated Eligibility Verification System (AEVS): The sole comprehensive source of the Department of Social Services' client eligibility information.

A.1.9 Behavioral Health Partnership ("Partnership" or "CT BHP"): An integrated behavioral health service system developed and managed by the Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services for HUSKY Part A and HUSKY Part B

members, Medicaid recipients not enrolled in Managed Care (Medicaid Fee-for-Service Members), Charter Oak Health Plan Members and children enrolled in the Voluntary Services Program operated by the Department of Children and Families

A.1.10 Behavioral Health Services: Services that are necessary to diagnose, correct or diminish the adverse effects of a psychiatric or substance use disorder.

A.1.11 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.1.12 Care Coordination: A voluntary service provided to Members with complex behavioral health service needs. Services include assessment, advocacy, referral, linkage and coordination of wrap around services according to an individualized recovery plan incorporating the input of individuals and their families or other natural supports. Services are provided in the community, and a primary goal is to assist members and their families in gaining access to needed behavioral health, medical, social, educational or other recovery support services. DMHAS and DCF provide and or fund services that are field-based and that typically involve considerable direct, face-to-face member contact.

A.1.13 Care Coordinator: Paraprofessionals who provide extensive direct support to members with complex behavioral health needs. Care Coordinators help Members and their families develop individualized recovery plans, broker and advocate for the provision of both traditional and non-traditional support services, coordinate and monitor specific service delivery and the implementation of the individualized recovery plan. Care coordinators may be employed by DMHAS's local health authorities, agencies under contract with DCF or agencies under contract with DMHAS.

A.1.14 Care Manager: An independently licensed behavioral health care clinician employed by the Contractor to perform utilization review on services that require prior authorization and concurrent review.

A.1.15 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. DMHAS and DCF provide and or fund case management services that are field-based and that typically involve considerable direct, face-to-face client contact, although DCF uses the term care coordination to describe these services.

A.1.16 Case Managers: Paraprofessionals whose responsibilities include

outreach, engagement, linkage, advocacy, and monitoring of assigned cases.

A.1.17 Certified Alcohol and Drug Abuse Counselor (CADC): Substance Abuse counselors, who have met the necessary criteria for certification by the State of Connecticut, demonstrated the competency requirements and completed the certification process as established by the State under Section 20-74s of the Connecticut General Statutes.

A.1.18 Children: Individuals under eighteen (18) years of age.

A.1.19 Clinical Management: The process of evaluating and determining the appropriateness of the utilization of behavioral health services as well as providing assistance to clinicians or members to ensure appropriate use of resources. It 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.1.20 Clinical Risk: The potential for direct or indirect injury or harm to self and/or others, including property damage which could directly or indirectly result in injury or harm to the individual and/or others.

A.1.21 Clinician: Unless otherwise designated by any or each of the Departments, a person who is licensed to practice in the State of Connecticut in the field of Social Work, Marital and Family Therapy, Professional Counseling, Nursing, Psychology, Medicine, or Alcohol and Drug Counseling (including certified alcohol and drug counselors).

A.1.22 Committed: Placement 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.1.23 Community Collaborative: A local consortium of health care providers, parents and guardians of children with behavioral health needs, and service and education agencies that have organized to develop coordinated, comprehensive community resources for children or youth with complex behavioral health service needs and their families in accordance with principles and goals of Connecticut Community KidCare.

A.1.24 Complaint: A written or oral communication to the Contractor from an individual expressing dissatisfaction with some aspect of the Contractor's services.

A.1.25 Complex Behavioral Health Service Needs: Behavioral health needs that require specialized, coordinated behavioral health services across several service systems (i.e., school, mental health, court).

A.1.26 Comprehensive Global Assessment: An intensive, multi-dimensional assessment for children and adolescents with complex behavioral health service needs. The purpose of the assessment is to provide clinical information necessary for the development of an individual service plan and to restore or help a child or adolescent attain the highest level of functioning possible in the community.

A.1.27 Concurrent Review: Review of the medical necessity and appropriateness of behavioral health services on a periodic basis during the course of treatment.

A.1.28 Connecticut Community KidCare: DCF's reform initiative that focuses on eliminating the major gaps and barriers that exist in the current children's behavioral health delivery system.

A.1.29 Connecticut Medical Assistance Program (CMAP): The Connecticut Medical Assistance Program is comprised 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), Connecticut Behavioral Health Partnership (CTBHP), Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (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 Program.

A.1.30 Consultant: A corporation, company, organization or person or their affiliates retained by the Departments to provide assistance in this project or any other project; not the Contractor or subcontractor.

A.1.31 Contract Administrator: The State of Connecticut employee designated by the Departments responsible for fulfilling the administrative responsibilities associated with this contract.

A.1.32 Contract Services: Those services that the Contractor is required to provide under this contract.

A.1.33 Contractor: ValueOptions, Inc., an Administrative Services Organization, providing a single source for clinical management, benefit information, member services, quality management, and other administrative services outlined in this Contract within a centralized information system framework.

A.1.34 Current Procedural Terminology (CPT): Current Procedural Terminology codes published by the American Medical Association.

A.1.35 Crisis Stabilization Program: A short-term residential service provided to a child or adult with a rapidly deteriorating psychiatric condition in order to reduce the risk of harm to self or others, assess underlying causes to

the psychiatric condition, stabilize psychiatric symptoms or behavioral and situational problems, and avert the need for psychiatric inpatient services.

A.1.36 Critical Incident/Significant Event: Any incident that results in serious injury, or risk thereof, serious adverse treatment response, death of a service user, or serious impact on service delivery as defined by DCF's and/or DMHAS' policies and procedures.

A.1.37 Data Warehouse: A data storage system or systems constructed by consolidating information currently being tracked on different systems by different contractors of the Departments.

A.1.38 Date of Application: The date on which a completed Medical Assistance application or a HUSKY application is received by the Department of Social Services, or its agent, containing the applicant's signature.

A.1.39 Day: Except where the term "business days" is expressly used, all references in this contract will be construed as calendar days.

A.1.40 Day Treatment: An intermediate level of treatment of less than 24 hours per day but typically lasting four (4) to six (6) hours per day, 3 to 5 days per week, provided to prevent the need for inpatient psychiatric hospitalization or as a step towards community reintegration. Treatment involves a distinct and organized, intensive ambulatory set of services provided by a mental health day treatment facility, a day or evening treatment facility or an outpatient psychiatric clinic for children, under the supervision of a physician.

A.1.41 DCF Identifier: An identifier on the EMS file that, for those children with DCF involvement, specifies the nature of that involvement.

A.1.42 Denial of Authorization: Any rejection, in whole or in part, of a request for authorization from a provider on behalf of a member.

A.1.43 Departments: The Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF) or their agents.

A.1.44 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.1.45 Discharge Review: A review by the Contractor of the discharge plan prior to a recipient's discharge from service.

A.1.46 Discharge Planning: The evaluation of a member's need for psychiatric or substance use disorder services, or both, developed in order to

arrange for appropriate care after discharge or upon transferring from one level of care to another level of care.

A.1.47 Diversion: An alternative level of care identified to meet the Members' needs following a clinical discussion between the referring clinician and Contractor or Mobile Crisis Team or Emergency Mobile Psychiatric Services (EMPS) staff. It is expected that identified alternative resource(s) will safely meet the needs of the identified individual in the least restrictive setting.

A.1.48 D02: The Medicaid coverage group designation in DSS's eligibility management information system for DCF state funded Medicaid members nearly all of whom are eventually enrolled in managed care under HUSKY A.

A.1.49 D05: Also known as the Limited Benefits Program, is the medical assistance coverage group for children and youth that are not eligible for HUSKY, but are involved with DCF through child protection, Voluntary Services or juvenile justice that affords limited behavioral health benefits funded by DCF.

A.1.50 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Care Coordination Services: Services such as making and facilitating referrals and development and coordination of a plan of services that will assist Medicaid members under twenty-one (21) years of age in gaining access to needed medical, social, educational, and other services.

A.1.51 Electronic Data Systems, Inc. (EDS): See definition for HP Enterprise Services (HP) formerly EDS.

A.1.52 Eligible: Eligible means that the individual has been approved or is entitled to services under the BHRP or Partnership or a particular program included under the BHRP or Partnership.

A.1.53 Eligibility Management System (EMS): An automated mainframe system operated by the Department of Social Services (DSS) for maintaining eligibility information regarding Medicaid (including HUSKY A) or Voluntary Services members. It also provides fully integrated data processing support for benefit calculation and issuance, financial accounting, and management reporting.

A.1.54 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.1.55 Emergency Mobile Psychiatric Services (EMPS): Services for children and adolescents that provide immediate, mobile assessment and intervention to individuals in an active state of crisis and can occur in a variety of settings including the member's home, school, local emergency department, or other community setting.

A.1.56 Emergency Services: Inpatient and outpatient services including, but not limited to, behavioral health and detoxification needed to evaluate or stabilize an emergency medical condition.

A.1.57 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 B programs that may include HUSKY application processing, HUSKY B eligibility determinations, passive billing and enrollment brokering, or other functions as required by DSS.

A.1.58 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 21 years of age in gaining access to needed medical, social, educational, and other services. The Contractor's intensive care management and care management programs shall include the provision of EPSDT case management services.

A.1.59 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.1.60 EPSDT Services: Comprehensive child health care services to members under twenty-one (21) years of age, including all medically necessary prevention, screening, diagnostic and treatment services listed in Section 1905 (r) of the Social Security Act.

A.1.61 Evidence Based Programs: Treatment services that have met strict scientific standards of effectiveness, and that require intensive training and supervision to ensure fidelity to the model.

A.1.62 Explanation of Benefits (EOB): The remittance advice received by the provider, which details how the service was adjudicated.

A.1.63 Extended Day Treatment: An intermediate level of care for children and adolescents who have returned from out-of-home care or are at risk of placement in out-of-home care due to behavioral health issues. Programs provide a site-based, comprehensive array of therapeutic services before and or after school with a focus on treatment and

psychosocial rehabilitation services.

A.1.64 External Quality Review Organization (EQRO): An entity responsible for conducting reviews of the quality outcomes, timeliness of the delivery of care and access to items and services for which the Contractor is responsible under this contract.

A.1.65 Extranet: An extranet is a secure private computer network that uses the Internet protocol and the public telecommunication system to securely share part of a business's information or operations with suppliers, contractors, partners, customers, or other businesses.

A.1.66 Family: Family means a child or youth with behavioral health needs 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.1.67 Fee for Service Member (see Medicaid Fee for Service Member): A Medicaid client who is not enrolled in a managed care plan.

A.1.68 Fee for Service Reimbursement (FFS): A reimbursement method for health services under which a provider charges separately for each patient encounter or service rendered.

A.1.69 Formulary: A list of selected pharmaceuticals determined to be the most useful and cost-effective for patient care, developed by a pharmacy and therapeutics committee at the MCO.

A.1.70 FQHC-Sponsored Contractor: A Contractor that is more than fifty (50) percent owned by Connecticut Federally Qualified Health Centers, certified by the Department of Social Services as a qualified entity to enroll Medicaid recipients.

A.1.71 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.1.72 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.1.73 Health Employer Data Information Set (HEDIS): A standardized performance measurement tool promulgated by the National Committee for Quality Assurance (NCQA) that enables users to evaluate quality 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.1.74 Home Health Care Services: Services provided by a home health care agency (as defined in Subsection d of section 19A-4890 of Connecticut General Statutes) that is licensed by the Department of Public Health, meets the requirements for participation in Medicare, and meets all DSS enrollment requirements.

A.1.75 HP Enterprise Services (HP) formerly EDS: The Department of Social Services' MMIS Contractor, contracted to process and adjudicate claims through the Medicaid Management Information System (MMIS) to support the Connecticut Medical Assistance Program.

A.1.76 HUSKY, Part A or HUSKY A: Connecticut implementation of managed care health insurance under the federal Medicaid program (Title XIX) for children and their relative caretakers. Eligibility is for children of families earning below 185% and relative caretakers of families earning below 185%, as well as pregnant women under 250% of the federal poverty groups pursuant to Section 17b-266 of the Connecticut General Statutes.

A.1.77 HUSKY, Part B or HUSKY B: The health insurance plan for children established pursuant to Title XXI (SCHIP) 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.1.78 Implementation: The date on which the Contractor assumes responsibility for the management of behavioral health benefits for Medicaid Fee-for-Service recipients and Charter Oak Health Plan Members.

A.1.79 Implementation Review: An on-site review the purpose of which is 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.1.80 Individualized Support Services: Individualized Support Services refers to a broad range of activities and or services, coordinated through an

individualized treatment plan, that focus on improving and or restoring the functioning of a child or adolescent with behavioral health needs.

A.1.81 Inpatient: Inpatient refers to a level of care including an array of behavioral health and medical services provided in a 24-hour medically managed setting to a child or adult in need of acute psychiatric care due to impaired thought processes or the potential for dangerousness to self or others.

A.1.82 Institution for Mental Disease (IMD): A facility of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illness.

A.1.83 Intensive Care Management (ICM): Intensive care management refers to specialized care management techniques that are activated by the ASO when an individual is experiencing difficulty with or barriers towards recovery and/or improved outcomes.

A.1.84 Intensive Care Manager: An independently licensed behavioral health clinician employed by the Contractor who is responsible for managing and coordinating the care of individuals who are eligible for intensive care management.

A.1.85 Intensive Home Based Service: An intensive rehabilitative service provided to children with complex behavioral health service needs and their families in the home, school or other community setting. This service is provided as part of an individualized service plan and is provided to children who have not been effectively treated in office-based behavioral health treatment and who require intervention in a naturalistic setting.

A.1.86 Intensive Outpatient Program (IOP): An organized, integrated and distinct intermediate care program of therapeutic services lasting typically three (3) to four (4) hours per day for up to five (5) days per week. Members typically are less acute than those requiring partial hospitalization but require a supervised, structured setting to prevent relapse.

A.1.87 Interactive Voice Response System (IVRS): A telephone system that will allow providers to determine authorization, eligibility or claims status without human intervention.

A.1.88 Intermediate Care: A class of outpatient treatment services including Partial Hospital Program (PHP), Day Treatment, Adult Day Treatment (ADT), Intensive Outpatient Program (IOP) and Extended Day Treatment (EDT).

A.1.89 Intermediate Duration Acute Psychiatric Care: An extended period of intensive clinical treatment and rehabilitation provided to an individual

with a documented DSM IV Axis I or Axis II diagnosis within a distinct unit of a general hospital by a specialized multi-disciplinary team focused on clinical stabilization, psychiatric rehabilitation, skill development and continuous observation during an average length of stay of 30-45 days.

A.1.90 Involuntary Admission: Under Connecticut law, a physician who has examined a person may authorize psychiatric treatment against the person's will by signing an emergency certificate certifying that the person has a psychiatric disability and is a danger to himself/herself or others and/or gravely disabled.

A.1.91 Level of Care (LOC) Guidelines: Guidelines that are used by the Contractor to conduct utilization management and which help to determine whether a behavioral health service is medically necessary and medically appropriate.

A.1.92 Local Mental Health Authority: A private non profit organization or a DMHAS state operated agency that is responsible for the coordination and direct provision of care for adults with severe and persistent mental health disorders.

A.1.93 Licensed Behavioral Health Professional: An individual holding a current Connecticut license for one of the following professions: physician who is board-certified in psychiatry, clinical social worker, marriage and family therapist, psychologist, nurse clinician who holds a clinical nurse specialty in psychiatry, professional counselor, or alcohol and drug counselor (including certified alcohol and drug counselors).

A.1.94 LINK: The State of Connecticut's Statewide Automated Child Welfare Information System (SACWIS). LINK is not an acronym.

A.1.95 Managed Care Organization (MCO): The organizations that provide managed care services under a contract with DSS for individuals enrolled in HUSKY A, HUSKY B or Charter Oak.

A.1.96 Managed Service System: A consortium of DCF-funded provider agencies convened under the authority of the DCF local Area Office to assure that a comprehensive and coordinated array of services is available at the local level to meet the behavioral health and community support needs of children and their families.

A.1.97 Medicaid: The Connecticut Medical Assistance Program 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.1.98 Medicaid Fee-for-Service (FFS) Member: A Medicaid client who is not enrolled in a managed care plan.

A.1.99 Medicaid Management Information System (MMIS): DSS' automated

claims processing and information retrieval system certified by CMS and currently operated by HP Enterprise Services. It is organized into six function areas--Member, Provider, Claims, Reference, Management and Administrative Reporting subsystem (MAR) and Surveillance and Utilization Review subsystem (SUR).

A.1.100 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.1.101 Member: An individual eligible for coverage of behavioral health services under the Partnership.

A.1.102 Mobile Crisis Service: A service for adults that provides immediate, mobile assessment and intervention to individuals in an active state of crisis and can occur in a variety of settings including the member's home, local emergency department, or other community setting.

A.1.103 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.1.104 Network Manager: An employee of the Contractor who supports provider development by providing profiling analyses and results, developing continuous quality improvement plans, and support providers and communities in the execution of the plans.

A.1.105 Normal Business Hours: The normal business hours for the Contractor will be 9 AM through 7 PM, Monday through Friday except for seven (7) holidays: New Years Day, Memorial Day, July 4th, Labor Day,

Thanksgiving Day, the day after Thanksgiving Day, and Christmas Day.

A.1.106 Operational: Performance by the Contractor of all of the major functions and requirements of this contract for all Partnership members.

A.1.107 Outlier Management: Utilization management protocols geared toward client- or provider-based utilization levels that fall below or exceed established thresholds.

A.1.108 Out-of-Network Provider: A provider that is not enrolled in the Connecticut Medical Assistance Program Provider Network.

A.1.109 Outpatient Treatment: Individual, family or group therapy provided in a non-inpatient (i.e. non-24 hour) care setting such as a physician's office, clinic, school, hospital outpatient department or a community health center.

A.1.110 Partial Hospital Program (PHP): Treatment of less than 24 hours per day but typically lasting four (4) to six (6) hours per day, 3 to 5 days per week, provided to prevent the need for inpatient psychiatric hospitalization or as a step towards community reintegration. Treatment involves a distinct and organized, intensive ambulatory set of services provided by a hospital or a community mental health center, under the supervision of a physician.

A.1.111 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.1.112 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.1.113 Peer Liaison: Adults in recovery who are trained to provide support, referral and educational information to individuals and/or agencies specific to recovery and recovery resources.

A.1.114 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.1.115 Peer Review Organization (PRO): (See Quality Improvement

Organization.)

A.1.116 Peer Specialists: Trained parents of children with behavioral health needs and adult members in recovery who provide education and outreach to members and families, to support engagement in treatment, navigation of the service system, and identification of natural supports. Peer Specialists for adults are trained individuals that provide support and advocacy to members engaged in the recovery process.

A.1.117 Performance Review: An on-site review by any one or each of the Departments the purpose of which is to determine whether and to what extent the Contractor is operating its administrative services in accordance with the terms of this contract.

A.1.118 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.1.119 Preferred Practice: Designation given by the Departments to recommend clinical/intervention practices.

A.1.120 Presumptive Eligibility: A method of determining temporary Medicaid eligibility for children under the age of nineteen (19) and pregnant women. The determination is made by organizations authorized under federal and State law and approved by DSS to make presumptive eligibility determinations. These organizations are called Qualified Entities or Qualified Providers. Children and pregnant women who are given presumptive eligibility become entitled to Medicaid benefits on the date the Qualified Entity or Qualified Provider makes the determination.

A.1.121 Primary Care Provider (PCP): A licensed health care professional responsible for performing or directly supervising the primary care services of members.

A.1.122 Prior Authorization: Refers to the Contractor's process for approving payment for 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 and medically appropriate.

A.1.123 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 HCPCS (which include CPT codes) and Revenue Center Codes (RCCs).

A.1.124 Professional: A behavioral health or medical practitioner licensed or certified by DPH, DCF, or DMHAS.

A.1.125 Provider: A person or entity under an agreement with one or any of the Departments to provide services to members.

A.1.126 Provider Network: Provider Network means all providers enrolled in the Connecticut Medical Assistance Program Provider Network that serves members.

A.1.127 Psychiatric Residential Treatment Facility (PRTF): An inpatient psychiatric facility that provides 24-hour medical management and psychiatric and other therapeutic services to individuals under age 21.

A.1.128 Psychiatric Security Review Board (PSRB): A review board responsible for the oversight of individuals who are declared not guilty by reason of insanity.

A.1.129 Qualified Entity: An entity that is permitted under federal and state law to determine presumptive eligibility for Medicaid.

A.1.130 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 DSS 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.1.131 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.1.132 Quality Management (QM): The process of reviewing, measuring and continually improving the processes and outcomes of care delivered.

A.1.133 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.1.134 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.1.135 Regional Network Manager: An employee of the Contractor who has expertise concerning local resources and professional and fiduciary relationships with contracted behavioral health service providers.

A.1.136 Registration: The process of notifying the department or its agent of the initiation of a behavioral health 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 Departments as requiring notification only.

A.1.137 Rehabilitation Services: Services designed to help an individual with the social skills and environmental supports they need to perform as successfully and independently as possible at home, in the family, at school, at work, and in other community roles and environments of their choice.

A.1.138 Requestor: The provider that is requesting authorization of a service on behalf of a member.

A.1.139 Residential Services: Therapeutic congregate care, independent living, and special foster care services that operate for the purpose of effecting positive change for adults, and positive change and normal development for children and youth with significant and complex behavioral health service needs.

A.1.140 Respite: A short-term service involving direct care or supervision of a member with behavioral health service needs. Respite is a non-clinical support service, which, in combination with clinical services, and as a component of an individualized service plan, is designed to facilitate a disposition from a hospital to avoid hospitalization and avoid placement out of the home.

A.1.141 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 and medically appropriate. Such reviews typically apply 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.1.142 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.1.143 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.1.144 Revenue Center Codes (RCC): A national coding system used to define

specific medical services used by hospitals and certain other providers.

A.1.145 Riverview: Riverview Hospital for Children and Youth is a psychiatric hospital, operated by the State of Connecticut that primarily serves children requiring extended acute stays, youth transferred from other hospital settings and youth who have been court ordered from detention centers.

A.1.146 Routine Cases: A symptomatic situation for which the Member is seeking care, but for which treatment is neither emergent nor urgent.

A.1.147 Standard Report: A report that once developed and approved will be placed into production on a routine basis as defined in the contract.

A.1.148 State Fiscal Year (SFY): July 1st through June 30th of the following year.

A.1.149 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.1.150 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.1.151 Substance Related Disorders: Substance Related Disorders include Substance Dependence and Substance Abuse with specific diagnostic criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (most recent edition).

A.1.152 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.1.153 Third Party: Any individual, entity or program that is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State plan.

A.1.154 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.1.155 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.1.156 Unique Provider Identifier (UPI): A single number or code assigned to each provider in a data system and used to individually identify that provider.

A.1.157 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 member's health and for which treatment cannot be delayed without imposing undue risk on the members' well-being until the member is able to secure services from his/her regular physician(s).

A.1.158 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 an individual within the State of Connecticut.

A.1.159 Utilization Management (UM) Protocol: Guidelines approved by the Departments and used by the Contractor in performing UM responsibilities.

A.1.160 Utilization Management (UM) Staff: Contractor's clinicians and care managers.

A.1.161 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.1.162 Voluntary Services: (PA. 97-272) A DCF operated program for children and adolescents with behavioral health disorders who are not otherwise committed to or involved with the Department. Voluntary Services allows access to services or treatment programs funded by DCF and supports family focused, community based treatment whenever possible.

A.1.163 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 Partnership member calls the Contractor regarding transportation, it would be expected that the Contractor would contact the appropriate DSS transportation broker and transfer the caller directly to the transportation broker or if a HUSKY member calls the Contractor regarding pharmacy, it would be expected that the Contractor would contact the member's MCO and transfer the caller directly to the MCO.

A.1.164 Well-care Visits: Routine physical examinations, immunizations and other preventive services that are not prompted by the presence of any adverse medical symptoms.

B. POPULATIONS TO BE SERVED AND ROLES OF THE DEPARTMENTS

The populations to be served by the Contractor through this contract are individuals with behavioral health disorders that are enrolled in the HUSKY A, HUSKY B, Medicaid fee for service (non-managed) and Charter Oak Health Plan programs and those Children who are

not otherwise enrolled in HUSKY A or HUSKY B but who may be involved with DCF through the Voluntary Services Program, child protective services, or juvenile justice. In addition, there are some children and adults in families who have recently qualified for Medicaid but have not yet been enrolled in a managed care plan as well as some children and adults who have been exempted from managed care because they are on Medicaid waivers (e.g., Katie Beckett, Acquired Brain Injury, Mental Health, Personal Care Assistance) or are designated to receive targeted case management services by either the Department of Developmental Services or the Department of Mental Health and Addiction Services.

DMHAS has the lead responsibility for the clinical management of publicly funded adult behavioral health services and DCF has the lead responsibility for the clinical management of publicly-funded behavioral health services to children, adolescents and families enrolled in the HUSKY A and HUSKY B Plans as well as children, adolescents and families served by DCF. The Departments will share three administrative functions including clinical management, claims processing and data management.

C. THE ROLE OF THE ADMINISTRATIVE SERVICES ORGANIZATION

The Contractor as the Administrative Services Organization (ASO) will be the primary vehicle for organizing and integrating clinical management processes across the payer streams. The Contractor's main function will be to support access to community-services, the delivery of quality services and to prevent unnecessary institutional care.

The Contractor will be expected to enhance communication and collaboration within the behavioral health delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system and provide integrated services supporting health and recovery by working with the Departments to recruit and retain both traditional and non-traditional providers.

C.1 The Contractor shall be responsible for administering the behavioral health benefits for Medicaid Fee-for-Service members; Charter Oak members; enrollees in the HUSKY A program and the federally subsidized portions of the HUSKY B program, including those benefits formerly managed by the HUSKY MCOs and their behavioral health subcontractors. In addition, if directed by DCF, the Contractor shall be responsible for administering the behavioral health benefits for children who are not otherwise enrolled in HUSKY A or HUSKY B, but who may be involved with DCF through the Voluntary Services program, child protective services, or juvenile justice. DCF will determine whether and to what extent these populations will be enrolled and have their benefits administered by the Contractor.

C.2 Utilization Management. The Contractor shall provide prospective, concurrent and retrospective utilization management (UM) services for eligible Members . Either registration or prior authorization will be required for most behavioral health services. The quality of services provided is monitored and managed and frequent users/potential frequent users of services are identified through prospective, concurrent and retrospective processes. The Utilization Management Program (UM Program) shall support providers in delivering clinically necessary and effective care with minimal administrative barriers. The Contractor shall utilize separate child and

adult specific level of care criteria approved by the Departments and provided to the Contractor. Denials of authorization must be based on the medical necessity definition as defined in A.1.111.

C.3 Intensive Care Management. Some Members receive intensive care management services when they meet criteria established by the Contractor and the Departments. Intensive care management (ICM) refers to specialized care management techniques that are activated by the Contractor when a member has been determined to meet the criteria for ICM services and is experiencing barriers to recovery. The Contractor may convene a multi-disciplinary team review when necessary. For those individuals who require ICM services, a written ICM plan will be required. Existing care plans will be reviewed with providers to ensure that they reflect the individual's needs and adequately address the complex behavioral health issues.

C.3.1 The Contractor shall provide ICM at the Contractor's central office in Connecticut and deploy Intensive Care Managers in the field when necessary. The Contractor's Intensive Care Managers may be assigned to local areas to establish a local presence and to build collaborative relationships with providers. The Intensive Care Managers apply state-of-the-art techniques in managing service delivery through the use of objective, standardized clinical protocols and outlier management programs. These Intensive Care Managers will intervene on behalf of members for whom the service system is not working effectively. With the support of others on the Contractor's staff, they will also be responsible for identifying over or under utilization of services, gaps in services and effective/ineffective treatment approaches. This information is conveyed to the Contractor's Regional Network Managers and Quality Management division.

C.3.2 On occasion, adults may receive care coordination services from DMHAS. Care coordinators provide extensive direct support to adult members with serious psychiatric and/or substance related disorders. DMHAS case managers are employed by DMHAS' local mental health authorities and contracted agencies. The local mental health authorities and contracted agencies determine eligibility for and regulate access to case management services.

C.3.3 By providing UM services and ICM services, the Contractor shall have a significant role in improving clinical care decisions. In doing so, the Contractor must make every effort to support collaborative clinical care decision-making at the local level, to inform and support care-planning processes, and support the meaningful participation of families and consumers in directing their own care.

C.3.4 The Contractor's UM and ICM processes must support effective system management, easy access to appropriate services, and the development and maintenance of high quality services.

D. CONTRACT MANAGEMENT AND ADMINISTRATION

D.1 Contract Oversight

D.1.1 The Departments recognize the importance of providing a unified point of contact and unified response in its administration of this contract.

D.1.2 The Departments shall each designate a Contract Manager (hereinafter individually and collectively referred to as "Contract Managers") to oversee management of this Contract. The Contract Manager will be the Contractor's first contacts and shall respond to all issues and inquiries that arise related to Contract implementation, operations, and program management.

D.1.3 The DSS Contract Administrator shall serve as the Contract Administrator for this Contract, an agent of the Departments under the direction of the Contract Managers and will among other things, issue formal opinions under the direction of the Contract Managers with regard to interpretation of the Contract, the Contractor's performance under the terms of the Contract, and the administration of Contract incentives and sanctions.

D.1.4 The Departments may, at their discretion, station one or more of their employees on-site at the Contractor's place(s) of business to provide consultation, guidance and monitoring regarding the administration of this Contract.

D.2 Key Person

D.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.

D.2.2 The Contractor's key person must be approved by the Departments. Such designation shall be made in writing to the Contract Administrator within five (5) working days of execution of this 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.

D.2.3 The Contractor's key person shall immediately notify the Contract Managers of the discharge of any personnel assigned to this Contract and such personnel shall be immediately relieved of any further work under this Contract.

D.2.4 The Contractor's key person or designee shall be the first contact for the

Departments regarding any questions, problems, and any other issues that arise during implementation and operation of this Contract.

D.3 Key Positions and Personnel

D.3.1 Key Positions shall mean executive or managerial positions. Key Personnel shall mean the person in the Key Position.

D.3.2 The Contractor's key positions and key personnel must be approved by the Departments. Such designations shall be made in writing to the Contract Administrator within five (5) working days of the execution of this Contract. No changes, substitutions, additions or deletions, whether temporary or permanent shall be made unless approved in advance by the Departments, whose approval shall not be unreasonably withheld.

D.3.3 During the course of this Contract, the Departments reserve the right to require the removal or reassignment of any Contractor personnel or subcontractor personnel assigned to this Contract found unacceptable by any of the Departments. Such removal shall be based on grounds which are specified in writing to the Contractor and which are not discriminatory.

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

D.3.5 The Departments shall approve the Contractor's implementation team for this contract and the implementation team shall remain involved until the Departments have agreed in writing that the implementation team is no longer required and full responsibility for all aspects of the Contract can transfer to the key person.

D.4 Contract Administration

D.4.1 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 Managers.

D.4.2 The Contractor shall first contact the Departments' Contract Managers for all matters stated above. In no instance shall the Contractor refer matters to the Contract Administrator unless an initial contact both verbally and in writing concerning the individual matter has been presented to the Departments' Contract Managers.

D.4.3 When responding to written correspondence by the Departments or when otherwise requested by the Departments, the Contractor shall provide written response.

D.4.4 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 this Contract to the Contract Managers.

D.4.5 The Contractor shall coordinate directly with the appropriate Department representatives as directed by the individual Contract Manager when individual issues arise involving clinical care, quality of care, or safety for a specific member.

D.4.6 The Contractor's key person or designee shall respond to telephone calls from the Departments within one (1) business day.

D.5 Deliverables – Submission and Acceptance Process

D.5.1 The Contractor shall submit to the Departments certain materials for their review and approval. For purposes of this section, any and all materials required to be submitted to the Departments for review and approval shall be considered a "Deliverable" and unless otherwise specified each "Deliverable" must be reviewed and approved by each Department.

D.5.2 The Contractor shall submit each Deliverable to each of the Departments' Contract Managers. As soon as possible, but in no event later than thirty (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 Departments' Contract Managers shall jointly give written notice of the Departments' unconditional approval, conditional approval or outright disapproval. Notice of conditional approval shall state the conditions necessary to be met to qualify the Deliverable for approval.

D.5.3 As soon as possible, but in no event later than ten (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 to each of the Departments' Contract Managers.

D.5.4 As soon as possible, but in no event later than ten (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 Departments' Contract Managers shall jointly give written notice of the Departments' unconditional approval, conditional approval or outright disapproval.

D.5.5 In the event that the Departments' Contract Managers fail 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.

D.5.6 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 fall(s) on a day other than a Business Day, such due date shall be the first Business Day following such day.

D.6 Committee Structure

The Contractor shall establish new committees or utilize existing committees with family, consumer, and provider representation to provide advice and guidance to the Departments and the Contractor regarding the scope of clinical and administrative services under this Contract. The Contractor shall, by April 1, 2011, submit to the Departments for their approval a plan for the establishment or use of existing committees. Thereafter, changes made to the approved plan shall be submitted to the Departments for approval.

D.7 Participation at Public Meetings

D.7.1 The Contractor shall ensure that the Contractor's key person attends, unless excused by the Departments, all of the meetings of any body established to provide legislative oversight of the work of the Partnership.

D.7.2 The Contractor shall make available, as directed by the Departments, the appropriate members of the Contractor's Key Personnel to attend the meetings of various bodies established to provide input to the Partnership or related services, including legislative and other public committees with responsibility for monitoring the budgets of the Departments.

D.8 Cooperation with External Evaluations

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

D.9 Policy Manual

The Contractor shall produce a single integrated manual of all of the policies and procedures pertaining to services provided under this Contract. The manual shall include, but may not be limited to the specific policies and procedures provided for in subsequent sections of this Contract, and which may require review and approval of the Departments. The Contractor shall post the manual on a website accessible to staff of the Departments. 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 Departments.

E. ELIGIBILITY

E.1.1 Eligibility Determination and File Production and Transmission

E.1.2 DCF and DSS will determine the initial and ongoing eligibility for medical assistance of each individual enrolled under this Contract in accordance with the appropriate Departments' eligibility policies. The Contractor will be responsible for maintaining a methodology to verify Member eligibility for the purpose of performing service authorization requests for Medicaid recipients.

E.1.3 Coverage for new Members can be effective any day of the month. Loss of eligibility will cause benefits to terminate on the last day of the month, except for individuals granted presumptive eligibility who do not ultimately become eligible. Presumptive eligibility could end at any point during the month.

E.1.4 The Departments shall produce and supply to the Contractor on a monthly basis the following eligibility files, in a format specified by the Departments, which shall be used to inform the Contractor of each member's eligibility and by the Contractor for the authorization of requested behavioral health services:

E.1.4.1 One eligibility roster file generated by the DSS eligibility management system (EMS) at the end of each month that lists all HUSKY A Members (enrolled in managed care), Medicaid Fee for Service members and D05 members who are eligible for services for the following month and Members who have been added retroactively.

E.1.4.2 One eligibility roster file generated by the DSS enrollment broker at the end of each month that lists HUSKY B and Charter Oak Health Plan members who are eligible for services for the following month and Members who have been added retroactively

E.1.5 The Departments shall produce and supply to the Contractor on a daily basis, daily file updates (adds/deletes) for HUSKY A/D05 and HUSKY B members.

E.1.6 DSS shall train Contractor staff to use the data fields within EMS.

E.1.7 DSS shall place the Medicaid FFS, HUSKY A/D05 file on a secured FTP server from which the Contractor will download the file. The HUSKY B and Charter Oak file will be placed on an FTP site, from which the Contractor will download the file.

E.1.8 All eligibility files will be in the 834 HIPAA compliant format. It is anticipated that the Department will place the eligibility files in a web mailbox from which the Contractor will download the files. A direct feed

to the Contractor will not be possible.

E.2 Eligibility Verification

E.2.1 The Contractor shall receive requests for the authorization of behavioral health services and shall for each authorization request received:

E.2.1.1 Maintain a methodology to verify Member eligibility for the purpose of performing service authorization requests for Members.

E.2.1.2 Determine whether the Member is eligible for coverage of the behavioral health service requested using the most recent eligibility file supplied by the Departments.

E.2.1.3 Validate eligibility through the web-based interface with DSS' Automated Eligibility Verification System (AEVS) if the Contractor is unable to validate eligibility by accessing the most recent eligibility file supplied by the Departments.

E.2.2 If eligibility is verified the Contractor shall obtain third party coverage information pertaining to the eligible Member and shall:

E.2.2.1 Notify DSS 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.

E.2.2.2 Implement one of the following applicable steps when the individual has third party coverage:

E.2.2.2.1 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:

E.2.2.2.1..1 Inform the provider that Medicaid funding sources is the payor of last resort, and the Contractor shall require the requestor to bill other known carriers first, before billing the Partnership.

E.2.2.2.1..2 Inform the provider to submit a claim to the DSS MMIS contractor only after the other insurance carrier(s) has processed the claim and to include the applicable Explanation of

Benefits (EOB) with the claim.

E.2.2.2.2 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:

E.2.2.2.2..1 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 (a) have the claim electronically crossed over from Medicare to Medicaid or (b) submit a claim to the MMIS vendor only after Medicare has processed the claim and to include the applicable Explanation of Medicare Benefits (EOMB) with the claim.

E.2.2.2.3 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.

E.2.2.3 Use the Unique Client Identification Number assigned by EMS (Eligibility Management System) to identify each eligible Member. EMS will assign a unique identification number for all individuals covered by this Contract, except for some children referred by DCF for residential services who may not be included on the eligibility file.

E.3 Special Procedures for DCF Residential Services

E.3.1 The Contractor shall perform residential service authorization requests for members referred by DCF who may not be identified in the eligibility file provided to the Contractor.

E.3.2 The Contractor shall assign a temporary unique client identification number prior to initiating the authorization evaluation steps further described in the "Utilization Management" Section for DCF referrals to residential services.

E.3.3 On a monthly or more frequent basis the Contractor shall check the eligibility status of children assigned a temporary client identifier and replace the temporary client identifier with the assigned EMS unique identification number if and when an EMS unique identification number is assigned.

F. UTILIZATION MANAGEMENT

F.1 General Provisions

Utilization Management (UM) is a set of Contractor processes that seeks to ensure that eligible members receive the most appropriate, least restrictive, and most cost effective treatment to meet their identified behavioral health needs. UM as used in this Contract includes practices such as Registration, Prior Authorization, Concurrent Review, Retroactive Medical Necessity Review and Retrospective Utilization Review. UM shall serve as a primary source of information for providers about the availability of services and the identification of new or alternative services.

F.2 Medical Necessity

F.2.1 All decisions made by the Contractor to authorize behavioral health services shall conform to the Departments' definition of medical necessity as follows:

F.2.1.1 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.

F.2.2 If the medical necessity definition should conflict with the level of care guidelines provided to the Contractor by the Departments, the medical necessity definition shall prevail and the Contractor shall notify the Departments of such conflict.

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

F.3 Approval of the Contractor's UM Program

F.3.1 The Contractor's UM Program, which shall include a program description, flow diagrams, and specific policies and procedures pertaining to UM practices, registration, prior authorization, concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, retrospective chart review, bypass programs and outlier management programs, shall be reviewed and approved by the Department's on an annual basis, no later than November 1 of each year.

F.3.2 The Contractor shall, by April 1, 2011 provide the Departments, for its review and approval, the Contractor's UM Program revised to address any changes to the approved UM Program necessitated by the addition of the Medicaid FFS and Charter Oak populations to be served by the Contractor through this contract.

F.3.3 The Departments shall provide comments to, reject or approve the Contractor's revised UM Program within 30 days of the Departments' receipt of the UM Program.

F.3.4 Once the revisions to the UM Program are approved by the Departments, the Contractor shall implement and follow the approved revised UM Program unless and until such approved program is revised with the approval of the Departments.

F.4 Design and Conduct of the Utilization Management Program

F.4.1 The Contractor shall design and conduct a UM Program that shall be cost-efficient and quality based. The processes utilized in the UM programs shall:

F.4.1.1 Be minimally burdensome to the provider.

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

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

F.4.1.4 Promote resiliency, family and consumer centered care, rehabilitation, treatment and support recovery.

F.4.1.5 Promote integrated services supporting health and recovery of children, families and adults.

F.5 Clinical Review Process

F.5.1 The Contractor's UM Program shall, at a minimum, require the Contractor to conduct reviews of behavioral health care services requested by or on behalf of Members in accordance with the applicable level of care guidelines provided by the Departments as follows:

F.5.1.1 Members under eighteen (18) with mental health (MH) disorders.

F.5.1.2 Members under eighteen (18) with substance use disorders.

F.5.1.3 Members eighteen (18) and over with mental health disorders.

F.5.1.4 Members eighteen (18) and over with substance use disorders.

F.5.2 The Contractor shall assist the Departments in ongoing and future reviews and modifications of the level of care guidelines.

F.5.3 For Members receiving services pursuant to an order of the court within the context of a jail diversion program or the Psychiatric Security Review

Board (PSRB) all requested services mandated by the court or PSRB shall be deemed Medically Necessary and so authorized.

F.5.4 For Members receiving services pursuant to an order of the court, requested services shall be authorized if they are determined to be Medically Necessary.

F.5.5 The Contractor shall conduct periodic reviews of authorized behavioral health services for timely and coordinated discharge planning.

F.5.6 The Contractor shall develop a process to identify individuals who will be reaching the age at which they would transition from DCF to DMHAS or the Department of Development Services (DDS) and other adult services as further described in the Young Adult and Transitional Services section of this Contract.

F.5.7 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.

F.5.7.1 If the requested service is the Medically Necessary and appropriate service or level of care and the existing service authorization is not the Medically Necessary level of care, the Contractor shall authorize the requested service and send the existing provider the requisite denial notice or Notice of Action (NOA).

F.5.7.2 If the existing service is the Medically Necessary and appropriate service or level of care, the Contractor shall continue the authorization of the existing service and send the requesting provider the requisite denial notice or Notice of Action.

F.5.7.3 If both levels of care are Medically Necessary and medically appropriate, the Contractor shall authorize both levels, but may reduce the amount of services under the existing authorization and send Notice of Action.

F.5.8 The Contractor shall verify that the services to be authorized and the provider to whom payment would be made are covered under the program from which the provider/member is seeking coverage, prior to completing an authorization for service.

F.5.9 The Contractor shall conduct retroactive medical necessity reviews resulting in a retroactive authorization or denial of service for Members 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. If the Member of the service in question is Medicaid eligible (including HUSKY

A), and the service is denied, then Notice Of Action (NOA) rules would apply. Otherwise Denial rules apply as outlined in "NOA, Denial, Appeals, and Administrative Hearings" Section of this Contract.

F.5.10 The Contractor shall request that emergency departments involve a mobile crisis team or other appropriate resources in order to evaluate the possible diversion of children and adults from inpatient admission and coordination of their admission to community-based care, if it seems likely that such an intervention will succeed and the emergency room or facility agrees. The Contractor shall assist hospital emergency departments with the coordination of care when requested by the emergency departments.

F.5.11 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 if a threshold is triggered.

F.6 Clinical Review Availability and Timeliness Requirements

F.6.1 The Contractor shall perform admission reviews for inpatient services (psychiatric hospital, general hospital, inpatient detoxification, residential detoxification) 24 hours a day, seven days a week.

F.6.2 Acute inpatient services in a general hospital are payable under Medicaid as a per discharge case rate. Consequently, the Contractor shall be required to conduct an admission authorizations, continued stay reviews and discharge reviews for acute inpatient services in general hospitals. Additional reviews may be necessary to facilitate timely discharge. Such reviews are also necessary for admissions to a DMHAS certified intermediate duration acute psychiatric care in a general hospital or inpatient admissions to a psychiatric hospital. In both cases, services are reimbursed by per diem and are not subject to per discharge cost settlement.

F.6.3 The Contractor shall perform admission reviews within the time parameters listed for the following levels of care that require prior authorization. All times are measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision, or, for cases referred for peer review, from the completion of the peer review:

F.6.3.1 The Contractor shall render a decision and communicate the decision to the provider by telephone within sixty (60) minutes for an admission to psychiatric hospital inpatient, general hospital inpatient, inpatient detoxification programs, residential detoxification program, Partial Hospital Program (PHP), Day Treatment Program, Intermediate Duration Acute Psychiatric Care, Intensive Outpatient

Program (IOP), Psychiatric Residential Treatment Facility (PRTF), and crisis stabilization program services. Such notice may also be communicated electronically.

F.6.3.2 The Contractor shall authorize or deny requests for admission to all other services within one business day.

F.6.4 The Contractor shall perform concurrent reviews within the time parameters listed for those levels of care that require concurrent review. All times are measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision, or, for cases referred for peer review, from the completion of the peer review.

F.6.4.1 The Contractor shall render a decision within sixty (60) minutes on the date that the authorization expires for psychiatric hospital inpatient, general hospital inpatient, inpatient detoxification, residential detoxification, PRTF, PHP, Intermediate Duration Acute Psychiatric Care, day treatment, IOP, or crisis stabilization program facilities.

F.6.4.2 For Home Health Services if the provider requests a concurrent review the Contractor shall render a decision,

F.6.4.2.1 during the first two months of operation, within two (2) weeks of the request;

F.6.4.2.2 during the third month of operation, within one (1) week of the request; and

F.6.4.2.3 during the fourth month of operation and thereafter through the end of the contract, within two (2) business days of the request.

F.6.4.3 For all other services, if the provider requests concurrent review, the Contractor shall render a decision within two (2) business days of the request.

F.7 By Pass Program

F.7.1 The Contractor shall develop, maintain and utilize a By Pass Program.

F.7.2 The By Pass program shall enable high performing providers to forego certain authorization requirements through the notification process, with monitoring and random retrospective audits by the Contractor to ensure quality of services, to validate compliance with medical necessity criteria and to ensure treatment and discharge plans support the member's recovery goals.

F.7.3 Eligibility for the By Pass Program shall be determined by the Contractor subject to the Departments' review and approval but shall, at a minimum include:

F.7.3.1 Demonstrated willingness and ability to work with the Contractor on treatment planning, coordination of care and discharge planning;

F.7.3.2 The existence and utilization of policies and procedures that support member inclusion in the discharge planning process, including development of a WRAP and crisis plan;

F.7.3.3 An average length of stay (ALOS) that favorably compares to the average length of stay for care;

F.7.3.4 Treatment of an annually determined minimum volume of members during the previous calendar year,

F.7.3.5 Verification that the facility, program or provider is not currently on a corrective action plan related to member complaints, adverse incidents or quality of care concerns; and

F.7.3.6 Compliance with quality improvement audits.

F.7.4 On an annual basis the Contractor shall conduct both random retrospective audits and reviews and produce an annual evaluation to:

F.7.4.1 Determine ongoing participation in the By-pass program; and

F.7.4.2 Modify provider participation if needed.

F.7.5 The Contractor shall provide the Departments with the results of the evaluation.

F.8 Peer Review Requirements

F.8.1 The Contractor shall conduct peer reviews on any request for authorization that fails to meet authorization criteria in the judgment of the first level review clinician. A doctoral level psychologist or a psychiatrist, ASAM (American Society of Addiction Medicine) certified physician, or certified addiction medicine specialist will conduct all peer reviews. Decisions to deny an authorization for service may only be made by an individual with one of the above credentials. The provider shall designate the appropriate individual to represent the provider in the peer review process. The provider shall not be required to submit additional written documentation for this peer review. The Contractor shall base its determination on peer desk review if the provider requests not to participate in a peer review.

F.8.2 Except as provided in F.6.1 the Contractor shall schedule the peer

review to occur within one (1) business day of the request for authorization unless the provider peer is unavailable, in which case the Contractor may make the determination based on a peer desk review. The Contractor shall complete such decisions within the timeframes set forth in Subsection F.6.3.1, F.6.3.2, F.6.4.1 and F.6.4.2 above.

F.8.3 The Contractor shall offer an appointment to providers for peer review to take place within sixty (60) minutes of the completion of the first line Care Manager review for all requests for inpatient psychiatric and within one hundred and twenty (120) minutes of the completion of the first line Care Manager review for inpatient or residential detoxification.

F.9 Out-of-State Providers

F.9.1 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 behavioral health 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 . This provision does not apply to DO5 members.

F.9.2 The Contractor shall render a decision in accordance with the timeframes set forth in the timeliness standards set forth in Sections F.6.3 and F.6.4 of this Contract. For authorization requests meeting these parameters, the Contractor shall:

F.9.2.1 Review the provider's credentials to determine whether the provider is eligible to enroll.

F.9.2.2 Review the request for behavioral health services for medical necessity.

F.9.2.3 If deemed medically necessary, provide an authorization number to the non-enrolled out-of-state provider seeking to authorize services to a Member. This authorization cannot be included in the transmission of authorizations to the DSS 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.

F.9.2.4 Provide provider enrollment instructions to non-enrolled out-of-state providers.

F.10 Written Notice

F.10.1 The Contractor shall make all decisions made on providers requests for service authorization, registration or continued stay available for download from the Web within twenty-four (24) hours of the decision. All decisions must reference the provider's CMAP identification number when the provider has enrolled with CMAP and all favorable decisions 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. If requested by the Provider the Contractor shall mail or fax the decision to the provider.

F.10.2 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 the "Notice of Action, Denials, Appeals and Administrative Hearings" Section of this Contract.

F.11 Retrospective Chart Review

F.11.1 On an annual basis and before the end of the fourth Quarter (Q4) of every calendar year covered by this Contract, the Contractor, in collaboration with the Departments shall identify those levels of care that would benefit from retrospective chart review during the coming year. This decision will be guided by the levels of care that are the focus of the Provider Analysis and Reporting (PARs) initiative, trends of concern in utilization, or on trends in the identification of Quality of Care concerns.

F.11.2 The Contractor shall use standard reports and its decision support tools to formulate its sampling strategy. Analysis shall include, but may not limited be to: average length of stay for each level of care by diagnosis by provider type; number and percentage of providers outside the average, and by what variance; variance in services that require authorization compared to those that can be registered; frequency with which providers do not comply with prior authorization requirements; treatment outcomes of recipients treated in each level of care; and use of inpatient services while being treated in a clinic or program.

F.11.3 When through the random chart reviews the Contractor identifies a provider who does not appear compliant with documentation standards, or who appears to have quality of care issues, the Contractor shall conduct an on-site review of a significantly expanded selection of records. The Contractor shall, in consultation with the Departments, decide whether the provider would be given prior notice of this follow-up retrospective review.

F.12 Web-Based Automation

F.12.1 The Contractor shall establish a secure automated, web- based system to receive, screen, and respond to service registration requests for

services outlined in Exhibit C, Proposed Child and Adult UM Scope and Thresholds. The web-based system must:

F.12.1.1 Verify the eligibility of the intended Member for behavioral health services.

F.12.1.2 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 to complete the review with a clinician if any of the following are true:

F.12.1.2.1 The provider is registering a member for a level of care for which an authorization already exists;

F.12.1.2.2 The provider is registering a member for a level of care that cannot be simultaneously authorized with an existing service without a clinical review; or

F.12.1.2.3 The provider is registering a member for a service that otherwise requires clinical review.

F.12.1.3 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.

F.12.1.4 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.

F.12.2 The Contractor shall provide to the Departments secure access to the Contractor's web-based application.

F.13 Staff Credentials, Training, and Monitoring

F.13.1 The Contractor shall utilize clinicians with the following relevant training and experience to conduct reviews for requests for behavioral health services. The Contractor shall ensure that the clinicians:

F.13.1.1 Are individually licensed behavioral health professionals.

F.13.1.2 Conducting adult reviews shall have, at a minimum, five (5) years direct service experience in the delivery of behavioral health services for adults.

F.13.1.3 Conducting child and adolescent reviews shall have, at a minimum, five (5) years direct service experience in the delivery of behavioral health services for children and adolescents.

F.13.1.4 Have licensure in the State of Connecticut or have licensure in another State with Connecticut eligibility.

F.13.1.5 Participate, at a minimum, in a combined total of fifty (50) hours of annual training in mental health and substance use disorder evaluation and treatment.

F.13.1.6 Have experience and a demonstrated competency with performing UM.

F.13.2 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 Departments annually. The Contractor shall:

F.13.2.1 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.

F.13.2.2 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.

F.13.3 The Contractor shall throughout the term of this Contract, retain a full-time Medical Director 100% of whose time is dedicated to the fulfillment of the Contractor's obligations under this Contract and to the clinical supervision of all of this Contractor's clinical management functions. The Medical Director must be on-site in the Connecticut Service Center. The Contractor shall require and ensure that the Medical Director is a board-certified psychiatrist in either or both child and adult psychiatry. The Contractor shall require and ensure that the Medical Director has or has access to staff with experience in both child and adult psychiatry, managed care and the clinical treatment and management of individual clients enrolled in a public sector health care program.

F.13.4 The Contractor shall, throughout the term of this Contract, retain an addiction medicine specialist, no less than half time, with experience in managed care and the clinical treatment and management of individual clients enrolled in a public sector health care program, whose time is dedicated to the fulfillment of the Contractor's obligations under this Contract.

F.14 Records

F.14.1 The Contractor shall, at a minimum, include the following data elements

in the service authorization process:

F.14.1.1 Member name, EMS issued ID number, social security number, DCF identifier, race, ethnicity, age, date of birth, gender and address;

F.14.1.2 Date and time the request for authorization or registration was made;

F.14.1.3 Type of service, level of care and units of service/length of stay requested (e.g. clinic & individual therapy);

F.14.1.4 Type of service and level of care authorized, denied or diverted including procedure codes;

F.14.1.5 Start and stop dates of authorization;

F.14.1.6 Number of visits, days, units of service, or dollar limit authorized;

F.14.1.7 Waiver and/or Money Follows the Person indicator;

F.14.1.8 Reason for referral or admission (including diagnostic information on all five (5) axes and multiple diagnoses on each axis if warranted);

F.14.1.9 Reason for denial;

F.14.1.10 Authorized provider name and number (or contact information);

F.14.1.11 Location where service will be provided (if provider has more than one location);

F.14.1.12 Authorization number, date and time;

F.14.1.13 The name of the individual and their credentials that authorized or denied the requested service;

F.14.1.14 The tracking status of any requested documentation;

F.14.1.15 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;

F.14.1.16 An indicator for when a member is receiving ICM or, by virtue of obtaining the requested service, has triggered an ICM threshold;

F.14.1.17 An indicator of court involvement and/or mandated activity by type related to the service authorization in question; and

F.14.1.18 An indicator for individuals eligible for ICM, which would include an

ICM start and end date.

F.14.2 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 Departments.

F.14.3 The Contractor shall maintain a UM system that has the capacity to enter and maintain text for the following:

F.14.3.1 The member's presenting symptoms, history, other services tried;

F.14.3.2 Clinical review notes;

F.14.3.3 Any inpatient admission request information for which an admission is not approved;

F.14.3.4 Notes from discussions with other medical professionals employed by or contracted by the Contractor;

F.14.3.5 Citation of review criteria for approval or denial; and

F.14.3.6 Any other information or call tracking related to a member's care including indication of need for coordination with physical medicine or Medicaid Waiver programs.

F.15 Inpatient and Residential Census Report

F.15.1 The Contractor shall by May 1, 2011, develop and present to the Departments for review and approval, a process to provide the Departments with a daily inpatient and residential census report as described in Exhibit E, which shall include all children and adults admitted to public and private general hospitals, private psychiatric hospitals, psychiatric residential treatment facilities, inpatient detoxification, mental health group homes, and residential facilities. The Departments shall provide comments to, accept or reject the process within 30 days of the receipt of the proposed process.

F.15.2 Once approved by the Departments the Contractor shall implement the process and maintain the same throughout the term of this Contract unless revised with the approval of the Departments.

F.16 Discharge Planning and Follow-up

F.16.1 The Contractor shall participate in discharge planning for Members with authorized inpatient or residential care. Participation activities shall include but not be limited to:

F.16.1.1 Discussion of anticipated discharge plans with inpatient providers at the time the service is authorized;

F.16.1.2 Identification of the cause where the discharge may be impeded or impacted by the need for housing or living arrangement. Notification as appropriate to DCF Area Office staff, with parent or guardian consent when applicable; DDS and/or DMHAS regarding the discharge delay.

F.16.1.3 Continued discussions with provider personnel throughout an admission, regardless of whether or not continued stay reviews are required;

F.16.1.4 Assisting providers, upon request, with discharge planning by providing information regarding covered services and providers' residential bed availability and when appropriate, provide on-site discharge planning support to the provider;

F.16.1.5 Obtaining complete information describing the aftercare plan including providers' names, dates of follow-up visits, referrals to care coordination, and transportation arrangements;

F.16.1.6 Reviewing plans for completeness prior to discharge especially to ensure that initial visits for essential services have been arranged prior to discharge and to review whether the provider has discussed the plan with the member or legal guardian and provided him or her with a written copy.

F.16.2 The Contractor shall monitor follow up care for high-risk members discharged from inpatient or residential services by:

F.16.2.1 Contacting the lead clinical provider as designated in the discharge plan within seven (7) days after discharge to ensure that the members have obtained follow-up care.

F.16.2.2 Offering assistance with appointment scheduling for members who have not obtained follow-up care.

F.16.2.3 Notifying Area Office for children in DCF care who have not obtained follow-up care.

F.16.2.4 Complying with reporting requirements as further described in Exhibit E, Reporting Matrix.

F.16.2.5 Identifying reasons for unsuccessful follow-up care and communicating this to the Contractor's Quality Management unit.

F.16.3 When an essential covered service under the discharge plan is not available, the Contractor shall:

F.16.3.1 Arrange for service under a single case agreement with the provider

and the Departments, or

F.16.3.2 Authorize an alternative service or higher level of care sufficient to meet the individual's treatment needs, and

F.16.3.3 Immediately communicate such authorizations to the Regional Network Manager and include the access issue in the access tracking report.

F.17 Emergency Department Diversion and Disposition Assistance

F.17.1 The Contractor shall request that emergency departments (ED) involve Emergency Mobile Psychiatric Services (EMPS) Mobile Crisis Teams, or other appropriate resources for individuals who are in acute crisis, but who may not require inpatient admission, in order to evaluate the appropriateness of diversion from inpatient admission and to coordinate the transition to community-based care when appropriate.

F.17.2 The Contractor shall provide or arrange for on-site assistance to hospital EDs to facilitate timely disposition when requested by the EDs. Such assistance shall be provided or arranged for within one business day of notification by the hospital.

F.18 Referral Assistance and Discharge Planning System

F.18.1 The Contractor shall develop and maintain an electronic tool that provides real time information on available acute inpatient psychiatric, Psychiatric Residential Treatment Facility (PRTF), residential beds, and intensive community supports (e.g. PHP, Day Treatment, IOP) in order to support effective discharge planning and smooth transitions across levels of care. The tool shall be Web-enabled and will allow Connecticut providers and border hospitals to enter their own data. The Contractor shall create a centralized registry to support access by all providers as well as non-providers (e.g. advocacy organizations) who assist in finding acute or subacute psychiatric and addiction services placements.

F.18.2 The Contractor shall provide or arrange for on-site assistance to hospital inpatient units to facilitate timely disposition when a member's discharge from the inpatient services has been delayed for more than 5 (five) days. Such assistance shall be provided or arranged for within one business day of notification by the hospital.

F.19 DCF Residential Utilization Management

F.19.1 There shall be established a Residential Care Team (RCT) comprised of staff of the Contractor and staff of DCF.

F.19.2 The Contractor's RCT staff shall participate along with the DCF RCT staff in the placement process of identified children into appropriate levels of

residential care. The Contractor will provide at a minimum 2.5 clinical FTE's for this purpose. In addition, the Contractor will provide administrative assistance to assist in the electronic data collection functions identified as necessary for the successful collection of data related to this area. Further the Contractor will work with DCF to design and produce reports that summarize key management and utilization processes. In order to ensure that optimum efficiency is maintained within this process DCF in cooperation with the contractor agree to a quarterly review of the operational functions.

F.19.3 The Contractor shall provide by May 1, 2007, for DCF's review and approval, a residential management policy and procedure. At a minimum, the policy and procedure will specify roles and responsibilities of the Contractor's staff and RCT management practices and procedures.

F.19.4 The Contractor shall prepare the following documents for the purposes of administering the placement process within the RCT:

F.19.4.1 Master list of children referred for residential placement;

F.19.4.2 List of children referred to Residential Treatment Centers (RTC) – unmatched;

F.19.4.3 List of children referred to Group Home (GH) 1 (Non-PASS) – unmatched;

F.19.4.4 List of children referred to Group Home 2 and GH 1 (PASS) programs – unmatched;

F.19.4.5 List of children in detention and on parole awaiting residential placement (matched and unmatched);

F.19.4.6 Members on inpatient psychiatric units in delayed discharge status awaiting residential service;

F.19.4.7 Report on the status of children matched to facilities with anticipated admission dates; and

F.19.4.8 Report on existing residential vacancies and vacancies anticipated within thirty (30) days.

F.19.5 Upon receipt of all necessary information to make a level of care (LOC) determination, Contractor staff will document and communicate such decision to referral source within 5 business days.

F.19.6 Once approved for a particular level of residential care, members will be entered into the census and tracking roster and presented at the next RCT Rounds when an appropriate bed is available for a possible match

for admission.

F.19.7 The Contractor will organize and participate in clinical rounds on a bi-weekly basis. Data will be collected and reported from the Child and Adolescent Needs and Strengths Assessment (CANS), the LOC review and the prioritization worksheet such that preliminary matches will be made for placement.

F.19.8 In the first year, the Contractor in collaboration with the DCF staff members of the RCT shall engage in an on going self evaluation/improvement process to ensure optimum functioning of this newly integrated project and conduct process improvement where necessary.

G. INTENSIVE CARE MANAGEMENT

G.1 Intensive Care Management Program Development and Approval

G.1.1 Intensive care management refers to specialized care management or care coordination techniques that are activated when an individual experiences barriers to recovery. The Departments believe that ICM is necessary and cost-effective when provided to those individuals requiring precise, strategic service delivery and coordination of care to achieve a favorable outcome.

G.1.2 The Contractor shall by April 1, 2011, submit to the Departments for review and approval their proposed ICM Program including a program description, policies, procedures, workflows, and qualifying criteria for children, adolescents and adults. Separate criteria for substance abuse and mental health ICM may be submitted if desired. The Departments shall review and comment, approve or reject the submission. Once approved by the Departments 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 Departments. The Contractor shall propose to the Departments modifications to the ICM Program including qualifying criteria at least annually and no later than July 1st of each subsequent year of the contract.

G.1.3 The Contractor's ICM Program shall focus on members for whom the Contractor determines that the typical care management process is inadequate, such as members who have had multiple ED admissions and members who repeatedly access Emergency Mobil Psychiatric Services (EMPS). The intensive care managers shall work with the care providers and engage additional providers, in order to improve individual outcomes.

G.1.4 The Departments may provide ICM guidelines to the Contractor for specified special populations and the Contractor shall incorporate such

guidelines into the ICM program.

G.1.5 The Contractor shall establish an ICM unit with dedicated ICM staff to provide ICM services to members effective on the implementation date and shall identify members who meet the criteria for ICM in accordance with the approved ICM Program. The ICM staff will collaborate on the coordination of care with the Local Mental Health Authorities (LMHA) or other contracted entities for individuals eligible to receive services from those entities.

G.2 Staffing and Credentials

G.2.1 The Contractor's intensive care managers shall be licensed behavioral health clinicians who intervene in the care of persons with complex needs. The clinicians shall have training and experience at least equivalent to that required of clinician reviewers in the section entitled "Utilization Management."

G.2.2 The intensive care managers shall report to and be supervised by the Contractor's management personnel, but shall be expected to collaborate with the Departments' personnel and with providers as necessary to obtain better member outcomes.

G.3 Geographic Assignment

G.3.1 Intensive care managers shall be designated to geographic areas, allowing for cross-coverage as needed.

G.3.2 DCF shall in DCF local areas provide for a limited number of the Contractor's ICM staff, work space with access to equipment necessary for the Contractor's ICM staff to carry out their duties.

G.3.3 The Contractor shall coordinate with DCF information systems operations division to ensure proper network access is available and is in compliance with DCF network protocols and policies.

G.3.4 The Contractor shall be required to provide all other office equipment, supplies, computers and absorb any/all associated costs of doing business within the State for this office space.

G.3.5 The Contractor shall co-locate intensive care managers in its central office and in the field in state agency office space, as directed by the Departments where such office space is available.

G.3.6 The intensive care managers shall establish a local presence and build collaborative relationships with providers.

G.3.7 The intensive care managers shall work in the field (i.e., outside of local area and central offices) on an as needed basis, but no less than as

appropriate to establish and maintain core job functions.

G.4 ICM Process

G.4.1 The Contractor shall assign an intensive care manager to members who meet the criteria for ICM.

G.4.2 The Contractor shall require the intensive care manager to:

G.4.2.1 Notify the member's primary behavioral health provider that the member has been identified for ICM.

G.4.2.2 Establish a plan, in collaboration with the primary behavioral health provider, the member, and/or other providers as necessary, for addressing barriers to care. Such plan must be documented in the Contractor's UM system.

G.4.2.3 Assist as necessary with linking members with appropriate services in accordance with the plan.

G.4.3 The Departments shall provide Members with priority access to receive care coordination services when recommended by the Contractor as a necessary component of the member's care plan.

G.5 Peer and Family Specialists

G.5.1 Peer Specialists shall be an integral part of the ICM program available to the HUSKY A, HUSKY B and Charter Oak populations. Peer Specialists significantly enhance the impact of ICM and broaden the array of support available to families because they are living proof of a family's ability to live with and love a child who has a complex behavioral health need; they can share information about how to manage difficult behavior, such as when parents learn new techniques, they gain confidence in raising their own children; they create a support network for stressful times for the child or family; and they can help parents learn self-advocacy skills needed to advocate for their child; and can help ease the transition for both child and family when the child returns home from hospitalization or out of home placement.

G.5.2 Peer Specialists may be used in emergency situations. Peer specialists may be used to support the diversion of emergency room visits and inpatient admissions as follows:

G.5.2.1 By operating a "warm line" to help divert crises or provide referrals;

G.5.2.2 By organizing respite services; and

G.5.2.3 By organizing natural supports for a family in crisis, especially

supervision for other children.

G.5.3 After an Intensive Care Manager has become familiar with a member's interests and needs, the Intensive Care Manager will offer the services of a Peer Specialist. The Intensive Care Manager will explain the responsibilities of a Peer Specialist directly to the Member or through the member's primary provider and offer to have the Specialist contact the member. The Contractor shall encourage families to work with a Peer Specialist, especially if they are new to the service delivery system. However, the decision to work with a Peer Specialist will be made by the member or family, which may refuse the service or terminate the relationship at any time.

G.5.4 Peer specialists shall be employees of the Contractor and shall be trained and paid by the Contractor. The Contractor shall work closely with DCF's Family Advocate Program contractor to be sure that the Contractor's Peer Specialists complement, and do not supplant, the professional Family Advocate program. Peer Specialists shall be trained in the principles of recovery and resilience and wraparound principles and will also go through a traditional peer training program. The Contractor shall solicit the involvement of Connecticut's family organizations in training peer specialists and of nationally known family members who design training curricula to develop Peer Specialist training especially for Connecticut.

G.6 Peer Liaisons

G.6.1 Peer Liaisons shall be available to Members in the Medicaid FFS population and to all CMAP providers to provide training, technical assistance and support to providers working to embrace a recovery driven system of care;

G.6.2 Peer Liaisons shall not be direct service providers, but shall give voice to the recovery movement and shall foster the visibility of member/family recovery and resiliency.

G.6.3 Peer Liaisons shall receive rigorous training to work with member services and provider relations departments to respond to member and provider inquiries; and

G.6.4 Peer Liaisons will work cross departmentally on a number of internal and external initiatives designed to improve awareness and integration of recovery within the Contractor's organization and external provider system initiatives.

G.7 Reporting

G.7.1 The Contractor shall provide a report as described in Exhibit E - Reporting Matrix of Members who have been identified by the Contractor

for ICM to the Departments.

G.7.2 The Contractor's ICM unit shall also prepare and submit a quarterly summary to the Contractor's Quality Management Department and the Departments. The summary shall identify the following:

G.7.2.1 Access gaps or barriers by level of care and by geographic area (see Exhibit E) and including but not limited to non-traditional services and services that are culturally competent;

G.7.2.2 New or promising services, supports and care delivery models that have been effectively used in one or more areas of the state to serve members;

G.7.2.3 Need for specialized treatments or interventions;

G.7.2.4 Areas where specialized clinical training may promote improved clinical outcomes; and

G.7.2.5 Cost-effective recommendations to resolve issues identified in the summary.

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

H.1 Access to EPSDT Exams under the Medicaid Program

H.1.1 Connecticut Medicaid members under the age of twenty-one (21) are entitled to Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) services. EPSDT, part of the federal Medicaid statute, requires that such individuals have regularly scheduled screening examinations and all necessary diagnostic and treatment services. In this subsection only, the terms "child" or "children" shall be used to refer to individuals under twenty-one (21).

H.1.2 EPSDT screenings are comprehensive well-care exams. One of the components of an EPSDT exam is an age-appropriate behavioral health and developmental assessment. In addition, EPSDT requires that states inform families about the importance of preventive care, inform families about how to obtain EPSDT services, ensure that EPSDT services are available, and ensure that necessary transportation and scheduling assistance are available. The responsibility for EPSDT services for HUSKY members has and will be delegated to the entity(ies) under contract with DSS responsible for the care management of physical health services for HUSKY members. Currently DSS is responsible for EPSDT services for Medicaid FFS recipients but DSS intends to delegate this responsibility to the entity(ies) under contract with DSS responsible for the care management of physical health services for Medicaid FFS

recipients.

H.1.3 The Departments shall require that the entity(ies) under contract with DSS responsible for the care management of physical health services for HUSKY A and Medicaid FFS recipients provide an assessment of a child's behavioral health in order to determine the existence of a behavioral health disorder as part of periodic EPSDT screening exams. The Departments also require that the entity(ies) under contract with DSS responsible for the care management of physical health services for HUSKY A and Medicaid FFS recipients provide inter-periodic screening exams when medically necessary to determine the existence of a physical or behavioral condition, including inter-periodic screening exams that may be determined by a professional who comes into contact with the child outside of the formal health care system. Such requirements of the entity(ies) under contract with DSS responsible for the care management of physical health services for HUSKY A and Medicaid FFS recipients shall be limited to exams as may be within the scope of practice of their network providers.

H.2 Access to ESPDT Exams under the Partnership

The Departments shall permit inter-periodic behavioral health screening exams to children provided by Partnership enrolled network providers and shall provide for reimbursement to enrolled network providers of such services without prior authorization.

H.3 Access to Services Recommended Pursuant to an EPSDT Exam

H.3.1 The Contractor shall authorize all medically necessary behavioral health services that may be recommended or ordered pursuant to an EPSDT periodic or inter-periodic examination including medically necessary services that are not otherwise covered under the Connecticut Medicaid Program, but excluding those services that can be safely and appropriately provided by the members' primary care provider.

H.3.2 The Contractor shall facilitate access to medically necessary behavioral 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.3.2.1 Provide families with information about how to obtain behavioral health care services for their children and where these services can be obtained.

H.3.2.2 Assist families with scheduling appointments with behavioral health service providers.

H.3.2.3 Assist with transportation for children and their families to

appointments for behavioral health services. Assistance includes providing the member and/or their family with the information necessary to arrange for transportation to the appointments through the entity(ies) under contract with DSS responsible for the provision of transportation services and/or providing assistance in coordinating such transportation for HUSKY A and Medicaid FFS recipients if the member and/or their family encounters barriers.

H.3.2.4 Arrange for the provision of the medically necessary behavioral health services that are not covered under the Connecticut Medicaid Program.

I. COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH CARE

I.1.1 Under the Partnership, the MCOs ,or other entity under contract with DSS responsible for the care management of physical health services for HUSKY Members, shall be responsible for primary care based screening, diagnosis and treatment of behavioral health disorders and behavioral health related transportation, pharmacy, laboratory, and ED services of HUSKY and Charter Oak Members.

I.1.2 Under the Partnership, the Contractor shall coordinate the behavioral health care needs of Medicaid Fee-For-Service Members directly with DSS and the Members' physical health care providers.

I.1.3 Care management for physical health services for Medicaid Fee-For-Service members will be managed by DSS. The Contractor shall coordinate covered services with DSS.

I.1.4 The Contractor shall promote coordination of physical health and behavioral health care with the MCOs or other entity under contract with DSS responsible for the care management of physical health services for HUSKY and Charter Oak Members. For HUSKY and Charter Oak Members who access behavioral health services but who do not have special physical health care needs, the Contractor shall promote communication between behavioral health providers and the physical health primary care providers and shall support primary care based management of psychiatric medications as medically appropriate. For HUSKY and Charter Oak Members who access behavioral health services and who also have special physical 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. The Contractor shall coordinate as appropriate, with DCF Health Care Advocates in order to ensure the effective and timely provision of necessary care for DCF

involved children.

I.1.5 If there is a conflict between a MCO or other entity under contract with DSS responsible for the care management of physical health services for HUSKY and Charter Oak Members and the Contractor regarding whether a HUSKY or Charter Oak Member's medical or behavioral health condition is primary, the medical director for the entity under contract responsible for the care management of physical health services for HUSKY or Charter Oak Members shall work with the Contractor to reach a timely and mutually agreeable resolution. If the Medical Director and the Contractor are not able to reach a resolution, the appropriate Departments will make a binding determination. 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 this Contract and its policies and procedures.

I.1.6 The MCO or other entity under contract with DSS responsible for the care management of physical health services for HUSKY and Charter Oak Members shall be responsible for the Members primary care and other services provided by primary care providers in independent practice and in hospitals regardless of diagnosis with the following exception. The MCO 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.

I.1.7 For a small subset of members, up to 300 members with significant physical and BH co-morbidities, the Contractor will utilize predictive modeling solution and chronic care management applications which integrates medical, pharmacy and behavioral health claims data. The Contractor will use episode grouping, risk identification algorithms and an analysis of departures from evidence-based gaps in care to produce:

I.1.7.1 A prospective health risk assessment/ profile for each member;

I.1.7.2 Identification and stratification of high-risk members for ICM and disease management interventions;

I.1.7.3 Identification of members who are at high-risk for hospitalization;

I.1.7.4 Identification of members who have not received services in accordance with best practice guidelines.

I.2 Responsibilities of DSS

I.2.1 DSS will be responsible for the utilization management of behavioral

health services provided by primary care providers to the Medicaid FFS population except as otherwise indicated in this section.

I.2.2 DSS will assume responsibility for primary care services such as:

I.2.2.1 Behavioral health related prevention and anticipatory guidance;

I.2.2.2 Screening for behavioral health disorders;

I.2.2.3 Treatment of behavioral health disorders that the CMAP Provider concludes can be safely and appropriately treated in a primary care setting; and

I.2.2.4 Management of psychotropic medications in conjunction with treatment by a non-medical behavioral health specialist when necessary.

I.2.3 DSS will 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.

I.2.4 DSS will collaborate with the Contractor to coordinate services for recipients with both behavioral health and special physical health care needs.

I.2.5 DSS will be responsible 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.

I.2.6 DSS will manage all ancillary services such as laboratory, radiology, and medical equipment, devices and supplies regardless of diagnosis.

I.3 Coordination with DSS and the CMAP Providers

I.3.1 The Contractor shall communicate and coordinate with DSS, DMHAS and the CMAP Providers as necessary to ensure the effective coordination of medical and behavioral health benefits for the Medicaid FFS population.

I.3.2 The Contractor shall support the provision of behavioral health services in primary care settings and psychiatric medication management by primary care providers for persons with behavioral disorders, when it is safe and appropriate to do so. The Contractor shall BY April 1, 2011 develop and present to the Departments for their review and approval a Primary Care Behavioral Health Consultation Program to support the psychiatric management of medication by the CMAP Providers. The

program shall include, but not be limited to:

I.3.2.1 Guidelines for primary care based screening and treatment of behavioral health disorders, indications for referral to a behavioral health specialist, and procedures for referrals, developed in coordination with DSS;

I.3.2.2 Provision of education and guidance to primary care providers with the participation of DSS;

I.3.2.3 Availability of telephonic psychiatric consultation services to DSS and the CMAP providers;

I.3.2.4 Identification by the Contractor of individuals receiving psychiatric medication management from behavioral health prescribing providers whose psychiatric medication management needs could be safely and appropriately provided through CMAP providers and the transition of such individuals from the behavioral health prescribing provider to a CMAP provider;

I.3.2.5 Provisions for the continuation of therapy services by the behavioral health providers (non-medical) in conjunction with the prescribing CMAP provider;

I.3.2.6 Communication and coordination between the behavioral health providers and CMAP providers as necessary to support appropriate medication monitoring and management in primary care settings; and

I.3.2.7 Plan for the provision of telephonic pharmacy consultation services to CMAP providers as provided for in the Pharmacy Consultation subsection below.

I.3.3 The Contractor shall collaborate with DSS to coordinate hospital inpatient services, ED services, laboratory services and other services administered by DSS.

I.3.4 The Contractor shall develop education and guidance for PCPs to support the psychiatric management of medication by primary care providers including, but not limited to, the following:

I.3.4.1 The identification of individuals whose psychiatric medication management needs could be safely and appropriately provided for by primary care providers;

I.3.4.2 The transition of psychiatric medication management of such individuals to primary care providers; and

I.3.4.3 The communication and coordination between non-medical

behavioral health providers and primary care providers as necessary to support appropriate medication monitoring and management in primary care settings.

I.3.5 The Contractor shall collaborate with DSS, DMHAS and the CMAP Providers to coordinate services for recipients with both behavioral health and special physical health care needs.

I.3.6 The Contractor shall provide for all necessary aspects of coordination between the Contractor and DSS, DMHAS and the CMAP Providers. 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 Departments for their review and approval by April 1, 2011.

I.3.7 Specifically the Contractor shall:

I.3.7.1 Contact DSS or the appropriate CMAP Provider when co-management of a member is indicated, such as for persons with special physical health and behavioral health care needs;

I.3.7.2 Respond to inquiries by DSS or the CMAP Provider regarding the presence of behavioral co-morbidities;

I.3.7.3 Coordinate management activities and services with DSS, DMHAS and the CMAP Providers when requested by DSS;

I.3.7.4 Promote and support coordination between medical providers and the behavioral health providers as appropriate; and

I.3.7.5 Participate with DSS, DMHAS and the CMAP Providers in the development of policies pertaining to coordination between the Contractor and DSS and shall adhere to such policies as approved by all parties, and as they may be revised from time to time.

I.3.8 The Contractor shall be responsible for management when home health services are required for the treatment of behavioral health diagnoses alone and when home health services are required to treat both medical and behavioral diagnoses but the behavioral diagnosis is primary or the individual's medical treatment needs cannot be safely and effectively managed by the psychiatric nurse or aide.

I.3.9 The Contractor shall be responsible for management of home health services for a member when the member has a diagnosis of autism as one of the first three diagnoses.

The Contractor shall perform all of the above within applicable HIPAA privacy regulations and Connecticut privacy and confidentiality regulations.

I.4 Coordination Requirements of DSS and the HUSKY MCOs or Other Entity

I.4.1 DSS shall require that the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members communicate and coordinate as necessary with the Contractor to ensure the effective coordination of medical and behavioral health benefits. DSS shall specifically require each entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members to:

I.4.1.1 Contact the Contractor when co-management of a member is indicated, such as for persons with special physical health and behavioral health care needs,

I.4.1.2 Respond to inquiries by the Contractor regarding the presence of medical co-morbidities,

I.4.1.3 Coordinate management activities and services with the Contractor when requested by the Contractor,

I.4.1.4 As appropriate, support coordination between behavioral health care providers and the contracted medical providers;

I.4.1.5 Develop quality improvement initiatives aimed at screening for psychiatric and substance related disorders in primary care settings, school based health centers, and for high-risk individuals, such as those with complex physical health needs;

I.4.1.6 When it is safe and appropriate to do so, support the contracted primary care providers of the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members ability to provide behavioral health services in primary care settings and psychiatric medication management for persons with behavioral disorders,

I.4.1.7 Collaborate with the Contractor to coordinate other services that might be provided to behavioral health members by the HUSKY MCOs or other entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members including transportation, pharmacy, hospital ED services, laboratory services, and other services as required under their contracts with DSS,

I.4.1.8 Notify or coordinate the notification of behavioral health prescribing providers regarding pharmacy requirements (e.g., preferred drug list or formulary, prior authorization, generic substitution) that may be

applicable to HUSKY A and HUSKY B enrollees, and

I.4.1.9 Provide the Contractor with quarterly pharmacy encounter extracts for the Contractor to use in its pharmacy analyses, pharmacy consultation with CMAP prescribing providers, and quality management.

I.5 Coordination Requirements of the Contractor with the HUSKY MCOs or Other Entity

I.5.1 The Contractor shall communicate and coordinate with the HUSKY MCOs or other entity(ies) responsible for the care management of physical health services for HUSKY Members as necessary to ensure the effective coordination of medical and behavioral health benefits.

I.5.2 The details of such coordination have been set forth by the Contractor in its Behavioral and Physical Health Coordination Program, approved by the Departments. Revisions to the approved Behavioral and Physical Health Coordination Program must be submitted to the Departments for their review and approval prior to their implementation.

I.5.3 The Coordination Program shall provide for all necessary aspects of coordination between the HUSKY MCOs or other entity(ies) responsible for the care management of physical health services for HUSKY Members and the Contractor and specifically shall require that the Contractor:

I.5.3.1 Contact the HUSKY MCOs or other entity(ies) responsible for the care management of physical health services for HUSKY Members when co-management of a member is indicated, such as for persons with special physical health and behavioral health care needs,

I.5.3.2 Respond to inquiries by the HUSKY MCOs or other entity(ies) responsible for the care management of physical health services for HUSKY Members regarding the presence of behavioral co-morbidities,

I.5.3.3 Coordinate management activities and services with the HUSKY MCOs or other entity(ies) responsible for the care management of physical health services for HUSKY Members when requested by the HUSKY MCOs or other entity(ies) responsible for the care management of physical health services for HUSKY Members, and

I.5.3.4 Promote and support coordination between behavioral health care providers and HUSKY MCO contracted medical providers as appropriate.

I.6 Support for Primary Care Behavioral Health

I.6.1 The Contractor shall continue to operate the Primary Care Behavioral Health Consultation Program approved by the Departments, to support the psychiatric management of medication by PCPs enrolled and funded by the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members. The program includes, but is not limited to:

I.6.1.1 Guidelines for primary care based screening and treatment of behavioral health disorders, indications for referral to a behavioral health specialist, and procedures for referring under the Partnership, developed in coordination with the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members;

I.6.1.2 Plan for the provision of education and guidance to primary care providers with the participation of the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members;

I.6.1.3 Identification by the Contractor of individuals receiving psychiatric medication management from the Partnership's behavioral health prescribing providers whose psychiatric medication management needs could be safely and appropriately provided through primary care providers and the transition of such individuals from the Partnership's behavioral health prescribing provider to a primary care provider;

I.6.1.4 Provisions for the continuation of therapy services by the Partnership's behavioral health providers (non-medical) in conjunction with the prescribing primary care provider;

I.6.1.5 Communication and coordination between the Partnership's behavioral health providers and primary care providers as necessary to support appropriate medication monitoring and management in primary care settings; and

I.6.1.6 Plan for the provision of telephonic pharmacy consultation services to primary care providers as provided for in the Pharmacy Consultation subsection below.

I.6.2 The Contractor shall adopt and implement similar measures for D05 members and those with commercial insurance, obtaining releases of information as necessary, to the extent permitted by state and federal law and to the extent that any given private insurer supports such collaboration.

I.6.3 The Contractor shall comply with the Health Insurance Portability and Accountability Act (HIPAA), privacy regulations promulgated there under,

and Connecticut privacy and confidentiality statutes and regulations.

I.6.4 The Contractor shall participate with the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members and the Departments in the development of policies pertaining to coordination between the Contractor and the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members and shall adhere to such policies as approved by all parties, and as they may be revised from time to time.

I.7 Pharmacy Consultation

I.7.1 The Contractor shall conduct a semi-annual pharmacy analysis to support improved coordination of services for members with both behavioral health and special physical health care needs and to ensure appropriate use of psychotropic medications. The Contractor shall provide the Departments with a written report and recommendations, within one hundred and eighty (180) days following the Contractor's receipt of pharmacy data from the Departments, and shall share results of the pharmacy analyses with the MCOs as appropriate for their review and further action, if indicated.

I.7.2 The Contractor's Medical Directors and Peer Advisors shall offer telephonic consultations to prescribers who call the Service Center's toll-free number and request the opportunity to review potential medications with a psychiatrist.

I.7.3 The Departments shall require that communications and educational materials for PCPs describe the availability of and procedures for accessing such telephonic consultation.

I.7.4 The Contractor shall provide telephonic consultation by a clinical pharmacist to CMAP enrolled prescribing providers whose member prescribing patterns fall outside expected parameters, based on a review of encounter data for psychotropic medications

J. COORDINATION WITH HOME AND COMMUNITY BASED WAIVER PROGRAMS

J.1 Coordination Agreements

The Contractor shall develop coordination agreements with other State agencies that serve Partnership Members, which include but may not be limited to the Department of Developmental Services (DDS) with respect to the management of services for individuals participating in DDS or DMHAS administered Home and Community Based Waiver (HCBW) programs; Court Support Services of the Judicial Branch and the Department of Education and local education agencies.

J.2 Other Coordination Responsibilities

The Contractor shall be required to coordinate with other HCBW programs including, but not limited to the Acquired Brain Injury waiver program, the Connecticut Home Care Program for Elders, the Personal Care Assistance waiver and the Money Follows the Person project administered by DSS with respect to the management of services for individuals participating in the DSS administered HCBW programs. In addition, if directed by the Departments, the Contractor shall be required to coordinate with any other HCBW waiver programs that may be established by DSS during the period of this contract. Once directed to perform coordination activities the Contractor and appropriate Department(s) shall develop, discuss and mutually agree upon the scope of the program specific coordination requirements.

K. FAMILIES

K.1 Introduction

The behavioral health of any individual family member is directly influenced by the health and development of all other family members and by the communication patterns and relationships that characterize family life. When developing care plans for children with complex behavioral health needs and adults with serious and persistent mental illness or substance use disorders, the behavioral health of other family members and the functioning of the family as a whole must be considered and addressed.

K.2 Family Oriented Management Processes

K.2.1 The Contractor shall inquire about family service needs during prior authorization and continued care reviews for selected levels of care when the review pertains to an individual with complex behavioral health service needs or a serious and persistent mental illness or substance use disorder.

K.2.2 The Contractor shall integrate the consideration of family service needs into the ICM process.

K.2.3 The Contractor shall, by July 1, 2011, develop and submit to the Departments for their review and approval, Family Service policies and procedures to ensure the Departments that the Departments' goals are met. The approved policies and procedures will be used by the Contractor:

K.2.3.1 At the time of service authorization in order to ensure that the needs of parents, children and whole families are appropriately considered;

K.2.3.2 To develop mechanisms for monitoring and tracking family service coordination efforts; and

K.2.3.3 To promote family empowerment at the point of service and at all levels of system planning and management by recognizing, addressing, and respecting cultural norms within the family unit; providing information in the caregiver's or member's preferred language; offering choice of providers; and offering choice of services whenever possible.

L. YOUNG ADULT AND TRANSITIONAL SERVICES

L.1 Introduction

L.1.1 The Departments are committed to supporting the provision of age and developmentally appropriate services and supports to young adults (18-21 years old) with behavioral health disorders as they transition into adulthood. Many of the children served under the Partnership will continue to be eligible for services funded by the Departments, either by continuing to qualify for HUSKY A or B, by qualifying for Medicaid FFS, or by continuing in the care of DCF. The Contractor will be expected to actively promote successful transitions from the child service system to the adult service system.

L.2 DCF and Eligibility Information

L.2.1 The Departments shall provide the Contractor with DCF criteria for DCF involved children that will require adult services funded and delivered by DCF, DMHAS, or DMR. DCF will also provide the Contractor with readily

available information regarding services and transition planning for this population as requested by the Contractor and permissible under state and federal law.

L.2.2 The Departments shall provide the Contractor with HUSKY A, HUSKY B, and D05 eligibility rules that will enable the Contractor to identify those children at risk of losing eligibility for DSS and/or DCF funded services.

L.3 Young Adult Transition Program

L.3.1 The Contractor shall on a monthly basis provide to DCF an authorization report that identifies all Members between the ages of 15 and 21 who have received a behavioral health service and who have a DCF priority diagnosis as defined by the DMHAS eligibility criteria. The report shall list the youth's name, social security number, date of birth, diagnosis, DCF identifier if appropriate, the service type received, provider and assigned ICM.

L.3.2 The Contractor shall, in collaboration with the Departments, ensure that the appropriate identification and behavioral health programming is assigned to youth ages 18 – 21 who are eligible for Partnership services.

M. QUALITY MANAGEMENT

M.1 Introduction

Quality Management (QM) refers to a comprehensive program of quality improvement and quality assurance activities responsive to the Departments' objectives. The Departments seek to ensure that all Members receive appropriate, effective, medically necessary, and cost efficient treatment. This can be accomplished by systematically and objectively monitoring the quality of behavioral health care services. By measuring access to care, demand for services and quality of care and by analyzing utilization data, satisfaction surveys, complaints, and other sources of quality information, continuous quality improvement strategies can be developed that are consistent with the vision and mission of the Departments. Quality Management Oversight

M.1.1 The Departments shall establish a Quality Management Committee (QMC) with representation from the three Departments, families and services recipients to oversee the Contractor's QM efforts. The Departments shall:

M.1.1.1 Review for approval prior to implementation the Contractor's revisions to the existing approved QM Program which incorporate the integration of ASO services to the Medicaid FFS and Charter Oak populations. The Contractor's integrated QM Program description shall describe initiatives, strategies, staff time and organization, methodologies for on-going quality assurance, quality

improvement, and concurrent system for identifying issues that require immediate attention of any or each of the Departments;

M.1.1.2 Require the Contractor to study and evaluate issues that the Departments may from time to time identify;

M.1.1.3 Develop post-implementation quality indicators to monitor the Contractor's performance of tasks related to ASO services provided to the Medicaid FFS and Charter Oak populations during the first nine (9) months of operation;

M.1.1.4 Establish annual performance targets as described in Section X of this contract "Performance Targets and Withhold"; and

M.1.1.5 Review for approval all member and provider surveys.

M.2 General Provisions

M.2.1 The Contractor shall, no later than April 1, 2011, provide the Departments, for their review and approval, a written description of the QM Program including revisions to the existing approved QM Program that identify specific initiatives for the Medicaid FFS and Charter Oak populations, 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.

M.2.2 The Contractor shall develop mechanisms to track and monitor the post-implementation quality indicators.

M.2.3 The Contractor shall 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.

M.2.4 The Contractor shall participate in the Departments' QM Committee as requested by the Departments to report on all QM activities that are part of the Annual Quality Management Program Plan or to review other issues identified by the Departments or the Contractor.

M.3 Annual Quality Management Project Plan and Program Evaluation

M.3.1 The Contractor shall, by April 1, 2011 and annually thereafter, propose to the Departments for its review and approval an Annual Quality Management Project Plan that outlines the objectives and scope of planned projects.

M.3.2 The Annual Quality Management Project Plan shall describe how the Contractor will conduct:

M.3.2.1 General Member, Members with Complex Needs, and Provider Satisfaction Surveys;

M.3.2.2 Clinical Issues Studies;

M.3.2.3 Ongoing Quality Management Activities; and

M.3.2.4 Quality Improvement Initiatives (beginning in year two).

M.3.3 The Contractor shall, by April 1, 2012 and annually thereafter, provide the Departments with a Quality Management Program Evaluation.

M.4 Satisfaction Surveys

M.4.1 The Contractor shall conduct Member and Provider Satisfaction Surveys on an annual and shall report the results of such surveys to the Departments. The Satisfaction Surveys shall be conducted within the following guidelines:

M.4.1.1 Frequency - The Contractor shall measure the satisfaction of Members, Members with complex needs, and providers once during each contract year.

M.4.1.2 Implementation - The Contractor shall commence the collection of Member, Member with complex needs and provider satisfaction survey data by July 1, 2011 and annually thereafter. The Contractor shall complete the data collection, analysis, interpretation and final reporting to the Departments by December 31, 2011 and annually thereafter.

M.4.1.3 Methodology - The methodology utilized by the Contractor shall be based on proven research methods ensuring an adequate sample size and statistically valid and reliable data collection practices. The Contractor shall utilize measures that are based on current scientific knowledge and clinical experience.

M.4.2 The Contractor shall contract with a specialized survey entity to conduct a survey of general service members including adults, parents or caregivers of children, and youth over twelve (12) years of age using a general satisfaction survey instrument approved by the Departments. Areas of assessment within the survey shall include but may not be limited to the following:

M.4.2.1 Satisfaction with the Contractor's performance including but not limited to responding to requests for information, telephone wait times, referral assistance, complaints, appeals courtesy and

professionalism;

M.4.2.2 Specific concerns of those members who change providers or facilities; and

M.4.2.3 Satisfaction with Behavioral Health services and supports funded by the Departments.

M.4.3 The Contractor shall conduct a survey of members or caregivers of members with complex behavioral health service needs using an instrument reviewed by members and caregivers, and approved by the Departments. The survey instrument shall include but may not be limited to the following:

M.4.3.1 Satisfaction with the care coordination services;

M.4.3.2 Satisfaction that the care coordination services as well as other services and supports were provided in a respectful, dignified and culturally sensitive manner;

M.4.3.3 Satisfaction with participation as a partner in service planning processes;

M.4.3.4 Satisfaction that the care offered by selected providers was helpful in meeting the member's needs; and

M.4.3.5 Satisfaction with the coordination of care regarding linkage to primary healthcare.

M.4.4 The Contractor shall conduct a provider satisfaction survey using a provider survey instrument approved by the Departments. 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, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing (including those aspects of claims processing administered by the MMIS) and the perceived administrative burden experienced by providers providing behavioral health services in the Partnership.

M.5 Mystery Shopper Surveys

M.5.1 The Contractor shall implement mystery shopper surveys of a scope and frequency mutually agreeable to the Departments and the Contractor in order to assess the quality and responsiveness of network providers.

M.6 Clinical Issue Studies

M.6.1 The Contractor shall propose to the Departments for their approval at

least three (3) annual clinical issue studies during each calendar year of the contract. Unless otherwise approved by the Departments, two of the three studies must be related to mental health and substance use in the adult populations with the third study related to child mental health issues. The content of each study shall be determined with the approval of the QMC.

M.6.2 The Contractor shall:

M.6.2.1 By March 1 of each calendar year of this Contract, propose to the Departments the scope of the clinical issue studies;

M.6.2.2 By June 1 of each calendar year of this Contract, or such other date as agreed to by the Departments and the contractor, submit to the Departments for their review and approval, a draft of the study report for each clinical issue study. The study report shall, at a minimum, include recommendations for intervention, and

M.6.2.3 Within the scope, budget and existing resources of this contract, implement the report recommendations upon approval by the Departments.

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

M.7 Ongoing Quality Management Activities

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

M.7.2 The Contractor shall on a monthly basis, propose to the Departments actions to be taken by the Departments or the Contractor to manage the problems identified above.

M.7.3 The Contractor shall propose to the Departments recommendations on innovative strategies related to Utilization Management and Care Coordination based on national trends and evidence-based practice.

M.7.4 The Contractor shall investigate and address 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. On behalf of the Departments, the Contractor may:

M.7.4.1 Review the quality of care rendered by the provider, including but

not limited to chart audits;

M.7.4.2 Conduct visits at the provider's service site;

M.7.4.3 Require corrective action plans of the provider;

M.7.4.4 Suspend referrals, registration, or authorizations; and

M.7.4.5 Report to the Departments if issues are of a serious nature or remain unresolved.

M.8 Quality Improvement Initiatives

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

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

M.8.1.2 The results of the General Member, Members with Complex Needs, and Provider Satisfaction Surveys;

M.8.1.3 The results of the Clinical Issues Studies; and

M.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.

M.8.2 The Contractor shall implement three (3), (two (2) adult and one (1) child) quality improvement initiatives each year of this Contract starting in year two of this Contract in coordination with and with the approval of the Departments which may include Provider Analysis and Reporting and/or Quality Improvement Plans.

M.9 Training

M.9.1 In addition to the standard training and orientation that the Contractor shall provide to all employees in the Connecticut Service Center, the Contractor shall ensure that Regional Network managers receive specialized training. Specialized training activities shall include but not be limited to:

M.9.1.1 An introduction to the Partnership and the goals for local areas, including the roles of Community Collaboratives, Managed Service Systems, Area Offices and DMHAS' Service System of Care including, Local Mental Health Authorities (LMHA), the Recovery Supports Program, Advocacy Communities, and other grant funded

services and supports.

M.9.1.1.1 An introduction to the initiative and background in principles of recovery oriented systems of care;

M.9.1.1.2 Background in the principles of recovery and resiliency for adults, children and families;

M.9.1.1.3 Training provided by Peer and Family Specialists and Peer Liaisons on the perspective of families and members;

M.9.1.1.4 Training in using decision-support tools and reports available to assist in assessing and evaluating local delivery systems, which will be provided by the Contractor's IT and Reporting staff; and

M.9.1.1.5 DCF shall provide training on DCF policies, procedures and systems as related to service to children and families with behavioral health needs; and

M.9.1.1.6 DMHAS shall provide training on DMHAS policies, procedures and systems as related to service to adults eighteen years and older with behavioral health needs.

M.10 Annual Quality Management Project Plan Evaluation

M.10.1 The Contractor shall submit to the Departments 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. At a minimum the evaluation report shall include the following:

M.10.1.1 A description of completed and ongoing Provider and Member Surveys, Clinical Issue Studies, ongoing QM Activities and annual QM Initiatives;

M.10.1.2 Summary of improvements (or lack thereof) in access, quality of care, coordination of physical and behavioral healthcare, youth transition, 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;

M.10.1.3 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 behavioral health system's performance;

M.10.1.4 Assessment of utilization and other indicators that suggest patterns of potential inappropriate utilization and other types of utilization problems;

M.10.1.5 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,

M.10.1.6 Assessment of provider network access based on standards defined by the Departments. Access standards apply to life threatening and non-life threatening emergency care services, urgent care services and routine care services;

M.10.1.7 Evaluation of the Contractor's performance with respect to targets and standards described in the Reporting Matrix (Exhibit E), with proposed interventions to improve performance (corrective action plans) and proposed intervention measures;

M.10.1.8 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

M.10.1.9 Overall impression of the Partnership system operations and functioning with recommendations for remediation.

M.11 Critical Incidents

M.11.1 The Contractor shall report to the Departments any Critical Incident or significant event within one (1) hour of becoming aware of the incident.

M.11.2 The Contractor shall report to the Departments, on a quarterly and 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).

M.12 Provider Analysis and Reporting (PARs)

M.12.1 The Contractor shall, by April 1, 2011 annually thereafter, produce for the Departments a Provider Analysis and Reporting (PARs) strategy and methodology for review and approval.

M.12.2 The Contractor shall work collaboratively with the provider and consumer stakeholders to inform them of the PARs methodology.

M.12.3 The Contractor shall develop or maintain production of network profiles.

M.12.4 The Contractor shall employ sufficient Network Managers to provide analysis or profiling results, to develop continuous quality improvement plans and to support providers and communities in the execution of the plans.

M.12.5 The Contractor shall provide the Network Managers with training and ongoing supervision to support their role in analyzing network information, developing quality improvement plans and promoting the development of best practices within provider organizations.

M.12.6 The Contractor shall ensure that their Network Managers have:

M.12.6.1 significant experience in the field of behavioral health,

M.12.6.2 demonstrated leadership and accomplishments in the management of behavioral health services,

M.12.6.3 moderate expertise in basic data analysis and reporting,

M.12.6.4 demonstrated experience in helping to develop a continua of health or behavioral health systems,

M.12.6.5 demonstrated experience in Total Quality Management,

M.12.6.6 the ability to develop and implement performance improvement

plans, and

M.12.6.7 experience in organizing and coordinating meetings while promoting communication and collaboration among stakeholders.

M.12.7 The Network Managers shall participate in QM Committee meetings at the request of the Departments, advise the Departments on issues pertaining to local area specific access and quality, and direct local quality management processes.

M.13 Geographic Area Assignment and Support

M.13.1 The Contractor shall require that the Network Managers be designated as a key contract contact for assigned areas and identified network providers.

M.13.2 The Contractor's geographic teams shall be responsible for improving the performance of their respective local areas and identified key providers based on indicators agreed upon in the PARs Quality Improvement Plans.

M.13.3 The Contactor shall ensure that the Network Managers participate in community service planning activities in their assigned local areas, time permitting. The Contractor's Network Managers or an appropriate designee from the Contractor's geographic team for this contract shall:

M.13.3.1 Participate as members in Community Collaboratives and further the identification of local resources for enhancing non-traditional support services within local systems of care.

M.13.3.2 Participate in Managed Service System meetings to review status of DCF involved children with complex needs who require coordinated care between local providers and/or those who are accessing high levels of care.

M.13.3.3 Provide the reports outlined in Exhibit E and other data in order to enable Area Offices and local area stakeholders to understand access, quality and utilization in local areas and statewide and in order to guide service system planning, implementation and monitoring;

M.13.3.4 Work with parent organizations and their leadership, DMHAS' state-operated and private non-profit local mental health authorities, local community providers, hospital administrators, residential providers, DCF Area Office staff, schools, and other key local service providers and leaders to identify system of care issues and plan and implement solutions; and

M.13.3.5 Serve as a source of information and expertise on Partnership and

Contractor policies, procedures and resources; local and national resources for system of care information and grant support; and expertise in national managed care and system of care initiatives and innovations related to adult, child and family services.

N. PROVIDER RELATIONS

N.1 Introduction

Throughout the term of this 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.

N.2 General Aims

N.2.1 The Contractor shall promote on-going and seamless communication between providers and the Contractor. The Contractor shall:

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

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

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

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

N.2.1.5 Post all policies and procedures, handbooks and other material, produced as a requirement under this Contract and as determined by the Departments, on the Partnership Website;

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

N.2.1.7 Notify providers of impending policy changes at least 45 days prior to implementation to the greatest extent possible;

N.2.1.8 Conduct satisfaction surveys at least once per year, sharing findings with provider advisors and involve the provider advisors in

implementing corrective action as indicated;

N.2.1.9 Beginning April 1, 2011, provide the Departments with a publication-ready newsletter for review and approval twice a year. The Contractor shall ensure that the newsletter includes articles covering both mental health and substance abuse 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 Partnership website once approved by the Departments; and

N.2.1.10 Assist the Departments 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 as part of re-credentialing, and inform the Departments if intervention is required in an urgent situation.

N.3 Provider Handbook

N.3.1 The Contractor shall, by March 1, 2011, produce for the Departments a Provider Handbook and shall make this handbook available on the Contractor's Partnership web site. The Contractor shall make the printed form of this handbook available for distribution upon request. The Provider Handbook shall include but may not be limited to the following:

N.3.1.1 Contractor corporate information;

N.3.1.2 Confidentiality provisions;

N.3.1.3 Mission statement of the Partnership;

N.3.1.4 Descriptive process for accessing services under the Partnership;

N.3.1.5 Procedures for communicating with the Departments and the ASO;

N.3.1.6 Summary of service and benefit structure;

N.3.1.7 Compliance with formularies or preferred drug lists for enrolled Members;

N.3.1.8 Procedures for submitting complaints and appeals;

N.3.1.9 Procedures for service authorization and registration;

N.3.1.10 Procedures for using WEB-based provider services;

N.3.1.11 Summary of UM requirements;

N.3.1.12 Summary of claims procedures and DSS MMIS contractor contact

information; and

N.3.1.13 Contact information of Provider Relations staff.

N.4 Provider Notification

N.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 Departments. The Contractor shall:

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

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

N.4.1.3 Post notification of policy changes on the Contractor's Partnership Website.

N.5 Provider Orientation

N.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 areas of the State. The schedule and specific locations for the orientation sessions shall be submitted to and approved in advance by the Departments.

N.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.

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

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

N.6 Provider Training and Targeted Technical Assistance

N.6.1 Throughout the term of this contract the Contractor shall:

N.6.1.1 Offer training and technical assistance to providers on clinical topics,

including introducing evidence-based and emerging best practices approved by the Departments;

N.6.1.2 Develop and implement an ongoing program of provider workshops and training sessions designed to meet the specialized needs and interests of providers;

N.6.1.3 If directed by the Departments in response to Providers' requests, provide provider workshops and training sessions on administrative issues such as cost accounting, claims generation, cash flow management, and documentation; and

N.6.1.4 Have available both clinical and administrative staff to provide targeted technical assistance onsite at the request of network providers and non-network providers seeking to become network providers.

N.7 Provider Inquiries and Complaints

N.7.1 Throughout the term of this Contract the Contractor shall:

N.7.1.1 Track and manage all provider inquiries and complaints related to clinical and administrative services covered under this Contract, except that the Contractor shall track transportation related complaints and forward such complaints to the entity(ies) responsible for transportation services for HUSKY A and B members or to the DSS transportation vendor and the DSS the transportation contract manager for Medicaid Fee-For-Service Members.

N.7.1.2 Ensure that all inquiries and complaints are addressed and resolved in compliance with the Contractor's approved QM Plan, no later than 30 days from receipt.

N.7.1.3 Inform the Departments immediately when urgent circumstances require an immediate response from the Departments.

N.7.1.4 Provide the Departments with a regular report outlining the Contractor's compliance with required timeframes and notifications related to inquiries and complaints. The Departments and the Contractor shall agree to the form, content and frequency of the report in advance.

N.7.1.5 Utilize the Contractor's management information system(s) (MIS) to track complaint related information and provide this data to the Departments upon request. Such data shall include, but may not be limited to the following:

N.7.1.5.1 Caller Name;

N.7.1.5.2 Date and Time of complaint;

N.7.1.5.3 Who complaint is regarding;

N.7.1.5.4 Category/type of complaint;

N.7.1.5.5 Actions taken to address complaint;

N.7.1.5.6 Complaint resolution outcome, date and time; and

N.7.1.5.7 Narrative details regarding complaint.

N.8 Web-based Communication Solution

N.8.1 By March 1, 2011, the Contractor shall update the existing Partnership Web site at www.CTBHP.com . The Partnership website shall demonstrate to the Partnership providers and members that the Contractor provides integrated services supporting health and recovery of children, families and adults in Connecticut.

N.8.2 The Contractor shall ensure that the Partnership Website provides information about the Contractor's services, a link to the Departments' primary websites and Partnership related websites (e.g., www.ctdssmap.com) and a link to the Contractor's corporate website. Coordination of this for the DSS websites should be done through the DSS Webmaster.

N.8.3 The Contractor shall, in collaboration with the Departments, determine what program content is to be published on the Partnership Website,

N.8.4 Throughout the term of this Contract, the Contractor shall provide Web-enabled transactional capabilities through the Partnership Website. Such capabilities shall include but may not be limited to:

N.8.4.1 Provider/member inquiries;

N.8.4.2 Submission of initial request for authorization, registration and re-registration;

N.8.4.3 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;

N.8.4.4 Electronic Transport System (ETS), a communication system designed for the interchange of electronic data files between providers and the Departments;

N.8.4.5 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;

N.8.4.6 A Web-based referral search system that will allow Contractor's and Departments' staff, CMAP providers, MCOs and their providers Partnership members and any other interested persons to locate network providers through an online searchable database. The searchable database shall include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and program types. The system shall permit searches using any combination of the following criteria: provider category (e.g., hospital, clinic, psychologist and others as determined by the Departments); service type (e.g., outpatient, inpatient, detoxification, intensive outpatient, day treatment, extended day treatment, home-based psychiatric and others as determined by the Departments); zip code; population served; languages spoken; sex of provider; ethnicity of provider; clinical specialty; last name; and first name. 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;

N.8.4.7 The use of ProviderConnect, a web-enabled service that allows providers to register on-line authorizations, verify member eligibility, view and print authorizations for all levels of care and allows the provider to update the providers contact information; and NetworkConnect is the internal application used to house and support provider credentialing and provider file updates.

N.8.4.8 An internet "library" of behavioral health information for providers, Partnership members, families and the Departments' staff. The library shall provide comprehensive information and practical recommendations related to mental and behavioral health, addiction and recovery, life events, and daily living skills in both English and Spanish.

O. PROVIDER NETWORK

O.1 Throughout the term of this Contract the Contractor shall provide limited network management and development functions which shall include the ability to develop a provider file, conduct a qualifications review, assess demand, perform network adequacy analysis, and provide network development assistance.

O.1.1 The Contractor shall interact with the providers as an administrative agent on behalf of the Departments. In this capacity, the Contractor shall assist the Departments in developing and maintaining the provider network capacity for the delivery of all covered services to all Members.

The Contractor may not contract with providers in the CMAP Provider network for the provision of covered services to Partnership members without the approval of the Departments.

O.1.2 The Contractor shall obtain provider network data from DSS, group home data from DMHAS and supplemental information regarding DCF funded providers (e.g., care coordination, EMPS, family support teams) from DCF and shall refine and maintain a provider file as specified in the "Information Systems" Section.

O.2 Access to Provider Files

O.2.1 Throughout the term of the Contract the Contractor shall:

O.2.1.1 Ensure that Contractor's staff have immediate access to all provider files through the integrated management information system to allow staff to search for a provider appropriate to a member's needs, preferences, and location; and

O.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.

O.3 Provider Search Function

O.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:

O.3.1.1 Provider type;

O.3.1.2 Service type/level of care;

O.3.1.3 Zip Code;

O.3.1.4 Population Served;

O.3.1.5 Language;

O.3.1.6 Gender;

O.3.1.7 Race/Ethnicity of Provider (when available);

O.3.1.8 Specialty;

O.3.1.9 Provider Last Name;

O.3.1.10 Provider First Name;

O.3.1.11 Provider Medicaid Number; and

O.3.1.12 Provider Number.

O.4 Network Assessment

O.4.1 The Contractor shall assess the size and scope of the current MCO and CMAP contracted provider network to assist the Departments in determining the need for provider recruitment. The Contractor shall:

O.4.1.1 Send data verification forms to any CMAP providers that are not currently in the Contractor's Connecticut network and to any new CMAP providers, requesting among other things, identification of their clinical specialties;

O.4.1.2 Load the provider and utilization data into the Contractor's MIS, perform a gap analysis and generate a density report to determine network inadequacies;

O.4.1.3 If the gap analysis performed indicates the need for additional providers, the Contractor shall compare the Departments' provider network with the Contractor's Connecticut provider network to identify providers most likely to join the DSS network and shall assist the Departments with recruiting the identified providers; and

O.4.1.4 Throughout the term of this contract the Department may, no more frequently than quarterly, require the Contractor to perform a gap analysis (GeoAccess study) and density report with a focus on priority areas as determined by the Departments and Contractor's advisory committees. Priority areas include language capacity, specialty services and appointment times.

O.4.2 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:

O.4.2.1 Tracking and trending information on services requested but not available;

O.4.2.2 Requesting the Contractor's advisory committees to identify services that are needed but unavailable;

O.4.2.3 Monitoring services for which authorization is continued for administrative reasons (e.g., lack of essential aftercare services);

O.4.2.4 Monitoring penetration rates by age, location and ethnic/minority;

O.4.2.5 Monitoring consumer-reported satisfaction with access to services;

O.4.2.6 Conducting Mystery Shopper Surveys as required under section M.6

of this contract;

O.4.2.7 Monitoring population growth; and

O.4.2.8 Utilizing findings of other local research, such as assessments done by the MCOs, Community Collaboratives, Managed Service Systems and LMHAs.

O.5 Network Development

O.5.1 The Contractor shall, within available resources, assist the Departments in addressing deficiencies in the CMAP Provider Network by developing the behavioral health provider network in geographic areas that do not provide adequate access to covered services including psychiatric evaluation and medication consultation services. Specifically, the Contractor shall:

O.5.1.1 Encourage the use of non-psychiatric physicians and other psychiatrist-extenders such as Advanced Practice Registered Nurses;

O.5.1.2 Offer clinical training at no additional charge to the Departments or to the providers;

O.5.1.3 Work with trade organizations and licensing boards to actively recruit providers;

O.5.1.4 Work with existing CMAP and Partnership providers to expand existing capacity and add new services;

O.5.1.5 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

O.5.1.6 Coordinate with the DSS MMIS contractor and the Departments as necessary to facilitate enrollment of new providers or the addition of new services to existing network providers.

O.6 Critical Access and Single Case Agreements

O.6.1 The Contractor shall negotiate and facilitate the execution of special service agreements on a case-by-case basis to address critical access issues. The terms of such agreements may be negotiated without the participation of the Departments but the final terms of the agreement shall be subject to approval by the Departments. Such agreements shall be entered into to address access issues including, but not limited to:

O.6.1.1 Provision of a service that is covered under the Partnership, but

unavailable in a particular local area;

O.6.1.2 Provision of a service to eligible members who are temporarily out-of-state and in need of services;

O.6.1.3 Provision of a service that is not in the network, but is covered under Medicaid EPSDT; and

O.6.1.4 Provision of a support service such as respite that is necessary for the success of a child with complex behavioral health service needs.

O.6.2 The Contractor shall coordinate with DMHAS and DCF to enable DMHAS and DCF to execute a provider agreement or contract for services that will not be reimbursed through the DSS MMIS.

O.6.3 The Contractor shall coordinate with DSS and the DSS MMIS contractor to enroll providers with whom a service has been negotiated that will be payable through the DSS MMIS.

O.7 Payment Related Troubleshooting and Technical Assistance

O.7.1 The Contractor shall facilitate the identification and resolution of provider payment problems. The Contractor shall:

O.7.1.1 Attend regular meetings hosted by the Departments and attended by the Departments' fiscal agent to address operational issues that are or may impact providers.

O.7.1.2 In coordination with the DSS MMIS Contractor, use overall and provider specific payment monitoring reports, including those identified in Exhibit E, to identify payment problems and diagnose the nature of those problems (i.e., authorization related vs. claims adjudication related).

O.7.1.3 Participate in a rapid response team consisting of DSS MMIS contractor personnel and Contractor personnel to resolve issues related to timely and accurate claims payment. The rapid response team activities shall include provisions for on-site assistance when problems persist for more than 60 days.

O.7.1.4 The contractor shall make available clinical staff to assist with the review and resolution of claims issues that may be authorization related. This work will occur in conjunction with the rapid response team and will assist in facilitating timely resolution to identified claims projects.

P. MEMBER SERVICES

P.1 General Requirements

P.1.1 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 ensure that member information is clearly communicated in a manner that is culturally sensitive and should supply sufficient information that enables members to make informed decisions to access behavioral health services.

P.1.2 Throughout the term of the contract the Contractor shall ensure that all member services staff shall demonstrate professionalism, respect, and communicate in a culturally appropriate manner with members.

P.1.3 The Contractor shall staff member services with competent, diverse professionals including Spanish-speaking individuals in order to best serve the needs of members.

P.1.4 The Contractor shall insure that TDD/TTY and language translation services are available for those recipients who require them.

P.1.5 The Contractor shall identify a "Key Person" responsible for the performance of the Member Services unit.

P.1.6 The Contractor shall develop and implement a formal training program and curriculum for staff that respond to member inquiries. The training program shall include training in how to recognize members that may need ICM and to make referrals as appropriate.

P.1.7 The Contractor shall develop a reference manual for member service representatives to use during daily operations.

P.1.8 The Contractor staff shall provide members with sufficient information concerning behavioral health coverage to enable members to make informed decisions regarding their needs;

P.1.9 The Contractor staff shall provide members with information that facilitates access to covered services and allows successful navigation of the behavioral health service system. Such information shall include information about how Members can arrange for transportation services and where to register complaints related to transportation difficulties.

P.1.10 The Contractor shall develop, plan and assist members with information related to community based, free care initiatives such as ALANON and other support groups (e.g., Alcoholic's Anonymous, Narcotics Anonymous)

P.1.11 The Contractor staff shall respond to member clinical care decision inquiries in a manner that promotes member self-direction and

involvement; and

P.1.12 The Contractor staff shall initiate a warm transfer for callers that are not Partnership members to DMHAS, the HUSKY enrollment brokers or eligibility workers for the Voluntary Services and Medicaid FFS programs as appropriate.

P.1.13 The Contractor shall develop a data base of providers as further described in Section O "Provider Network" identifying providers with cultural competency and linguistic capabilities. The Contractor shall use this information to refer recipients to behavioral health services that are culturally and linguistically responsive to the preferences of recipients.

P.1.14 When requested by recipients, the Contractor shall identify participating providers, facilitate access, and assist with appointment scheduling when necessary. The contractor shall develop a database to support this function as necessary.

P.2 Policies and Procedures

P.2.1 The Contractor shall, no later than February 15, 2011, develop and submit to the Departments for their review and approval a Member Inquiry Process which shall include policies and procedures for resolving and responding to member inquiries. The policies and procedures shall address the tracking and reporting of the following:

P.2.1.1 Complaints regarding the Contractor's performance;

P.2.1.2 Complaints related to the service delivery system;

P.2.1.3 Complaints related to specific providers;

P.2.1.4 Resolution of complaints not later than 30 days from receipt;

P.2.1.5 Routine, urgent and emergent (crisis) calls;

P.2.1.6 Inquiries regarding the status of any denial, reduction, suspension or termination of services;

P.2.1.7 Inquiries related to the status of authorization requests;

P.2.1.8 Inquiries regarding member rights and responsibilities including those related to complaints and appeals;

P.2.1.9 Forms and instructions for filing a written complaint;

P.2.1.10 Requests for referral, taking into consideration linguistic and cultural preferences when requested;

P.2.1.11 Request to facilitate access and assist with appointment scheduling

when necessary;

P.2.1.12 Requests for coverage information including benefits and eligibility;

P.2.1.13 Inquiries related to community based free care initiatives such as ALANON and other support groups (e.g., Alcoholic's Anonymous, Narcotic's Anonymous); and

P.2.1.14 Inquiries regarding information related to the Partnership.

P.3 Transportation

P.3.1 Throughout the term of the contract the Contractor, through its member services staff shall facilitate and coordinate access to transportation services. The Contractor shall:

P.3.1.1 Determine whether the caller is Partnership eligible.

P.3.1.2 Inform the caller enrolled in D05 or HUSKY B that non-emergency medical transportation is not a covered service and shall assist the caller in identifying other transportation options.

P.3.1.3 If the caller is enrolled in HUSKY A, determine the entity responsible for the coordination of non-emergency medical transportation services and provide a warm transfer to the appropriate entity.

P.3.1.4 Facilitate and coordinate access to transportation services for any Medicaid eligible individual by referring the individual to the appropriate DSS transportation services broker. The Contractor shall offer to provide a warm transfer to the transportation broker; and

P.3.1.5 Ask the caller to call the Contractor back if problems are encountered in accessing transportation.

P.4 Semi-Annual Community Meetings

P.4.1 The Contractor's staff shall work with staff from the Departments to develop semi-annual community meetings. The purpose of the community meetings shall be to share information and feedback with members, parents of members, family members, advocacy groups, providers, and members of Community Collaboratives.

P.4.2 The community meetings shall be conducted in at least five (5) locations throughout the State, as proposed by the Contractor and approved by the Departments.

P.4.3 At the Departments' discretion the Contractor shall be directed to schedule the first series of community meetings and shall focus such

meetings on orienting members of the community to the Partnership.

P.4.4 The Contractor shall:

P.4.4.1 Develop agendas with common topics across all regions as well as specific local topics suggested by local stakeholders;

P.4.4.2 Select sites and times that will encourage the largest number of participants;

P.4.4.3 Publicize the event throughout the region and across the State;

P.4.4.4 Arrange for a keynote speaker, panel presentation or main focus; and

P.4.4.5 Provide a mechanism for all attendees to evaluate the meeting and offer suggestions for future regional committee meetings.

P.5 Member Brochure

P.5.1 The Contractor shall develop an informational member brochure by February 15, 2011 to be written at no greater than a fourth grade reading level, in both English and Spanish. The contents of the brochure shall:

P.5.1.1 Explain behavioral health benefits for members;

P.5.1.2 Describe how to access providers;

P.5.1.3 Describe how to contact the Contractor for assistance in using the Behavioral Health system; and

P.5.1.4 Describe member rights and responsibilities, including grievances, complaints and appeals.

P.5.2 The Contractor shall produce, print, and distribute the informational member brochure according to a plan approved by the Departments and mail a brochure to any member or provider upon request.

P.5.3 The Contractor shall supply the Departments with brochures to be distributed by the Department at the time that eligibility is granted and shall supply large provider sites with brochures for provider distribution at their sites of service.

P.5.4 The Contractor shall revise and update the Member brochure as required by the Departments but not more often than annually and shall distribute the revised brochures according to the distribution plan approved by the Departments. The Contractor will consider other means of communication including web based video feeds.

P.6 Member Handbook

P.6.1 The Contractor shall, by May 1, 2011, develop a Member Handbook. The Member Handbook shall include:

P.6.1.1 The benefits available to members;

P.6.1.2 The procedures for accessing services covered under the Partnership and related services such as transportation and pharmacy for which coverage is provided through DSS or the entity(ies) responsible for the care management of physical health services for HUSKY and Charter Oak Members; and

P.6.1.3 Rights and responsibilities, including Notice of Action, appeal and complaints rights.

P.6.2 The Contractor shall include a member services section on the Partnership Website and such section shall:

P.6.2.1 Contain information for members and their families concerning behavioral illnesses and the assistance available for recovery through the Partnership;

P.6.2.2 Ensure that the website has the capability of exchanging Partnership information and member information with providers and members;

P.6.2.3 Include the text of the Member handbook; and

P.6.2.4 Include security provisions approved in advance and required by the Departments.

Q. TELEPHONE CALL MANAGEMENT

Q.1 General Requirements

Q.1.1 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 voice response system (AVR) 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.

Q.1.2 The Contractor shall provide and operate call management services through a location in Connecticut. After hours services, such as crisis triage and provider authorizations may, with the Departments' advance approval, be managed out of state but within the United States.

Q.1.3 The Contractor shall include up to (3) nationwide toll free lines, one of which shall be dedicated to fax communications.

Q.1.4 The Contractor shall develop, implement and maintain operational procedures, manuals, forms, and reports necessary for the smooth operation of the Telephone Call Management Services.

Q.2 Line Specifications

Q.2.1 The Contractor shall establish and maintain a toll free telephone line for members and providers with the following specifications:

Q.2.1.1 Access to a limited menu automated voice response (AVR) system (Speech recognition is optional);

Q.2.1.2 Ability to receive transferred calls from other AVR Systems;

Q.2.1.3 Ability to transfer calls to local department offices, as specified by the Departments;

Q.2.1.4 Ability to warm transfer to the Departments, the Care Management Plans, and DSS's agents for dental, pharmacy, transportation, and claims services;

Q.2.1.5 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;

Q.2.1.6 Conferencing capability;

Q.2.1.7 TDD/TTY capability for hearing-impaired;

Q.2.1.8 Multi-lingual Capabilities;

Q.2.1.9 Overflow capability; and

Q.2.1.10 Voicemail capability.

Q.2.2 The Contractor shall establish and maintain the following menu options for members that call the main toll free telephone line:

Q.2.2.1 Crisis Calls. The crisis calls that are received during normal business hours shall be routed to clinical staff. Crisis calls that occur after business hours shall be handled in a manner agreed to by the Departments and the Contractor; and

Q.2.2.2 Member Services. The Member Services Line shall enable members to call with questions, information and clinical requests during normal business hours.

Q.2.3 The Contractor shall establish and maintain the following menu options for providers that call the main toll free telephone line:

Q.2.3.1 Authorization requests twenty-four (24) hours a day and seven (7) days per week;

Q.2.3.2 Provider Services during normal business hours; and

Q.2.3.3 Authorization Verification: This option shall allow a provider to obtain information regarding the status of an authorization request.

Q.3 Performance Specifications

Q.3.1 Throughout the term of the Contract the Contractor shall meet or exceed the following Performance Specifications for Telephone Call Management. The Contractor shall:

Q.3.1.1 Ensure that the AVR system provides the options menu to all callers within two (2) rings;

Q.3.1.2 Ensure that the member and provider call-in lines never have a busy signal;

Q.3.1.3 During normal business hours, provide sufficient and appropriate staff to answer all AVR 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%. When crisis calls are not answered within the first fifteen (15) seconds, the AVR 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;

Q.3.1.4 After business hours, provide sufficient and appropriate staff to answer all AVR transferred crisis calls and dispatch the caller to a live person with the appropriate mobile crisis team or program the phone system to automatically distribute the caller to the appropriate crisis line, as described above. All crisis calls shall be answered within fifteen (15) seconds or automated phone transfers shall occur within ten (10) seconds;

Q.3.1.5 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 thirty (30) seconds and maintain an abandonment rate under 5% during Normal Business Hours. During non-business hours when a staff person is not available for routine calls, the AVR shall respond with a recording within ten (10) seconds of the AVR call activation, instructing the caller to call back during normal business hours;

Q.3.1.6 Produce a monthly report for the Departments' review that documents each rerouting incident (including AVR transferred crisis calls) the answer time and the associated reason for the rerouting. This report shall be identified as the Network Call Rerouting (NCR) Report;

Q.3.1.7 Provide sufficient and appropriate staff to answer all AVR transferred calls to the Authorization Line 24 hours a day, seven (7) days a week for providers, shall answer 90% of such calls with a live person within (thirty) 30 seconds and maintain an abandonment rate of less than 5%. 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;

Q.3.1.8 Provide sufficient and appropriate staff to answer all AVR transferred calls to "Provider Services" who shall answer 90% of calls with a live person within thirty (30) seconds and maintain an abandonment rate under 5% during Normal Business Hours. During non-business hours when a staff person is not available, the AVR shall respond with a recording within ten (10) seconds of the AVR call activation instructing the caller to call back during normal business hours;

Q.3.1.9 Ensure that Contractor's staff and AVR can communicate in English and Spanish on an as needed basis and that access is provided to a language line twenty-four hours a day, seven days a week to serve members; and

Q.3.1.10 Ensure that Contractor's telephone staff greet all callers, identify themselves by first name when answering and treat every caller in a responsive and courteous manner.

Q.4 Automatic Call Distribution Reporting

Q.4.1 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:

Q.4.1.1 Number of incoming calls;

Q.4.1.2 Total number of answered calls by Contractor staff;

Q.4.1.3 Average number of calls answered by each Contractor staff member;

Q.4.1.4 Average call wait time by staff member;

Q.4.1.5 Average talk time by staff member;

Q.4.1.6 Percent of crisis calls answered by staff in less than fifteen (15) seconds during normal business hours after the selection of a menu option;

Q.4.1.7 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;

Q.4.1.8 Percent of routine Member Services calls answered by staff in less than thirty (30) seconds after the selection of a menu option;

Q.4.1.9 Percent of provider Authorization calls answered by staff in less than thirty (30) seconds after the selection of a menu option;

Q.4.1.10 Percent of Provider Services calls answered by staff in less than thirty (30) seconds after the selection of a menu option;

Q.4.1.11 Number of calls placed on hold and length of time on hold; and

Q.4.1.12 Number and percent of abandoned calls. (For purposes of this section abandonment refers to those calls abandoned 30 seconds after the entire menu selection has been played). The call abandonment rate shall be measured by each hour of the day and averaged for each month.

Q.4.2 The Contractor shall maintain phone statistics daily and shall tally and submit the statistics to the Departments in accordance with the reporting schedule and format outlined in Exhibit E, Reporting Matrix. The Departments reserve the right to change the reporting timeframe for these reports; however, any revised timeframes must be mutually agreed upon by the Departments and the Contractor.

R. DATA REPORTING REQUIREMENTS

R.1 General Requirements

R.1.1 The Contractor shall store all operational data collected in an information system that is compliant with Open Database Connectivity Standards (ODBC) and allow for easy data capture;

R.1.2 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.

R.1.3 The Contractor shall provide the Departments with a mutually agreeable electronic or Web-based file format of the MIS data dictionary of all data

elements in all databases maintained in association with this Contract.

R.1.4 The Contractor shall ensure that any database used in association with this contract can execute ANSI SQL.

R.1.5 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.

R.1.6 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.

R.2 Report Production, Integrity and Timeliness

R.2.1 The Contractor shall establish and notify the Departments of the "Key Person" responsible for the coordination of the transmission of reports, correction of errors associated with the reports, as well as the resolution of any follow up questions.

R.2.2 The Contractor shall track report requests and work hours expended to satisfy the request.

R.2.3 The Contractor shall comply with requests from the Departments to modify or add to the reporting requirements set forth herein unless the Contractor demonstrates to the Departments 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.

R.2.4 The Contractor shall provide the Departments, for their 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").

R.2.5 The Contractor and the Departments agree that the required reports, including due dates and prescribed format and medium are memorialized in Exhibit E - Reporting Matrix.

R.2.6 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.

R.2.7 The Contractor and the Departments 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.

R.2.8 The Contractor and the Departments may agree to change Exhibit E, however, such change shall only be effective as of the date that the Departments and the Contractor agree, in writing, to the change.

R.2.9 The Contractor shall not be held liable for the failure to comply with a reporting requirement set forth in Exhibit E, as changed by agreement of the parties from time to time, in the event that the Contractor's failure is a result of the Departments' failure to provide the necessary data and/or data extracts.

R.2.10 The Contractor shall produce all reports accurately with minimal revisions following submission.

R.2.11 The Contractor shall advise the Departments, within one (1) business day, when the Contractor identifies an error in a line item of a report and submit a corrected report within five (5) business days of becoming aware of the error.

R.2.12 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.

R.2.13 If it is apparent that 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 Departments no later than one business day before the scheduled due date of the report.

R.3 Data Storage and Elements

R.3.1 In addition to the data elements necessary to complete the reports in the Reporting Matrix (E) and further described in the "Utilization Management" Section, 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:

R.3.1.1 EMS Unique Client Identifier;

R.3.1.2 Age (including summarization by age bands and or focus on a specific age, including those age bands specified in Exhibit E);

R.3.1.3 Gender;

R.3.1.4 Diagnoses;

R.3.1.5 Significant co-morbidities, including pregnancy;

R.3.1.6 ICM Indicators;

R.3.1.7 Local areas as defined by the Departments;

R.3.1.8 Program or coverage category (HUSKY A, HUSKY B, D05, Medicaid LIA, ABD, etc.; Charter Oak) and special population identifier if any;

R.3.1.9 Court involvement/mandate type;

R.3.1.10 DCF identifier, if applicable;

R.3.1.11 Ethnicity and Race;

R.3.1.12 Provider type;

R.3.1.13 Provider specialty;

R.3.1.14 Provider identifiers and TIN;

R.3.1.15 Service type/level of care;

R.3.1.16 Procedure code/revenue code;

R.3.1.17 Fiscal Year or Calendar Year;

R.3.1.18 Periodic Comparison (month to month, year to year);

R.3.1.19 Compilation by day, week, month, quarter, semiannually, and yearly, and

R.3.1.20 Member attrition to medical home or other entity.

R.4 Data Aggregation

R.4.1 The Contractor shall aggregate the data collected statewide by standard human service regions and by the individual Departments' defined regions;

R.4.2 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;

R.4.3 The Contractor shall ensure that all authorization data reflects units denied and authorized.

R.5 Standard and Ad-hoc Reports

R.5.1 The Contractor shall produce for the Departments Standard and Ad-hoc reports including those that may be required of the Departments (e.g., by the legislature);

R.5.2 The Contractor shall produce Standard reports on a regularly scheduled

basis as defined by the Departments on all activities and measures in the format outlined in the Data Reporting Requirements section and Exhibit E, Reporting Matrix. The Departments may modify the format and specifications of these Standard reports.

R.5.3 The Contractor shall produce Ad-hoc reports upon request of the Contract Managers. 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, authorization database and credentialing database. 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 Contract Managers to prioritize requests in order to accommodate requested reports within available resources. If requested reports cannot be so accommodated, the Contractor and the Departments shall negotiate the cost of accommodating the request.

R.5.4 The Contractor shall produce and deliver such Ad-hoc reports to the Departments within five (5) business days of the Contractor's receipt of the Departments' written request. 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's that 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.

S. INFORMATION SYSTEM

S.1 System Requirements

S.1.1 The Contractor shall be required to transmit authorization data to the DSS MMIS contractor, integrate claims and authorization data and to produce extracts for the DSS, DCF, and DMHAS data warehouses.

S.1.2 The Contractor shall establish and maintain a HIPAA compliant computer system to accommodate all operational and reporting functions set forth herein.

S.1.3 The Contractor shall establish and maintain connectivity between the Contractor's information system and the Departments' systems and contractors to support the required eligibility data exchanges based upon the Departments' standards.

S.2 Eligibility Data

S.2.1 The Contractor shall accept eligibility, membership and enrollment data (eligibility data) from the Departments and the Departments' contractors

through magnetic media or electronic communications.

S.2.2 Upon receipt of the eligibility data from DSS and/or a DSS contractor, the Contractor shall conduct a quality assurance or data integrity check of the eligibility data. Any eligibility audit report that results in an error rate below two percent shall be loaded into the Contractor's information system within two business days of receipt.

S.2.3 The Contractor shall, in a format specified by DSS, notify DSS of any eligibility record that errors out due to missing or incorrect data and post corrected data to the Contractor's eligibility system.

S.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.

S.2.5 The Contractor shall assemble a single comprehensive eligibility database incorporating the following eligibility data:

S.2.5.1 HUSKY A, Medicaid FFS and D05 member eligibility information including but not limited to demographic within forty-eight (48) hours from the time at which such extracts are made available by DSS.

S.2.5.2 HUSKY B prospective and retrospective eligibility information within forty-eight 48 hours of receiving daily batch file extracts from DSS' HUSKY B administrative agent.

S.2.6 The Contractor shall provide all authorized Intensive Care Managers with on-line access to the Contractor's comprehensive eligibility database to serve members and providers.

S.2.7 The Contractor shall verify the eligibility of persons not yet showing in the monthly eligibility file utilizing PC-based software, Provider Electronic Solutions (PES), to query the DSS Automated Eligibility Verification System (AEVS).

S.2.8 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 monthly eligibility file but who is listed on AEVS.

S.3 Build and Maintain the Provider File

S.3.1 Initial Provider File Information and Updates

S.3.1.1 The Contractor shall receive an initial provider extract from the DSS MMIS contractor in a file layout and media determined by DSS and load the information into the Contractor's MIS;

S.3.1.2 The Contractor shall accept from the DSS MMIS contractor, at a frequency agreeable to the Contractor and the Departments and in a format and media determined by DSS, provider adds and changes and shall, within three business days of receipt, update the Contractor's MIS provider file accordingly;

S.3.1.3 The Contractor shall accept from DCF a monthly network update file and update the Contractor's MIS provider file accordingly within five business days of receipt; and

S.3.1.4 The Contractor shall accept from the Departments additional source provider data that it may otherwise obtain from providers and use such information to build a more comprehensive provider file; and

S.3.1.5 The Contractor shall manage the provider file locally and such file shall reside on a server located in the Connecticut Service Center, unless the Contractor is able to satisfy the Departments that it can comply with all of the requirements with a provider file that does not reside locally.

S.3.2 Supplemental Information

S.3.2.1 The Contractor shall customize the Contractor's MIS provider file to accommodate supplemental information required by the Departments;

S.3.2.2 The Contractor shall update the Contractor's MIS provider file to include the supplemental data elements obtained through the provider re-enrollment process and the uniform provider application developed by the Departments.

S.3.3 Provider Identification

S.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.

S.3.4 Data Elements

The Contractor shall store the minimum provider data elements in the table below in the Contractor's MIS provider file.

Data Elements	
Provider Type	Clinical Specialties

Service Types	Discipline License Level
Provider ID	Provider Specialty
Location ID	Service Address 1
CMAP ID	Service Address 2
CMAP Provider type	Service City
CMAP Provider specialty	Service State
Last Name	Service Zip
First Name	Service Phone
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	Number of beds (as applicable)
Billing City	
Billing Zip	

S.3.5 Other Requirements

S.3.5.1 The Contractor shall ensure that the Contractor's MIS provider file can identify where services reside by location, provider type and specialty.

S.3.5.2 The Contractor shall ensure that provider searches can also be conducted in the Provider Subsystem, Care Coordination module, and the Inquiry Tracking module.

S.3.5.3 The Contractor shall ensure that the provider subsystem supports processes involving provider entry, reports, inquiry, and other fields to meet the requirements of the Partnership.

S.4 Data Extracts from the Departments to the Contractor

S.4.1 The Contractor shall receive paid and unpaid claims extract files for behavioral health services from the DSS MMIS contractor and match the paid claims with open authorizations to determine units used and units available.

S.4.2 DSS shall provide the Contractor with claims extracts from the DSS MMIS contractor on a monthly or more frequent basis for reporting purposes.

S.4.2.1 DCF shall provide the Contractor with claims extracts from LINK on a monthly basis for reporting purposes.

S.4.2.2 DCF shall provide and the Contractor shall receive and integrate information into its eligibility file, pertaining to local area assignment for each child with a DCF identifier. Local area assignment for non-DCF children shall be performed by the Contractor based on assignment rules established by DCF.

S.5 Batch Authorization Files

S.5.1 The Contractor shall provide to the DSS MMIS contractor a daily Prior Authorization (PA) Transaction batch file of all authorized services and authorization updates identifying service member ID, CMAP ID, procedure/revenue code, units, span dates, diagnosis, and any other information specified by the DSS MMIS contractor. The batch file layout will be in a custom (i.e., non-HIPAA compliant) format specified by the DSS MMIS contractor.

S.5.2 DSS 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 no later than three (3) days after the corresponding PA Transaction file is

received.

S.5.3 The PA Transaction file from the Contractor and the Daily Error file to the Contractor from the DSS MMIS contractor shall be transferred electronically via File Transfer Protocol (FTP) or other mutually agreeable and secure means of transmission.

S.5.4 The Contractor shall provide to DCF, twice monthly, a batch file of all authorized residential services and authorization updates identifying service member ID, provider ID, service class, span dates, diagnosis, and any other information specified by DCF. The batch file layout will be in a custom (i.e., non-HIPAA compliant) format specified by DCF.

S.6 Data Extracts from Contractor to the Departments

S.6.1 The Contractor shall provide the Departments with the complete provider file and authorization file as required by the Departments in a format specified by the Departments.

S.6.2 The Contractor shall provide data from its databases to the Departments' systems and data warehouses as specified below and as otherwise required by the Departments. The Contractor shall:

S.6.2.1 Submit records of all requested, authorized and denied services including all data fields listed in the UM subsection and any other information about the claim authorization specified by the Departments to the DMHAS and DCF data warehouses, in a mutually agreeable electronic format and means and frequency of transmission; and

S.6.2.2 Submit records of all requested, authorized, and denied services for eligible individuals regardless of age, including all data fields listed in the UM subsection and any other information about the claim authorization specified by the Departments to the DSS data warehouse, in a mutually agreeable electronic format and means and frequency of transmission.

S.7 Access by the Contractor to DSS's Data Warehouse

If required by DSS, DSS shall train the Contractor staff to use the DSS data warehouse for inquiry and reporting. If requested by DSS the Contractor shall use the DSS data warehouse to generate required ad-hoc reports directed by DSS.

S.8 Access by Departments to Contractor's Databases/Data Warehouse

S.8.1 The Contractor shall provide a secure and mutually agreeable mechanism by which DCF, DMHAS, and DSS 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 pertaining to the work performed under this Contract.

S.8.2 The Contractor shall develop procedures for granting the Departments secure access through terminals at the Contractor's Connecticut Service Center and for training a minimum of six and a maximum of nine DCF, DMHAS and DSS personnel in report generation and ad hoc querying. At the Departments' request, the Contractor shall provide training in any Open Database Connectivity (ODBC) compliant reporting tools used by the Contractor's reporting staff to provide reports to the Departments.

S.8.3 The Contractor shall, if requested by the Departments, provide a workstation or a personal computer with access rights to the Contractor's reporting software tools, databases and data warehouse related to this Contract, at the Connecticut Service Center for use by the Departments.

S.9 Telecommunications and IT Systems Outage

S.9.1 The Contractor shall notify the Departments when it experiences a telecommunications outage during normal business hours that exceeds 15 minutes.

S.9.2 The Contractor shall track any outages to any mission critical part of its IT or telecommunications system, including date of the outage, duration of the outage, and reason for the outage and make this report available to the Departments upon request.

S.10 Disaster Recovery and Business Continuity

S.10.1 The Contractor shall, on an annual basis within thirty (30) days of the end of each calendar year covered by this contract, provide to the Departments with a Disaster Recovery and Business Continuity plan that will, at a minimum, prevent the loss of historical data and ensure continuous operations. Continuous operations means 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. The plan shall include a backup schedule and the Contractor's plan for seamlessly responding to phone calls in the event of local power failures, phone system failures or other emergencies.

S.10.2 During any such period that the disaster recovery plan is in effect, the Contractor shall be responsible for all costs and expenses related to the provision of the alternate services under its normal Administration fee. The Contractor shall, within twenty-four (24) hours of onset of the problem requiring the implementation of the disaster recovery plan, notify the Contract Administrator 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.

S.10.3 The Departments shall review and approve the Disaster Recovery Plan or provide the Contractor with comments and changes. The Contractor is required to advise the Departments, in writing if the Contractor anticipates making changes to those sections of the Contractor's Disaster Recovery Plan that have been approved by the Departments.

S.10.4 The Contractor shall maintain and execute the Disaster Recovery and Business Continuity plan to ensure compliance with the Departments' IT requirements even if a disaster interrupts normal business and IT operations. The Disaster Recovery or "IT Business Continuity" plan shall include:

S.10.4.1 Daily Backups: Traditional daily system backups shall be done on all servers to ensure:

S.10.4.1.1 That the content of all of both host and local area network systems can be recovered in the event of a disaster;

S.10.4.1.2 Software and production data files are copied to digital tape or other suitable media.

S.10.4.1.2..1 A verification and audit program shall be used to confirm that the system backup tapes are complete and accurate and can be properly restored.

S.10.4.1.2..2 Copies of the tapes shall be created and stored in a secure off-site location to be used to reload the production systems.

S.10.4.1.2..3 System backup tapes shall be rotated regularly to ensure physical integrity of the tapes and to minimize tape parity error problems;

S.10.4.2 Backup Power : The Contractor's MIS will support the Departments using the IT infrastructures located in the Natural Data Center Site, the Connecticut offices, and National Data Center Site 2.

S.10.4.2.1 National Data Center Site 1 shall house the AS400 server and supporting hardware.

S.10.4.2.2 A backup power generator shall support the

Contractor's information systems wherever such systems shall reside and shall be able to restore power to the systems within minutes in the event of a power failure. The Connecticut Service Center computer room shall be supported with its own uninterruptible power supply to continue operations while the building backup power generator is activated;

S.10.4.3 Recovery

The Contractor shall be able to have the Contractor's IT system back online within 15 to 30 minutes and operating in a secure environment; and

S.10.4.4 Testing

Testing of the disaster recovery process, at a minimum, shall be provided for annually with preparation and delivery of a report to the Departments within one month of the test.

T. NOTICES OF ACTION, DENIAL NOTICES, APPEALS AND ADMINISTRATIVE HEARINGS

T.1 General Requirements

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 Departments vary by program (HUSKY Program, D05, Medicaid FFS, and Charter Oak) and may change. To the extent that there are changes in state or federal law 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 Departments.

T.2 Notices of Action and Denial Notices

T.2.1 The Contractor shall meet or exceed the Notice of Action and Denial Process Requirements as specified for each program and set forth in this Section. The Contractor shall, no later than February 15, 2011 submit to the Departments for their 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.

T.2.2 The Contractor shall automatically create authorization letters from its computer system whenever a request for authorization is entered and make such letters available through ProviderConnect.

T.2.3 The Contractor shall create Notices of Action and Denial Notices specific to each program and each type of action. For HUSKY A, D05, Medicaid

FFS, the Contractor shall issue notices for both denials and partial denials on the approved notice, as applicable. 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. These requests also include additional requests and/or re-authorization requests. The Contractor shall issue denial notices to HUSKY B and Charter Oak members if the Contractor denies a provider's request for services covered under the applicable benefit package, regardless of whether such determination was made before, during or after provision of the service. 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.

T.2.4 For HUSKY A, D05, and Medicaid FFS, the Contractor shall issue notices for terminations, suspensions and reductions of previously authorized services, on the approved notice, as applicable. Termination/Suspension/Reduction notices related to previously authorized covered services shall be communicated in writing ten (10) days in advance of the effective date. 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. The Contractor may shorten the 10-day advance notice in the circumstances described in 42 C.F.R. § 431.214.

T.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 F.6 and F.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.

T.2.6 The Departments shall, by February 7, 2011, provide the Contractor with templates for the Notices of Action and Denial Notices required by this section. The Departments shall provide templates for the following: Notice of Action pertaining to Denials/Partial Denials for Medicaid; Notice of Action pertaining to Termination, Suspension, Reduction for Medicaid; Denial Notice for Charter Oak; Appeal/Administrative Request form for Medicaid; Appeal Application Form/DOI Instructions for Charter Oak. The Contractor shall submit final standardized Notices of Action and Denial Notices to the Departments for review and approval, the format and content of which may not be altered without the prior written approval of the Departments. All notices shall include the specific reason for denial in English and in Spanish.

Program	Template
D05	NOA for Denials/Partial Denials NOA for Termination, Suspension, Reduction Appeal / DCF Instructions
HUSKY A Medicaid FFS	NOA for Denials/Partial Denials NOA for Termination, Suspension, Reduction Appeal / DSS Hearing Process
HUSKY B Charter Oak	Denial Notice Appeal Application Form / DOI Instructions

T.2.7 The Contractor shall mail the applicable notice to one of the following individuals:

T.2.7.1 The member, if the member is 18 years of age or older and, if applicable, the member's conservator;

T.2.7.2 The member's head of household or member's parent or guardian if the member is under the age of 18; or

T.2.7.3 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.

T.2.8 The Contractor shall require and advise members that the member may file an appeal in writing within sixty (60) days of the receipt of the notice on a form provided by the Departments. Appeals may be filed by the member, the member's authorized representative, a conservator, or the member's parent or guardian if the member is under the age of 18. A provider may initiate a medical necessity appeal, on the provider's own behalf or on behalf of a member. The provider shall obtain a written authorization from the member for an appeal that is submitted on behalf of the member and shall retain the written authorization on file.

T.2.9 The Contractor shall track in a database all cases sent to a Peer Advisor for review, as well as the outcomes of each review. 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. Daily reports shall be run from this database. Decisions to deny, partially deny, terminate, suspend or reduce services shall be entered into a database. All Notices of Action and Denial Notices, with appropriate appeals rights, shall be generated from this database. All letters shall be generated within three (3) business days. The letters follow the verbal notification of the decision to the provider.

T.2.10 The Contractor shall complete a quality control check on 100 percent of all Notices of Action and Denial Notices. 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. Letters generated shall be compared with the report of all cases that have been sent to a Peer Advisor to ensure that letters are generated for all denials, partial denials, terminations, suspensions and reductions, within one business day of the decision. 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.

T.3 Continuation of Benefits Pending Appeal

T.3.1 If the Contractor terminates, suspends or reduces an existing authorization for services being provided to a HUSKY A, DO5 or Medicaid FFS member, the member has a right to continuation of those services, 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. The right to continuation of services applies to the scope of services previously authorized. 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.

T.4 Contractor Appeals Process – Routine

T.4.1 The Contractor shall develop and implement a timely and organized appeal process to resolve disputes between the Contractor and members concerning the Contractor's denial/partial denial, termination, suspension, or reduction of services for HUSKY A, DO5 or Medicaid FFS members and for the denial of services for HUSKY B and Charter Oak members. Such processes shall include the development of written policies and procedures for appeals. 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.

T.4.2 The Contractor shall designate one primary and one back up contact person for its appeal/administrative hearing process.

T.4.3 The process for pursuing an appeal and for requesting an administrative hearing shall be unified for HUSKY A and Medicaid FFS members. The Contractor and DSS shall treat the filing of a Medicaid FFS appeal as a simultaneous request for an administrative hearing.

T.4.4 Appeals for DO5, 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.

T.4.5 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 Advisors who were not involved in making the medical decision related to the denial or other action. The Peer Advisors shall be doctoral level behavioral health specialists. At least one of the Peer Advisors shall have child or adult expertise depending on the age of the member, with expertise in the area that is the focus of the appeal.

T.4.6 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.

T.4.7 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 DSS' regional Offices, any of the DSS office locations may be available for video conferencing.

T.4.8 The Contractor shall attempt to resolve the appeal at the earliest point possible, but no later than thirty (30) days following the filing of the appeal. The Contractor shall resolve all HUSKY A and Medicaid FFS appeals no later than the date of the administrative hearing or within thirty (30) days of the filing of the appeal, whichever is earlier. The Contractor shall 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 DSS, by the date of the DSS administrative hearing for HUSKY A or Medicaid FFS members or within thirty (30) days of receipt of the appeal for HUSKY B, D05, or Charter Oak members.

T.4.9 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. 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 also send a copy of an application form and relevant instructions on the process for filing an appeal through the Department of Insurance (DOI) external appeals process.

T.4.10 Along with the appeal determination, the Contractor shall remind the member on a form, which shall be approved by the Departments, of the option to appeal to DSS if the member is dissatisfied with the Contractor's denial, partial denial, reduction, suspension, or termination of goods or services. For HUSKY A and Medicaid FFS members, the form shall state that DSS has already reserved a time to hold an administrative hearing concerning that determination. For D05 Members, the form shall state that the member has a right to appeal the Contractors decision to DCF.

T.4.11 HUSKY A and Medicaid FFS appeal determinations shall remind the member that DSS has reserved a time for the administrative hearing and, 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 HUSKY A , D05, and Medicaid FFS members are 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.

T.5 Contractor Appeals Process – Expedited

T.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. The postmark on the envelope or the date stamp of the fax will be used to determine the date the appeal was filed. 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. 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 Departments.

T.5.2 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 three (3) business days from the Contractor's receipt of the appeal from DSS or from the member, unless the member asks to meet with the decision maker or to submit additional information. 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 DSS, and the Contractor shall issue its determination not later than five (5) business days after receipt of the appeal. The meeting with the member may be held via the telephone or at a location accessible to the member; subject to approval of DSS' Regional Offices any of DSS' office locations may be available for video conferencing.

T.5.3 The Contractor shall propose a process for conducting an expedited review within one calendar day of the Contractor's receipt of a request by an ED for inpatient psychiatric admissions when the member, parent or guardian, authorized representative, conservator, or provider maintains that the Member individual is at imminent risk if returned home or provided with a diversionary alternative to inpatient admission. The expedited review process shall provide for a one-day provisional authorization for admission pending the result of the expedited review. The Contractor shall implement the expedited review process following the Departments' review and approval of the process.

T.6 Administrative Hearings-Medicaid

T.6.1 If a member is dissatisfied with the results of the appeal determination or the Contractor has not issued the appeal determination, DSS shall conduct the Administrative hearing as scheduled. If a D05 member is dissatisfied with the results of the appeal determination, the member shall have thirty (30) days from receipt of the appeal to request a DCF Administrative hearing. DCF shall schedule an administrative hearing for D05 members within thirty (30) calendar days of receipt of the hearing request and notify the Contractor of the hearing date and location.

T.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 Departments as appropriate. The Contractor shall make available staff that is familiar with the case. This file shall include a summary of the clinical justification supporting the original decision and subsequent appeal determination. The Contractor shall prepare a summary for the administrative hearing, subject to approval by the Departments no later than five (5) days prior to the hearing, and shall present proof of all facts supporting its initial action. The Contractor shall present any provisions of this Contract or any policies or guidelines that support its decision. The Contractor shall be bound by the Departments' hearing decision. If the Departments reverse 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.

T.7 External Review – HUSKY B and Charter Oak

T.7.1 If a 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 Insurance ("DOI"). External appeals must be filed within thirty (30) days of receipt of the final written appeal determination for HUSKY B Members and within sixty (60) days of the receipt of the final written appeal determination for Charter Oak Members. The member may be required to file a filing fee for the DOI appeal. DSS shall pay the filing fee on behalf of any HUSKY B member whose family economic filing unit income exceeds 185 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level (members in Income Bands 1 and 2). The member may be asked to submit certain information in support of his or her appeal request, including a photocopy of his or her Charter Oak enrollment card. The member (or the member's legal representative) may also be asked to sign a release of medical records. The DOI will assign the appeal to an outside, independent entity. The reviewers will conduct a preliminary review and determine whether the appeal meets eligibility for review. The member will be notified within five (5) business days of DOI's receipt of the request whether the appeal has been accepted or denied for full review.

T.7.2 The Contractor's appeal determination for a Charter Oak member shall advise the HUSKY B or Charter Oak member that they may file an external appeal of the denial of services with the Department of Insurance ("DOI") within thirty (30) days for HUSKY B and sixty (60) days for Charter Oak of the Member's receipt of the final written appeal determination. The Contractor shall provide a copy of the DOI External Appeal Consumer Guide and an external appeal application form with a Charter Oak appeal determination. The Contractor shall also advise Charter Oak and/or HUSKY B members that they may obtain additional information about the external review process from the DOI at Connecticut Department of Insurance, P.O. Box 816, Hartford, CT 06142 or (860) 297-3910 or www.ctgov/cid -"External Appeals".

T.7.3 The Contractor shall comply with DOI's external appeal determination.

U. PROVIDER APPEALS

U.1 General Provisions

U.1.1 A provider may lodge medical necessity and administrative appeals with the Contractor.

U.1.2 The Contractor shall, no later than April 1, 2011, submit to the

Departments for review and approval a Provider Appeals Process including policies and procedures related to the administration of denial, and internal appeals processes.

U.2 Medical Necessity Appeals

U.2.1 Level One

U.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 behavioral health service.

U.2.1.2 The Contractor shall arrange for peer review within one (1) business day or peer desk review if the provider peer is unavailable. The Contractor shall render a determination of the appeal and notify the provider telephonically no later than one (1) hour after 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.

U.2.2 Level Two

U.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 must submit additional documentation in support of the appeal including the medical record within thirty (30) calendar days of the request for the appeal.

U.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.

U.3 Administrative Appeals

U.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.

U.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.

U.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.

U.4 Outcome of Appeal

U.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.

U.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.

V. SECURITY AND CONFIDENTIALITY

V.1 Compliance with State and Federal Law

V.1.1 The Departments are required by state and federal law to protect the privacy of applicant and client information. The Departments are "covered entities," as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E. Accordingly, the Contractor shall be required to comply with these and all other state and federal laws concerning privacy and security of all client information provided to the Contractor by the Departments or acquired by the Contractor in performance of the contract. This includes all client information whether maintained or transmitted verbally, in writing, by recording, by magnetic tape, or electronically. Compliance with privacy laws includes compliance with the HIPAA Privacy Rule and also compliance with other federal and state confidentiality statutes and regulations that apply to the Departments. The Departments also require the Contractor to continually update and improve its privacy and security measures as client data becomes more vulnerable to external technological developments.

V.1.2 The Contractor shall comply with state and federal privacy law as an agent of the Departments and comply with the HIPAA Privacy Rule (federal regulations) as a "business associate" of the Departments.

V.1.3 The Contractor shall comply with state security laws as an agent of the Departments and comply with the HIPAA Security Rule (compliance date April 20, 2005) as a "business associate" of the Departments.

V.1.4 The Contractor shall maintain and store information and records in accordance with state and federal laws and record retention schedules.

V.2 Staff Designation

V.2.1 The Contractor shall designate the Contractor's VP of Quality and/or their designee to serve as the local Security and Privacy Officer at the Connecticut Service Center, responsible for implementation and monitoring of compliance with privacy and security policies and procedures and for reporting any security or privacy breaches.

V.2.2 The Departments shall designate and notify the Contractor of the specific staff authorized by the Departments to access and request client information from the Contractor in order to maintain the security and confidentiality of applicant and client information.

V.2.3 The Departments shall review and approve all Contractor staff that will have access to the DSS data warehouse on either a routine, periodic, or ad hoc basis.

V.3 Security and Privacy Plan

V.3.1 The Contractor shall develop a local Security and Privacy Plan with policies and procedures that comply with state and federal law concerning the use, disclosure, and security of client data in order to maintain the security and confidentiality of applicant and client information.

V.3.2 The Contractor shall submit the Security and Privacy Plan to the Departments for review and approval by February 1, 2011.

V.3.3 The Contractor's Security and Privacy Plan shall be consistent with state and federal laws that pertain to the Departments and shall address, at a minimum, the following topics:

V.3.3.1 Preventing privacy and security breaches by:

V.3.3.1.1 Implementing steps to prevent the improper use or disclosure of information about clients Contractor and subcontractors;

V.3.3.1.2 Training all employees, director, and officers concerning state and federal privacy and security laws;

V.3.3.1.3 Requiring that each employee or any other person to whom the Contractor grants access to client information under this Contract sign a statement indicating that he or she is informed of, understands, and will abide by state and federal statutes and regulations concerning confidentiality, privacy and

security;

V.3.3.1.4 Limiting access to client information held in its possession to those individuals who need client information for the performance of their job functions and ensuring that those individuals have access to only that information that is the minimum necessary for performance of their job functions;

V.3.3.1.5 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;

V.3.3.1.6 Implementing security provisions to prevent unauthorized changes to client eligibility files;

V.3.3.1.7 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 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; restricting access to input and output documents, including a "view-only" access and other restrictions designed to protect data;

V.3.3.1.8 Complying with all security and use requirements established by the Departments for parties using EMS, AEVS, LINK and ACS, including the signing of confidentiality forms by all employees and personnel working for subcontractors who have access to client eligibility data;

V.3.3.1.9 Complying with the requirement of the HIPAA privacy and security regulations that apply to business associates of the Departments, including, but not limited to, returning or destroying all client information created or received by the Contractor on behalf of the Departments, as directed by the Departments;

V.3.3.1.10 Monitoring privacy and security practices to determine whether breaches have occurred;

V.3.3.1.11 Developing systems for managing the occurrence of a

breach, including but not limited to:

V.3.3.1.11..1 Review of breaches in privacy and security that have been reported to them by the Contractor;

V.3.3.1.11..2 A system of sanctions for any employee, subcontractor, officer, or director who violates the privacy and security policies;

V.3.3.1.11..3 A system to ensure that corrective action occurs and mechanisms are established to avoid the reoccurrence of a breach; and

V.3.3.1.11..4 Practices established to recover data that has been released without authorization.

V.4 Security or Privacy Breaches

V.4.1 The Contractor shall notify the Departments, in writing by the next business day upon receipt of knowledge, that an employee, director, officer or subcontractor has:

V.4.1.1 Improperly disclosed client information or improperly used, copied or removed client data; or

V.4.1.2 Misused or used without proper authorization, an operator password or authorization numbers, whether or not such use has resulted in fraud or abuse.

V.5 Requests for Personal Healthcare Information

V.5.1 The Contractor shall notify the Departments, in writing, and consult with the Departments by the next business day, of the existence of:

V.5.1.1 A subpoena that has been served on the Contractor related to the Contract; or

V.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.

W. CONTRACT COMPLIANCE, PERFORMANCE STANDARDS, AND SANCTIONS

W.1 General Requirements

W.1.1 In an effort to ensure continued quality service, the Departments have

established specific Performance Standards that shall be met by the Contractor throughout the term of this Contract. 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.

W.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 Departments indicate that the Contractor failed to meet these Standards within the specifications under consideration, the Departments shall adjust the Contractor's payment by a predetermined dollar amount set for each Performance Standard. The Reporting Matrix in Exhibit E and deliverable due dates specified in Exhibit B "Contract Deliverables" 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. The Contractor shall not be penalized for reporting delays that are a consequence of delays that are the fault of the Departments or their agents.

W.2 Responsibilities of the Departments

W.2.1 The Departments 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 Departments shall have the sole authority to determine whether the Contractor has met, exceeded or fallen below any or all of the Performance Standards.

W.2.2 The Departments 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 Departments to the Contractor.

W.2.3 The Departments shall review and approve the development of, modification to and implementation of corrective action plans.

W.3 Responsibilities of the Contractor

W.3.1 The Contractor shall provide the required reports as indicated in Exhibit E. Failure to provide the Departments with these reports may, at the Departments' discretion, be considered a failure to meet the corresponding standard.

W.3.2 Within fifteen (15) business days of the date of the Departments' written sanction notification to the Contractor for failure to meet a specified standard, the Contractor shall submit to the Departments 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 Departments for review.

W.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.

W.3.4 Implementation of any sanction provision or the decision of the Departments 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.

W.3.5 Implementation of a sanction provision is not to be construed as the Departments' sole remedy or as an alternative remedy to the specific performance of the contract requirement and/or injunctive relief.

W.4 Alternative Effort Determination

W.4.1 The Departments may provide or procure the services reasonably necessary to cure a default by the Contractor if, in the reasonable judgment of the Departments:

W.4.1.1 A default by the Contractor is not so substantial as to require termination;

W.4.1.2 Reasonable efforts to induce the Contractor to cure the default are unavailing; and

W.4.1.3 The default is capable of being cured by the Departments or by another resource without unduly interfering with continued performance by the Contractor.

W.5 Alternative Effort Implementation

W.5.1 If the Departments exercise their 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 Departments exercise this right, the Contractor shall:

W.5.1.1 Cooperate with such entities the Departments may obtain to cure the default and shall allow those entities access to the facility, documentation, software, utilities and equipment.

W.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.

X. PERFORMANCE TARGETS AND WITHHOLD ALLOCATION

X.1 General Provisions

X.1.1 The Departments shall withhold 6% of each quarterly administrative payment during each year of the contract. 3.5% of the withhold shall 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. The remaining 2.5% shall be guaranteed and invoiced quarterly. Although a total of six (6) percentage points will be placed at risk, no more than 3.5% will be retained by the Departments in any given contract year.

X.1.2 The established Performance Targets are tied to objectives such as access, quality, overall child and adult community service to inpatient service ratio, and overall 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.

X.1.3 The Departments shall measure the Contractor's success in meeting the Performance Targets. The Departments shall establish specifications mutually agreeable to the Departments 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.

X.1.4 The Contractor's failure to provide the Departments 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.

X.1.5 The Departments 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 Departments shall be final.

X.1.6 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%.

X.1.7 When a Performance Target includes the performance of a random sample, the sample size will be mutually agreed upon by the Departments 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 Departments and the Contractor.

X.1.8 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 nine (9) months following the close of the calendar year to allow for claims run out.

X.1.9 The Departments shall notify the Contractor of its success or failure in meeting the Performance Targets.

X.1.10 If the Contractor has failed to meet a Performance Target the Contractor shall, within fifteen (15) business days of the date of the Departments' notification of the Contractor's failure to meet a specified Performance Target(s), submit a written report to the Departments 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.

X.1.11 In the case of the Contractor's success in meeting a Performance target that is not based on a claims report, the Departments shall return the specified portion of the withhold associated with a Performance Target within sixty (60) days of the Departments' determination that the Contractor has met or exceeded the Performance Target.

X.1.12 In the case of the Contractor's success in meeting a Performance Target that is based on a claims report, the Departments shall 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 Departments shall provide a reconciliation and adjust the withhold allocation as necessary within twelve (12) months after the close of the calendar year. Exhibit A: Performance Targets shall be altered at least annually and executed through a change order or contract amendment. In the event of an amendment to this contract, any change order language shall be incorporated into the subsequent amendment.

Y. TRANSITION REQUIREMENTS – Medicaid Fee-for-Service Members

Y.1 General Provisions

Y.1.1 The Departments are committed to a smooth transition of the Medicaid Fee-for-Service Members to the Contractor. The start-up phase begins at contract execution and ends on at 12:01 am April 1, 2011, at which time the Contractor will assume responsibility for managing behavioral health benefits for all Partnership members.

Y.1.2 DSS shall notify all eligible fee-for-service members of the new administrative requirements associated with the Partnership including when authorizations granted under the existing fee-for-service program shall expire and the procedures for obtaining authorization under the Partnership.

Y.1.3 DSS shall provide the Contractor with a complete behavioral health authorization file as of the date of implementation.

Y.1.4 DSS shall notify all behavior health providers in their networks about the new administrative requirements under the Partnership.

Y.2 Contractor Responsibilities

Y.2.1 The Contractor shall manage all behavioral health services listed in Exhibit D, regardless of date of admission or intake, on the date of implementation.

Y.2.2 The Contractor shall implement registration and continued care review procedures for outpatient and other behavioral health services as of implementation.

Y.2.3 The Contractor shall accept an extract of open authorizations from the DSS.

Y.2.4 The Contractor shall conduct training sessions with providers as described in Section N "Provider Relations" on a schedule and at locations approved by the Departments. The Contractor shall respond to provider questions and make best efforts to ensure that providers are aware of the need to obtain necessary authorizations and associated procedures (e.g. registration).

Y.2.5 The Contractor shall facilitate safe and appropriate transition for members that no longer meet criteria for a given level of care, but do require continued treatment at a lower level of care.

Y.2.6 The Contractor shall facilitate safe and appropriate transition for members who require continued treatment, but who are receiving services from providers that do not wish to enroll as providers in the CMAP Provider Network.

Y.2.7 The Contractor shall propose a plan for authorizing services that providers failed to prior authorize and to educate those providers about

the UM procedures, during a transition period.

Y.2.8 The Contractor shall create a provider file as described in the subsection O "Provider Network".

Z. CONTRACT IMPLEMENTATION, REVIEW AND TERMINATION PROVISIONS

Z.1 Implementation Plan

Z.1.1 The Departments shall engage in good faith negotiations to execute a contract before April 1, 2011.

Z.1.2 The Contractor shall develop and provide to the Departments for review and approval an Implementation Plan prior to the execution of the contract 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 the Contractor's integrated behavioral health administrative system for both the Original Coverage Groups and the Expanded Coverage Groups and thereafter be responsible for managing behavioral health services for all eligible members.

Z.1.3 The Departments shall upon receipt from the Contractor review the Contractor's Implementation Plan and periodic updates and not unreasonably withhold approval of the Plan and updates.

Z.1.4 The Contractor shall continue to perform administrative services for the Original Coverage Groups and by the date indicated in the Contractor's approved implementation plan or on such other date as the Contractor and the Departments may agree in writing become operational to provide administrative services for the Expanded Coverage Groups.

Z.1.5 The Departments and the Contractor have and shall continue to work, in good faith towards an April 1, 2011 at 12:01 am implementation date for the integration of the Expanded Coverage Groups into the Contractor's behavioral health administrative system for the Original Coverage Groups . The failure of the Contractor to pass the "Implementation Review" or the failure of the Contractor to integrate the Expanded Coverage Groups into the Contractor's behavioral health administrative system for the Original Coverage Groups as of 12:01 am on March 1, 2011 or on such other date as the Contractor and the Departments may agree in writing or the failure of the Contractor to maintain a fully operational system thereafter will cause considerable harm to the Departments and their eligible members.

Z.1.6 The Departments require 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 Departments 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 Departments for resulting harm if the Contractor has failed to integrate the Expanded Coverage Groups into the Contractor's behavioral health administrative system for the Original Coverage Groups as of 12:01 am on April 1, 2011 or on such other date as the Contractor and the Departments may agree in writing . The Contractor shall not be liable for such harm if the Departments have failed to meet their obligations under this Contract and that failure of the Departments was a material cause of a delay of the Contractor's ability to integrate the Expanded Coverage Groups into the Contractor's behavioral health administrative system for the Original Coverage Groups and continue to perform its administrative services by the date agreed to by the Contractor and the Departments.

Z.2.2 To mitigate such harm the Departments require 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 $2,000,000 on or before 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 Departments.

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 Departments.

Z.3 Implementation Review

Z.3.1 The Departments 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 Departments shall conduct this Implementation Review at least 30 days prior to the date by which the Contractor will begin to operate its administrative services for the Expanded Coverage Groups as indicated in the Contractor's approved Implementation Plan.

Z.3.3 The Departments shall notify the Contractor in writing of the results of its review within five (5) business days of the review. The Departments 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 Departments determine that the Contractor has failed to make sufficient progress to integrate the Expanded Coverage Groups into the Contractor's behavioral health administrative system and continue to be operational and to perform administrative services for the Original Coverage Groups by the date indicated 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 Departments' satisfaction.

Z.3.5 In addition and irrespective of the Contractor's corrective action, the Departments at their option may take such additional steps as they deem necessary to provide seamless delivery of behavioral 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 Departments 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 120 days of implementation.

Z.4.2 The Departments 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 Departments and the Contractor upon such terms and conditions as they may agree;

Z.5.1.2 By the Departments for convenience, upon not less than one hundred-eighty (180) days written notice to the Contractor;

Z.5.1.3 By the Departments, for cause, upon failure of the Contractor to materially comply with the terms and conditions of this Contract.

Z.5.1.3.1 The Departments 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 Departments 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 Departments, in the event of default by the Contractor, which is defined as the inability of the Contractor to provide services, where such inability is not otherwise excused pursuant to this Contract, as described in this Contract or the Contractor's insolvency.

Z.5.1.4.1 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 Departments, in the event of notification by the Connecticut Department of Insurance 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 Departments, 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 Departments, in the event it determines that the health or welfare of members is in jeopardy should the contract continue.

Z.5.1.7.1 For purposes of this paragraph, termination of the

contract requires a written finding by the Departments that a substantial number of members face the threat of immediate and serious harm;

Z.5.1.8 By the Departments, in the event of the Contractor's failure to comply with the Scope of Work.

Z.5.1.8.1 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 Departments, in the event a petition for bankruptcy is filed by or against the Contractor;

Z.5.1.10 By the Departments, if the Contractor fails substantially to authorize medically necessary items and services that are required under this Contract;

Z.5.1.11 By the Departments, if the Contractor intentionally misrepresents or falsifies information that is furnished to the Secretary of Health and Human Services, the Departments or Medicaid recipients, potential recipients 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 Departments 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 Departments' programs. This includes, but is not limited to, allowing the Departments' 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 Departments terminate this Contract pursuant to this Article and unless otherwise specified in this Article, the Departments shall provide the Contractor written notice of such termination at least sixty (60) days prior to the effective date of the termination, unless the Departments itself receives less than sixty (60) days notice, in which case the Departments

shall provide the Contractor with as much notice as possible. If the Departments determine 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 Departments 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 Departments. Such agreement shall be concluded within thirty (30) days of the notice of termination. If agreement is not reached regarding the termination agreement within the specified thirty (30)-day period, the contract shall terminate thirty (30) days thereafter.

AA. STAFFING, RESOURCES AND PROJECT MANAGEMENT

AA.1 Key Personnel

AA.1.1 The Contractor certifies that all key positions presented by the Contractor and approved by the Departments in accordance with Section D.3.2 of this Contract. No changes, substitutions, additions or deletions, whether temporary or permanent, shall be made unless approved in advance by the Departments, which approval shall not be unreasonably withheld.

AA.1.2 All personnel filling the key positions presented by the Contractor and approved by the Departments in accordance with Section D.3.2 of this Contract shall continue for the duration of the Contract. No changes, substitutions, additions or deletions, whether temporary or permanent, shall be made unless approved in advance by the Departments, which approval shall not be unreasonably withheld. 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 Departments. The Contractor shall, upon request, provide the Departments 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 Departments and the Contractor.

AA.1.3 The Departments reserve 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 Departments.

AA.1.4 The Contractor's Project Manager shall immediately notify the Departments' Contract Managers of the discharge of any personnel assigned to this Contract and such personnel shall be immediately relieved of any further work under this Contract.

AA.2 Project Management

AA.2.1 From the time of the Departments' 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 Departments. The Project Manager shall be permanently located in the Contractor's Connecticut office and shall respond to requests by the Departments for status updates and ad hoc and interim reports.

AA.3 Implementation Team

AA.3.1 The Implementation Team shall:

AA.3.1.1 Organize initial and subsequent planning meetings with the Departments;

AA.3.1.2 Facilitate communications between the Contractor and the Departments;

AA.3.1.3 Meet with providers;

AA.3.1.4 Participate in the initial account operations following the completion of the implementation until responsibilities have been transitioned to the Project Manager and staff;

AA.3.1.5 Oversee site selection, build-out, furnishing and equipping for operation of the Connecticut Service Center; and

AA.3.1.6 Remain primarily responsible for the conduct of the implementation until such time as the Departments' approve the Project Manager and the transition of the implementation team's responsibilities to the Project Manager and staff.

AA.3.2 The Implementation Team shall be comprised of individuals approved by

the Departments.

AA.4 Staffing Levels – Ongoing Operations

AA.4.1 By January 5, 2011 the Contractor shall provide the Departments 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 Departments with an updated organizational chart each time changes are made to the number, type and/or category of personnel.

AA.4.2 The Contractor certifies that the Connecticut Service Center shall staff to conduct UM for services designated by the Departments. The services include, but may not be limited to those presented in Exhibit C.

AA.4.3 For the first year of operations including the Expanded Coverage Groups the Contractor's budget, approved by the Departments, includes UM staffing necessary to comply with the scope of work under this Contract. The number of prior authorizations, concurrent reviews and associated level of staffing shall be reviewed by the Contractor and the Departments and, if necessary, adjusted in subsequent years for changes to actual enrollment, and if applicable, changes to the scope of work set forth in this Contract.

AA.4.4 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.4.4.1 That clinical support staff shall perform a variety of non-clinical functions to increase the productivity of Care Managers and Intensive Care Managers;

AA.4.4.2 That the Contractor's MIS accepts and processes registrations entered on the IVR and via the Web automatically, therefore staff time is not required;

AA.4.4.3 That authorization letters are generated automatically and therefore, staff time is not required;

AA.4.4.4 That prior authorizations and concurrent reviews will take on average, ten (10) to twenty (20) minutes depending on the level of care and complexity of the presenting issues.; and

AA.4.4.5 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 prior authorizations and concurrent reviews that they will conduct. Intensive Care Managers will, however, be responsible for the reviews of those members on their

own caseloads.

AA.4.5 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 departments 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.4.5.1 ICM clinicians assigned to facilities as well as cases will be expected to carry, during a 3 month period on average a minimum of thirty (30) cases and on average, an annual minimum caseload of (120) one hundred and twenty. Facility ICM clinicians have a variety of additional administrative duties and functions not experienced by ICM clinicians with a caseload dedicated to individual member care only. These responsibilities include but are not limited to: Regular travel to assigned facilities, minute taking, case summary for all CT BHP cases reviewed at a facility, discharge planning for all CT BHP cases on the unit, triage and communication to multiple DCF Area Office's, DMHAS' Service System of Care, including LMHAs and other grant funded providers, and Emergency Department meetings as requested, and additional meetings in the community. In addition, at the discretion of the Contractor and within available Contract funds, ICM's may be assigned on call mobile responsibility to assigned facilities during high volume periods (i.e., periods of seasonal volume surge in high volume Emergency Departments);

AA.4.5.2 ICM clinicians not assigned a facility will be expected to carry on average a minimum caseload of 35 members during a 3 month period and on average an annual minimum of 130 cases. In addition to managing individual cases these clinicians will frequently serve as the Partnership Geo Team liaisons at the local area MSS meeting, as well as attend Emergency Department meetings as requested, collaterals meetings and treatment and discharge planning meetings;

AA.4.5.3 Total individuals served on an annual basis shall be no less than 2200 individuals, no less than1,100 of whom will be HUSKY and DCF-involved Members and the remaining 1,100 will be Charter Oak and FFS Members; and

AA.4.5.4 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.4.6 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 the Partnership and designing and producing reports.

AA.4.7 The Contractor certifies that the staffing levels for the Telephone Call Management Center functions shall be based on the following assumptions:

AA.4.7.1 That upon implementation, the Contractor shall be staffed to handle call volumes based on 570,000 – 600,000 Members, adjusted in subsequent months and years for increases in actual enrollment;

AA.4.7.2 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.4.7.3 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 Departments' fiscal agent;

AA.4.7.4 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.4.7.5 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.5 Staff, Infrastructure Location and Priority Hiring

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.6 Utilization of Minority Business Enterprises

Pursuant to Section 4a-60g(b) of the Connecticut General Statutes, the Departments are required to set-aside at least twenty-five percent (25%) of all contracts for small contractors and/or minority business enterprises. To assist the Departments 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 pursuant to 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

BB.1.1 This section sets forth the payment provisions and conditions for goods and services provided or performed, as the case may be, pursuant to this contract.

BB.2 Contractor Reimbursement – Start-up Period

BB.2.1 The maximum value of this contract for the performance of the administrative services required to meet each of the requirements of this contract during the start-up period, defined as January 1, 2011 through the date that the Departments release the Contractor's implementation team, shall not exceed $2,405,426 and shall be expended in accordance with the budget in Exhibit F.

BB.2.2 The Contractor shall be paid 1/4 of the start-up budget, less 3.5% of the start-up budget profit, upon the Contractor's completion and the Departments' acceptance of each of the following milestones:

BB.2.2.1 Contract execution;

BB.2.2.2 Successful loading of a complete eligibility file with Contractor assigned local area field;

BB.2.2.3 Successful authorization test file with the DSS MMIS contractor; and

BB.2.2.4 Successful pre-implementation readiness review.

BB.2.3 Within forty-five (45) days of the date the Implementation Team is released by the Departments, the Contractor shall submit to the Departments a reconciliation of the actual expenditures incurred and paid by the Contractor during the start-up period against the payments received from the Departments. The Departments may require the return of any under expenditures or the reinvestment of the under expenditure into the Contract's scope of work.

BB.2.4 Up to three percentage points of the start-up profit shall be earned by the Contractor if the Contractor successfully meets the implementation target of April 1, 2011 or such later date as agreed to by the Departments.

BB.2.5 Up to three percentage points of the start-up profit shall be earned the Contractor at such time as the Departments have determined that the implementation has been successfully completed in accordance with the terms of the Contract based on the Departments' post-implementation review and the Departments have approved the release of the Contractor's implementation team and transition of on-going operations to the Contractor's Connecticut Service Center staff.

BB.2.6 The Departments may determine that the Contractor failed to earn all percentage points of the start-up profit as established in A.2.4 and A.2.5 or that the Contractor has earned all or a portion of the said points based on the extent to which the Department has determined that the Contractor fulfilled the requirements of A.2.4 and A.2.5. Although a total of 6 percentage points of the start-up profit will be placed at risk, no more than 3.5% will be retained by the Departments in any given contract year. Failure to achieve a start-up target, in whole or in part, associated with any of the 6 percentage points, shall be applied against the 3.5% withhold.

BB.3 Contractor Reimbursement – 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 during each of the three years of full contract operations shall not exceed:

BB.3.1.1 for the period January 1, 2011 to March 31, 2011, $2,739,313. The Contractor may invoice for the full operating budget starting on March 1, 2011.

BB.3.1.2 for the period April 1, 2011 to December 31, 2011, $12,139,830 or $4,046,610 per quarter. Source of funds for 2011 include Charter Oak roll-over and base contract extension;

BB.3.1.3 for the period January 1, 2012 to December 31, 2012, $17,716,683 or $4,429,170.75, per quarter; and

BB.3.1.4 for the period January 1, 2013 to December 31, 2013, $18,265,900 or $4,566,475, per quarter.

BB.3.2 The Departments and the Contractor agree that the maximum value of each full contract year of operations and its corresponding budget was developed and negotiated based upon the following corridors for enrollment projections:

BB.3.2.1 for the period January 1, 2011 to December 31, 2011, monthly enrollment of at least 570,000 members but not to exceed 600,000 members;

BB.3.2.2 for the period January 1, 2012 to December 31, 2012, monthly enrollment of at least 590,000 members but not to exceed 620,000 members;

BB.3.2.3 for the period January 1, 2013 to December 31, 2013, monthly enrollment of at least 610,000 members but not to exceed 640,000 members.

BB.3.3 The Contractor and/or the Departments 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.

BB.3.4 During each of the time periods identified in subsections BB.3.1.1 through BB.3.1.4 above, the Contractor shall utilize the funds paid under this contract by the Departments for the administrative services provided under this contract in accordance with the corresponding budgets set forth in Exhibit F.

BB.3.5 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 the operation of the Connecticut Service Center. Such "Total Salary and Fringe" expenses are limited to expenses incurred by full or part-time staff, whose time is either 100% on-site in Connecticut or out of state call center staff dedicated to the operation of the Connecticut Service Center after normal business hours of the Connecticut Service Center. The Contractor agrees that the percentage of total salaries used to calculate the total fringe benefits shall not exceed 21.5% without the prior written approval of the Departments. In addition, the Contractor agrees that throughout the term of the Contract "Total Other Direct Costs" as a percentage of "Total Salary and Fringe" shall not exceed 25%. In addition, "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 the Connecticut Service Center located in Connecticut.

BB.3.6 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 Departments 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 $300,000.

BB.3.7 The Contractor must submit and the Departments 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 $300,000.

BB.3.8 The Departments shall respond to a written request for a budget revision within ten (10) business days after the receipt of the request.

BB.3.9 Following the execution and approval of this contract, the Contractor shall submit to DSS an invoice for payment for operating expenses on a quarterly basis in accordance with the following schedule. Each invoice must be signed and dated and submitted to the Contract Managers for review and approval. The actual invoice should be for the following amounts, which do not include the negotiated withhold of 3.5%.

On or after this date the Contractor shall request a payment:	The maximum payment request shall be:	The payment request shall be for the operation of the program through the period:	Payments are contingent upon the DEPARTMENT'S receipt and approval of financial reports due on or before:
February 1, 2011	$2,648,864.00	January 1, 2011 – March 31, 2011	N/A
April 1, 2011	$3,912,996.00	April 1, 2011 – June 30, 2011	N/A
July 1, 2011	$3,912,996.00	July 1, 2011 – September 30, 2011	45 days after the close of the first calendar quarter.
October 1, 2011	$3,912,996.00	October 1, 2011 – December 31, 2011	45 days after the close of the second calendar quarter.
January 1, 2012	$4,282,924.80	January 1, 2012 – March 31, 2012	45 days after the close of the third calendar quarter.
April 1, 2012	$4,282,924.80	April 1, 2012 – June 30, 2012	N/A
July 1, 2012	$4,282,924.80	July 1, 2012 – September 30, 2012	45 days after the close of the fifth calendar quarter.
October 1, 2012	$4,282,924.80	October 1, 2012 – December 31, 2012	45 days after the close of the sixth calendar quarter.
January 1, 2013	$4,415,695.42	January 1, 2013 – March 31, 2013	45 days after the close of the seventh calendar quarter.
April 1, 2013	$4,415,695.42	April 1, 2013 – June 30, 2013	N/A
July 1, 2013	$4,415,695.42	July 1, 2013 – September 30, 2013	45 days after the close of the ninth calendar quarter.
October 1, 2013	$4,415,695.42	October 1, 2013 – December 31, 2013	45 days after the close of the tenth calendar quarter.

BB.3.10 The 3.5% withhold shall 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. The remaining 2.5% shall be guaranteed and shall be included in the quarterly invoice. Although a total of 6 percentage points will be placed at risk as mutually agreed upon and set forth in Exhibit A, no more than 3.5% will be retained by the Departments in any given contract year. Failure to achieve a target associated with any of the 6 percentage points, shall be applied against the 3.5% withhold.

BB.3.11 Each payment request must be submitted on a **DSS W-1270 Form** to the DSS Contract Manager. Request for payment will be honored and funds released based on submission of the invoice by the Contractor, with review and acceptance by the Departments, the availability of funds and the Contractor's satisfactory compliance with the terms of the contract.

BB.3.12 The form and content of the financial reports shall be developed by and agreed to by the Contractor and the Departments in advance of the due date of the first financial report.

BB.3.13 When the Departments' review of any financial report, 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 Departments may, with advance notice to and in consultation with the Contractor, demand the return to the Departments, in full, any unexpended funds; alter the payment schedule for the balance of the contract period; 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.3.14 The Departments shall conduct a final reconciliation of the payments received by Contractor against actual expenditures as reported in the audited financial statements or agreed upon procedures required to be submitted by the Contractor pursuant to Part II Section 11 of the Contract, "Audit Requirements." The Departments shall require the return of any disallowed expenditures and may require the Contractor to return the funds to the Departments or reinvest any unexpended funds into the scope of work in the Contract.

BB.3.15 Throughout the term of the contract the Contractor shall reconcile actual expenditures as reported in the audited financial statements or agreed upon procedures against payments received from the Departments. The reconciliation shall be prepared by the Contractor and submitted to the Contract Managers, in accordance with the following schedule:

For the Period	The reconciliation is due on or before:
January 1, 2011 – December 31, 2011	May 31, 2012
January 1, 2012 – December 31, 2012	May 31, 2013
January 1, 2013 – December 31, 2013	May 31, 2014

BB.4 Optional Tasks/Change Orders

BB.4.1 The Contractor authorizes its Service Center Vice President to request or agree to, in response to the Departments' requests, minor modifications to the Contract's scope of work within this Contract. If the requested changes are within the Scope of Work, the Service Center Vice President does not have to receive approval from other corporate managers.

BB.4.2 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 Departments provide 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.4.3 If the requested changes do not pertain to an existing task and are therefore outside the Scope of Work in this contract the Departments 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 Departments, 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.5 Capital Purchases

BB.5.1 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 Departments, the Contractor shall provide the Departments 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 Departments 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 Departments' the Contractor shall be reimbursed for the actual cost, not to exceed the maximum total cost set forth in the Departments' approval, incurred through the purchase of the requested equipment.

BB.6 Withholding of Payment

BB.6.1 The Departments 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 Departments and Contractor. With respect to such requirements, the Departments shall have the discretion to withhold payment in the event Contractor fails to perform or provide the administrative requirements as agreed to with the Departments. The withholding of payment shall be subject to the requirements set forth in subsection BB.6.2, below.

BB.6.2 If the Departments determine 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 Departments and Contractor, the Departments shall notify Contractor of that fact in writing. Such written notice shall include a description of the deficiency and any suggestions or recommendations the Departments may have for addressing the deficiency. The Contractor shall have thirty (30) 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 Departments upon a plan for correcting such deficiency. If the Contractor fails to correct the deficiency or agree with the Departments upon a plan for correcting the deficiency within the thirty (30) calendar day time period, or such other time period as the parties have agreed, then the Departments may withhold payment to the Contractor. The Departments may withhold up to 10 percent of the quarterly payment as set forth in subsection BB.3.9 of this contract owed to the Contractor for each quarter during which the Departments 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 D.7 of this Contract. The Departments shall release the withheld payment to the Contractor immediately upon the Departments' determination that the deficiency has been corrected as agreed or the Contractor has prevailed in its dispute of the alleged deficiency.

PART II: MANDATORY TERMS AND CONDITIONS

The Contractor agrees to comply with the following mandatory terms and conditions.

A. CLIENT-RELATED SAFEGUARDS.

1. **Inspection of Work Performed.** The Agency or its authorized representative shall at all times have the right to enter into the Contractor's premises, or such other places where duties under the Contract are being performed, to inspect, to monitor or to evaluate the work being performed. 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.

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.

B. CONTRACTOR OBLIGATIONS.

1. **Cost Standards.** Effective January 1, 2007, the Contractor and funding state Agency shall comply with the Cost Standards issued by OPM, as may be amended from time to time. The Cost Standards are published by OPM on the Web at http://ct.gov/opm/fin/cost_standards. Such Cost Standards shall apply to:

    a. all new contracts effective on or after January 1, 2007;

    b. all contract amendments modifying funding, effective on or after January 1, 2007;

c. all contracts in effect on or after July 1, 2007.

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 the Contract and the 180 days following its date of Termination and/or Cancellation, the Contractor shall submit to the Agency copies of the following within thirty (30) days after having filed them:

   a. its most recent IRS Form 990 submitted to the federal 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.

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.

   c. Contractor acknowledges that is 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 termination of this Contract.

d. 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.

e. Contractor represents that it is not excluded, debarred, suspended or otherwise ineligible to participate in federal health care programs.

f. 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 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.

6. Related Party Transactions.

a. 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:

1. real estate sales or leases;

2. leases for equipment, vehicles or household furnishings;

3. mortgages, loans and working capital loans; and

4. 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 B.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;

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. **Encryption of Data.**

    a. The Contractor, at its own expense, shall encrypt any and all electronically stored data now or hereafter in its possession or control located on non-state owned or managed devices that the State, in accordance with its existing state policies classifies as confidential or restricted. The method of encryption shall be compliant with the State of Connecticut Enterprise Wide Technical Architecture ("EWTA") or such other method as deemed acceptable by the Agency. This shall be a continuing obligation for compliance with the EWTA standard as it may change from time to time. The EWTA domain architecture documents can be found at http://www.ct.gov/doit/cwp/view.asp?a=1245&q=253968.

    b. In the event of a breach of security or loss of State data, the Contractor shall notify the Agency and the OAG as soon as practical but not later than twenty-four (24) hours after the discovery or suspicion of such breach or loss that such data has been comprised through breach or loss. The requirements of this section are in addition to those that may apply under Part II, Section E.

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.

C. 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 Connecticut Attorney General.

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.

   1. 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.

   2. The Contractor shall comply with requests for documentation deemed to be appropriate by the Agency in considering whether to consent to such assignment.

   3. 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.

   4. 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.

b. 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.

c. The Notice may include an effective Contract Termination 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 Termination date, no further action shall be required of any party to effect the Termination as of the stated date.

d. If the notice does not set forth an effective Contract Termination date, then the non-breaching party may terminate the Contract by giving the breaching party no less than twenty four (24) hours' prior written Notice after the expiration of the cure period.

e. If the Agency believes that the Contractor has 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.

f. 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.

g. 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.

h. 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. 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.

    1. Such Notice of Termination shall be sent in accordance with the Notice provision contained on page 1 of this Contract.

    2. 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, 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 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 for operation or transition of program(s) under this Contract shall not be subject to recoupment.

f. Transition after Termination or Expiration of Contract. If this Contract is terminated for any reason 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.

g. 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.

D. 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)1, 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).

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[1] The effective date of the HITECH Act is February 17, 2010.

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.

i. In the event that an individual requests that the Business Associate

1. restrict disclosures of PHI;

2. provide an accounting of disclosures of the individual's PHI; or

3. provide a copy of the individual's PHI in an electronic health record, the Business Associate agrees to notify the covered entity, in writing, within two business days of the request.

j. Business Associate agrees that it shall not, directly or indirectly, receive any remuneration in exchange for PHI of an individual without

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

2. 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

k. Obligations in the Event of a Breach.

1. 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.

2. 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.

3. The Business Associate agrees to include in the notification to the Covered Entity at least the following information:

    a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

    b. 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).

    c. The steps the Business Associate recommends that individuals take to protect themselves from potential harm resulting from the breach.

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

    e. 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.

4. 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 and a postal address. Business Associate agrees to include in the notification of a breach by the Business Associate to the Covered Entity, a written description of the

procedures that have been established to meet these requirements. Costs of such contact procedures will be borne by the Contractor.

5. 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.

6. Permitted Uses and Disclosure by Business Associate.

    a. 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.

    b. Specific Use and Disclosure Provisions

        i. 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.

        ii. 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.

        iii. 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).

7. Obligations of Covered Entity.

    a. 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.

b. 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.

c. 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.

8. 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.

9. Term and Termination.

   a. 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.

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

      i. 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

      ii. Immediately terminate the Contract if Business Associate has breached a material term of this

Section of the Contract and cure is not possible; or

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

c. Effect of Termination.

i. Except as provided in (I)(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.

ii. 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.

d. Miscellaneous Sections.

i. 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.

ii. 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.

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

iv. 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.

e. 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.

f. 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.

g. 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 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. The following subsections are set forth here as required by section 4a-60 of the Connecticut General Statutes:

        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, 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. 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, 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;

        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 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 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 sections 46a-68e and 46a-68f and with each regulation or relevant order issued by said commission pursuant to sections 46a-56, 46a-68e and 46a-68f;

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 section 46a-56.

b. 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 project.

c. "Minority business enterprise" means any small contractor or supplier of materials fifty-one per cent 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 section 32-9n; and

4. "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations. "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.

d. 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.

e. The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the commission, of its good faith efforts.

f. The Contractor shall include the provisions of sections (a) and (b) above 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 section 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.

g. The following subsections are set forth here as required by section 4a-60a of the Connecticut General Statutes:

    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 of 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 section 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 section 46a-56.

h. The Contractor shall include the provisions of section (g) above 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 section 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.

i. For the purposes of this entire Non-Discrimination section, "Contract" or "contract" includes any extension or modification of the Contract or contract, "Contractor" or "contractor" includes any successors or assigns of the Contractor or contractor, "marital status" means being single, married as recognized by the state of Connecticut, widowed, separated or divorced, and "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. For the purposes of this section, "Contract" does 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 C.G.S.§ 1-120,

    3. any other state, including but not limited to any federally recognized Indian tribal governments, as defined in C.G.S.§ 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).

6. **Freedom of Information.**

   a. Contractor acknowledges that the Agency must comply with the Freedom of Information Act, C.G.S. §§ 1-200 et seq. ("FOIA") which requires the disclosure of documents in the possession of the State upon request of any citizen, unless the content of the document falls within certain categories of exemption, as defined by C.G.S. § 1 - 210(b).

   b. Governmental Function. In accordance with C.G.S. § 1-218, if the amount of this Contract exceeds two million five hundred thousand dollars ($2,500,000), and the Contractor is a "person" performing a "governmental function", as those terms are defined in C.G.S. §§ 1-200(4) and (11), the Agency is entitled to receive a copy of the Records and files related to the Contractor's performance of the governmental function, which may be disclosed by the Agency pursuant to the FOIA.

7. **Whistleblowing.** This Contract is subject to C.G.S. § 4-61dd if the amount of this Contract is a "large state contract" as that term is defined in C.G.S. § 4-61dd(h). In accordance with this statute, if an officer, employee or appointing authority of the Contractor takes or threatens to take any personnel action against any employee of the Contractor in retaliation for such employee's disclosure of information to any employee of the Contracting state or quasi-public agency or the Auditors of Public Accounts or the Attorney General under subsection (a) of such statute, the Contractor shall be liable for a civil penalty of not more than five thousand dollars ($5,000) for each offense, up to a maximum of twenty per cent (20%) of the value of this Contract. Each violation shall be a separate and distinct offense and in the case of a continuing violation, each calendar day's continuance of the violation shall be deemed to be a separate and distinct offense. The State may request that the Attorney General bring a civil action in the Superior Court for the Judicial District of Hartford to seek imposition and recovery of such civil penalty. In accordance with subsection (f) of such statute, each large state Contractor, as defined in the statute, shall post a notice of the relevant sections of the statute relating to large state Contractors in a conspicuous place which is readily available for viewing by the employees of the Contractor.

8. **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:

NOTICE TO EXECUTIVE BRANCH STATE CONTRACTORS AND PROSPECTIVE STATE CONTRACTORS OF CAMPAIGN CONTRIBUTION AND SOLICITATION BAN

This notice is provided under the authority of Connecticut General Statutes § 9-612(g)(2), as amended by P.A. 07-1, and is for the purpose of informing state contractors and prospective state contractors of the following law (italicized words are defined below):

Campaign Contribution and Solicitation Ban

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, or solicit contributions 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;

In addition, no holder or principal of a holder of a valid prequalification certificate, shall make a contribution to, or solicit contributions on behalf of (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.

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—$2000 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 $2000 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 $5000 in fines, or both.

Contract Consequences

Contributions made or solicited in violation of the above prohibitions may result, in the case of a state contractor, in the contract being voided.

Contributions made or solicited in violation of the above prohibitions, in the case of a prospective state contractor, 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 will 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 and the entire text of P.A. 07-1 may be found on the website of the State Elections Enforcement Commission, www.ct.gov/seec. Click on the link to "State Contractor Contribution Ban."

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 or a loan to an individual for other than commercial purposes.

"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.

9. **Non-smoking.** If the Contractor is an employer subject to C.G.S. § 31-40q, the Contractor shall provide the Agency with a copy of its written rules concerning smoking. Evidence of compliance with C.G.S. § 31-40q must be received prior to Contract approval by the Agency.

10. **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.

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ACCEPTANCES AND APPROVALS

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

In the interest of time, this contract may be executed in counterparts.

VALUEOPTIONS, INC.

E Paul Dunn, Jr. 4/1/11

Authorized Official (Signature) Date

E. Paul Dunn, Jr., Chief Financial Officer

Title and Printed Name

DEPARTMENT OF SOCIAL SERVICES

_____/____/____

MICHAEL P. Starkowski, Commissioner Date

DEPARTMENT OF CHILDREN AND FAMILIES

_____/____/____

JOETTE KATZ, Commissioner Date

DEPARTMENT OF MENTAL HEALTH AND ADDITCTION SERVICES

_____/____/____

PATRICIA REHMER, Commissioner Date

OFFICE OF THE ATTORNEY GENERAL

_____/____/___

ASST./ASSOC. Attorney General (Approved as to form & legal sufficiency) Date

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DEPARTMENT OF SOCIAL SERVICES

_____ 4/1/11

MICHAEL P. Starkowski, Commissioner Date

DEPARTMENT OF CHILDREN AND FAMILIES

_____/___/___

JOETTE KATZ, Commissioner Date

DEPARTMENT OF MENTAL HEALTH AND ADDITCTION SERVICES

_____/___/___

PATRICIA REHMER, Commissioner Date

OFFICE OF THE ATTORNEY GENERAL

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ASST./ASSOC. Attorney General (Approved as to form & legal sufficiency) Date

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VALUEOPTIONS, INC.

_____/___/___

Authorized Official (Signature) Date

_____

Title and Printed Name

DEPARTMENT OF SOCIAL SERVICES

_____/___/___

MICHAEL P. Starkowski, Commissioner Date

DEPARTMENT OF CHILDREN AND FAMILIES

_____ 4/1/16

JOETTE KATZ, Commissioner Date

DEPARTMENT OF MENTAL HEALTH AND ADDITCTION SERVICES

_____/___/___

PATRICIA REHMER, Commissioner Date

OFFICE OF THE ATTORNEY GENERAL

_____/___/___

ASST./ASSOC. Attorney General (Approved as to form & legal sufficiency) Date

ACCEPTANCES AND APPROVALS

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

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VALUEOPTIONS, INC.

_____/___/____

Authorized Official (Signature) Date

_____

Title and Printed Name

DEPARTMENT OF SOCIAL SERVICES

_____/___/____

MICHAEL P. Starkowski, Commissioner Date

DEPARTMENT OF CHILDREN AND FAMILIES

_____/___/____

JOETTE KATZ, Commissioner Date

DEPARTMENT OF MENTAL HEALTH AND ADDITCTION SERVICES

Patricia A Rehmer 4/1/2011

PATRICIA REHMER, Commissioner Date

OFFICE OF THE ATTORNEY GENERAL

_____/___/___

ASST./ASSOC. Attorney General (Approved as to form & legal sufficiency) Date

ACCEPTANCES AND APPROVALS

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

In the interest of time, this contract may be executed in counterparts.

VALUEOPTIONS, INC.

_____/____/____

Authorized Official (Signature) Date

_____

Title and Printed Name

DEPARTMENT OF SOCIAL SERVICES

_____/____/____

MICHAEL P. Starkowski, Commissioner Date

DEPARTMENT OF CHILDREN AND FAMILIES

_____/____/____

JOETTE KATZ, Commissioner Date

DEPARTMENT OF MENTAL HEALTH AND ADDITCTION SERVICES

_____/____/____

PATRICIA REHMER, Commissioner Date

OFFICE OF THE ATTORNEY GENERAL

_____ 4/15/11

ASST./ASSOC. Attorney General (Approved as to form) Date

ASSOC. ATTY. GENERAL

VALUEOPTIONS®
Innovative Solutions. Better Health.

CERTIFICATION

I, **Paul M. Rosenberg, Secretary of ValueOptions, Inc.,** a corporation organized under the laws of the Commonwealth of **VIRGINIA,** hereby certify that the following is a full and true copy of a resolution adopted at a meeting of the Board of Directors of said company, duly held on the 1st day of April, 2011:

> "RESOLVED that **E. Paul Dunn, Jr., Executive Vice President, Treasurer and Chief Financial Officer** is hereby authorized to make, execute and approve on behalf of this company, any and all contracts and amendments and to execute and approve on behalf of this company, other instruments, a part of or incident to such contracts and amendments effective until otherwise ordered by the Board of Directors."

Also, I do further certify that the above resolution has not been in any way altered, amended or repealed, and is in full force and effect.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the corporate seal of said company this 1st day of April, 2011.

Paul M. Rosenberg, Secretary
ValueOptions, Inc.

State of Virginia ::
City of Norfolk ::

Personally appeared before me this 4 st/th day of April, 2011, Paul M. Rosenberg (name of Secretary),
Secretary of ValueOptions, Inc., and made oath that the above is a true copy from the records of (name of corporation)
the corporation.

Notary Public

My commission expires on: 12/31/14

Sarah Dawn Gay
Commonwealth of Virginia
Notary Public
Commission No. 361092
My Commission Expires 12/31/2014

Exhibit A

Behavioral Health Partnership

Implementation and Year One ASO Performance Targets

DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Table of Contents

Target 1: Data Management Related to Authorization and Payment

Value: 1%

The ASO will have to perform a variety of functions prior to and during the first year in order to ensure the transmission of reliable authorization data to the Departments' claims vendor. All percentages shall be calculated annually. One fifth of the applicable withhold assigned for each domain shall be returned for each domain in which the Contractor achieves the target level of performance. Fifty percent (50%) of the amount of the applicable withhold assigned for each domain shall be returned if the Contractor's performance falls within 95% to 99.99% of the target level of performance.

Table 1

Domain	Description	Target
Eligibility file	Contractor shall build and update an eligibility file.	See Note 1 below.
Provider file	Contractor shall build and maintain a comprehensive provider file.	See Note 2 below.
Authorization file timeliness	The Contractor shall provide to the DSS MMIS contractor a daily Prior Authorization (PA) Transaction batch file of all authorized services and authorization updates.	98% shall occur timely which means prior to start of business the day following production of the authorization file.
Authorization file accuracy	(same)	The error rate shall be less than 2% as a percentage of total authorization records transmitted.
Authorization file error correction	(same)	98% of errors shall be corrected within two (2) business days of date identified, excluding Home Health for the first six months post implementation.

Note 1:

Eligibility File

The contractor will up load 98% of all monthly full files within 2 business days, and all daily update files within 1 business day provided the preprocessing validation results in a client-driven (i.e. file format, missing or invalid data elements) error rate of 2% or less. The turn-around time calculation is based on the results for all files submitted and processed annually. Files received after 2:00pm will be considered received on the following business day.

Files where the client-driven error rate exceeds 2% will not be up loaded and will be reported to the applicable State agency to determine corrective action within the following 2 business days; all subsequent eligibility file processing will be suspended if appropriate, and all related files will be excluded from the calculation of the timely turn around time target.

The percent of errors resulting from conditions solely within the Contractor's control will not preclude a file from being uploaded to our system.

Records that failed to upload from each file will be processed as follows:

- Records that failed to upload due to a condition that is solely within the Contractor's ability to correct will be re-processed within the TAT requirement. If this action does not result in an error rate of less than 2% the file will not be considered processed within the required time frame. Remaining errors from full files will be resolved within 5 business days, and those from daily files will be resolved within 3 business days.

- Records that failed to upload due to a condition that is not solely within the Contractor's ability to correct will be reported to the appropriate State agency within the following 2 business days

    - records that require correction on the part of the appropriate State agency or its representative are expected to be included in a subsequent eligibility file.

    - records that require updated information to be passed from a State agency to the Contractor for updating of the Contractor's processing system will be reprocessed by the Contractor within 4 business days of receipt of the updated information.

Sample method of tracking and calculation of TAT:

	File date	File Type	Actual TAT	TAT requirement met	Comments
Starting file	1/1/2011	Full	2	Yes	
Mon	1/2/2011	Incr	1	Yes	
Tue	1/3/2011	Incr	1	Yes	
Wed	1/4/2011	Incr	1	Yes	
Thu	1/5/2011	Incr	1	Yes	
Fri	1/6/2011	Incr	1	Yes	
Mon	1/9/2011	Incr	4		
Tue	1/10/2011	Incr	1	Yes	
Wed	1/11/2011	Incr	1	Yes	
Thu	1/12/2011	Incr	1	Yes	
Fri	1/13/2011	Incr	1	Yes	
Mon	1/16/2011	Incr	4		
Tue	1/17/2011	Incr	1	Yes	
Wed	1/18/2011	Incr	1	Yes	
Thu	1/19/2011	Incr	1	Yes	
Fri	1/20/2011	Incr	1	Yes	
Mon	1/23/2011	Incr	1	Yes	
Tue	1/24/2011	Incr	1	Yes	
Wed	1/25/2011	Incr	1	Yes	
Thu	1/26/2011	Incr	1	Yes	
Fri	1/27/2011	Incr	1	Yes	
Mon	1/30/2011	Incr	1	Yes	
Tue	1/31/2011	Incr	1	Yes	
Wed	2/1/2011	Full	1	Yes	
Thu	2/2/2011	Incr	1	Yes	
Fri	2/3/2011	Incr	1	Yes	

Total # of Files	26		
# of files excluded from TAT	1	1/16 file	
# of files met TAT	24		
% met TAT	96.00%	24 of 25 files were processed within the agreed upon TAT	

Note 2:

Provider File

The Contractor will receive and upload from the DSS MMIS contractor an initial provider file load of information into the Contractor's MIS within 48 business hours of receipt of a clean file. The Contractor will receive subsequent weekly and monthly changes and updates files and/or reports. The Contractor will update 98% of the provider file weekly adds or changes within three business days upon receipt of clean data, and within five business days for monthly updates upon receipt of clean data, to their MIS. Files/reports received after 2:00 pm ET will be considered received on the following business day. The turn-around time calculation is based on the results for all clean data elements submitted and processed annually.

The Contractor will perform random quarterly quality audits on data elements processed from the weekly and monthly provider file/reports. The Contractor will have a 98% accuracy rate on data element (any single field in the provider file/report) processed from the monthly and weekly provider file/reports. The accuracy rate is calculated on the results for all quarterly random quality audits on an annual basis. A sample size for 95% confidence level will be determined by the number of changes sent, per quarter by the State's MMIS contractor. Quarterly random sample with 95% confidence level will be pulled from Contractor's MIS provider file and compared to monthly provider change files sent by the State's MMIS. Error analysis report will be sent to the State quarterly.

Summary

a) Initial Provider File Load - The contractor will receive and upload from the DSS MMIS contractor a load of information into the Contractor's MIS within 48 hours of receipt of a clean file.

b) Monthly and Weekly network update files - The Contractor will update 98% of the provider file weekly adds or changes within three business days and five business days for monthly updates to their MIS.

c) Quality Audits - 98% accuracy rate of monthly and weekly network update files. Quarterly random audits with a sample size having a 95% confidence level of the Contractor's MIS provider file to the States MMIS provider file data provided.

Target 2: Provider Satisfaction

Value: 1%

An annual provider satisfaction survey shall be conducted. The survey shall assess ASO specific performance. The Contractor's staff will provide input on the design of the survey process and the questions included in the survey. ASO specific performance measurement shall include the domains listed in the table below. The ASO must achieve a favorable average rating from 85% of providers surveyed in order to earn a return of 100% of the withhold. Seventy five percent (75%) of the amount of the withhold shall be returned if the Contractor achieves a favorable average rating of 80% of providers surveyed. A provider's average rating is calculated by computing each provider's average score including all valid responses. A provider would have a favorable average rating if the computed average is >2.5 on a 4-point Likert scale or >3 on a 5-point Likert scale.

Table 2

Domain	Description
Provider relations/call management	- courteous, professional - knowledgeable - helpful with issue resolution
Clinical management processes	- authorization procedures are easy to use and understand - authorization and registration processes are simple/efficient/low administrative burden - WEB interface is easy to use, convenient - information requested for review is necessary and sufficient - absence of mystery - care managers are courteous, professional, responsive - follow-up with provider is timely - process fair and reasonable - decisions are consistent with guidelines - peer reviews are scheduled at a convenient time - peer advisors are polite and professional - peer advisors are clinically knowledgeable
Authorization information	- ease of confirming authorization status - authorization status information appears to be accurate and reliable
Denials/appeals	- satisfaction with clinical denial appeals process, fair, timely, efficient, user-friendly
Complaints	- satisfaction with complaint resolution process

Target 3: Member Satisfaction

Value: 1%

Members will be surveyed with respect to satisfaction with ASO performance in the domains noted below. The Contractor's staff will provide input on the design of the survey process and the questions included in the survey. The ASO must achieve a favorable average rating from at least 85% of members surveyed in each of the domains listed in order to earn a return of 100% of the withhold. Seventy five percent (75%) of the amount of the withhold shall be returned if the Contractor achieves a favorable average rating from at least 80% of members surveyed.

A member's average rating is calculated by computing each member's average score including all valid responses. A member would have a favorable average rating if the computed average is >2.5 on a 4-point Likert scale or >3 on a 5-point Likert scale.

Table 3

Domain	Description
Member services	- Courtesy, professional - Knowledgeable - Helpful, provided timely appropriate assistance
Member materials	- Handbook clearly written and helpful. - Member Brochure clearly written and helpful
Peer specialists	- Courtesy, professional - Knowledgeable - Helpful, provided timely appropriate assistance
Complaints	- Satisfaction with complaint resolution process

Target 4: Licensed Home Health Care Agency Services

Value: .5%

The Contractor will assume utilization management responsibilities for Home Health on or around April 1, 2011. Performance targets for this level of care will be determined by the Departments on or before July 1, 2011.

Target 5: Maintaining the Reduction of Discharge Delay for Children and Adolescents Receiving Inpatient Behavioral Health Treatment

Value: 1%

Over the next calendar year, the Contractor will maintain discharge delay days, at 20% or less of total inpatient days. Specifically, "Pct. Of Inpatient Days in delay status for All Members during Qtr" as reported on the 10B Part 7 report (All Members, IPF & IPM, and excluding Riverview) shall total no more than 20% in CY 2011. Acute average length of stay shall increase by no more than 3% in CY 2011 from the baseline established during Q3 and Q4 of CY 2008 of 12.92 days.

For the purposes of this project, acute average length of stay will be computed via the use of the Contractor's Discharge-based Acute/Discharge Delay Average Length of Stay utilization reports (#8066 and #8076).

One hundred percent (100%) of the amount of the withhold shall be returned if the Contractor achieves a total of no more than 20% of inpatient discharge delay days in CY 2011.

Seventy five percent (75%) of the amount of the withhold shall be returned if the Contractor achieves a total of no more than 22.5% of inpatient discharge delay days.

Fifty percent (50%) of the amount of the withhold shall be returned if the Contractor achieves a total of no more than 25% of inpatient discharge delay days.

The State shall have discretion regarding the value of the withhold awarded by taking other key environmental factors which impact discharge delay into consideration. These factors include:

1. A process refinement whereby a DCF on-site staff member assigned to a child/adolescent inpatient facility will represent the clinical needs and interests of a youth who has DCF involvement, regardless of the youth's nexus to a DCF Area Office

2. CT BHP's pay for performance initiative with the PRTF programs is continued in SFY 2009/2010

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of the withhold.

If DCF experiences significant changes (i.e. Voluntary Service restrictions, reduced access to DCF funded services or constraints in access attributable to closure of State facilities, lack of access to GH 2 or a decrease in Flex Fund availability, etc.) that negatively impact total length of stay for the Discharge Delay population and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full return of the withhold.

If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

Target 6: Enhancement and Implementation of a Provider Analysis and Reporting Program for CT Hospital Emergency Departments

Value: .5%

One of the key goals for the CT BHP is to decrease the number of members inappropriately receiving behavioral health treatment in Emergency Departments (EDs), decrease the number of members inappropriately admitted to behavioral health inpatient treatment from the ED, and increase the number of members appropriately diverted to a behavioral health level of care other than inpatient. Building on the work done by the CT BHP during CY 2010 when a Provider Analysis and Reporting program (PARs) for CT Hospital EDs was developed, ValueOptions will move the existing program forward by completing the following actions within the following timeframes during CY 2011:

A. By April 30, 2011, working with DSS, re-evaluate the methodology for computing the measures of the:
   1. number of visits to the emergency department and
   2. percentage of admits to inpatient from the emergency department.

   During the 2010 development phase of this performance target, the methodology for pulling claims data on ED visits and integrating it with authorization data (initially designed in 2009) was used again to report the two measures listed above. Both of these measures are fundamental to the PARs programs with EDs as they both serve as the basis to measure the success of any interventions to decrease use of the ED for behavioral health services as well as the number of unnecessary admissions to the hospital from the ED. However, it is not clear whether the variability within the same facility across four reporting periods of six months found during 2010 is a result of flaws in the methodology or whether it is an accurate display of the variability of the measures.

   As a result, the methodology used needs to be reevaluated thoroughly before decisions can be made regarding the viability of the continued use of the measures for the ED PARs program.

B. By May 31, 2011, use the MCO provided ED data and VO queried Medicaid claims data to establish the number of behavioral health visits (as identified with a primary diagnosis of 291 - 316) to the emergency department by CT BHP youth and match the ED use with authorization data to establish the following metrics for CT BHP youth:

   - Behavioral health inpatient hospital admission rate (as measured by an authorized inpatient service within 3 days of the ED stay)
   - Behavioral health routine outpatient level of care rate (as measured by a registered routine outpatient service within 7 days of the ED stay)

- Behavioral health intermediate outpatient level of care rate (as measured by an authorized/registered service within 7 of days of the ED stay)
- No known behavioral health service (as measured by the absence of an authorized behavioral health service within 7 of days of the ED stay

Additionally, the ED data will be used to match on-site EMPS evaluations (as measured by the presence of paid claim with procedure code S9485 on the same day as the ED stay) for CT BHP youth.

C. By June 30, 2011, the revised methodology will be used to produce draft PARs ED profiles that, at a minimum, will include:
   1. Each ED's volume of Medicaid youth members treated in the ED
   2. Each ED's inpatient hospital admission rate, routine outpatient rate, intermediate outpatient care rate, and no known behavioral health service rate,
   3. Each ED's use of on-site EMPS evaluation of Medicaid youth treated in the ED.

   Please note that additional measures may be added as determined by the workgroup made up of representatives from EDs, the departments, and the contractor.

D. By August 15, 2011, the Contractor shall have the Departments' review and approval of the draft ED Profiles.

E. By October 31, 2011, the Contractor shall have completed the first cycle of the ED PARs program by sharing the profiles with individual EDs in face to face meetings, via conference call, or by mail.

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed as having met the required target for full or partial return of the withhold.

If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

If DCF or their contractor responsible for producing reports based on PSD CRS data experiences significant changes so that they are unable to produce timely, accurate reports regarding ED use of EMPS, OR the Contractor is unable to

access claims data from DSS in order to assess inpatient admissions that follow ED visits, AND all requirements of this performance target under the control of the Contractor have been successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full return of the withhold.

Target 7: Evaluating Residential Treatment Center (RTC) and Therapeutic Group Homes Performance and Outcomes

Value: 1%

Between 2008 and 2010, the Connecticut Department of Children and Families (DCF) has worked with RTC providers to establish a mutually agreed upon set of performance indicators that would allow providers to compare their performance and outcomes with each other and against mean statewide averages. In order to support and expand this effort during 2011, ValueOptions will continue work with DCF to supply the data necessary to report on these performance indicators. In addition, VO will continue to work with the RTCs to inform and educate them regarding their performance through face to face meetings with individual providers and through the production and dissemination of provider specific reports that track and document progress across the designated performance variables. Upon review and further analysis of the Residential system, VO will work with DCF to identify and develop strategies to reconfigure the congregate care system that will enhance positive outcomes and minimize the need for out-of-state placements. These strategies may include reprocurement initiatives involving the issuance of Requests for Proposals for clinically informed congregate care services designed to meet the needs of those youth currently served in out of state facilities. Additionally, ValueOptions will work with DCF to identify tools and develop methods to quantitatively norm the acuity levels of children on admission to RTCs and during their stay.

A. Value Withhold = .75% *(weighted higher than B.)*

DCF has identified the following RTC performance indicators that require data collected by ValueOptions:

I. Post-placement experience:
   a. Percentage of children with a planned discharge admitted to a lower level of care within 60 days,
   b. Percentage of children hospitalized within 60/90/180 days of a planned discharge,
   c. Percentage of children readmitted to the same LOC within 60/90/180 days of a planned discharge.

II. Experience in Placement:
   a. Average length of time to achieve readiness for planned discharge to a lower LOC,(AKA Average Acute Length of Stay).
   b. Average number of inpatient hospitalizations during RTC stay.

III. Process Measurement of Provider Performance,
   a. Average number of days in discharge delay in program beyond clinical necessity, (Average Length of Stay in Discharge Delay).
   b. Percentage of matches (referrals) accepted for admission into the program (Denominator = # Matches accepted, + # Matches

declined + # Matches no decision; Numerator = # Program accepts for admission).

IV. Therapeutic Group Home Length of Stay
   a. Reports will be prepared for each of the Therapeutic Group Homes and distributed to them in a manner that is mutually agreed upon between DCF and VO; these reports include LOS described above and other outcome data collected and supplied to VO by DCF.

Note: Replacement of a performance indicator, or edit to an existing performance indicator, as noted above, is acceptable upon mutual agreement by the Department and the Contractor

B. Value Withhold = ____.25%____ *(weighted lower than A.)*

At the direction of DCF the Contractor will research strategies and collaborate with DCF to develop a systemic intervention designed to reconfigure the existing in-state congregate care system. The goal of this initiative is to enable the in-state network of providers to better address the behavioral health needs of youth requiring residential care with an emphasis on the needs of those youth currently receiving care out-of-state, Strategies to be considered include identification of alternative service/facility types and reprocurement strategies involving the potential issuance of Requests for Proposals for in-state residential or alternative services.

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of the withhold.

If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

RFP Section V	Name	Description	Initial date due	Subsequent
B.3.2 (page 76)	Key Positions	Candidates for all Key Positions submitted to the Departments for final approval.	Key person within 5 working days of contract execution. Remaining positions by January 5, 2011.	Departmental review and approval prior to any changes in key staff designations or new hires
D. 3.2 (page 82)	Care Management Program (UM)	Includes program description, flow diagrams, and specific policies and procedures pertaining to UM practices, registration, prior authorization, concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, retrospective chart review, and the bypass program.	Feb 15, 2011	Annually (Nov 1)
D.13.1 (page 90)	Inpatient Census Reporting Process	Children and adults admitted to general hospitals, public and private psychiatric hospitals, psychiatric residential treatment facilities, inpatient detoxification, mental health group homes, and residential facilities.	May 1, 2011	Departmental review and approval prior to changes/modific ations
E.1.2 (page 93)	Intensive Care Management (ICM) Program	Includes program description, policies, procedures, workflows, and qualifying criteria for children, adolescents and adults.	Apr 1, 2011	Annually (July 1)

RFP Section V	Name	Description	Initial date due	Subsequent
G.2.2 (page 99)	Primary Care Behavioral Health Consultation Program	Plan to support the psychiatric management of medication by Medicaid enrolled and funded primary care providers	Apr 1, 2011	Departmental review and approval prior to changes/modifications
G.2.6 (page 100)	Behavioral and Physical Health Coordination Program	Plan for communication and coordination with DSS or the CMP's as necessary to ensure the effective coordination of medical and behavioral health benefits	Apr 1, 2011	Annually November 1
G.3.1 (page 101)	Pharmacy Analysis	Written report and recommendations to support improved coordination of services for members with behavioral health and special physical health care needs and to assure appropriate use of psychotropic medications	Within 180 days of receipt of data	Semi-annually Jan1/July 1
I.2.3 (page 103)	Family Oriented Management Processes	Policies and procedures to ensure the needs of parents, children and whole families are appropriately considered; family empowerment at the point of service and at all levels of system planning and management; providing information in the caregiver's or member's preferred language offering choice of providers and services.	Jul 1, 2011	Departmental review and approval prior to changes/modifications
J.3.1 (page 104)	QM Program (description and policies)	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	Apr 1, 2011	Departmental review and approval prior to changes/modifications

RFP Section V	Name	Description	Initial date due	Subsequent
J. 4.1 (page 104)	Annual Quality Management Project Plan	Outlines the objectives and scope of planned QM projects for a given year.	Apr 1, 2011	Annually April 1
J.5.1.2 (page 105)	Provider and Member Satisfaction Survey results	Data collection, analysis, interpretation and reporting of member, member with complex needs and provider satisfaction surveys.	Commence July 1, 2011 with first report due December 31, 2011	Annually (December 1)
J.6.2 (page 106)	Clinical Issues Study	Proposal for clinical issues studies, one related to mental health and the other related to substance use.	Commence design activities July 1, 2011 (data collection), determine scope (09/01/11), deploy data collection (01/01/12) with first report draft due June 1, 2012	Annually (June)
J.9.1 (page 108)	Provider Profiling Strategy	Strategy and methodology for provider profiling and sharing results with providers.	Apr 1, 2011	Annually (April)
K.2.1.9 (page 112)	Provider Newsletter	Prepare, produce and disseminate newsletter with articles covering both mental health and substance abuse topics of interest to providers who work both with children and adults.	Apr 1, 2011	Semi-annually; Departmental review and approval prior to release
K. 3.1 (page 113)	Provider Handbook	Provider Handbook to be posted on website; printed version available for distribution upon request by January 1, 2011.	Mar 1, 2011	Departmental review and approval prior to changes/modifications

RFP Section V	Name	Description	Initial date due	Subsequent
K.8.1 (page 115)	Behavioral Health Partnership Website	Website shell for achieving full scope of provider/member communications, with draft provider handbook and competed care management policies and procedures.	Mar 1, 2011	Departmental review and approval prior to changes/modifications
L.7.1.3 (page 120)	Payment Problem Resolution Plan. VO states this is N/A since it already exists	Plan for coordinating problem assessment and intervention with provision for on-site assistance by rapid response team when problems persist for more than 60 days	Jan 1, 2011	STRUCK
M.2.1 (page 122)	Member Inquiry Process	Policies and procedures for resolving and responding to member inquiries and complaints	Feb 15, 2011	Departmental review and approval prior to changes/modifications
M.4.3 (page 124)	Community Meetings	Five meetings in different locations throughout the state to share information and gather input from members, providers, advocacy groups and local stakeholders.	First meeting set to be held during March 2010	Semi-annually
M.5.1 (page 124)	Member Brochure	Development of informational member brochure describing benefits, ways to access providers, members rights and responsibilities and how to contact Contractor	Feb 28, 2011	Departmental review and approval prior to changes/modifications
M.6.1 (page 125)	Member Handbook	Description of member benefits, rights, responsibilities and procedures for accessing services	May 1, 2011	Bi-annually on March 1
P.10.1 (page 139)	Disaster Recovery or "Business Continuity" plan	Assure continuous operations, meaning no break in service of more than thirty (30) minutes in the event of a system failure and no break in service of more than five (5) business days for all other administrative funcitons.	Annually	Annual test

RFP Section V	Name	Description	Initial date due	Subsequent
Q.2.1 (page 141)	Member Appeals Process	Policies and procedures related to the administration of notices of action, denial notices, and internal appeals processes.	Feb 15, 2011	Departmental review and approval prior to changes/modifications
R.1.1 (page 147)	Provider Appeals Process	Policies and procedures related to the administration of denial and internal clinical and administrative appeals processes.	Feb 15, 2011	Departmental review and approval prior to changes/modifications
S.3.2 (page 150)	Security and Privacy Plan	Policies and procedures that comply with state and federal law concerning the use, disclosure, and security of client data in order to maintain the security and confidentiality of applicant and client information.	Feb 1, 2011	Departmental review and approval prior to changes/modifications
W.1 (page 157)	Implementation Plan	A 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 behavioral health services for all eligible members.	Prior to the execution of the contract	NA

Type of service	CHILD/ ADOL	ADULT	Prior Auth Units/Days precert	Continued Stay Auth/Days as clinically indicated	Transition of Care - Open Authorizations for FFS adults
Inpatient - General Hospital*	x	x	Required 1-3 days initial auth with planned contact	Required 1-3 days	All open psych or detox IP authorizations for FFS adults initiated prior to go live date will sunset on discharge date allowing for run out of open authorizations. Any new requests will be made to VO.
Inpatient - Private Free Standing Psychiatric Hospital*	x	x	Required 1-3 days	Required 1-3 days	
Inpatient Detox		x	Required 1-4 days	Required 1 day per CCR	
Inpatient - State Run Psychiatric Hospital	x		Riverview (1- 14 days)	Riverview (1- 14 days)	
Inpatient - Acute Intermediate Duration		x	Required 7-14 days	Required 7-14 days	N/A
Observation beds (23 hrs)	x	x	Required 1 unit	Not applicable	N/A
Crisis Stabilization Bed (CARES unit)	x		Registration 3 days	Required 3-5 days	N/A
ECT		x	Required 4 week period up to 12 (Temporary)	Required 12 month period up to 20	All open authorizations for FFS members initiated prior to go live date will sunset on discharge date allowing for run out of open authorizations. Any new requests will be made to VO.
Partial Hospitalization Program Adult Day Treatment	x	x	Required 14 days (child) 5-7 days(adult)	Required 7 days (child) 3-5 days (adult)	All open authorizations for FFS members initiated prior to go live date will sunset on discharge date allowing for run out of open authorizations. Any new requests will be made to VO.
Extended Day Treatment	x		Required 30 units (Temporary)	Required 14-30 units	All open authorizations for FFS members initiated prior to go live date will sunset on discharge date allowing for run out of open authorizations. Any new requests will be made to VO.
Adult MH Group Home		x	Required up to 6 months	Required up to 6 months	All open authorizations for FFS members initiated prior to go live date will sunset on discharge date allowing for run out of open authorizations. Any new requests will be made to VO.
Child/Adolescent Group Home	x		Required 14-30 days	Required 7-30 days	N/A
Child/Adolescent Psychiatric Residential Treatment Facility (PRTF)	x		Required 14-30 days	Required 7-30 days	N/A
Home Based Services	x		Registration 3-6 months	Required 1-3 months	N/A
Family Support Team	x		Registration 3-6 months	Re-Registration 3-6 mons	N/A
Case Management	x		Required pass thru 3 hrs (12 units) temporary	Required up to 10 hrs (40 units) per 1 year period	N/A

** for those hospitals in the By-pass Program, initial authorization will change from 6 days to 5 days effective 04/01/11*

Type of service	CHILD/ ADOL	ADULT	Prior Auth Units/Days precert	Continued Stay Auth/Days	Transition of Care -
Psychological Testing	x	x	Required	N/A	All open authorizations for FFS members initiated prior to go live date will sunset on discharge date allowing for run out of open authorizations. Any new requests will be made to VO.
Routine Outpatient Services including all 908XX psychotherapy CPT codes	x	x	Registration 90 units (child) 90 units (adult) per 1 year period	Required 45 units (child) 45 units (adult) per 1 year period	Providers will be allowed up to 60 days following go-live to enter OP auth requests to continue services for existing patients entering treatment prior to 04/01/11. ProviderConnect allows only a 21 day window for entries, for time spans greater than 21 but less than 60, please call for assistance.
Intensive Outpatient Program	x	x	Registration per 4 wk period 10 units (child) 10 units (adult) 2-4 hrs/day = 1 unit	Required 10 units (days) 10 units (child) 10 units (adult)	Same approach as described in OP-FFS. Providers will be allowed up to 30 days following go-live (04/01-04/30/11) to enter IOP auth requests to continue services for existing patients entering treatment prior to 04/01/11. ProviderConnect allows only a 21 day window for entries, for time spans greater than 21 but less than 30, please call for assistance.
Methadone Maintenance	x	x	Registration 52 units per 12mon period	Re-Registration 52 units per 12mon period	Same approach as described in OP-FFS. Providers will be allowed up to 60days following go-live (04/01-05/31/11) to enter MM auth requests to continue services for existing patients entering treatment prior to 04/01/11. ProviderConnect allows only a 21 day window for entries, for time spans greater than 21 but less than 30, please call for assistance. Note: Clinics will need to notify VO if a patient is administratively discharged at any time. Re-entering treatment following an admin discharge will require a new registration.
Residential Detox		x	Required 3-5 days	Required 1-3 days, up to a 10 day maximum	Same approach as described in OP-FFS. Providers will be allowed up to 14 days following go-live (04/01-04/15/11) to enter Resi Detox auth requests to continue services for existing patients entering treatment prior to 04/01/11
Ambulatory Detox		x	Registration Alcohol = 7 units (days)/week Opiates & Benzos = 21 visits (days)/ 21 days	Required	
Home Health Care	x	x	Registration 96 units/90 day period	Registration 90 units/90 day period	All open authorizations for FFS members initiated prior to go live date where no further modifications have been requested will sunset on discharge date allowing for run out of open authorizations. Any new requests will be made to VO

Coverage Responsibility Legend:	1= DSS FFS or MCO– All diagnoses 2= BHP - All diagnoses 3= BHP for Primary Diagnoses 291-316, DSS all other diagnoses 4= Not a covered service except under EPSDT					
	Note: PSR = Provider Specific Rate				Coverage Pertains to:	
Code	**General Hospital Inpatient**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**	**HUSKY A, HUSKY B and Charter Oak members**	**All other Medicaid members**
101	CARES	3	01	001	Y	Y
110	Room & Board- Private	3	01	001	Y	Y
111	Room & Board- Private -Med/Surg/Gyn	3	01	001	Y	Y
112	Room & Board- Private -OB	3	01	001	Y	Y
113	Room & Board- Private -Pediatric	3	01	001	Y	Y
114	Room & Board – Private - Psychiatric	2	01	001	Y	Y
115	Room & Board- Private -Hospice	3	01	001	Y	Y
116	Room & Board – Private - Detox	2	01	001	Y	Y
117	Room & Board- Private -Oncology	3	01	001	Y	Y
118	Room & Board- Private -Rehab	3	01	001	Y	Y
119	Room & Board- Private -Other	3	01	001	Y	Y
120	Room & Board-Semi-Private/2 Bed	3	01	001	Y	Y
121	Room & Board-Semi-Private/ 2 Bed- Med/Surg/Gyn	3	01	001	Y	Y
122	Room & Board-Semi-Private/ 2 Bed -OB	3	01	001	Y	Y
123	Room & Board-Semi-Private/ 2 Bed-Pediatric	3	01	001	Y	Y
124	Room & Board – Semi-Private/2 Bed - Psychiatric	2	01	001. 010	Y	Y
125	Room & Board-Semi-Private/ 2 Bed-Hospice	3	01	001	Y	Y
126	Room & Board - Semi-Private/2 Bed - Detox	2	01	001	Y	Y
127	Room & Board-Semi-Private/ 2 Bed-Oncology	3	01	001	Y	Y
128	Room & Board-Semi-Private/ 2 Bed-Rehab	3	01	001	Y	Y
129	Room & Board-Semi-Private/ 2 Bed-Other	3	01	001	Y	Y
130	Room & Board-Semi-Private/3-4 Bed	3	01	001	Y	Y
131	Room & Board-Semi-Private/3-4 Bed- Med/Surg/Gyn	3	01	001	Y	Y
132	Room & Board-Semi-Private/3-4 Bed-OB	3	01	001	Y	Y
133	Room & Board-Semi-Private/3-4 Bed-Pediatric	3	01	001	Y	Y
134	Room & Board - Semi-Private/3-4 Bed - Psychiatric	2	01	001	Y	Y
135	Room & Board-Semi-Private/3-4 Bed-Hospice	3	01	001	Y	Y
136	Room & Board - Semi-Private/3-4 Bed - Detox	2	01	001	Y	Y
137	Room & Board-Semi-Private/3-4 Bed-Oncology	3	01	001	Y	Y
138	Room & Board-Semi-Private/3-4 Bed-Rehab	3	01	001	Y	Y
139	Room & Board-Semi-Private/3-4 Bed-Other	3	01	001	Y	Y
140	Room & Board-Private-Deluxe	3	01	001	Y	Y
141	Room & Board-Private-Deluxe- Med/Surg/Gyn	3	01	001	Y	Y
142	Room & Board-Private - Deluxe-OB	3	01	001	Y	Y
143	Room & Board-Private - Deluxe-Pediatric	3	01	001	Y	Y
144	Room & Board - Private - Deluxe - Psychiatric	2	01	001	Y	Y
145	Room & Board-Private - Deluxe-Hospice	3	01	001	Y	Y
146	Room & Board – Private – Deluxe – Detox	2	01	001	Y	Y
147	Room & Board-Private - Deluxe-Oncology	3	01	001	Y	Y
148	Room & Board-Private - Deluxe-Rehab	3	01	001	Y	Y
149	Room & Board-Private - Deluxe-Other	3	01	001	Y	Y
150	Room & Board – Ward	3	01	001	Y	Y
151	Room & Board – Ward - Med/Surg/ Gyn	3	01	001	Y	Y
152	Room & Board – Ward – OB	3	01	001	Y	Y
153	Room & Board – Ward – Pediatric	3	01	001	Y	Y
154	Room & Board - Ward - Psychiatric	2	01	001	Y	Y
155	Room & Board – Ward – Hospice	3	01	001	Y	Y
156	Room & Board - Ward - Detox	2	01	001	Y	Y
157	Room & Board – Ward – Oncology	3	01	001	Y	Y
158	Room & Board – Ward – Rehab	3	01	001	Y	Y
159	Room & Board – Ward - Other	3	01	001	Y	Y
160	Other Room & Board	3	01	001	Y	Y
164	Other Room & Board – Sterile Environment	3	01	001	Y	Y
167	Other Room & Board – Self Care	3	01	001	Y	Y
169	Other Room & Board - Other	3	01	001	Y	Y
170	Room & Board- Nursery	3	01	001	Y	Y

171	Room & Board- Nursery – Newborn	3	01	001	Y	Y
172	Room & Board- Nursery – Premature	3	01	001	Y	Y
175	Room & Board- Nursery – Neonatal ICU	3	01	001	Y	Y
179	Room & Board- Nursery - Other	3	01	001	Y	Y
190	Subacute Care	3	01	001	Y	Y
200	Intensive Care	3	01	001	Y	Y
201	Intensive Care – Surgical	3	01	001	Y	Y
202	Intensive Care – Medical	3	01	001	Y	Y
203	Intensive Care – Pediatric	3	01	001	Y	Y
204	Intensive Care – Psychiatric	2	01	001	Y	Y
205	Intensive Care – Post ICU	3	01	001	Y	Y
207	Intensive Care – Burn Treatment	3	01	001	Y	Y
208	Intensive Care – Trauma	3	01	001	Y	Y
209	Intensive Care – Other	3	01	001	Y	Y
210	Coronary Care	3	01	001	Y	Y
211	Coronary Care – Myocardial Infarction	3	01	001	Y	Y
212	Coronary Care – Pulmonary	3	01	001	Y	Y
213	Coronary Care – Heart Transplant	3	01	001	Y	Y
214	Coronary Care – Post CCU	3	01	001	Y	Y
219	Coronary Care – Other	3	01	001	Y	Y
224	Late discharge/Medically necessary	4	N/A	N/A	Y	Y
	Note: MCOs cover alcohol detoxification on a medical floor.					
Code	**General Hospital Emergency Department**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
450	Emergency Room General Classification	1	01	007	Y	Y
451	EMTALA Emergency Medical Screening Services	1	01	007	Y	Y
452	Emergency Room Beyond EMTALA Screening	1	01	007	Y	Y
456	Urgent Care	1	01	007	Y	Y
459	Other Emergency Room	1	01	007	Y	Y
762	Observation room	3	01	007	Y	Y
981	Professional Fee – Emergency Department	1	N/A	N/A	Y	Y
Code	**General Hospital Outpatient**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
490	Ambulatory Surgery	1	N/A	N/A	Y	Y
513	Psychiatric Clinic Visit	2	01	007	N	Y
562	Child First - Medical Social Services - Hour	2	01	007	Y	Y
569	Child First - Medical Social Services - Other	2	01	007	Y	Y
761	CARES	3	01	007	Y	Y
762	Observation room	3	01	007	Y	Y
900	Psychiatric Services General (Evaluation)	2	01	007	Y	Y
901	Electroconvulsive Therapy	2	01	007	Y	Y
905	Intensive Outpatient Services – Psychiatric	2	01	007	Y	Y
906	Intensive Outpatient Services – Chemical Dependency	2	01	007	Y	Y
907	Community Behavioral Health Program (Day Treatment) (Clients under 21 only)	2****	01	007	Y	Y
913	Partial Hospital	2	01	007	Y	Y
914	Psychiatric Service-Individual Therapy**	2	01	007	Y	N
915	Psychiatric Service-Group Therapy**	2	01	007	Y	N
916	Psychiatric Service-Family Therapy**	2	01	007	Y	N
918	Psychiatric Service – Testing	3	01	007	Y	Y
919	Other--Med Administration**	2	01	007	Y	N
961	Professional Fees-Psychiatric	4	N/A	N/A	Y	Y
All others		1	N/A	N/A	Y	Y
	**Covered for HUSKY A, HUSKY B and Charter Oak clients; not covered for all others					
Code	**General Hospital Outpatient - Enhanced Care Clinic (ECC)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
490	Ambulatory Surgery	1	N/A	N/A	Y	N
762	Observation room	3	01	007	Y	N
900	Psychiatric Services General (Evaluation)	2	01	007	Y	N
901	Electroconvulsive Therapy**	2	01	007	Y	N
905	Intensive Outpatient Services – Psychiatric	2	01	007	Y	N

906	Intensive Outpatient Services – Chemical Dependency	2	01	007	Y	N
907	Community Behavioral Health Program (Day Treatment)	2	01	007	Y	N
913	Partial Hospital	2	01	007	Y	N
914	Individual Therapy	2	01	007	Y	N
915	Group Therapy	2	01	007	Y	N
916	Family Therapy	2	01	007	Y	N
918	Psychiatric Service – Testing	3	01	007	Y	N
919	Other - Med Admin	2	01	007	Y	N
961	Professional Fees-Psychiatric	4	N/A	N/A	Y	N
All others		1	N/A	N/A	Y	N
Code	**Psychiatric Hospital Inpatient (including state operated hospitals*)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
100	All inclusive room and board plus ancillary	4	N/A	N/A	Y	Y
124	Room and Board-Psychiatric	2	01	002, 003, 004	Y	Y
126	Room & Board - Semi-Private/2 Bed - Detox	2	01	002, 003, 004	Y	Y
128	Room & Board-Semi-Private/ 2 Bed-Rehab	4	N/A	N/A	Y	Y
190	Subacute Care	2	01	002, 003, 004	Y	Y
224	Late discharge/Medically necessary	4	N/A	N/A	Y	Y
	* State operated hospitals subject to IGT agreement					
Code	**Psychiatric Hospital Outpatient (including state operated hospitals*)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
490	Ambulatory Surgery	1	N/A	N/A	Y	Y
513	Psychiatric Clinic Visit	2	01	008	N	Y
762	Observation room	2	01	008	Y	Y
900	Psychiatric Services General (Evaluation)	2	01	008	Y	Y
901	Electroconvulsive Therapy	2	01	008	Y	Y
905	Intensive Outpatient Services - Psychiatric	2	01	008	Y	Y
906	Intensive Outpatient Services - Chemical Dependency	2	01	008	Y	Y
907	Community Behavioral Health Program (Day Treatment) (Clients under 21 only)	2****	01	008	Y	Y
913	Partial Hospital-More Intensive	2	01	008	Y	Y
914	Psychiatric Service-Individual Therapy	2	01	008	Y	Y
915	Psychiatric Service-Group Therapy	2	01	008	Y	Y
916	Psychiatric Service-Family Therapy	2	01	008	Y	Y
918	Psychiatric Service-Testing	2	01	008	Y	Y
919	Other - Med Admin	2	01	008	Y	N
	* State operated hospitals subject to IGT agreement					
Code	**Alcohol and Drug Abuse Center (Non-hospital Inpatient Detox)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
H0011	Acute Detoxification (residential program inpatient)	2	63	001	Y	Y
H2036	Residential Rehab	2	63	001	Y	Y
Code	**Alcohol and Drug Abuse Center (Ambulatory Detoxification)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
H0014	Ambulatory Detoxification	2	63	007	Y	Y
Code	**PRTF**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
T2048	Psychiatric health facility service, per diem (Clients under 21 only)	2	12	033	Y	Y
Code	**DCF Residential**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
2073Y	Private Non-Medical Institutions Services (Children)	2	12	580	N	N
2075Y	PNMI - Therapeutic Group Homes	2	12	580	N	N

Code	Mental Health Group Home	Coverage	Provider Type(s)	Provider Specialty, Specialties		
2074Y	Mental health rehabilitation services for adults in PNMI's	2	12	511	N	Y
	Note: Costs will be billed to DMHAS under the current Mental Health Group Home agreement					
Code	**Long Term Care Facility**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
100	Per diem rate	1	N/A	N/A	Y	Y
183	Home reserve	1	N/A	N/A	Y	Y
185	Inpatient hospital reserve	1	N/A	N/A	Y	Y
189	Non-covered reserve	4	N/A	N/A	Y	Y
	Note: Includes inpatient at special care hospitals.					
Code	**MH Clinic**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Psychiatric Diagnostic Interview	2	08	525	Y	Y
90802	Interactive Psychiatric Diagnostic Interview	2	08	525	Y	Y
90804	Individual Psychotherapy- Office or other Outpatient (20-30 min)	2	08	525	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	08	525	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	08	525	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	08	525	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	08	525	Y	Y
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	08	525	Y	Y
90810	Interactive Individual Psychotherapy-Office or other	2	08	525	Y	Y
90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	08	525	Y	Y
90812	Interactive Individual Psychotherapy-Office or other	2	08	525	Y	Y
90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	08	525	Y	Y
90814	Interactive Individual Psychotherapy-Office or other	2	08	525	Y	Y
90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	08	525	Y	Y
90846	Family Psychotherapy (without the patient present)	2	08	525	Y	Y
90847	Family Psychotherapy (conjoint psychotherapy) (with	2	08	525	Y	Y
90849	Multi-family group psychotherapy	2	08	525	Y	Y
90853	Group psychotherapy	2	08	525	Y	Y
90857	Interactive group psychotherapy	2	08	525	Y	Y
90862	Pharmacologic management	2	08	525	Y	Y
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons.	2	08	525	Y	Y
96101	Psychological testing, per hour	2	08	525	Y	Y
96110	Developmental testing and report, limited	2	08	525	Y	Y
96111	Developmental testing and report, extended	2	08	525	Y	Y
96118	Neuropsychological testing battery, per hour	2	08	525	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	3	08	525	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	3	08	525	Y	Y
H0015	Intensive Outpatient-Substance Dependence*	2	08	525	Y	Y

H0035	Mental health partial hospitalization, treatment, less	2	08	525	Y	Y
H2012	Extended Day Treatment	2****	08	525	Y	Y
H2013	Partial Hospitalization (non-CMHC)*	2*	08	525	Y	Y
H2019	Therapeutic Behavioral Services, per 15 minutes (IICAPS, MST, MDFT, FFT, FST, HVS) (Clients under 21 only)	2***	08	525	Y	Y
J0515	Injection, Benzotropine Mesylate, per 1mg	2	08	525	Y	Y
J0735	Injection, Clonidine Hydrochlorine (HCL), 1mg/Injection	2	08	525	Y	Y
J0780	Injection, Prochlorperazine, up to 10 mg	2	08	525	Y	Y
J1200	Injection, Diphenhydramine HCL, up to 50 mg	2	08	525	Y	Y
J1320	Injection, Amitryptyline HCL, up to 20 mg	2	08	525	Y	Y
J1630	Injection, Haloperidol, up to 5 mg	2	08	525	Y	Y
J1631	Injection, Haloperidol decanoate, per 50 mg	2	08	525	Y	Y
J1990	Injection, Chlordiasepoxide HCL, up to 100 mg	2	08	525	Y	Y
J2060	Injection, Lorazepam, 2 mg	2	08	525	Y	Y
J2680	Injection, Fluphenazine decanoate, up to 25 mg	2	08	525	Y	Y
J2794	Injection, Risperidone, long acting, 0.5 mg	2	08	525	Y	Y
J3230	Injection, Chlorpromazine HCL, up to 50 mg	2	08	525	Y	Y
J3310	Injection, Perphenazine, up to 5 mg	2	08	525	Y	Y
J3410	Injection, Hydroxyzine HCL, up to 25 mg	2	08	525	Y	Y
J3411	Injection, Thiamine HCL, 100 mg	2	08	525	Y	Y
J3486	Injection, Ziprasidone Mesylate, 10 mg	2	08	525	Y	Y
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders	2	08	525	Y	Y
S9475	Ambulatory setting, substance abuse treatment or detoxification services	4	N/A	N/A	Y	Y
S9480	Intensive Outpatient-Mental Health	2	08	525	Y	Y
S9484	Emergency mobile mental health service, follow-up (Restricted to clients under 18 only)	2***	08	525	Y	Y
S9485	Emergency mobile mental health service, initial evaluation (Restricted to clients under 18 only)	2***	08	525	Y	Y
T1016	Case Management - Coordination of health care services - each 15 min.	2	08	525	Y	Y
T1017	Case management - home/community, each 15 minutes (part of home-based services only - IICAPS, MST, MDFT, FFT, FST, HVS) (Clients under 21 only)	2	08	525	Y	Y
	*Coverage restricted to providers approved by DSS to provide this service					
	*** Coverage restricted to providers certified by DCF to provide this service					
	****Coverage restricted to providers licensed by DCF to provide this service					
Code	**MH Clinic- Enhanced Care Clinic (ECC)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Psychiatric Diagnostic Interview	2	08	525	Y	Y
90802	Interactive Psychiatric Diagnostic Interview	2	08	525	Y	Y
90804	Individual Psychotherapy- Office or other Outpatient (20-30 min)	2	08	525	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	08	525	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	08	525	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	08	525	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	08	525	Y	Y
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	08	525	Y	Y
90810	Interactive Individual Psychotherapy-Office or other	2	08	525	Y	Y

90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	08	525	Y	Y
90812	Interactive Individual Psychotherapy-Office or other	2	08	525	Y	Y
90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	08	525	Y	Y
90814	Interactive Individual Psychotherapy-Office or other	2	08	525	Y	Y
90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	08	525	Y	Y
90846	Family Psychotherapy (without the patient present)	2	08	525	Y	Y
90847	Family Psychotherapy (conjoint psychotherapy) (with the patient present)	2	08	525	Y	Y
90849	Multi-family group psychotherapy	2	08	525	Y	Y
90853	Group psychotherapy	2	08	525	Y	Y
90857	Interactive group psychotherapy	2	08	525	Y	Y
90862	Pharmacologic management	2	08	525	Y	Y
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons.	2	08	525	Y	Y
96101	Psychological testing, per hour	2	08	525	Y	Y
96110	Developmental testing and report, limited	2	08	525	Y	Y
96111	Developmental testing and report, extended	2	08	525	Y	Y
96118	Neuropsychological testing battery, per hour	2	08	525	Y	Y
99241	Office consult, new/established patient, approx 15 min	2	08	525	Y	Y
99242	Office consult, new/established patient, approx 30 min	2	08	525	Y	Y
99243	Office consult, new/established patient, approx 40 min	2	08	525	Y	Y
99244	Office consult, new/established patient, approx 60 min	2	08	525	Y	Y
99245	Office consult, new/established patient, approx 80 min	2	08	525	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	3	08	525	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	3	08	525	Y	Y
H0015	Intensive Outpatient-Substance Dependence*	2	08	525	Y	Y
H0035	Mental health partial hospitalization, treatment, less	2	08	525	Y	Y
H2012	Extended Day Treatment	2****	08	525	Y	Y
H2013	Partial Hospitalization (non-CMHC)*	2*	08	525	Y	Y
H2019	Therapeutic Behavioral Services, per 15 minutes (IICAPS, MST, MDFT, FFT, FST, HVS) (Clients under 21 only)	2***	08	525	Y	Y
J0515	Injection, Benzotropine Mesylate, per 1mg	2	08	525	Y	Y
J0735	Injection, Clonidine Hydrochlorine (HCL), 1mg/Injection	2	08	525	Y	Y
J0780	Injection, Prochlorperazine, up to 10 mg	2	08	525	Y	Y
J1200	Injection, Diphenhydramine HCL, up to 50 mg	2	08	525	Y	Y
J1320	Injection, Amitryptyline HCL, up to 20 mg	2	08	525	Y	Y
J1630	Injection, Haloperidol, up to 5 mg	2	08	525	Y	Y
J1631	Injection, Haloperidol decanoate, per 50 mg	2	08	525	Y	Y
J1990	Injection, Chlordiasepoxide HCL, up to 100 mg	2	08	525	Y	Y
J2060	Injection, Lorazepam, 2 mg	2	08	525	Y	Y
J2680	Injection, Fluphenazine decanoate, up to 25 mg	2	08	525	Y	Y
J2794	Injection, Risperidone, long acting, 0.5 mg	2	08	525	Y	Y
J3230	Injection, Chlorpromazine HCL, up to 50 mg	2	08	525	Y	Y
J3310	Injection, Perphenazine, up to 5 mg	2	08	525	Y	Y
J3410	Injection, Hydroxyzine HCL, up to 25 mg	2	08	525	Y	Y
J3411	Injection, Thiamine HCL, 100 mg	2	08	525	Y	Y
J3486	Injection, Ziprasidone Mesylate, 10 mg	2	08	525	Y	Y

M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders	2	08	525	Y	Y
S9475	Ambulatory setting, substance abuse treatment or detoxification services	4	N/A	N/A	Y	Y
S9480	Intensive Outpatient-Mental Health	2	08	525	Y	Y
S9484	Emergency mobile mental health service, follow-up (Restricted to clients under 18 only)	2***	08	525	Y	Y
S9485	Emergency mobile mental health service, initial evaluation (Restricted to clients under 18 only)	2***	08	525	Y	Y
T1016	Case Management - Coordination of health care services - each 15 min.	2	08	525	Y	Y
T1017	Case management - home/community, each 15 minutes (part of home-based services only - IICAPS, MST, MDFT, FFT, FST, HVS) (Clients under 21 only)	2	08	525	Y	Y
	*Coverage restricted to providers approved by DSS to provide this service					
	*** Coverage restricted to providers certified by DCF to provide this service					
	****Coverage restricted to providers licensed by DCF to provide this service					
Code	**FQHC Mental Health Clinic**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Psychiatric Diagnostic Interview	2	08	522	Y	Y
90802	Interactive Psychiatric Diagnostic Interview	2	08	522	Y	Y
90804	Individual Psychotherapy- Office or other Outpatient (20-30 min)	2	08	522	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	08	522	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	08	522	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	08	522	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	08	522	Y	Y
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	08	522	Y	Y
90810	Interactive Individual Psychotherapy-Office or other	2	08	522	Y	Y
90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	08	522	Y	Y
90812	Interactive Individual Psychotherapy-Office or other	2	08	522	Y	Y
90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	08	522	Y	Y
90814	Interactive Individual Psychotherapy-Office or other	2	08	522	Y	Y
90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	08	522	Y	Y
90846	Family Psychotherapy (without the patient present)	2	08	522	Y	Y
90847	Family Psychotherapy (conjoint psychotherapy) (with	2	08	522	Y	Y
90849	Multi-family group psychotherapy	2	08	522	Y	Y
90853	Group psychotherapy	2	08	522	Y	Y
90857	Interactive group psychotherapy	2	08	522	Y	Y
90862	Pharmacologic management	2	08	522	Y	Y
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons.	2	08	522	Y	Y
96101	Psychological testing, per hour	2	08	522	Y	Y
96110	Developmental testing and report, limited	2	08	522	Y	Y
96111	Developmental testing and report, extended	2	08	522	Y	Y
96118	Neuropsychological testing battery, per hour	2	08	522	Y	Y
H0015	Intensive Outpatient-Substance Dependence*	2	08	522	Y	Y

H0020	Methadone service; rate includes all services for which the source of service is the methadone maintenance clinic.	2	08	522	Y	Y
H2012	Extended Day Treatment	2****	08	522	Y	Y
H2013	Partial Hospitalization (non-CMHC)*	2*	08	522	Y	Y
J1630	Injection, Haloperidol, up to 5 mg	2	08	522	Y	Y
J1631	Injection, Haloperidol decanoate, per 50 mg	2	08	522	Y	Y
J2680	Injection, Fluphenazine decanoate, up to 25 mg	2	08	522	Y	Y
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders	2	08	522	Y	Y
S9475	Ambulatory setting, substance abuse treatment or detoxification services	4	N/A	N/A	Y	Y
S9480	Intensive Outpatient-Mental Health	2	08	522	Y	Y
S9484	Emergency mobile mental health service, follow-up (Restricted to clients under 18 only)	2***	08	522	Y	Y
S9485	Emergency mobile mental health service, initial evaluation (Restricted to clients under 18 only)	2***	08	522	Y	Y
T1015	Clinic visit/encounter all-inclusive (For use by FQHC MH Clinics)	2	08	522	Y	Y
	*Coverage restricted to providers approved by DSS to provide this service					
	*** Coverage restricted to providers certified by DCF to provide this service					
	****Coverage restricted to providers licensed by DCF to provide this service					
Code	**State Institution Mental Health Clinic**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Psychiatric Diagnostic Interview	2	90	111	Y	Y
90804	Individual Psychotherapy- Office or other Outpatient (20-30 min)	2	90	111	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	90	111	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	90	111	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	90	111	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	90	111	Y	Y
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	90	111	Y	Y
90810	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	90	111	Y	Y
90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	90	111	Y	Y
90812	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	90	111	Y	Y
90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	90	111	Y	Y
90814	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	90	111	Y	Y
90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	90	111	Y	Y
90853	Group psychotherapy	2	90	111	Y	Y
99201	Office or other outpatient visit, 10 minutes, new patient	2	90	111	Y	Y
99202	Office or other outpatient visit, 20 minutes, new patient	2	90	111	Y	Y
99203	Office or other outpatient visit, 30 minutes, new patient	2	90	111	Y	Y

99204	Office or other outpatient visit, 45 minutes, new patient	2	90	111	Y	Y
99205	Office or other outpatient visit, 60 minutes, new patient	2	90	111	Y	Y
99211	Office or other outpatient visit, 5 minutes, established patient	2	90	111	Y	Y
99212	Office or other outpatient visit, 10 minutes, established patient	2	90	111	Y	Y
99213	Office or other outpatient visit, 15 minutes, established patient	2	90	111	Y	Y
99214	Office or other outpatient visit, 25 minutes, established patient	2	90	111	Y	Y
99215	Office or other outpatient visit, 40 minutes, established patient	2	90	111	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	3	90	111	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	3	90	111	Y	Y
H0015	Intensive Outpatient-Substance Dependence*	2	90	111	Y	Y
H2013	Partial Hospitalization (non-CMHC)*	2	90	111	Y	Y
J0515	Injection, Benzotropine Mesylate, per 1mg	2	90	111	Y	Y
J0735	Injection, Clonidine Hydrochlorine (HCL), 1mg/Injection	2	90	111	Y	Y
J0780	Injection, Prochlorperazine, up to 10 mg	2	90	111	Y	Y
J1200	Injection, Diphenhydramine HCL, up to 50 mg	2	90	111	Y	Y
J1320	Injection, Amitryptyline HCL, up to 20 mg	2	90	111	Y	Y
J1630	Injection, Haloperidol, up to 5 mg	2	90	111	Y	Y
J1631	Injection, Haloperidol decanoate, per 50 mg	2	90	111	Y	Y
J1990	Injection, Chlordiasepoxide HCL, up to 100 mg	2	90	111	Y	Y
J2060	Injection, Lorazepam, 2 mg	2	90	111	Y	Y
J2680	Injection, Fluphenazine decanoate, up to 25 mg	2	90	111	Y	Y
J2794	Injection, Risperidone, long acting, 0.5 mg	2	90	111	Y	Y
J3230	Injection, Chlorpromazine HCL, up to 50 mg	2	90	111	Y	Y
J3310	Injection, Perphenazine, up to 5 mg	2	90	111	Y	Y
J3410	Injection, Hydroxyzine HCL, up to 25 mg	2	90	111	Y	Y
J3411	Injection, Thiamine HCL, 100 mg	2	90	111	Y	Y
J3486	Injection, Ziprasidone Mesylate, 10 mg	2	90	111	Y	Y
S9480	Intensive Outpatient-Mental Health	2	90	111	Y	Y
	*Coverage restricted to providers approved by DSS to provide this service					
	Note: State operated mental health clinics subject to IGT agreement					
Code	**Rehabilitation Clinic**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Psychiatric Diagnostic Interview	3	08	040	Y	Y
90804	Individual Psychotherapy- Office or other Outpatient (20-30 min)	3	08	040	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	3	08	040	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	3	08	040	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	3	08	040	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	3	08	040	Y	Y
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	3	08	040	Y	Y
90846	Family psychotherapy (without the patient present)	3	08	040	Y	Y
90847	Family psychotherapy (conjoint)	3	08	040	Y	Y
90853	Group psychotherapy	3	08	040	Y	Y
90857	Interactive Group therapy	3	08	040	Y	Y
96118	Neuropsychological testing battery, per hour	3	08	040	Y	Y
All others		1	N/A	N/A	Y	Y

Code	Freestanding Medical Clinic (including non-FQHC School-Based Health Centers)	Coverage	Provider Type(s)	Provider Specialty, Specialties		
90782	Therapeutic or diagnostic injection; subcutaneous or intramuscular	1	N/A	N/A	Y	Y
90783	Therapeutic or diagnostic injection; intra-arterial	1	N/A	N/A	Y	Y
90784	Therapeutic or diagnostic injection; intravenous	1	N/A	N/A	Y	Y
90801	Psychiatric Diagnostic Interview	3	08	523	Y	Y
90804	Individual psychotherapy (20-30 min)	3	08	523	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	3	08	523	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	3	08	523	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	3	08	523	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	3	08	523	Y	Y
90846	Family psychotherapy (without the patient present)	3	08	523	Y	Y
90847	Family psychotherapy (conjoint psychotherapy w/patient present)	3	08	523	Y	Y
90853	Group psychotherapy (other than of a multiple-family group)	3	08	523	Y	Y
90862	Pharmacologic management	2	08	523	Y	Y
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. (Typically 5 minutes)	1	N/A	N/A	Y	Y
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: problem focused history; problem focused examination; straightforward medical decision-making. (Typically 10 minutes face-to-face)	1	N/A	N/A	Y	Y
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: expanded problem focused history; expanded problem focused examination; medical decision making of low complexity. (Typically 15 minutes face-to-face)	1	N/A	N/A	Y	Y
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: detailed history; detailed examination; medical decision making of moderate complexity (Typically 25 minutes face-to-face)	1	N/A	N/A	Y	Y
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: comprehensive history; comprehensive examination; medical decision making of high complexity (Typically 40 minutes face-to-face)	1	N/A	N/A	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	3	08	523	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	3	08	523	Y	Y
All others		1	N/A	N/A	Y	Y
Code	**FQHC Medical Clinics (including those operating as School-Based Health Centers)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		

90782	Therapeutic or diagnostic injection; subcutaneous or intramuscular	1	N/A	N/A	Y	Y
90783	Therapeutic or diagnostic injection; intra-arterial	1	N/A	N/A	Y	Y
90784	Therapeutic or diagnostic injection; intravenous	1	N/A	N/A	Y	Y
90801	Psychiatric Diagnostic Interview	3	08	521	Y	Y
90804	Individual psychotherapy (20-30 min)	3	08	521	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	3	08	521	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	3	08	521	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	3	08	521	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	3	08	521	Y	Y
90846	Family psychotherapy (without the patient present)	3	08	521	Y	Y
90847	Family psychotherapy (conjoint psychotherapy w/patient present)	3	08	521	Y	Y
90853	Group psychotherapy (other than of a multiple-family group)	3	08	521	Y	Y
90862	Pharmacologic management	3	08	521	Y	Y
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. (Typically 5 minutes)	1	N/A	N/A	Y	Y
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: problem focused history; problem focused examination; straightforward medical decision-making. (Typically 10 minutes face-to-face)	1	N/A	N/A	Y	Y
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: expanded problem focused history; expanded problem focused examination; medical decision making of low complexity. (Typically 15 minutes face-to-face)	1	N/A	N/A	Y	Y
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: detailed history; detailed examination; medical decision making of moderate complexity (Typically 25 minutes face-to-face)	1	N/A	N/A	Y	Y
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: comprehensive history; comprehensive examination; medical decision making of high complexity (Typically 40 minutes face-to-face)	1	N/A	N/A	Y	Y
T1015	Clinic visit/encounter all-inclusive (For use by FQHC Clinics)	3	08	521	Y	Y
All others		1	N/A	N/A	Y	Y
Code	**Methadone Clinic**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
H0020	Methadone service; rate includes all services for which the source of service is the methadone maintenance clinic.	2	08	096	Y	Y
Code	**MD, DO and APRN other than Psychiatrist or Psychiatric APRN**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
00104	Anesthesia for electroconvulsive therapy	1	N/A	N/A	Y	Y

80100	Drug screen, qualitative, chromatographic method, each procedure	1	N/A	N/A	Y	Y
81000	Urinalysis, by dip stick or tablet reagent, non-automated, with microscopy	1	N/A	N/A	Y	Y
83840	Methadone chemistry (quantitative analysis)	1	N/A	N/A	Y	Y
90782	Therapeutic or diagnostic injection; subcutaneous or intramuscular	1	N/A	N/A	Y	Y
90783	Therapeutic or diagnostic injection; intra-arterial	1	N/A	N/A	Y	Y
90784	Therapeutic or diagnostic injection; intravenous	1	N/A	N/A	Y	Y
908XX	Psychotherapy codes	4	N/A	N/A	Y	Y
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. (Typically 5 minutes)	1	N/A	N/A	Y	Y
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: problem focused history; problem focused examination; straightforward medical decision making (Typically 10 minutes face-to-face)	1	N/A	N/A	Y	Y
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: expanded problem focused history; expanded problem focused examination; medical decision making of low complexity. (Typically 15 minutes face-to-face)	1	N/A	N/A	Y	Y
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: detailed history; detailed examination; medical decision making of moderate complexity (Typically 25 minutes face-to-face)	1	N/A	N/A	Y	Y
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: comprehensive history; comprehensive examination; medical decision making of high complexity (Typically 40 minutes face-to-face)	1	N/A	N/A	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	1	N/A	N/A	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	1	N/A	N/A	Y	Y
All others		1	N/A	N/A	Y	Y
Code	**Psychiatrist (MD or DO)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Diagnostic Interview	2	31, 72	339	Y	Y
90802	Interactive Diagnostic Interview	2	31, 72	339	Y	Y
90804	Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	31, 72	339	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	31, 72	339	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	31, 72	339	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	31, 72	339	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	31, 72	339	Y	Y
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	31, 72	339	Y	Y
90810	Interactive Individual Psychotherapy-Office or other	2	31, 72	339	Y	Y

90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	31, 72	339	Y	Y
90812	Interactive Individual Psychotherapy-Office or other	2	31, 72	339	Y	Y
90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	31, 72	339	Y	Y
90814	Interactive Individual Psychotherapy-Office or other	2	31, 72	339	Y	Y
90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	31, 72	339	Y	Y
90816	Individual Psychotherapy-Facility Based (20-30 min)	2	31, 72	339	Y	Y
90817	90816 with medical evaluation and management	2	31, 72	339	Y	Y
90818	Individual psychotherapy, insight oriented 45-50 minutes	2	31, 72	339	Y	Y
90819	90818 with medical evaluation and management	2	31, 72	339	Y	Y
90821	Individual Psychotherapy-Facility Based (75-80 min)	2	31, 72	339	Y	Y
90822	Individual Psychotherapy-Facility Based (75-80 min)	2	31, 72	339	Y	Y
90823	Interactive Individual Psychotherapy-Facility Based (20-30 min)	2	31, 72	339	Y	Y
90824	Interactive Individual Psychotherapy-Facility Based (20-30 min) med management	2	31, 72	339	Y	Y
90826	Interactive Individual Psychotherapy-Facility Based (45-50 min)	2	31, 72	339	Y	Y
90827	Interactive Individual Psychotherapy-Facility Based (45-50 min) med management	2	31, 72	339	Y	Y
90828	Interactive Individual Psychotherapy-Facility Based (75-80 min)	2	31, 72	339	Y	Y
90829	Interactive Individual Psychotherapy-Facility Based (75-80 min) med management	2	31, 72	339	Y	Y
90846	Family Psychotherapy (without the patient present)	2	31, 72	339	Y	Y
90847	Family Psychotherapy (conjoint)	2	31, 72	339	Y	Y
90849	Multi-family group psychotherapy	2	31, 72	339	Y	Y
90853	Group Psychotherapy	2	31, 72	339	Y	Y
90857	Interactive Group psychotherapy	2	31, 72	339	Y	Y
90862	Pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	2	31, 72	339	Y	Y
90865	Narcosynthesis for Psychiatric Diagnostic and Therapeutic purposes	2	31, 72	339	Y	Y
90870	Electroconvulsive therapy (including necessary	2	31, 72	339	Y	Y
90875	Individual psychophysiological therapy incorporating biofeedback training (20-30 min)	2	31, 72	339	Y	Y
90876	Individual psychophysiological therapy incorporating biofeedback training (45-50 min)	2	31, 72	339	Y	Y
90880	Hypnotherapy	2	31, 72	339	Y	Y
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons.	2	31, 72	339	Y	Y
96101	Psychological testing, per hour	2	31, 72	339	Y	Y
96110	Developmental testing with report	2	31, 72	339	Y	Y
96111	Developmental testing, extended	2	31, 72	339	Y	Y
96118	Neuropsychological testing battery, per hour	2	31, 72	339	Y	Y
99201	Office or other outpatient visit, 10 minutes, new patient	2	31, 72	339	Y	Y
99202	Office or other outpatient visit, 20 minutes, new patient	2	31, 72	339	Y	Y
99203	Office or other outpatient visit, 30 minutes, new patient	2	31, 72	339	Y	Y
99204	Office or other outpatient visit, 45 minutes, new patient	2	31, 72	339	Y	Y
99205	Office or other outpatient visit, 60 minutes, new patient	2	31, 72	339	Y	Y
99211	Office or other outpatient visit, 5 minutes, established patient	2	31, 72	339	Y	Y
99212	Office or other outpatient visit, 10 minutes, established patient	2	31, 72	339	Y	Y

99213	Office or other outpatient visit, 15 minutes, established patient	2	31, 72	339	Y	Y
99214	Office or other outpatient visit, 25 minutes, established patient	2	31, 72	339	Y	Y
99215	Office or other outpatient visit, 40 minutes, established patient	2	31, 72	339	Y	Y
99217	Observation care discharge	2	31, 72	339	Y	Y
99218	Initial observation care, low severity	2	31, 72	339	Y	Y
99219	Initial observation care, moderate severity	2	31, 72	339	Y	Y
99220	Initial observation care, high severity	2	31, 72	339	Y	Y
99221	Inpatient hospital care, 30 minutes	2	31, 72	339	Y	Y
99222	Inpatient hospital care, 50 minutes	2	31, 72	339	Y	Y
99223	Inpatient hospital care, 70 minutes	2	31, 72	339	Y	Y
99231	Subsequent hospital care, 15 minutes	2	31, 72	339	Y	Y
99232	Subsequent hospital care, 25 minutes	2	31, 72	339	Y	Y
99233	Subsequent hospital care, 35 minutes	2	31, 72	339	Y	Y
99234	Observation of inpatient hospital care, low severity	2	31, 72	339	Y	Y
99235	Observation of inpatient hospital care, moderate severity	2	31, 72	339	Y	Y
99236	Observation of inpatient hospital care, high severity	2	31, 72	339	Y	Y
99238	Hospital discharge day management 30 minutes or less	2	31, 72	339	Y	Y
99239	Hospital discharge day management more than 30 minutes	2	31, 72	339	Y	Y
99241	Office consultation for a new or established patient, approximately 15 minutes	2	31, 72	339	Y	Y
99242	Office consultation for a new or established patient, approximately 30 minutes	2	31, 72	339	Y	Y
99243	Office consultation for a new or established patient, approximately 40 minutes	2	31, 72	339	Y	Y
99244	Office consultation for a new or established patient, approximately 60 minutes	2	31, 72	339	Y	Y
99245	Office consultation for a new or established patient, approximately 80 minutes	2	31, 72	339	Y	Y
99251	Initial inpatient consultation, 20 minutes	2	31, 72	339	Y	Y
99252	Initial inpatient consultation, 40 minutes	2	31, 72	339	Y	Y
99253	Initial inpatient consultation, 55 minutes	2	31, 72	339	Y	Y
99254	Initial inpatient consultation, 80 minutes	2	31, 72	339	Y	Y
99255	Initial inpatient consultation, 110 minutes	2	31, 72	339	Y	Y
99271	Confirmatory consultation, limited or minor	2	31, 72	339	Y	Y
99272	Confirmatory consultation, low severity	2	31, 72	339	Y	Y
99273	Confirmatory consultation, moderate severity	2	31, 72	339	Y	Y
99274	Confirmatory consultation, moderate to high severity	2	31, 72	339	Y	Y
99275	Confirmatory consultation, high severity	2	31, 72	339	Y	Y
99281	Emergency department visit, minor severity	2	31, 72	339	Y	Y
99282	Emergency department visit, low to moderate severity	2	31, 72	339	Y	Y
99283	Emergency department visit, moderate severity	2	31, 72	339	Y	Y
99284	Emergency department visit, high severity	2	31, 72	339	Y	Y
99285	Emergency department visit, high severity with significant threat	2	31, 72	339	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	3	31, 72	339	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	3	31, 72	339	Y	Y
J0515	Injection, Benzotropine Mesylate, per 1mg	2	31, 72	339	Y	Y
J0735	Injection, Clonidine Hydrochlorine (HCL), 1mg/Injection	2	31, 72	339	Y	Y
J0780	Injection, Prochlorperazine, up to 10 mg	2	31, 72	339	Y	Y
J1200	Injection, Diphenhydramine HCL, up to 50 mg	2	31, 72	339	Y	Y
J1320	Injection, Amitryptyline HCL, up to 20 mg	2	31, 72	339	Y	Y
J1630	Injection, Haloperidol, up to 5 mg	2	31, 72	339	Y	Y
J1631	Injection, Haloperidol decanoate, per 50 mg	2	31, 72	339	Y	Y
J1990	Injection, Chlordiasepoxide HCL, up to 100 mg	2	31, 72	339	Y	Y
J2060	Injection, Lorazepam, 2 mg	2	31, 72	339	Y	Y
J2680	Injection, Fluphenazine decanoate, up to 25 mg	2	31, 72	339	Y	Y
J2794	Injection, Risperidone, long acting, 0.5 mg	2	31, 72	339	Y	Y

J3230	Injection, Chlorpromazine HCL, up to 50 mg	2	31, 72	339	Y	Y
J3310	Injection, Perphenazine, up to 5 mg	2	31, 72	339	Y	Y
J3410	Injection, Hydroxyzine HCL, up to 25 mg	2	31, 72	339	Y	Y
J3411	Injection, Thiamine HCL, 100 mg	2	31, 72	339	Y	Y
J3486	Injection, Ziprasidone Mesylate, 10 mg	2	31, 72	339	Y	Y
M0064	Brief office visit for the sole purpose of monitoring or changing prescriptions used in the treatment of mental psychoneurotic or personality disorders	4	31, 72	339	Y	Y
T1016	Case Management - Coordination of health care services - each 15 min.	2	31, 72	339	Y	Y
All others		4	N/A	N/A	Y	Y
Code	**Psychiatric APRN**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Diagnostic Interview	2	09, 70	339	Y	Y
90802	Interactive Diagnostic Interview	2	09, 70	339	Y	Y
90804	Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	09, 70	339	Y	Y
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	09, 70	339	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	09, 70	339	Y	Y
90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	09, 70	339	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	09, 70	339	Y	Y
90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	09, 70	339	Y	Y
90810	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	09, 70	339	Y	Y
90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	09, 70	339	Y	Y
90812	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	09, 70	339	Y	Y
90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	2	09, 70	339	Y	Y
90814	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	09, 70	339	Y	Y
90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	2	09, 70	339	Y	Y
90816	Individual Psychotherapy-Facility Based (20-30 min)	2	09, 70	339	Y	Y
90817	90816 with medical evaluation and management	2	09, 70	339	Y	Y
90818	Individual psychotherapy, insight oriented 45-50 minutes	2	09, 70	339	Y	Y
90819	90818 with medical evaluation and management	2	09, 70	339	Y	Y
90821	Individual Psychotherapy-Facility Based (75-80 min)	2	09, 70	339	Y	Y
90822	Individual Psychotherapy-Facility Based (75-80 min) with med management	2	09, 70	339	Y	Y
90823	Interactive Individual Psychotherapy-Facility Based (20-30 min)	2	09, 70	339	Y	Y
90824	Interactive Individual Psychotherapy-Facility Based (20-30 min) med management	2	09, 70	339	Y	Y
90826	Interactive Individual Psychotherapy-Facility Based (45-50 min)	2	09, 70	339	Y	Y
90827	Interactive Individual Psychotherapy-Facility Based (45-50 min) med management	2	09, 70	339	Y	Y
90828	Interactive Individual Psychotherapy-Facility Based (75-80 min)	2	09, 70	339	Y	Y
90829	Interactive Individual Psychotherapy-Facility Based (75-80 min) med management	2	09, 70	339	Y	Y
90846	Family Psychotherapy (without the patient present)	2	09, 70	339	Y	Y

90847	Family Psychotherapy (conjoint)	2	09, 70	339	Y	Y
90849	Multi-family group psychotherapy	2	09, 70	339	Y	Y
90853	Group Psychotherapy	2	09, 70	339	Y	Y
90857	Interactive Group psychotherapy	2	09, 70	339	Y	Y
90862	Pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	2	09, 70	339	Y	Y
90865	Narcosynthesis for Psychiatric Diagnostic and Therapeutic purposes	2	09, 70	339	Y	Y
90870	Electroconvulsive therapy (including necessary monitoring); single seizure	2	09, 70	339	Y	Y
90875	Individual psychophysiological therapy incorporating biofeedback training (20-30 min)	2	09, 70	339	Y	Y
90876	Individual psychophysiological therapy incorporating biofeedback training (45-50 min)	2	09, 70	339	Y	Y
90880	Hypnotherapy	2	09, 70	339	Y	Y
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons.	2	09, 70	339	Y	Y
96101	Psychological testing, per hour	2	09, 70	339	Y	Y
96110	Developmental testing with report	2	09, 70	339	Y	Y
96111	Developmental testing, extended	2	09, 70	339	Y	Y
96118	Neuropsychological testing battery, per hour	2	09, 70	339	Y	Y
99201	Office or other outpatient visit, 10 minutes, new patient	2	09, 70	339	Y	Y
99202	Office or other outpatient visit, 20 minutes, new patient	2	09, 70	339	Y	Y
99203	Office or other outpatient visit, 30 minutes, new patient	2	09, 70	339	Y	Y
99204	Office or other outpatient visit, 45 minutes, new patient	2	09, 70	339	Y	Y
99205	Office or other outpatient visit, 60 minutes, new patient	2	09, 70	339	Y	Y
99211	Office or other outpatient visit, 5 minutes, established patient	2	09, 70	339	Y	Y
99212	Office or other outpatient visit, 10 minutes, established patient	2	09, 70	339	Y	Y
99213	Office or other outpatient visit, 15 minutes, established patient	2	09, 70	339	Y	Y
99214	Office or other outpatient visit, 25 minutes, established patient	2	09, 70	339	Y	Y
99215	Office or other outpatient visit, 40 minutes, established patient	2	09, 70	339	Y	Y
99217	Observation care discharge	2	09, 70	339	Y	Y
99218	Initial observation care, low severity	2	09, 70	339	Y	Y
99219	Initial observation care, moderate severity	2	09, 70	339	Y	Y
99220	Initial observation care, high severity	2	09, 70	339	Y	Y
99221	Inpatient hospital care, 30 minutes	2	09, 70	339	Y	Y
99222	Inpatient hospital care, 50 minutes	2	09, 70	339	Y	Y
99223	Inpatient hospital care, 70 minutes	2	09, 70	339	Y	Y
99231	Subsequent hospital care, 15 minutes	2	09, 70	339	Y	Y
99232	Subsequent hospital care, 25 minutes	2	09, 70	339	Y	Y
99233	Subsequent hospital care, 35 minutes	2	09, 70	339	Y	Y
99234	Observation of inpatient hospital care, low severity	2	09, 70	339	Y	Y
99235	Observation of inpatient hospital care, moderate severity	2	09, 70	339	Y	Y
99236	Observation of inpatient hospital care, high severity	2	09, 70	339	Y	Y
99238	Hospital discharge day management 30 minutes or less	2	09, 70	339	Y	Y
99239	Hospital discharge day management more than 30 minutes	2	09, 70	339	Y	Y
99241	Office consultation for a new or established patient, approximately 15 minutes	2	09, 70	339	Y	Y
99242	Office consultation for a new or established patient, approximately 30 minutes	2	09, 70	339	Y	Y
99243	Office consultation for a new or established patient, approximately 40 minutes	2	09, 70	339	Y	Y

99244	Office consultation for a new or established patient, approximately 60 minutes	2	09, 70	339	Y	Y
99245	Office consultation for a new or established patient, approximately 80 minutes	2	09, 70	339	Y	Y
99251	Initial inpatient consultation, 20 minutes	2	09, 70	339	Y	Y
99252	Initial inpatient consultation, 40 minutes	2	09, 70	339	Y	Y
99253	Initial inpatient consultation, 55 minutes	2	09, 70	339	Y	Y
99254	Initial inpatient consultation, 80 minutes	2	09, 70	339	Y	Y
99255	Initial inpatient consultation, 110 minutes	2	09, 70	339	Y	Y
99271	Confirmatory consultation, limited or minor	2	09, 70	339	Y	Y
99272	Confirmatory consultation, low severity	2	09, 70	339	Y	Y
99273	Confirmatory consultation, moderate severity	2	09, 70	339	Y	Y
99274	Confirmatory consultation, moderate to high severity	2	09, 70	339	Y	Y
99275	Confirmatory consultation, high severity	2	09, 70	339	Y	Y
99281	Emergency department visit, minor severity	2	09, 70	339	Y	Y
99282	Emergency department visit, low to moderate severity	2	09, 70	339	Y	Y
99283	Emergency department visit, moderate severity	2	09, 70	339	Y	Y
99284	Emergency department visit, high severity	2	09, 70	339	Y	Y
99285	Emergency department visit, high severity with significant threat	2	09, 70	339	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	3	09, 70	339	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	3	09, 70	339	Y	Y
J0515	Injection, Benzotropine Mesylate, per 1mg	2	09, 70	339	Y	Y
J0735	Injection, Clonidine Hydrochlorine (HCL), 1mg/Injection	2	09, 70	339	Y	Y
J0780	Injection, Prochlorperazine, up to 10 mg	2	09, 70	339	Y	Y
J1200	Injection, Diphenhydramine HCL, up to 50 mg	2	09, 70	339	Y	Y
J1320	Injection, Amitryptyline HCL, up to 20 mg	2	09, 70	339	Y	Y
J1630	Injection, Haloperidol, up to 5 mg	2	09, 70	339	Y	Y
J1631	Injection, Haloperidol decanoate, per 50 mg	2	09, 70	339	Y	Y
J1990	Injection, Chlordiasepoxide HCL, up to 100 mg	2	09, 70	339	Y	Y
J2060	Injection, Lorazepam, 2 mg	2	09, 70	339	Y	Y
J2680	Injection, Fluphenazine decanoate, up to 25 mg	2	09, 70	339	Y	Y
J2794	Injection, Risperidone, long acting, 0.5 mg	2	09, 70	339	Y	Y
J3230	Injection, Chlorpromazine HCL, up to 50 mg	2	09, 70	339	Y	Y
J3310	Injection, Perphenazine, up to 5 mg	2	09, 70	339	Y	Y
J3410	Injection, Hydroxyzine HCL, up to 25 mg	2	09, 70	339	Y	Y
J3411	Injection, Thiamine HCL, 100 mg	2	09, 70	339	Y	Y
J3486	Injection, Ziprasidone Mesylate, 10 mg	2	09, 70	339	Y	Y
M0064	Brief office visit for the sole purpose of monitoring or changing prescriptions used in the treatment of mental psychoneurotic or personality disorders	4	09, 70	339	Y	Y
T1016	Case Management - Coordination of health care services - each 15 min.	2	09, 70	339	Y	Y
All others		4	N/A	N/A	Y	Y
Code	**Psychologist and Psychologist Group**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		**(Limited to Medicare Crossover claims or clients under 21 years of age)**
90801	Diagnostic Interview	2	33, 86	112	Y	Y
90802	Interactive Diagnostic Interview	2	33, 86	112	Y	Y
90804	Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	33, 86	112	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	33, 86	112	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	33, 86	112	Y	Y
90810	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	33, 86	112	Y	Y

90812	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	33, 86	112	Y	Y
90814	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	33, 86	112	Y	Y
90816	Individual Psychotherapy-Facility Based (20-30 min)	2	33, 86	112	Y	Y
90818	Individual psychotherapy, insight oriented 45-50 minutes	2	33, 86	112	Y	Y
90821	Individual Psychotherapy-Facility Based (75-80 min)	2	33, 86	112	Y	Y
90823	Interactive Individual Psychotherapy-Facility Based (20-30 min)	2	33, 86	112	Y	Y
90826	Interactive Individual Psychotherapy-Facility Based (45-50 min)	2	33, 86	112	Y	Y
90828	Interactive Individual Psychotherapy-Facility Based (75-80 min)	2	33, 86	112	Y	Y
90846	Family Psychotherapy (without the patient present)	2	33, 86	112	Y	Y
90847	Family Psychotherapy (conjoint)	2	33, 86	112	Y	Y
90849	Multi-family group psychotherapy	2	33, 86	112	Y	Y
90853	Group Psychotherapy	2	33, 86	112	Y	Y
90857	Interactive Group psychotherapy	2	33, 86	112	Y	Y
90875	Individual psychophysiological therapy incorporating biofeedback training (20-30 min)	2	33, 86	112	Y	Y
90876	Individual psychophysiological therapy incorporating biofeedback training (45-50 min)	2	33, 86	112	Y	Y
90880	Hypnotherapy	2	33, 86	112	Y	Y
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons. .	2	33, 86	112	Y	Y
96101	Psychological testing, per hour	2	33, 86	112	Y	Y
96105	Assessment of Aphasia (Includes assessment of expressive and receptive language function. . .) with interpretation and report, per hour	2	33, 86	112	Y	Y
96110	Developmental testing with report	2	33, 86	112	Y	Y
96111	Developmental testing, extended	2	33, 86	112	Y	Y
96118	Neuropsychological testing battery, per hour	2	33, 86	112	Y	Y
99406	Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes (pregnant women only)	2	33, 86	112	Y	Y
99407	Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes (pregnant women only)	2	33, 86	112	Y	Y
T1016	Case Management - Coordination of health care services - each 15 min.	2	33, 86	112	Y	Y
Code	**Independent Practice Behavioral Health Professional (LCSW, LMFT, LPC, LADC)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		**(Limited to Medicare Crossover claims or clients under 21 years of age)**
90801	Diagnostic Interview	2	33, 86	115,119,118,121	Y	Y
90802	Interactive Diagnostic Interview	2	33, 86	115,119,118,121	Y	Y
90804	Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	33, 86	115,119,118,121	Y	Y
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	33, 86	115,119,118,121	Y	Y
90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	33, 86	115,119,118,121	Y	Y
90810	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min)	2	33, 86	115,119,118,121	Y	Y
90812	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	33, 86	115,119,118,121	Y	Y
90814	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min)	2	33, 86	115,119,118,121	Y	Y
90816	Individual Psychotherapy-Facility Based (20-30 min)	2	33, 86	115,119,118,121	Y	Y

90818	Individual psychotherapy, insight oriented 45-50 minutes	2	33, 86	115,119,118,121	Y	Y
90821	Individual Psychotherapy-Facility Based (75-80 min)	2	33, 86	115,119,118,121	Y	Y
90823	Interactive Individual Psychotherapy-Facility Based (20-30 min)	2	33, 86	115,119,118,121	Y	Y
90826	Interactive Individual Psychotherapy-Facility Based (45-50 min)	2	33, 86	115,119,118,121	Y	Y
90828	Interactive Individual Psychotherapy-Facility Based (75-80 min)	2	33, 86	115,119,118,121	Y	Y
90846	Family Psychotherapy (without the patient present)	2	33, 86	115,119,118,121	Y	Y
90847	Family Psychotherapy (conjoint)	2	33, 86	115,119,118,121	Y	Y
90849	Multi-family group psychotherapy	2	33, 86	115,119,118,121	Y	Y
90853	Group Psychotherapy	2	33, 86	115,119,118,121	Y	Y
90857	Interactive Group psychotherapy	2	33, 86	115,119,118,121	Y	Y
90875	Individual psychophysiological therapy incorporating biofeedback training (20-30 min)	2	33, 86	115,119,118,121	Y	Y
90876	Individual psychophysiological therapy incorporating biofeedback training (45-50 min)	2	33, 86	115,119,118,121	Y	Y
90880	Hypnotherapy	2	33, 86	115,119,118,121	Y	Y
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or other responsible persons.	2	33, 86	115,119,118,121	Y	Y
96110	Developmental testing with report	2	33, 86	115,119,118,121	Y	Y
96111	Developmental testing, extended	2	33, 86	115,119,118,121	Y	Y
T1016	Case Management - Coordination of health care services - each 15 min.	2	33, 86	115,119,118,121	Y	Y
Code	**Home Health Care Agencies***	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
RCC/HCPC						
421	Physical Therapy	1	N/A	N/A	Y	Y
424	Physical Therapy Evaluation	1	N/A	N/A	Y	Y
431	Occupational Therapy	1	N/A	N/A	Y	Y
434	Occupational Therapy Evaluation	1	N/A	N/A	Y	Y
441	Speech Therapy	1	N/A	N/A	Y	Y
444	Speech Therapy Evaluation	1	N/A	N/A	Y	Y
570/T1004	Services of a qualified nursing aide, up to 15 minutes	3	05	050	Y	Y
580/S9123	Nursing care, in the home by an RN, per hour	3	05	050	Y	Y
580/S9124	Nursing Care, in the home by an LPN, per hour	3	05	050	Y	Y
580/T1001	Nursing Assessment/Evaluation	3	05	050	Y	Y
580/T1002	RN Services, up to 15 minutes	3	05	050	Y	Y
580/T1003	LPN/LVN services, up to 15 minutes	3	05	050	Y	Y
580/T1502	Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit	3	05	050	Y	Y
	*BHP covers home health services for children with autism including when autism is co-morbid with mental retardation.					
Code	**DMHAS Targeted Case Management****	**Coverage**	**Provider**	**Provider**		
T2023	Targeted Case Management; per month	2*	53	530	Y	Y
	* Coverage restricted to providers certified by DMHAS to provide this					
	**Private providers non-cash claims; DMHAS payment for public TCM providers addressed under separate IGT agreement.					
Code	**Independent Occupational Therapist**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
All codes		1	N/A	N/A	Y	Y
Code	**Independent Physical Therapist**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
All codes		1	N/A	N/A	Y	Y

Code	Medical Transportation	Coverage	Provider Type(s)	Provider Specialty, Specialties		
All codes		1	N/A	N/A	Y	Y
Code	**Emergency Medical Transportation**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
All codes		1	N/A	N/A	Y	Y
Code	**Independent Laboratory Services**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
All codes		1	28	280	Y	Y
Code	**Hospital Laboratory Services**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
RCC = 300,301,305,307 or 309 with one of the following HCPC						
All codes		1	01	007	Y	Y
Code	**Pharmacy**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
All codes		1	N/A	N/A	Y	Y
Code	**Other Community Services (Clients under 21 only)**	**Coverage**	**Provider Type(s)**	**Provider Specialty, Specialties**		
90801	Psychiatric Diagnostic Interview	2	12	585	Y	N
90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	2	12	585	Y	N
90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	2	12	585	Y	N
90846	Family Psychotherapy (without the patient present)	2	12	585	Y	N
90847	Family Psychotherapy (conjoint)	2	12	585	Y	N
H2017	Psychosocial Rehabilitation services, per 15 minutes	2***	12	585	Y	N
H2019	Therapeutic Behavioral Services, per 15 minutes (IICAPS, MST, MDFT, FFT, FST, HBV)	2***	12	585	Y	N
H2032	Activity Therapy, per 15 minutes (Therapeutic Mentoring/Behavioral Management Service)	2***	N/A	N/A	Y	N
S9484	Emergency mobile mental health service, follow-up	2	12	585	Y	N
S9485	Emergency mobile mental health service, initial evaluation)	2	12	585	Y	N
T1016	Case Management - Coordination of health care services - each 15 min.	2	12	585	Y	N
T1017	Case management - home/community, each 15 minutes (part of home-based services only - IICAPS, MST, MDFT, FFT, FST, HVS)	2***	12	585	Y	N
	***Coverage restricted to providers certified by DCF to provide this service					
	****Coverage restricted to providers licensed by DCF to provide this service					

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					Dashboard Report							
Summary	**1. Dashboard Report**	Report for senior management of Departments summarizing across all required reports all key trends, issues, or achievements that management should address or consider.	N/A	A	M (20 days)	M	N/A	N/A	N/A	In production		
					Call Management							
	1. Timeliness of Telephone Access	**Note: All call management reporting elements will be based on clinical queues, customer service queues and crisis queues.**										
Call Mgmt.	**1.A. Total Number of Calls**	Total number of calls received by clinical queues, customer service queues, and crisis queue in the identified reporting time frame.	T	1	Q = Q, Y	QY*	N/A	N/A	N/A	In production	C	
Call Mgmt.	**1.B. Average Speed of Answer (ASA)**	Average number of seconds to answer all calls with a live person coming into the call center including after hours calls and authorization lines, measured by the selection of a menu option (e.g.crisis queue).	T	1	Q = Q, Y	QY*	30 seconds - clinical and customer service queues. 15 Seconds - Crisis queue.	Performance Standard	$1,000/QT	In production	C	
Call Mgmt.	**1.C. Call Abandonment Rate (CAR)**	Total number and percentage of calls abandoned coming into the call center including after hours calls. Measured by each hour of the day and average for the month.	T	1	Q = Q, Y	QY*	5%	Performance Standard	$5,000/QT	In production	C	
Call Mgmt.	**1. D. Calls Answered with in 30 Seconds**	Total number and the percentage of calls coming into the call center answered within 30 seconds.	T	1	Q = Q, Y	QY*	90%	Performance Standard	$5,000/QT	In production	C	
Call Mgmt.	**1. E. Busy No Answer**	Total number of telephone calls and percentage of calls that reached a busy signal when calling into the call center.	T	1	Q = Q, Y	QY*	Monitoring Indicator	N/A	N/A	In production	C	
Call Mgmt.	**1. F. Number and Percentage of calls placed on hold and average length of time on hold for Clinical Services.**	Total number of telephone calls placed on hold and average length of time on hold.	T	1	Q = Q, Y	QY*	5 minutes	Performance Standard	$5,000/QT	In production		

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Call Mgmt.	**1. G. Number and Percentage of calls placed on hold and average length of time on hold for Customer Services.**	Total number of telephone calls placed on hold and average length of time on hold.	T	1	Q = Q, Y	QY*	3 minutes; 1 minute for crisis calls	Performance Standard	$5,000/QT	In production		
Call Mgmt.	**1. H. Average length of time of call.**	Average length of time of call.	T	1	Q = Q, Y	QY*	N/A	N/A	N/A	In production		
Call Mgmt.	**1. I. Network Call Rerouting (NCR) Report**	Report that documents each rerouting incident (including AVR transferred crisis calls) the answer time and the associated reason.	T	1	Q = Q, Y	QY*	N/A	N/A	N/A	In production		
					Utilization Management							
UM	**2. Timeliness of UM Decision Making (includes telephonic and online)**											
UM	**2.A. Higher Levels of Care Timeliness Summary for Initial Auths - With & Without Peer Review**	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. (Without Peer Reveiw - 60 minutes: Psych IP , General IP, IP Detox, Obs Beds, PRTF, PHP/Day Tx, and IOP. With Peer Review - 120 minutes: Psych IP, General IP; 180 minutes: IP detox; 1 business day: PHP, IOP, PRTF, and Crisis Stabilization)	T	1	Q = M, Q	QM*	95% of decisions communicated within designated timeframe	Performance Standard	$6,000/QT	In production		
UM	**2.B. Lower Levels of care Timeliness Summary for Initial Auths -With and Without peer Review.**	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. (Without Peer Reveiw - 1business day. With Peer Review - 1 business day)	T	1	Q = M, Q	QM*	95% of decisions communicated within designated timeframe	Performance Standard	$6,000/QT	In production		

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UM	**2.C. Higher levels of Care Timeliness Report for Concurrent Reviews - With and Without Peer Review**	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. (Without Peer Reveiw - 60 minutes: Psych IP , General IP, IP Detox, Res Detox, PHP, and IOP; 2 business days: Crisis Stabilization. With Peer Review - 1 business day: Psych IP, General IP, IP detox, Res Detox; 2 business day: PHP, IOP, PRTF, and Crisis Stabilization)	T	1	Q = M, Q	QM*	95% of decisions communicated within designated timeframe	Performance Standard	$6,000/QT	In production		
UM	**2.D. Lower levels of Care Timeliness Report for Concurrent Reviews - With and Without Peer Review**	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. (Without Peer Reveiw - 2 business day. With Peer Review -2 business day)	T	1	Q = M, Q	QM*	95% of decisions communicated within designated timeframe	Performance Standard	$6,000/QT	In production		
UM	**3.A Timeliness of UM Decision Written Notification - Authorization letter extract**	Summary report that identifies the timeliness of UM Decision Written Notification. 3.A summarizes authorization notification extract validity and completeness, i.e., the percentage of authorization records that resulted in an appropriate notification record on the authorization notification extract. (See contract language)	T	1	Q = M, Q, Y	MQY	98% of all authorization decisions result in an appropriate notification contained in an authorization notification extract	Performance Standard	$3,000/QT for first two quarters of the contract then $1,500/QT	In production		
UM	**4.A. 1 Utilization Statistics Ages 0-21**	Utilization statistics reported for all levels of care based on authorizations and reported uniquely for adult and child services by unique users and total number of admission/starts, admits/starts/1000, days/visits/1000, average length of stay (ALOS) and median length of stay .	D	A	Q = M, Q, Y	D		N/A	N/A	In production	C	
	4.A.2	Monthly auth-based utilization statistics by LOC with summary. Includes admissions, admissions/1000 member months, days/1000 member months, and average and Median LOS. Each program will be reported in a separate report.	C	2.4	Q = M, Q, Y	MQY*				In production		

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	4.A.3	Monthly auth-based utilization statistics by LOC, broken down by Area and child vs. adult. Includes admissions, admissions/1000 member months, days/1000 member months, and average and Median LOS	C, L	TBD	Q, Y	QY				To be produced on-demand rather than on a fixed schedule		
UM	**4.B. Utilization Statistics by treatment type and level of care by authorizations**	Utilization statistics reported for all levels of care based on authorizations and reported uniquely for adult and child services by unique users and total number of admission/starts, admits/starts/1000, days/visits/1000, average length of stay (ALOS).	B, C, G, R	TBD	BI		N/A	N/A	N/A	To be produced on-demand rather than on a fixed schedule		
UM	**4.C. Utilization Statistics by treatment type and level of care by claims paid**	Utilization statistics will be reported for all levels of care based on claims paid and reported uniquely for adult and child services by unique users and total number of admission/starts, admits/starts/1000, discharges/1000 (IP and residential only), days/visits/1000, average length of stay (ALOS).	A, C, D, L	TBD	Q = M, Q, Y	TBD	Monitoring Indicator	N/A	N/A	Currently suspended	C	
UM	**4.D. Utilization Statistics by treatment type and level of care by claims paid**	(Same as above)	B, C, G, R	TBD	BI	TBD	N/A	N/A	N/A	Currently suspended		
UM	**4.E. Utilization Statistics - Emergency Department**	See Exhibit A	C	See Exxhibit A	A	See Exhibit A	See Exhibit A	Performance Target	See Exhibit A	In production		
UM	**5. High Volume Provider Reports**	**Note: All High Volume Provider Reports generated monthly will include the top 10 providers and be based on authorizations. The quarterly and annual report will include all providers with a year to date column and be based on claims paid during that period.**		TBD		TBD	N/A	N/A	N/A	To be produced on-demand rather than on a fixed schedule		
UM	**5.A Acute Inpatient Provider Report**	List the facilities for each reporting period by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Adult report only.	C, L	4	Q = M, Q, Y A	QY*	Monitoring Indicator	N/A	N/A	New Report		

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UM	**5.B. Top Residential High Volume Provider Report**	List the top 10 facilities for each reporting period by total number of admissions (cases), by approved number of days authorized, and average number of approved days per case.	L	TBD	Q = M, Q, Y A	TBD	Monitoring Indicator	N/A	N/A	To be produced on-demand rather than on a fixed schedule		
UM	**5.C. Partial Hospital Program (PHP) High Volume Provider Report**	List the top 10 facilities for each reporting period by total number of admissions (cases), by approved number of days authorized, and average number of approved days per case.	C, L	TBD	Q = M, Q, Y A	TBD	Monitoring Indicator	N/A	N/A	To be produced on-demand rather than on a fixed schedule		
UM	**5.D. Intensive Outpatient Program (IOP) High Volume Provider Report**	List the top 10 facilities for each reporting period by total number of starts (cases), by approved number of units authorized, and average number of approved units per case.	C, L	TBD	Q = M, Q, Y A	TBD	Monitoring Indicator	N/A	N/A	To be produced on-demand rather than on a fixed schedule		
UM	**5.E. Top Outpatient Providers High Volume Provider Report**	List the top 25 facilities for each reporting period by total number of starts (cases), by approved number of units authorized, and average number of approved units per case.	C, L	TBD	Q = M, Q, Y A	TBD	Monitoring Indicator	N/A	N/A	To be produced on-demand rather than on a fixed schedule	C	
UM	**6. Consistency of UM Decision Making among Contractor Staff**	Include total number of clinical staff being tested (including all psychiatrists making medical necessity decisions) and test score percentage. To report pass/fail, not specific scores.	N/A	TBD	Q	TBD	Monitoring Indicator	N/A	N/A	To be produced on-demand rather than on a fixed schedule	C	
UM	**7. Concurrent Authorization Report**	Analysis of level of care for simultaneous authorizations to other levels of care by provider and member denoting those individuals who have been identified for ICM.	C, D, L, P	TBD	M	TBD	NA	NA	NA	To be produced on-demand rather than on a fixed schedule		
UM	**8.A. High Utilizer/ Rapid Recidivist Summary**	Authorization report by member name, demographics and program for a 6 month period of time with 4 or more admits to the same or different levels of care. The contractor shall have the capability to modify criteria with the approval of the Departments.	T	2	M	M	NA	NA	NA	New Report		
UM	**8.B. High Utilizer Statistics**	Number of high utilizers, percentage of users that are high utilizers, and high utilizers/1000	A, B, C, D, L	TBD	Q = M, Q, Y	TBD	Monitoring indicator first year	TBD	TBD	To be produced on-demand rather than on a fixed schedule		
UM	**9. Summary of Admissions Report**	A summary of admissions by high utlizers of all levels of care.	B, C, D, L, P	TBD	M	TBD	NA	NA	NA	To be produced on-demand rather than on a fixed schedule		

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UM	**10A. Inpatient and Residential Current Daily Census Report**	A listing of all members in 24-hour care, indicating status and reason for delay. The electronic report shall be sortable by: name, ID, facility, facility type, local area, MCO, date of admission, length of stay, DX, DCF identifier, gender, race/ethnicity, provider, and program ID. This is a Census Report.		A	D	D	N/A	N/A	N/A	In production		
UM	**10.B.1. Facility Census Analysis Report**	Quarterly report showing statistics about members in care during the quarter, by service class and provider. Includes members who were discharged during the quarter or were still in care at the end of the quarter. Total Days in Care reflects the days of care provided during an entire episode of care, not just those occurring during the quarter. Every service class is eligible for the report.		2, 4	Q	Q	N/A	N/A	N/A	In production		
UM	**10.B.2**	Quarterly report showing statistics (e.g., total days in delay status, number of members in delay status, average days in delay status) about occurrences of discharge delays by service class and provider. Includes only those members who received service for IPD, IPF, IPM, residential detoxification, PRTF, Mental Health Group Home, or RTC at any time during the quarter, and were discharged during the quarter, and were discharged during the quarter or still in care at the end of the quarter. Occurrences of reason code 36 ("Not Applicable") are ignored.	T	2, 4	Q	Q	N/A	N/A	N/A	In production		
UM	**10.B.3.A, B, and C**	Quarterly report showing statistics (e.g., number of individuals in delay status, total days in delay status, average days in delay status, range of days in delay status) about occurrences of discharge delays by service class and provider. Includes only those members who received service for (3.A) IPD, IPF, IPM, (3.B) residential detoxification, or (3.D)Mental Health Group Home at any time during the quarter, and were discharged during the quarter, and were discharged during the quarter or still in care at the end of the quarter. Occurrences of reason code 36 ("Not Applicable") are ignored.	L	4	Q	Q	N/A	N/A	N/A	New Report		

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UM	10.B.4.A, B, C, and D	Quarterly report showing counts of occurrences of discharge delay reasons, by local area. Includes members who received service for (4A) IPF, (4B) PRT, (4C) RTC, and (4D) IPD, IMP and were discharged during the quarter or were still in care at the end of the quarter. Occurrences of reason code 36 ("Not Applicable") are ignored	L	3	Q	Q	N/A	N/A	N/A	In production		
UM	10.B.5	Report showing statistics about discharge delays which occurred during the quarter, by service class, for those adults in care. Includes only those members who received services, and were discharged during the quarter or were still in care at the end of the quarter.	T	4	Q	Q	N/A	N/A	N/A	New Report		
UM	10.B.6	Report showing statistics about discharge delays which occurred during the quarter, by service class, for those children who were in DCF custody. Includes only those members who received services, and were discharged during the quarter or were still in care at the end of the quarter. Occurrences of delay reason code 36 ("Not Applicable") are ignored	D	3	Q	Q	N/A	N/A	N/A	In production		
UM	10.B.7	Report showing statistics about discharge delays which occurred during the quarter, by service class. Includes only those members who received service for IPF, IPM, PRT, or RTC, and were discharged during the quarter or were still in care at the end of the quarter. IPF and IPM data are combined. Occurrences of reason code 36 ("Not Applicable") are ignored. For members age 0-18.		3	Q	Q	N/A	N/A	N/A	In production		
UM	10.B.8	Report showing statistics about discharge delays which occurred during the quarter, by service class broken out by local area. Includes only those members who received service for IPF, IPM, PRT, or RTC, and were discharged during the quarter or were still in care at the end of the quarter. IPF and IPM data are combined. Occurrences of reason code 36 ("Not Applicable") are ignored. For members age 0-18.		3	Q	Q	N/A	N/A	N/A	In production		
UM	11. ICM Actives	Report should include basic member demographics and contact info for ICM case manager.	T	2	M	M	N/A	N/A	N/A	In production		

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UM	**12. Treatment Timeliness and Connection Measures**											
UM	**12.A. Connect to Care**	Connect to Care means successful connection to aftercare following an episode of intensive non-inpatient (i.e., other than routine outpatient) service.	B, C, D, L	TBD	M Q = Q, Y	TBD	Monitoring indicator first year, then performance target	TBD	TBD	To be produced on-demand rather than on a fixed schedule		
UM	**12.B. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**	Description TBD	C, L	TBD	Q = M, Q, Y	TBD	Monitoring indicator first year, then performance target	TBD	TBD	Currently suspended		
UM	**12.C. ED Discharge Delay**	Members with delayed ED discharge (more than 12 hours), average length of stay of such members, reason for delay, and disposition; statewide and by hospital; using data compiled by Contractor in its daily survey of hospital EDs.	C	2, 4	M, Q	M	N/A	N/A	N/A	N/A		
UM	**12.D. Access Delay**	Report summarizing frequency of delay in access due to lack of availability of requested service by type of service.	A, C, D, L	TBD	Q	TBD	Monitoring indicator first year, then performance target	TBD	TBD	To be produced on-demand rather than on a fixed schedule		
UM	**13. Inpatient Follow-up**											

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UM	**13.A. 7 Day Follow-up Inpatient, PRTF, and Residential**	Receipt of a follow up visit within 7 days of discharge from an inpatient facility based on HEDIS but modified to include multiple levels of inpatient/residential care (acute general hospitals, acute psych hospitals, detox, and PRTFs) and expanded to include additional community services. Must report by race/ethnicity when requested. Separate reports for MH and SA. Inpatient and PRTF may be combined, Residential reported separately.	C, D, L	2	Q = M, Q, Y	M	Monitoring indicator first year, then performance target	TBD	TBD		S	
UM	**13.B. 30 Day follow-up Inpatient, PRTF and Residential**	Receipt of a follow up visit within 30 days of discharge from an inpatient facility based on HEDIS but modified to include multiple levels of inpatient/residential care (acute general hospitals, acute psych hospitals, detox, and PRTFs) and expanded to include additional community services. Must report by race/ethnicity when requested. Separate reports for MH and SA. Inpatient and PRTF may be combined, Residential reported separately.	C, D, L	2	BI	M	See Exhibit A, not to include Residential first or second year	Performance Target	See Exhibit A		S	
UM	**14. Readmission Report**	An authorization report that lists inpatient discharges subsequently readmitted to inpatient level of care within 30 days. Overnight passes shall not be treated as discharges. A sub-report lists the member demographics of in-patient discharges by facility.	C, D, L	2, 3, 4	Q = M, Q, Y	MQY	Monitoring Indicator	N/A	N/A	New Reort		
UM	**15. Use of PCP by BH Member**	TBD	A, C, L		Q, Y		Monitoring Indicator - 80%	TBD	TBD	TBD		
Notice of Action/Denials and Denials												

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NOA/ Denials	16.A.1. Total Number of NOAs and Denials issued	This report reflects the number of NOA's and Denials issued for lack of Medical Necessity or coverage within the designated reporting period. The report is broken by Adult/Child cases, and Levels of care based on the type of NOA/Denial issued. This version does not contain administrative.denials. Quarterly totals and YTD totals also include a count of NOAs/Denials per 1000.	C	2	Q, M	QM	NA	NA	NA	In production		
NOA/ Denials	16.B. Reduction Summary Report	Report will include all service requests that did not meet medical necessity requirements and for which authorization was provided for a reduced level of care. This report shall be broken out by level of care requested and the resulting level of care that was authorized.	A, C, L	2,4	W (IRR) Q = M, Q, Y	MQY*	N/A	N/A	N/A	Weekly for the first six months	Weekly for the first six months	
NOA/ Denials	16.A.2. Total Number of Administrative Denials issued	This report reflects the number of administrative Denials issued within the designated reporting period. The report is broken by Adult/Child cases, and Levels of care based on the type of Denial issued. This version contains only administrative denials. Quarterly totals and YTD totals also include a count of Denials per 1000.	C	2,4	Q, M	QM	NA	NA	NA	In production		
NOA/ Denials	17.A Percent and number of NOAs and Denials issued within 1 day.	Report consistent with attached template	A.,T	2,4	W (IRR) Q = M, Q, Y	MQY*	100% within one business day	Performance Standard	$2000/Q	Weekly for the first six months		
Quality Management												
QM	18. Accessibility of Behavioral Healthcare Services and Appointment wait times											

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QM	**18.A - Routine Outpatient Registration Dashboard**	Quartertly metrics on specific question selection on the Service Registration Form for only routine outpatient services (OTP). Selections are counted based on the beginning date of reqeusted services.	C, L, D	2	Q = M, Q, Y	MQY	Monitoring Indicator	TBD	TBD	In production		
QM	**18.B. Methadone Mainteneance Outpatient Registration Dashboard**	Quartertly metrics on specific question selection on the Service Registration Form for only methadone maintenacne outpatient services (MET). Selections are counted based on the beginning date of reqeusted services.	C, L, D	2	Q = M, Q, Y	MQY	Monitoring Indicator	TBD	TBD	In production	C	
QM	**18.C. Ambulatory Detox Outpatient Registration Dashboard**	Quartertly metrics on specific question selection on the Service Registration Form for only ambulatory detox outpatient services (AMD). Selections are counted based on the beginning date of reqeusted services.	C, L, D	2	Q = M, Q, Y	MQY	Monitoring Indicator	TBD	TBD	In production	C	
	18.D. Outpatient Registration (OTP) Timely Receipt of Evalutaions Dashboard - Non-ECC	Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures. Excluding ECCs.	C, L, D	2	Q = M, Q, Y	MQY	?	?	?	In production		

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	18.E -Outpatient Registration (OTP) Timely Receipt of Evalutaions Dashboard - ECC	Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining ECC compliance with Emergent/Urgent/Routine Access measures.	C, L, D	2	Q = M, Q, Y	MQY	?	?	?	In production		
QM	**18.F. ECC Access Standard Compliance Tracking**	Quarterly metrics for all outpatient services (OTP) provided by ECCs. Report broken out by individual ECC provider. Routine, Urgent and Emergent performance reported separately. Allows the determination of ECC compliance with Emergent/Urgent/Routine Access measures. Data on timeliness of initial evaluations for emergent, urgent and routine clients are measured through provider input into WEB-based registration system. ECC eligibility for exemption from	A, B, E	2	Q = Q,Y	QY	Monitoring Indicator	TBD	TBD	N/A		
	18.G. ECC Access Standard Compliance - Mystery Shopper Surveys	Enhanced Care Clinic Mystery Shopper Survey and Report – Contractor makes three to five telephone calls to each of five (5) randomly selected ECCs each quarter, with follow-up mystery shopper calls to low performing providers. Selections will be made from those ECC clinics that primarily serve adult MH and SA individuals. Survey will measure centralized point of access, no reject, as well quality and timing of screening and triage of new clients and other elements of ECC access	A,C,E	2	Q = Q,Y	QY	Monitoring Indicator	TBD	TBD	N/A		
QM	**19. Critical Incident Reporting**	Total number of cases and incident type. Broken out by provider, incident type, summary of incident, action taken and outcome of action.	C	2	Q = Q,Y	QY	Monitoring Indicator	N/A	N/A	In production	C	
QM	**20. Complaints: Responsiveness**											
	20.A-B Complaint Tracking Report by Status and Month and Total Number of Complaints Received by Quarter	Summarizes complaints received.	D, L	2	M	M	Monitoring Indicator	N/A	N/A	In production		
	20.C-D Complaints Meeting Turnaround Time (TAT) and Average Amount of Time to Resolve Complaints (in Days) by Quarter	Total number of provider and member complaints received and the percent that were responded to appropriately within 30 days or 45 days with an extension requested. Broken out by provider and member. Second part reflects average time taken to respond to complaints.	T	2	M	M	Performance Standard	90%	$1500/ Quarter	In production		

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	20.E. Complaints broken out by reason code.	Complaints received YTD by complaint reason and received month. Broken down by provider vs. member.	L	2	M	M						
QM	**21A. Member Satisfaction Survey - General Service Recipients**	See Exhibit A	A, C, L	See Exxhibit A	A	See Exhibit A	See Exhibit A	Performance Target	See Exhibit A		C	
QM	**21B. Member Satisfaction Survey - Recipients with Complex Behavioral Health Service Needs**	Survey shall include care coordination and intensive care management members: Satisfaction with the care coordination services, experience of this and other services and supports with respect to dignity, respect, cultural competence, and participation as a partner in service planning processes. Must report by race/ethnicity and gender when requested.	A, L	TBD	A	TBD	Monitoring Indicator	N/A	N/A	TBD	C	
QM	**21C. Provider Satisfaction Survey**	See Exhibit A	L	See Exxhibit A	A	See Exhibit A	See Exhibit A	Performance Target	See Exhibit A		C	
QM	**22. Clinical Issue Studies**	Three Clinical (1 child focus and 2 adult focus) In addition, the report shall include all raw data upon request.	C	TBD	TBD		N/A	N/A	N/A		C	
					Appeals							
Appeals	**23.A. Provider Appeals and Determination Timeliness**	Level 1: Total number of first level provider clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage resolved timely. Number and percentage overturned. Level 2: Total number of second level provider clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage resolved timely. Number and percentage overturned.	C	2	Q= M, Q	MQ	Level 1: Percentage of total child and adult appeals resolved timely; greater than or equal to 90%; Level 2: Percentage of total child and adult appeals resolved timely; greater than or equal to 90%	Performance Standard	$1000/ Q for Level 1 and $1000/Q for Level 2	In production		

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Appeals	**23.B. Member Appeals and Determination Timeliness**	Total number of member clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage of member appeal determinations that met the 30 calendar day timeframe for routine appeals and the 3 day (5 day with a member meeting) timeframe for expedited appeals. Number and percentage overturned. Report all of above separately for routine and expedited appeals and combined.	C		Q= M, Q		Level 1: Percentage of total child and adult routine and expedited (combined) appeals resolved timely; greater than or equal to 90%;	Performance Standard	$1000/ Q	In production		
Appeals	**24. Appeals - Administrative**	Total number of administrative appeals resolved, by type of appeal for original denial, during the reporting time period. Number and percentage resolved timely (7 day timeframe). Number and percentage overturned.	C	2	Q = M, Q	MQ	Percentage of total child and adult appeals resolved timely; greater than or equal to 90%	Performance Standard	$1000/Q	In production		
					Provider Network							
Provider Network	**25. Network Adequacy**											
Provider Network	**25.A. Access**	Track access by providers within TBD radius by provider type.	C	1	BI	A	Monitoring Indicator	TBD	TBD	In production	C	
Provider Network	**25.B. Ease of access**	Report based on random survey of outpatient providers using mystery shopper method. Assess willingness to accept referrals by provider type and average wait time to next appointment by provider type and service.	C, L	2	A	A	Monitoring Indicator	TBD	TBD	Mystery Shopper	C	

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Provider Network	25.C. Density -Managed Care Accessibility Analysis	Shows ratio of members to providers, by county, for identified providers. Also shows members with more than faspecifiied distance to providers. Statewide report shall be issued only on demand, rather than at specified times. Urban/suburban/rural breakdown shall be used in the statewider report, but not in the area reports.	T	2	BI	A	Monitoring Indicator	TBD	TBD	In production	C	
Provider Network	25.D. Network Development	Quantify the number of providers recruited by type and specialty and location.	T	2	Q, A	QA	Monitoring Indicator	TBD	TBD	In production	C	
Provider Network	26. Bypass/Pass Through Program	Reports that enable the monitoring of the bypass program; allows Departments to review performance of each participating and non-participating provider with respect to average length of stay and performance on quality metrics (if applicable) in	TBD	2	TBD	QA	TBD	TBD	TBD	In production		
Provider Network	27.A. Provider Profiles	Provider specific perfomance reports. These shall include all facility providers. Which shall at a minimum include the provider ID, access timeliness, connect to care %, re-connects, re-admits, no care and admits which exceed 90 days, total	C	2	A	A	Monitoring Indicator	N/A	N/A	In production	C	
Provider Network	27.B. ED profile	See Exhibit A	C	See Exhibit A	See Exhibit A	See Exhibit A	See Exhibit A	N/A	N/A	N/A		
Provider Network	27.C. Home health agency profile	See Exhibit A	N/A	See Exhibit A	See Exhibit A	See Exhibit A	See Exhibit A	N/A	N/A	N/A		
Provider Network	27.D. Home health physician profile	See Exhibit A	N/A	See Exhibit A	See Exhibit A	See Exhibit A	See Exhibit A	N/A	N/A	N/A	C	

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Claims , File Transmission and Record Resolution Reporting												
Claims	28.A.Claims Turn Around Report	Description TBD	N/A	TBD	Q = M, Q, Y	TBD	N/A	N/A	N/A	Currently suspended		
Claims	28.B.Claims Status Report - All providers	Description TBD	N/A	TBD	Q = M, Q, Y	TBD	N/A	N/A	N/A	Currently suspended		
Claims	28.C.Single Provider Claims Report Over Date Range	Description TBD	N/A	TBD	Q	TBD	N/A	N/A	N/A	Currently suspended		
Claims	28.E.Denials Break down Report	Description TBD	N/A	TBD	M	TBD	N/A	N/A	N/A	Currently suspended		
Claims	28.F.Denials for Identified Providers	Description TBD	N/A	TBD	BW	TBD	N/A	N/A	N/A	Currently suspended		

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Claims	28.G.Authorization Timeliness	See Exhibit A	T	See Exhibit A	Y	See Exhibit A	See Exhibit A	Performance Target	See Exhibit A	In production		
Finance												
Finance	29. Budget to Actual Report	Report of contracted budget to actual budget.	T	1	Q	Q	N/A	N/A	N/A	In production		
Finance	30. Audited Financials	Audited Financial Statements	T	1	A- 60 days after completion of audit	A	Monitoring Indicator	N/A	N/A	In production		
Management Information/Telecommunications System												
MIS	31. MIS Down time	Down time for MIS and telecommunications systems (separately) measured in hours	N/A		Q		TBD	Performance Standard	TBD	In production		
Cultural Sensitivity												
Cultural Sensitivity	32. A. Cultural Sensitivity	Description TBD	C	TBD	BI	TBD	Monitoring Indicator	TBD	TBD	Currently suspended		
Cultural Sensitivity	32. B. Cultural Sensitivity	Description TBD	C	TBD	BI	TBD	Monitoring Indicator	TBD	TBD	Currently suspended		
Young Adults												

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Young Adults	33. Young Adult Transitional Assistance Report	Report of youth that require transitional assistance by category as outlined in subsection I, 3.1, and including age, race/ethnicity, service history, and diagnoses; transitional assistance provided; and outcomes.	A, D, P		M		Monitoring Indicator	TBD	TBD	TBD		
Young Adults	34. Young Adult Service Outcome Measures	TBD	TBD		M		N/A	N/A	N/A	TBD		
Young Adults	35. Young Adult Service Utilization Report	A report which will summarize as well as provide a person specific detail related to the utilization of services used by Young Adults in transitional services. This report shall at a minimum include the race/ethnicity, length of stay, diagnosis and level of care.	A, D, P		M		N/A	N/A	N/A	TBD		
					Residential Care Team							
RCT UM	36. Referrals	Master list of children referred for residential placement		?	M	?	N/A	TBD	TBD	In production		
RCT UM	37. Referrals (unmatched)	List of children referred to a) RTC, b) GH1 (Non-PASS), c) GH2 and GH1 (PASS) who have not been matched.		?	M	?	N/A	TBD	TBD	In production		
RCT UM	38. Referrals - Parole and Detention (matched and unmatched)	List of children in a) parole and b) detention referred to any residential service (matched and unmatched)		?	M	?	N/A	TBD	TBD	In production		

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RCT UM	**39. Referrals - Members on Inpatient Delay Status**	Members on inpatient psychiatric units in delayed discharge status awaiting residential services		?	M	?	N/A	TBD	TBD	In production		
RCT UM	**40. Members matched and awaiting admission**	Report on status of children matched to facilities but awaiting admission		?	M	?	N/A	TBD	TBD	In production		
RCT UM	**41. Residential Vacancies**	Report of existing residential service vacancies and vacancies anticipated within 30 days		?	M	?	N/A	TBD	TBD	In production		

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	Note 1: All reports submitted on a quarterly and annual basis will require the Reporting and Performance Measure Data Analysis form.											
	Note 2: The Departments will generate additional reports related to pharmacy, primary care BH treatment, Antidepressant Medication Management (HEDIS), and other areas to be determined.											
	Note 3: The Contractor will be required to exclude dual eligible clients from all non-Home Health reports including but not limited to those reports that utilize member months in the calculation (e.g., inpatient authorizations/1000 member months) and for which Medicare is the primary payer.											

Report Breakout Legend

1	Report summarized by all CT BHP
2	Report summarized by Child (FFS <18, HUSKY <19) vs. Adult (FFS 18 and Over, HUSKY 19 and Over, CHOAK, MLIA)
3	Report summarized by DCF identifier (DCF, Non-DCF) through age 21
4	Adult portion of report summarized by program (HUSKY, MLIA, CHOAK, FFS less Duals and LTC)
5	Child report summarized by DCF designated local area
6	DMHAS portion of report summarized by specific age breakout 18-20, 21-25, 26-64
7	Report summarized by mental health and substance abuse
8	Adult report summarized by DMHAS designated region
*	Include Long Term Care in FFS Portion of report

Usefulness to be determined

Data Reporting Frequency Legend

A	Annual
BW	Bi-weekly
D	Daily
M	Monthly with quarterly and year-to-date subtotals
Q	Quarterly
MQ	Quarterly report with breakdown by month and quarter subtotals
MQY	Quarterly report with breakdown by month, quarter and year-to-date subtotals
QY	Quarterly report with year-to-date subtotals
W	Weekly with monthly subtotals
(IRR)	Implementing Reporting Requirement

Exhibit F
CY11 - Implementation - January 1, 2011 - March 31, 2011

Total Projected Revenue for the Period	**$**	**2,405,426**	
			% TO TOTAL PROJECTED COST
TOTAL SALARY AND FRINGE (PERSONAL SERVICES)	$	713,916	35.19%
TOTAL OTHER DIRECT COSTS		1,314,935	64.81%
SUBTOTAL DIRECT COST		2,028,851	100.00%
CORPORATE ALLOCATION		240,419	11.85%
TOTAL PROJECTED INCOME		56,732	2.50%
		79,424	3.50%

Exhibit F
CY11 - January 1, 2011 - December 31, 2011

Total Projected Revenue for the Period	**$**	**14,879,143**	
			% TO TOTAL PROJECTED COST
TOTAL SALARY AND FRINGE (PERSONAL SERVICES)	$	10,121,397	80.65%
TOTAL OTHER DIRECT COSTS		2,428,382	19.35%
SUBTOTAL DIRECT COST		12,549,779	100.00%
CORPORATE ALLOCATION		1,487,149	11.85%
TOTAL PROJECTED INCOME		350,923	2.50%
	$	491,291	3.50%

Exhibit F
CY11 - January 1, 2012 - December 31, 2012

Total Projected Revenue for the Period	**$**	**17,716,683**	
			% TO TOTAL PROJECTED COST
TOTAL SALARY AND FRINGE (PERSONAL SERVICES)	$	12,050,884	80.65%
TOTAL OTHER DIRECT COSTS		2,892,212	19.35%
SUBTOTAL DIRECT COST		14,943,096	100.00%
CORPORATE ALLOCATION		1,770,757	11.85%
TOTAL PROJECTED INCOME		417,846	2.50%
	$	584,984	3.50%

Exhibit F
CY11 - January 1, 2013 - December 31, 2013

Total Projected Revenue for the Period	**$**	**18,265,900**	
			% TO TOTAL PROJECTED COST
TOTAL SALARY AND FRINGE (PERSONAL SERVICES)	$	12,424,461	80.65%
TOTAL OTHER DIRECT COSTS		2,981,871	19.35%
SUBTOTAL DIRECT COST		15,406,332	100.00%
CORPORATE ALLOCATION		1,825,650	11.85%
TOTAL PROJECTED INCOME		430,800	2.50%
	$	603,118	3.50%