STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONTRACT AMENDMENT

Contractor:	HEALTH MANAGEMENT SYSTEMS, INC.
Contractor Address:	360 PARK AVENUE SOUTH, 17TH FLOOR, NEW YORK, NY 10010
Contract Number:	999HMS-QUA-02 / 12DSS0602FO
Amendment Number:	A1
Amount as Amended:	$35,085,705
Contract Term as Amended:	10/01/12 - 09/30/17

The contract between Health Management Systems, Inc. (the Contractor) and the Department of Social Services (the Department), which was last executed by the parties and signed by the Office of the Attorney General on 03/19/13, is hereby amended as follows:

1. Effective June 1, 2013 the address for HMS's corporate principal place of business found on page 1 of the original contract is changed to:

   Health Management Systems, Inc.
   360 Park Avenue South, 17th Floor
   New York, New York 10010

2. The maximum contract value shall be increased by $1,308,340.00 from $33,777,365.00 of the original contract to $35,085,705.00 to be utilized for the additional services as described in 6. P. New Hires Database Maintenance and EMS Processing Services 1-4 found on page 2 of this Contract Amendment.

3. The following acronyms and definitions shall be appended to Part I, Scope of Services, Definitions found on page 2 of the original contract:

AMEN	Suh-menu in Eligibility System
AU	Assistance Unit – defines program client/family are eligible for
Client ID	State Unique Identifier assigned to our recipients on assistance
CPU	Central Processing Unit
DO	Department District/Regional Office
DOL	Connecticut Department of Labor
DEPARTMENT	Connecticut Department of Social Services

EMS	Eligibility Management System – Department's eligibility system
ERN1	Screen in Eligibility System
EWID	Eligibility Worker's Identification Number
Hit Sheet	Paper forms used as to generate letters to clients and turn around document from eligibility worker
OMEN	Sub-menu in Eligibility System
PF	Function Key in Eligibility System
SSN	Social Security Number
STAT	Screen in Eligibility System
W-69	Department form number assigned to "hit sheet"

4. The following language is appended to PART I SECTION I A.4 found on page 7 of the original contract:
n. New Hires Database Maintenance and EMS Processing Services.

5. The following shall be appended to the Notices Section found on page 7-8 of the original contract:
Effective immediately and pursuant to the Business Associate Agreement, notices to HMS should be sent to:

Alexandra Holt, Chief Compliance Officer
360 Park Avenue South, 17th Floor
New York, New York 10010

6. The following provisions shall be appended to PART ONE, Description of Services and Payment Provisions SECTION I. Overview and Project Management C. Department's Responsibilities found on page 13 of the original contract:

k. New Hires Database Maintenance and EMS Processing Services

i. Department eligibility workers will do all necessary follow-up with the client and take appropriate actions in EMS, and will enter a 'completion code' onto the DOL New Hires Hit Form and will return the forms to the Contractor.

ii. Hit forms that are sent to the Department Central Office/CPU, shall be sent to the Contractor no less than weekly, at the Department's expense.

iii. The Department shall be responsible for running the twice monthly match of active Department clients, with known employment information (as applicable) with the Connecticut Department of Labor's database of newly hired employees.

iv. The Department shall be responsible for loading new data/hits from the DOL match into the DOL/New Hires database.

ii. The Department shall have access to the New Hires database at all times.

iii. The Department shall be responsible for granting access to the DOL/New Hires database.

iv. The Department shall be responsible for granting appropriate access to EMS.

v. The Department shall be responsible for the printing of and mailing of client letters, after entered/generated by the Contractor.

vi. The Department shall be responsible for providing the client customer service phone line and for taking phone calls related to the letters, and all eligibility decisions.

vii. The Department shall provide support to the Contractor as needed related to DOL/New Hires Database and EMS operations, communications with regional office staff, Department clients/case members.

viii. The Department does not guarantee the number of "hits" "letters" nor "completion codes" per month.

ix. The Department shall provide as much notice as possible and work with the Contractor should there be a need to change the above outlined process, due to changes in or with the current or any subsequent eligibility system.

x. The Department may rescind the New Hires Database and Maintenance and EMS Processing Services in accordance with PART ONE Description of Services and Payment Provisions SECTION I Overview and Project Management A. THIRD PARTY LIABILITY 9. Change Order Process found on page 8 of the original Contract.

7. The following provisions shall be appended to PART ONE, Description of Services and Payment Provisions SECTION II. DESCRIPTION OF SERVICES found on page 51 of the original contract:

P. New Hires Database Maintenance and EMS Processing Services

1. Processing Hits (step 1)

The Contractor shall review hits within the DOL/New Hire Database against the Department's Eligibility system (EMS) to verify whether the employment information from DOL is accurately reflected in EMS by performing the following tasks that include, but are not limited to:

a. Open a hit in the DOL/New Hires database.

b. Obtaining the Client ID number from the DOL/New Hires database and entering it into EMS (AMEN screen, selection C).

c. In EMS, select the AU# listed in the DOL/New Hire database, or any other active AU (PF13/Shift + F1 key).

i. If there is no active AU#s in EMS, it is an invalid hit and should be coded and processed as such in the DOL/New Hires database.

d. On the STAT screen in EMS, verify the DO# and EW ID# match the information in the DOL/New Hires database. If it does not match, edit the DOL/New Hire database to match EMS.

i. If you update/change the EW ID#, the Supervisor's ID may need to be updated as well.
- From the STAT (PF16/Shift + F4) to OMEN. Select option 'I' and enter EW ID#. You will see the Supervisor's ID listed. Enter in DOL/New Hires database.

e. From the STAT screen, navigate to the ERN1 01 screen for the client listed (member could be 01, 02, 03 etc.).

f. Verify that EMS client name and DOL/New Hires database name match.

   i. If names do not match it is an invalid hit and should be coded as such in the DOL/New Hires database.

g. Look to see if the DOL/New Hires employment info is in EMS/ERN1 screen. (check all months from date of hire to current).

   i. If employment information is in EMS, but the employers FEIN is missing, the Contractor shall add the FEIN (from DOL/New Hires database) into EMS.
   ii. FEIN is to be added to each applicable month, one month at a time.
   iii. After the FEIN is entered in EMS, the Contractor shall close out the hit in the DOL with the appropriate code, and checking "employment known" box.

h. When the employment information is not known in EMS, Contractor shall navigate to the ADDR screen and verify that the EMS address matches the DOL address.

   i. Obtain primary language information. (E for English, S for Spanish).
      - In DOL/New Hires database note required follow-up:
        - N = name discrepancy
        - A = address discrepancy
        - W = work/wage info missing from EMS
   ii. Select 'letter sent' box.
   iii. Select the language the letter will be sent in (English/Spanish).
   Click on process/ok to move the hit from the 'main' section of the DOL/New Hires database to the 'pending' section.

2. Client Letters (step 2)

When employment information from DOL is not accurately reflected in EMS, the Contractor shall generate a letter to the client, through EMS, by performing the following tasks that include, but are not limited to:

a. Printing hit sheets (source for generating letters) from DOL/New Hires database.

b. Personalize pre-filled letter with the employee's name listed on the "regards name" line, and after "Dear" in the body of the letter, and enter the DOL employer name (as listed on hit sheet) into the body of the letter.

   i. In EMS, the letters are to be generated from FMEN, selection A.
   ii. letter type: L069 = English, L070 = Spanish.

3. Send completed DOL/New Hires Hit sheets to the Department after letter generation

The Contractor shall forward hit sheets for clients after letters that have been entered into EMS should be sent to the Department, or our designee, daily in one of the following manners, as determined by the Department:

a. Option 1: Batch forms by the Department regional office and mail them via USPS to each of the thirteen Department offices.

b. Option 2: Batch forms by Department regional office and email PDF version of forms to a designated contact in each of the thirteen Department offices.

c. Option 3: Batch forms and mail via USPS to the Department's scanning Contractor.

d. Option 4: Batch forms and email PDF version of forms to the Department's scanning Contractor.

Contractor shall be responsible for mailing costs for sending completed forms to the Department and/or its scanning Contractor.

4. Enter Completion Codes in New Hires Database (step 3)

Upon receipt of DOL/New Hires Hit forms from the Department, with completion codes, the Contractor shall enter the completion codes into the DOL/New Hires database by performing the following tasks that include, but are not limited to:

a. In the DOL/New Hires database.

i. select pending records.
ii. enter in the recipient SSN.
iii. double click SSN to open the hit.
iv. if the client shows up multiple times, use the "import date" listed on the hit sheet.

b. In the completion code drop down menu, select code (1-8) based on the hit sheet returned from the eligibility worker.

c. Enter date received.

d. Process and move the hit to the closed file.

Q. Additional Contractor Responsibilities

1. Contractor can propose automation/process improvements to the Department. Any changes in the process require prior approval from the Department. The Department may require a demonstration of any proposed changes before giving approval.

2. Contractor shall be responsible for notifying the Department CPU as soon as possible if there are any issues with the DOL/New Hires database.

3. Inaccurate processed hits, letters and/or completion codes produced by the Contractor shall result in credits back to the Department.

4. Contractor shall be responsible for reporting the number of hits processed to the Department on a weekly basis for the first two months, then on a monthly basis.

8. The Contractor shall advise and report to the Department when it determines that it needs to perform tasks outside of the scope of work described in PART ONE, Description of Services and Payment Provisions SECTION II. DESCRIPTION OF SERVICES P. New Hires Database Maintenance and EMS Processing Services 1-4, page 51 of the original contract and 6. P. 1-4 of this Contractor Amendment. The Contractor shall provide a written description of the new task(s), the reason that the new task(s) need to be performed, why the new business need cannot be met by the Contractor's existing requirements, and the specific amount of consulting hours that it will need to perform the new work.

9. The following provision shall be appended to PART ONE Description of Services and Payment Provisions SECTION III BUSINESS COST SECTION, found on page 52 of the original contract:

e. Program Reimbursement - The Contractor will be reimbursed a fee of $4.18 per completed hit, reportable and billable to the Department monthly.
Per processed hit to be determined using the following formula:

- Beginning balance of unprocessed hits in DOL/New Hires database.
- Plus,(add), new hits added to DOL/New Hires database.
- Minus, (subtract) ending balance of unprocessed hits in DOL/New Hires database.
- Equals total hits processed.
- Minus, (subtract) credits for inaccurate actions.
- Equals billable cases to the Department at $4.18 each.

The Contractor may impose an hourly consulting fee of $82.00 for any scope of work performed outside of the scope listed above.

The Department shall authorize and approve the total number of consulting hours the Contractor will be reimbursed prior to start of the new work. For the specific work associated with the new business need, in no circumstance shall the Contractor be reimbursed more than one-hundred and sixty (160) consulting hours at a rate of $82 per hour.

10. The HIPAA provisions found on page 113 of the original contract are deleted in their entireties and replaced by the following 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"), the Contractor must comply with all terms and conditions of this Section of the Contract. If the Contractor is not a Business Associate under HIPAA, this Section of the Contract does not apply to the Contractor for this Contract.

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

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

(d) The Contractor, on behalf of the Agency, performs functions that involve the use or disclosure of "individually identifiable health information," as that term is defined in 45 C.F.R. § 160.103; and

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

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

(g) Definitions

(1) "Breach" shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. § 17921(1)).

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) "Unsecured protected health information" shall have the same meaning as the term as defined in section 13402(h)(1)(A) of HITECH. Act. (42 U.S.C. §17932(h)(1)(A)).

(h) Obligations and Activities of Business Associates.

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

(2) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for in this Section of the Contract.

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

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

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

(6) Business Associate agrees to insure that any agent, including a subContractor, to whom it provides PHI received from, or created or received by Business Associate, on behalf of the Covered Entity, agrees to the same restrictions and conditions that apply through this Section of the Contract to Business Associate with respect to such information.

(7) Business Associate agrees to provide access, at the request of the Covered Entity, and in the time and manner agreed to by the parties, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524.

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

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

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

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

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

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

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

(A) restrict disclosures of PHI;

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

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

(D) the Business Associate agrees to notify the covered entity, in writing, within five (5) business days of the request.

(15) Business Associate agrees that it shall not, directly or indirectly, receive any remuneration in exchange for PHI of an individual without

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

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

(16) Obligations in the Event of a Breach.

(A) The Business Associate agrees that, following the discovery of a breach of unsecured protected health information, it shall notify the Covered Entity of such breach in accordance with the requirements of section 13402 of HITECH (42 U.S.C. § 17932(b)) and this Section of the Contract.

(B) Such notification shall be provided by the Business Associate to the Covered Entity without unreasonable delay, and in no case later than 30 days after the breach is discovered by the Business Associate, except as otherwise instructed in writing by a law enforcement official pursuant to section 13402(g) of HITECH (42 U.S.C. § 17932(g)). A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate. The notification shall include the identification and last known address, phone number and email address of each individual (or the next of kin of the individual if the individual is deceased) whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

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

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

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

3. The steps the Business Associate recommends that individuals take to protect themselves from potential harm resulting from the breach.

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

5. Whether a law enforcement official has advised either verbally or in writing the Business Associate that he or she has determined that notification or notice to individuals or the posting required under section 13402 of the HITECH Act would impede a criminal investigation or cause damage to national security and; if so, include contact information for said official.

(D) Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed by the Covered Entity of a breach by the Business Associate have the opportunity to ask questions and contact the Business Associate for additional information regarding the breach. Such procedures shall include a toll-free telephone number, an e-mail address, a posting on its Web site or a postal address. For breaches involving ten or more individuals whose contact information is insufficient or out of date to allow written notification under 45 C.F.R. § 164.404(d)(1)(i), the Business Associate shall notify the Covered Entity of such persons and maintain a toll-free telephone number for ninety (90) days after said notification is sent to the Covered Entity. Business

Associate agrees to include in the notification of a breach by the Business Associate to the Covered Entity, a written description of the procedures that have been established to meet these requirements. Costs of such contact procedures will he horne hy 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 hehalf 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 PI II.

(3) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PI-II 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.

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.

SIGNATURES AND APPROVALS

999HMS-QUA-02 / 12DSS0602FO A1

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.

CONTRACTOR - HEALTH MANAGEMENT SYSTEMS, INC.

Maria Perrin

Maria Perrin, *Executive Vice President*

1/6/14

Date

DEPARTMENT OF SOCIAL SERVICES

Kathleen M. Brennan

KATHLEEN M. BRENNAN, DEPUTY COMMISSIONER

1/7/14

Date

OFFICE OF THE ATTORNEY GENERAL

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

Joseph Rubin

1/13/14

Date

PSA

Original Contract Number:	999HMS-QUA-02/12DSS0602FO	
Amendment Number:		
Maximum Contract Value:	$33,777,365.00	
Contractor Contact Person:	Keith Reinold	Tel: (617) 398-1361
DSS Contact - Contract:	Kathy Brennan	Tel: (860) 424-5693
Program:	John McCormick	Tel: (860) 424-5903

STATE OF CONNECTICUT
PERSONAL SERVICE AGREEMENT
("PSA", "Contract" and/or "contract")

Revised February 2010

The State of Connecticut DEPARTMENT OF SOCIAL SERVICES
Street: 25 SIGOURNEY STREET
City: HARTFORD State: CT Zip: 06106
Tel#: (800) 842-1508 ("Agency" and/or "Department"), hereby enters into a Contract with:

Contractor's Name: HEALTH MANAGEMENT SYSTEMS, INC.
Street: 401 PARK AVENUE SOUTH
City: NEW YORK State: NY Zip: 10016
Tel#: (202) 857-5470 FEIN/SS#: [redacted]

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

Contract Term	This Contract is in effect from 10/01/12 through 09/30/17.
Statutory Authority	The Agency is authorized to enter into this Contract pursuant to § 4-8, 4-98 as applicable, and 17b-3 of the Connecticut General Statutes ("C.G.S.").
Set-Aside Status	Contractor ☐ IS or ☒ IS NOT a set aside Contractor pursuant to C.G.S. § 4a-60g.
Effective Date	This Contract shall become effective only as of the date of signature by the Agency's authorized official(s) and, where applicable, the date of approval by the Office of the Attorney General ("OAG"). Upon such execution, this Contract shall be deemed effective for the entire term specified above.
Contract Amendment	This Contract may be amended only be means of a written instrument signed by the Agency, the Contractor, and, if required, the OAG.

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

If to the Agency:	STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES 25 SIGOURNEY STREET HARTFORD, CT 06106 Attention: Kathy Brennan	If to the Contractor:	Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016 Attention: Keith Reinold

A party may modify the addressee or address for Notices by providing 10 days' prior written Notice to the other party. No formal amendment is required.

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PART I SCOPE OF SERVICES

Definitions

The following acronyms, abbreviations, and definitions apply to this Contract:

1. Beneficiary Data Exchange (BENDEX) System - A data exchange between the state agency and the Social Security Administration designed to provide states with Title II information (the BENDEX System includes Medicare Part A and Medicare Part B information)

2. Benefit recovery - Recovery that occurs when the State Medicaid Agency either learns of the existence of a liable third party or benefits become available from a third party after a Medicaid claim is paid (it is required to seek recovery of reimbursement from the third party up to the legal limit of liability)

3. Centers for Medicare and Medicaid Services (CMS) - A division within the U.S. Department of Health and Human Services (DHHS) [this division was formerly known as the Health Care Financing Administration] that oversees the Federal Medicare and State Medicaid programs

4. Connecticut Child Support Enforcement System (CCSES) - The automated system used by the Bureau of Child Support Enforcement and its cooperating agencies to collect and distribute child support and maintain related records including medical insurance information

5. Cost avoidance - A State Medicaid Agency's requirement of denying or rejecting a Medicaid claim when the agency has established the probable existence of third party liability at the time the claim is filed

6. Cost Avoidance Information – commercial health insurance data including but not limited to: DSS health insurance carrier code, policy holder name, policy holder social security number, type of coverage, start date of coverage, stop date of coverage, health insurance group number, and health insurance policy number, which is captured on the DSS Eligibility Management System (EMS) client eligibility record.

7. Deficit Reduction Act of 2005 (DRA) - A U.S. budget bill codified at Public Law No. 109-171, 120 Stat. 4 (February 8, 2006) DRA §6035, Enhancing Third Party Recovery, that requires that States have laws in place that clarify the State Medicaid Agency's right of recovery against any third party legally responsible for payment of claim for a health item or service and obligates legally liable third parties to provide the State Medicaid Agency with coverage eligibility and claims data

8. Defense Enrollment Eligibility Reporting System (DEERS) - A computerized database of military sponsors, families, and others worldwide entitled under the law to TRICARE benefits (DEERS registration is required for TRICARE eligibility)

9. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services - Specific services defined under 42 CFR §441 Subpart B, which the State Medicaid Agency is required to provide for eligible recipients under age twenty-one to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions

10. Electronic Data Systems Corporation (EDS) – The fiscal agent administering the DSS Medicaid Management Information System (MMIS) for Medicaid fee-for-service claim processing, reimbursements, financial, MAR and SUR reporting and Medicare Buy-In processing

11. Legally Liable Third Parties – An insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(i) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service furnished to an applicant or recipient, which may or may not be financially at risk for the cost of a health care item or service

12. Managed Care Organization Cost of Care – An MCO's claim payment (cost) to its network provider for a client health care encounter. Under Connecticut General Statute 17b-265 DSS is subrogated to right of recovery from client third party liability for an MCO's cost of care. Thus, the Department may recover MCO encounter claims from client third party liability.

13. Medicaid - The Connecticut Medical Assistance Program (CTMAP) operated by the Department of Social Services under Title XIX of the Federal Social Security Act and related State and Federal rules and regulations

14. Medicaid Fee-For-Service Program (FFS) - The Connecticut Medical Assistance Program in which DSS is directly at financial risk for the cost of a client's health care. For clients enrolled in FFS providers submit claims directly to EDS.

15. Medicaid Managed Care Organization (MCO) - An organization that provides managed care for qualified Medicaid clients enrolled in an MCO's Managed Care Plan (MCP)

16. Medicaid Managed Care Program (HUSKY A) - A Medicaid program that targets children and families with incomes at or below 185 percent of the Federal poverty level and pregnant women up to 250 percent of the Federal poverty level

17. Medicaid Managed Care (HUSKY A) At Risk Model - A Medicaid Managed Care Program model in which a client chooses to enroll in a MCO.A client accesses health care through the MCO's providers. The MCO is at financial risk for the cost of care by reimbursing its network providers.

18. Medicaid Managed Care (HUSKY A) Administrative Service Organization Prepaid Inpatient Health Plan Model – A Medicaid Managed Care Program model in which a client chooses to enroll in a health plan; the health plan performs case and disease management, member services and other functions. In this model the health plan is not a financial risk for the cost of care as client services are paid under the traditional Medicaid fee-for-service program.

19. Medicaid Management Information System (MMIS) - The Department of Social Services' Federally approved claims processing system

20. Medicare - A social insurance program administered by the U.S. government, providing health insurance coverage to people either aged sixty-five or older or who meet other special criteria

21. Medicare Advantage Plan - Health plan options that are part of the Medicare program (All of a beneficiary's Medicare-covered health care is generally covered through that plan, which can include prescription drug coverage. Medicare Advantage Plans include Medicare Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-service Plans, and Medicare Special Needs Plans.)

22. Medicare Buy-In – The Department of Social Services pays Medicare Part A (in limited situations) and Medicare Part B premiums for about 70,000 clients each month. This is known as Medicare Buy-In. Connecticut Department of Social Services clients can qualify for Buy-In in a variety of ways. In all cases the client must be eligible for Medicare according to the Social Security Administration (SSA). A client qualifies for Buy-In if they are: 1) eligible for the Qualified Medicare Beneficiaries Program (QMB – Q01), 2) eligible for one of the other two Medicare Savings Programs: Specified Low Income Medicare Beneficiaries (SLMB – Q03) or Additional Low Income Medicare Beneficiaries Under 135% of Poverty (QI1 – Q04), 3) eligible for Medicaid and SSI, or 4)eligible for Medicaid and State Supplement or Temporary Family Assistance.

23. Medicare Modernization Act (MMA) - The act which amends Title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program and to modernize the Medicare Program (also known as the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173))

24. Medicare Modernization Act (MMA) Return File - The file that the Centers for Medicare and Medicaid Services (CMS) submits to Electronic Data Systems Corporation (EDS) on behalf of the Department of Social Services to provide the Department of Social Services with Medicare Part D data on dual eligible recipients (receiving both Medicare and Medicaid)

25. National Medical Support Notice (NMSN) - A Notice to Withhold for Health Care Coverage, which informs the employer that the identified employee is obligated by a court or administrative child support order to provide health care coverage for the children identified on the Notice. The employer is required to respond indicating whether the children are enrolled and, if not, why enrollment cannot be completed. Follow up with the employer.

26. State Children's Health Insurance Program (SCHIP or HUSKY B) - Federal program under Title XXI of the Social Security Act that targets children in families with incomes above 185 percent of the Federal poverty level and is designed to provide children with health insurance (depending on the family's income, monthly premiums may be charged)

27. Support Enforcement Services (SES) - The unit responsible for the following aspects of Connecticut's Child Support Enforcement Program:

    - Monitoring child support awards for compliance with financial, medical insurance, and child care orders
    - Initiating court-based enforcement actions, such as income withholdings and contempt applications
    - Reviewing financial support orders and initiating modifications when the order substantially deviates from the Connecticut Child Support and Arrearage Guidelines and filing modifications to add medical insurance orders
    - Serving as clerk of the court in interstate child support actions initiated under the Uniform Interstate Family Support Act

28. 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

29. Third party liability - The section of Federal law found at 42 CFR §433 Subpart D, which sets forth the State Medicaid Plan requirements concerning the legal liability of third parties to pay for services provided under the plan, the assignment to the State of an individual's rights to third party payments, and cooperative agreements between the Medicaid agency and other entities for obtaining third party payments

30. TRICARE - The U.S. military's health care plan for military personnel, military retirees, and their dependents (the TRICARE benefit is also available to some members of the Selected Reserve and their dependents)

31. TRICARE Management Activity (TMA) - The Federal agency that oversees the contractors administering the TRICARE health insurance plans (Currently, the Department of Social Services has a billing agreement with TMA, which establishes a billing procedure for the Department of Social Services to seek recovery of reimbursement for pharmacy, medical, and mental health services for its clients who were also eligible for TRICARE benefits at the time the services were rendered.)

PART ONE: Description of Services and Payment Provisions

SECTION I. Overview and Project Management

A. THIRD PARTY LIABILITY

1. Health Management Systems, Inc. (hereinafter referred to as "Contractor") shall administer third party liability identification, benefit recovery and other recovery projects to ensure that the Department of Social Services (hereinafter referred to as "DSS" or "Department") is the payer of last resort if any legally liable third parties exist that will pay all or part of the cost of a client's health care provided under the Connecticut Medical assistance program. The Connecticut Medical Assistance Program provides benefits defined under Title XIX of the Social Security Act (Medicaid) in both traditional fee-for-service (FFS) and managed care environments. In FFS, the Department's current Medicaid Management Information System (MMIS) contractor, Electronic Data Systems Corporation (EDS), administers third party liability claims processing. The MMIS insures that the Department is in third party liability compliance by coordinating benefits between legally liable third parties and the Connecticut Medical Assistance Program by cost avoiding or denying Medicaid claims when known third party liability exists. To insure the Department is in complete third party liability compliance the Contractor shall perform: (1) client third party liability identification, (2) benefit recovery of Medicaid fee-for-service and MCO cost of care, (3) Medicaid program integrity projects, and (4) other recovery projects as more specifically described in Section II – Description of Services. Although reference is made to Medicaid payments herein, the term should be interpreted to include State-funded medical programs as well.

2. Contract Period

   This contract shall be in effect from October 1, 2012 through September 30, 2017.

3. Legal Requirement

   Supporting Regulations/Authority - Third Party Liability comes under the authority of:

   a. Federal regulation specified at Title 42 CFR Part 433 Subpart D, Third Party Liability

   b. Third Party Liability provisions of the Deficit Reduction Act of 2005

   c. §1902(a)(25)(I) (42 USC 1396a) of the Social Security Act

   d. Connecticut General Statute (C.G.S.) §§17b-137 and 17b-265

4. Third Party Liability Functions
   Throughout the term of this contract, the Contractor shall perform the following Third Party Liability and program integrity functions:

   a. Benefit Recovery of Medicaid Paid Claims

   b. Third Party Liability Verification

   c. Third Party Liability Health Insurance Suspect Reporting

   d. Third Party Liability Information Form

e. Third Party Liability Data Match and Identification

f. Trauma Recovery

g. Child Support Medical Insurance Identification

h. Acute Care Hospital and Skilled Nursing Facility Credit Balance/Overpayment Audits, Applied Income Project, Maintenance of Online Credit Balance Reporting System for Long-term Care Facilities, and Recovery Audit Contractor (RAC) Program

i. Workers Compensation Recovery

j. Other Recovery Projects As Identified

k. Connecticut Insurance Premium Assistance Program – "CIPA"

l. Enhanced Benefit Recovery of Third Party-Denied Medicaid Paid Claims

m. Other Recovery Projects As Identified

5. Financial Liability - The Contractor shall be financially liable for any penalties imposed by CMS on the Department for any of its third party liability functions performed under the terms and conditions of this contract, which was not adequately performed and adversely affects the state agency's compliance under Title 42 of the Code of Federal Regulations, Part 433 Subpart D - Third Party Liability or other applicable Federal regulations or state laws.

6. Contractor Bank Lock-box Account - The Contractor shall establish and maintain a bank lock-box account for the deposit of all recovery checks. All deposits shall be made within twenty-four (24) hours of receipt. The Contractor fees shall be deducted from the lock-box account balances as documented by invoices and confirmed by Lock-box bank statements. Secure financial controls shall be established to ensure that all Department recoveries are deposited to the lock box account. Interest received on the lock box account shall revert to the Department. The Contractor shall provide the Department with a monthly lock box account report of all deposits and withdrawals.

7. Contract Liaison
Both parties agree to have specifically named liaisons at all times. These representatives of the parties will be the first contacts regarding any questions and problems that arise during implementation and operation of this contract.

8. Notices

Wherever under this contract one party is required to give notice to the other, such notice shall be deemed given upon delivery, if delivered by hand (in which case a signed receipt will be obtained), or three days after posting if sent by registered or certified mail, return receipt requested. Notices shall be addressed as follows:

In case of notice to the Contractor:

Kevin McDonald
Vice President, Government Services North
Health Management Systems, Inc.
5615 High Point Drive
Irving, TX 75038

In case of notice to the Department regarding this contract:

Andrea Alexander
Contract Administration
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

John F. McCormick
Office of Quality Assurance
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

In case of notice(s) to the Department regarding the scope of services:

John F. McCormick
Office of Quality Assurance
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Said notices shall become effective on the date of receipt or the date specified in the notice, whichever comes later. Either party may change its address for notification purposes by mailing a notice stating the change and setting forth the new address, which shall be effective on the tenth day following receipt.

9. Change Order Process

The Department may, at any time, with written notice to the Contractor, make changes within the general scope of the contract. Such changes may include activities required by new or amended Federal or State laws or regulations or quality related projects that are identified following the execution of the contract. The Department may reimburse the Contractor for any activities required by new or amended Work or for any other changes outside the Scope of Work defined in the contract, which the Department deems necessary.

The written Change Order issued by the Department shall specify whether the change is to be made on a certain date or placed into effect only after approval of the Contractor's fee or cost submission as described in the following paragraph. No changes in scope are to be conducted except by the express written approval of the Department's Contract Administrator.

As soon as possible after receipt of a written Change Order request, but in no event more than five business days thereafter, the Contractor shall provide the Department with a written statement that the change has a cost neutral effect on the Department, or that there is a cost impact, in which case the statement shall include a description of the cost involved in implementing the change.

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 the project.

B. PROJECT MANAGEMENT

1. Key Personnel

The Contractor shall designate the following Key Personnel as the project management team who shall be responsible for the coordination of all third partly liability (TPL) project operations:

- Kevin McDonald — Account Executive and Project Advisor
- Keith Reinold — Project Director
- Lauren Rizzo — Program Manager
- Lynne Holloway — Windsor Office Manager

The Contractor's Program Manager shall be responsible for oversight of the day-to-day TPL project operations. The Program Manager shall:

a. Implement and manage the Third Party Liability function,

b. Monitor and ensure the performance of duties and obligations in accordance with the terms of the contract,

c. Oversee the day-to-day functions of the Third Party Liability project,

d. Attend all Third Party Liability meetings at the request of the Department of Social Services, and

e. Respond to all Department inquiries and other communications related to implementation, operations, and program management of TPL activities.

The Contractor certifies that the above named Key Personnel shall perform as the project management team throughout the duration of the contract. No changes, substitutions, additions, or deletions shall be made unless approved in advance by the Department. In the event of resignation, incapacity, or death the Department shall approve the substitution of key personnel. Substitutions shall be made within thirty days of the resignation, incapacity, or death of a key person.

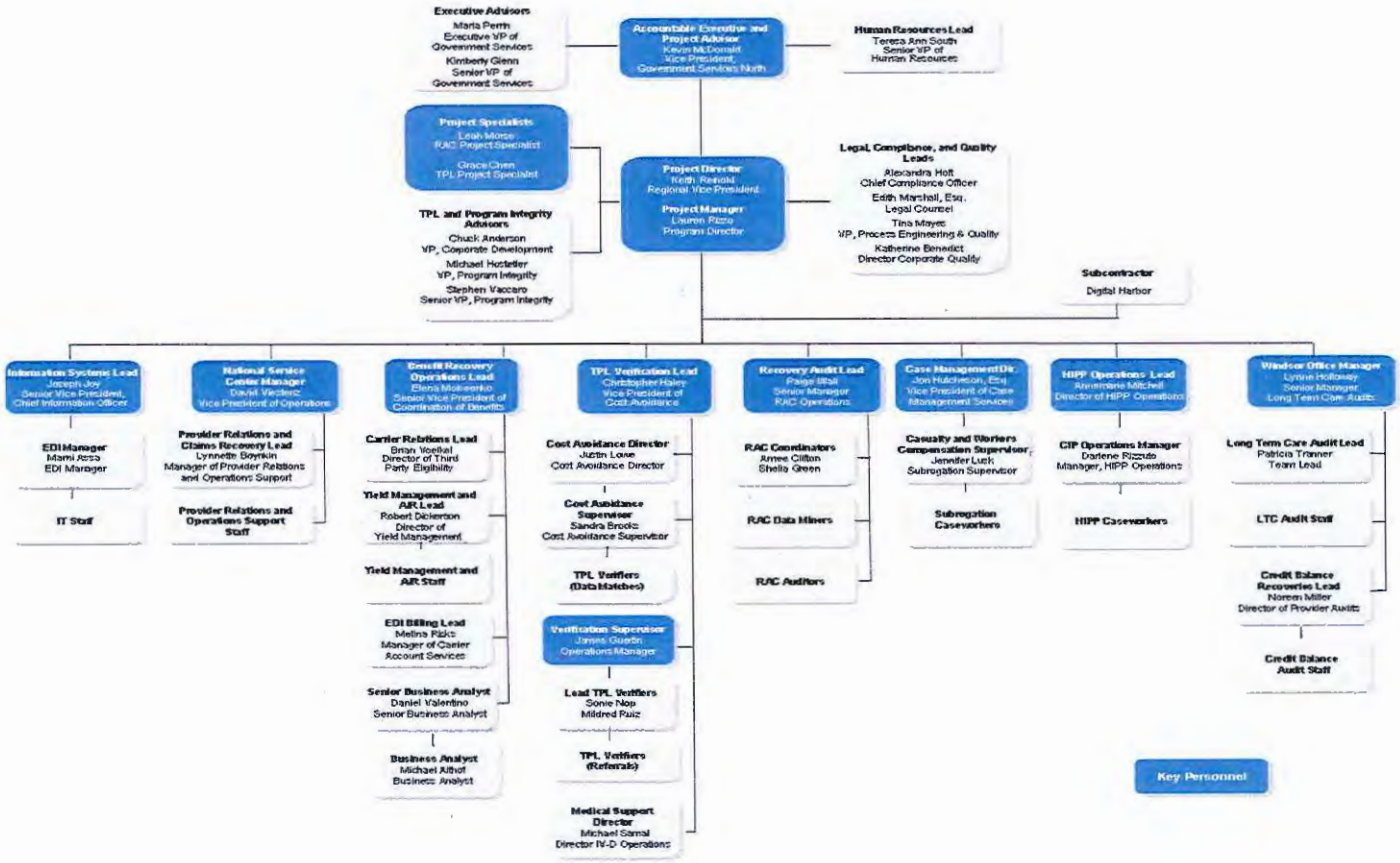
2. Staffing Resources

During the course of the contract, the Department of Social Services reserves the right to approve or disapprove the Contractor's and any subcontractor's staff assigned to the contract, to approve or disapprove any proposed changes in staff, or to require the removal or reassignment of any contractor employee found unacceptable by the Department.

Any employee of the Contractor, who in the opinion of the Department is uncooperative, inept, incompetent, or otherwise unacceptable, shall be removed from the contract. In the event that an employee is removed pursuant to the Department's written request, the Contractor shall have thirty days to fill the vacancy with an acceptable employee. Replacement of any personnel including those who have terminated employment shall be with personnel of equal capability and qualifications as approved by the Department. The Contractor shall, upon request, provide the Department with a resume for any member of its staff or of a subcontractor's staff assigned or proposed to be assigned to any aspect of the performance of the contract.

Kevin McDonald*	Vice President of Government Services North	Accountable Executive and Project Advisor	16
Keith Reinold*	Regional Vice President	Project Director	60
Lauren Rizzo*	Program Director	Project Manager	160
Leah Morse*	Project Specialist	RAC Project Specialist	160
Grace Chen*	Project Specialist	TPL Project Specialist	160
Maria Perrin	Chief Marketing Officer	Executive Advisor	4
Kimberly Glenn	Senior Vice President of Government Services	Executive Advisor	8
Chuck Anderson	Vice President of Corporate Development	TPL Advisor	8
Michael Hostetler	Vice President of Program Integrity	Program Integrity Advisor	8
Stephen Vaccaro	Senior Vice President of Program Integrity	Program Integrity Advisor	8
Tracy South	Senior Vice President of Human Resources	Human Resources Lead	4
Alexandra Holt	Chief Compliance Officer	Chief Compliance Officer	6
Edith Marshall	Legal Counsel	Legal Counsel	6
Tina Mayes	Vice President, Process Engineering & Quality	Process Engineering & Quality	6
Katherine Benedict	Director, Corporate Quality	HIPAA and Quality Compliance Lead	8
Lynne Holloway*	Senior Manager, Long Term Care Operations	Windsor Office Manager	120
Patricia Tranner	Long Term Care Audit Lead	Long Term Care Audit Lead	160
Various	Long Term Care Audit Staff	Long Term Care Audit Staff	480
Noreen Miller	Director of Provider Audits	Credit Balance Recoveries Lead	16
Various	Credit Balance Audit Staff	Credit Balance Audit Staff	120
Annemarie Mitchell	Director, HIPP Operations	HIPP Operations Lead	12
Darlene Rizzutto	Manager, HIPP Operations	Manager, CIPA Operations	50
Various	HIPP Caseworkers	HIPP Caseworkers	160
Jon Hutcheson, Esq.*	Vice President of Case Management Services	Case Management Director	16
Jennifer Lusk	Subrogation Supervisor	Casualty and Workers Compensation Supervisor	16
Various	Subrogation Caseworkers	Subrogation Caseworkers	50
Paige Wall	Senior Manager, RAC Operations	RAC Manager	16
Amee Clifton	RAC Coordinator	RAC Coordinator	16

Shelia Green	RAC Coordinator	RAC Coordinator	35
Various	RAC Data Miners	RAC Data Miners	160
Various	RAC Auditors	RAC Auditors	400
Christopher Haley*	Vice President of Cost Avoidance	TPL Verification Lead	8
Justin Lowe	Cost Avoidance Director	Cost Avoidance Director	8
Sandra Brooks	Cost Avoidance Supervisor	Cost Avoidance Supervisor	8
James Guertin*	Operations Manager	Verification Supervisor	80
Sonie Nop	Lead Verifier	Lead Verifier	160
Mildred Ruiz	Lead Verifier	Lead Verifier	160
Various	TPL Verifiers	TPL Verifiers	800
Michael Samal	Director, IV-D Operations	Medical Support Director	32
Elena Moiseenko*	Senior Vice President of Coordination of Benefits	Benefit Recovery Operations Lead	8
Brian Voelkel	Director of Third Party Eligibility	Carrier Relations Lead	16
Robert Dickerson	Director of Yield Management	Yield Management and A/R Lead	16
Various	Yield Management and A/R Staff	Yield Management and A/R Staff	300
Melina Ricks	Manager of Carrier Account Services	EDI Billing Lead	16
Daniel Valentino	Senior Business Analyst	Senior Business Analyst	40
Michael Althof	Business Analyst	Business Analyst	120
David Viestenz*	Vice President of Operations	National Service Center Manager	8
Lynnette Boykin	Manager of Provider Relations and Operations Support	Provider Relations and Operations Support	16
Various	Provider Relations and Operations Support Staff	Provider Relations and Operations Support Staff	480
Joseph Joy*	Senior Vice President and Chief Information Officer	Information Systems Lead	8
Marni Assa	EDI Manager	EDI Manager	16
Various	IT Staff	IT Staff	320
TOTAL	29 FULL TIME EQUIVALENTS		5,066


Executive Advisors
Maria Perm
Executive VP of Government Services
Kimberly Glenn
Senior VP of Government Services
Accountable Executive and Project Advisor
Kevin McDonald
Vice President, Government Services North
Human Resources Lead
Teresa Ann South
Senior VP of Human Resources
Project Specialists
Leah Morse
RAC Project Specialist
Grace Chen
TPL Project Specialist
TPL and Program Integrity Advisors
Chuck Anderson
VP, Corporate Development
Michael Hostetler
VP, Program Integrity
Stephen Vaccaro
Senior VP, Program Integrity
Project Director
Keith Arnold
Regional Vice President
Project Manager
Lauren Rizio
Program Director
Legal, Compliance, and Quality Leads
Alexandra Holt
Chief Compliance Officer
Edith Marshall, Esq.
Legal Counsel
Tina Mayes
VP, Process Engineering & Quality
Katherine Benedict
Director Corporate Quality
Subcontractor
Digital Harbor
Information Systems Lead
Joseph Joy
Senior Vice President, Chief Information Officer
EDI Manager
Mami Ressa
EDI Manager
IT Staff
National Service Center Manager
Daniel Vickers
Vice President of Operations
Provider Relations and Claims Recovery Lead
Lynnette Boykin
Manager of Provider Relations and Operations Support
Provider Relations and Operations Support Staff
Benefit Recovery Operations Lead
Elena Makarenko
Senior Vice President of Coordination of Benefits
Carrier Relations Lead
Brian Voelkel
Director of Third Party Eligibility
Yield Management and AR Lead
Robert Dickerson
Director of Yield Management
Yield Management and AR Staff
EDI Billing Lead
Melina Ricks
Manager of Carrier Account Services
Senior Business Analyst
Daniel Valentino
Senior Business Analyst
Business Analyst
Michael Alhot
Business Analyst
TPL Verification Lead
Christopher Haley
Vice President of Cost Avoidance
Cost Avoidance Director
Justin Lowe
Cost Avoidance Director
Cost Avoidance Supervisor
Sandra Brooks
Cost Avoidance Supervisor
TPL Verifiers (Data Matches)
Verification Supervisor
James Guerin
Operations Manager
Lead TPL Verifiers
Sonie Nop
Mildred Ruiz
TPL Verifiers (Referrals)
Medical Support Director
Michael Samal
Director IV-D Operations
Recovery Audit Lead
Paige Wall
Senior Manager RAC Operations
RAC Coordinators
Aimee Clifton
Sheila Green
RAC Data Miners
RAC Auditors
Case Management Dir.
Jon Hutchison, Esq.
Vice President of Case Management Services
Casualty and Workers Compensation Supervisor
Jennifer Luck
Subrogation Supervisor
Subrogation Caseworkers
HIPP Operations Lead
Annemarie Mitchell
Director of HIPP Operations
CIP Operations Manager
Darlene Rizzuto
Manager, HIPP Operations
HIPP Caseworkers
Windsor Office Manager
Lynne Holloway
Senior Manager, Long Term Care Audits
Long Term Care Audit Lead
Patricia Tranner
Team Lead
LTC Audit Staff
Credit Balance Recoveries Lead
Noreen Miller
Director of Provider Audits
Credit Balance Audit Staff
Key Personnel

3. Location

The Contractor's Connecticut office facility shall be located at 100 Corporate Drive, Suite 110, Windsor, CT 06095.

4. Subcontractor

Digital Harbor (Subcontractor)

The Contractor shall employ Digital Harbor, Inc. as a subcontractor to provide data mining and analysis services under the contract.

HMS Business Services, Inc. will provide the employee workforce for Health Management Systems, Inc. and Allied Management Group (AMG) will provide technical support for the FWA services under the contract. Each is a co-subsidiary of HMS Holdings Corp. along with Health Management Systems, Inc.

C. DEPARTMENT RESPONSIBILITIES

1. The Department of Social Services Shall:

a. Appoint a Program Manager to monitor program progress with final authority to approve/disapprove program deliverables; coordinate all needed contacts between the Contractor and Department staff and review, evaluate, and approve all deliverables before the Contractor is released from further responsibility.

b. Retain final authority for making policy decisions affecting completion of the Third Party Liability function.

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

d. Respond to written requests for policy interpretations.

e. Provide technical assistance to the Contractor, as needed.

f. Allow access to the Department's automated databases, as available and permitted.

g. Allow access to management reports and case files, as appropriate.

h. Hold regularly scheduled program meetings with the Contractor.

i. Provide a process for and facilitate open discussions with staff and personnel to gather information regarding recommendations for improvement.

j. Provide data as required by the Contractor to perform Third Party Liability functions.

SECTION II. DESCRIPTION OF SERVICES

A. BENEFIT RECOVERY OF MEDICAID PAID CLAIMS

1. Third Party Liability Recovery

The Contractor shall implement an integrated Third Party Liability Benefit Recovery System, capturing all phases of the Department's Medicaid FFS and Managed Care at risk encounter claim recoveries from legally liable third parties. The Contractor's TPL Benefit Recovery System shall be compatible with the Department's EMS and interChange systems. The Contractor shall perform the following services:

1) *Recover Medicaid paid claims from client health insurance or Medicare when third parties are identified after the Department has paid for the cost of care*

i. *Receive and Prepare Data.* The Contractor shall:

(a) Receive copies of the following TPL source data files for use in determining clients with third party coverage and identifying claims paid or overpaid by the Department during a period of third party entitlement.

TPL Data Files

DSS Files

- DSS Eligibility
- DSS Paid Claims File
- DSS Client TPL File
- DSS Provider File
- MCO Encounter Claims
- Child Support Case File

Federal Government and Commercial Carrier Files

- Insurance eligibility files from 357 local and national insurance carriers, and additional third parties identified during the life of the contract.
- TRICARE / DEERS Response files

(b) Convert files to a data processing format.

(c) Receive and track, utilizing a unique Internal Control Number (ICN), all MCO encounter claims on a monthly basis from the Department's External Quality Review Organization consultant, MMIS interchange claims files, and / or other sources.

(d) Receive and track all Medicaid paid and adjusted paid and adjusted denied claims on a monthly basis from the Department or its MMIS contractor.

ii. *Identify Commercial Insurance for Department Clients:* The Contractor shall:

(a) Perform monthly data matches between the Department's source eligibility data and data from commercial insurance and other sources to identify client commercial insurance coverage.

(b) Provide the Department with a matrix, updated as needed, which defines the Contractor's criteria used in comparing the DSS Eligibility File with the insurance eligibility files. Such criteria may include but not be limited to: client last name, client first name, client gender, client date of birth, client social security number, and client city and town address.

(c) Perform monthly data matches with insurance carrier eligibility data and add identified coverage to its TPL Coverage Database.

(d) Perform on behalf of DSS either an annual or as required under regulation, data match with TRICARE Management Activity to identify dual and non-dual eligible clients eligible for TRICARE benefits.

(e) Perform a high quality commercial insurance verification process including but not limited to: manual and web based health insurance interrogation, data match, electronic commerce, and/or other verification processes.

iii *Identify Medicare coverage for Department clients:* The Contractor shall:

(a) Perform on a monthly frequency, in conjunction with its receipt of the DSS Eligibility File, interrogation of the DSS Eligibility File to identify new or changed client Medicare information captured on the file, either electronically by BENDEX, or by a manual update.

iv. *Identify DSS Paid Claims for Which a Third Party Is Liable:* The Contractor shall:

(a) Select Medicaid claims for benefit recovery from commercial insurance based upon verified client health insurance information.

(b) Select Medicaid claims for benefit recovery from commercial insurance based upon the claim selection matrix found at Exhibit 1a and 1b. The Contractor may recommend changes to the claim selection matrix that would enhance the selection of Medicaid claims for benefit recovery to commercial insurance.

(c) Accumulate monthly Department paid claims data into a Consolidated Claims Database (CCDB).

(d) Match the Contractor's TPL Coverage Database to the CCDB to identify claims paid by the Department when Medicare or commercial insurance coverage was available.

(e) Perform a series of edits to exclude claims from direct billings and provider disallowances including non-covered services, beyond timely filing requirements, missing critical data (i.e., procedure, diagnosis, or provider information).

(f) Verify the insurance coverage is consistent with the services that the client received.

(g) Match the claims selected for billing against the Contactor's accounts receivable database and claims adjustment records and drop any duplicates. The Contractor shall bill all open or denied claims determined to have coverage from a different third party.

v. *Perform Quality Assurance Reviews:* The Contractor shall:

(a) Upon completion of the final claims selection process, produce summary Quality Assurance/Cycle reports and forward to the Department for internal review and approval.

(b) Compare billing to an established "Be Sure" document, which contains Department-specific edits to ensure that only claims that meet all of the established criteria are billed.

(c) Release bills for production only after the Contractor's internal Quality Assurance team approves the cycle.

b. Benefit Recovery Methods

The Contractor shall utilize both Direct Carrier Billings and provider recoupments (disallowances) to produce third party recoveries for the Department. The Contractor shall:

i. Prepare and submit electronic or paper billings to commercial insurance, depending on the third party's individual requirements. The Contractor shall format and submit files to carriers through various methods including telenet access, Direct connection, Secure FTP, network Data Mover, and Physical media (tape, cartridge, CD-ROM, DVD). The Contractor shall:

(a) Verify whether the third party has received the submitted claim files through the : a) ANSI 997 Functional and Acknowledgement File, b) NCPDP Response File, c) Carrier or Clearinghouse, d) TRICARE, or e) other verification source.

(b) Monitor Claim Adjudication and post 100% of the electronic and paper remittances received.

(c) Send a DSS transmittal letter to each commercial insurance billed either electronically or on paper that apprises the third party of the DSS subrogation right of recovery, timely adjudication requirements, a location to remit payment, and how to contact the Contractor.

c. Medicare and Commercial Insurance Provider Recoupments

The Contactor shall perform Medicare and commercial insurance provider recoupments, or disallowances. The Contractor shall process commercial insurance disallowances for applicable claims after fully verifying insurance coverage for the clients on the claimed dates of service for carriers approved by the Department.

The Contractor shall utilize telephone communication, written communication, the Provider Portal, and/or a Web-enabled system, to facilitate communication with providers and expedite involvement in projects.

The Contractor shall prepare and forward Recoupment Letters to the affected providers that:

i. Notify providers of the Department's intent to recover a population of claims and identify the specific claims that will be recovered by the Department.

ii. Instruct providers to bill claims to the Medicare fiscal intermediary/carrier or commercial insurance as necessary.

iii. Notify providers that the Department shall process voids/adjustments for all claims that the notice identifies unless the provider submits proper documentation to the Contractor; this documentation must indicate that the provider billed Medicare or commercial insurance and obtained a denial of payment or that the client did not have coverage on the date of service.

iv. Provide a 60-day provider response period for submitting all documentation. This 60-day provider response period may be modified at the Department's discretion.

v. Contact providers during the response period to confirm that reports and documentation have been received and to answer any inquiries.

vi. Respond timely to all provider inquiries regarding process questions, provide supplemental data, and manage provider correspondence.

vii. Receive and process documentation (denials, checks, remittance advices, etc.) from providers related to the claims listed on the Recoupment Letter and update the Provider Portal, and Accounts Receivable (A/R).

viii. At the end of the provider response period, submit to the Department a void/adjust file using the Department's new interChange format of those claims that the Department should recover.

ix. Receive from EDS, MMIS Recoupment and Error reports for reconciliation and potential follow-up.

x. Review provider documentation that supports erroneous recoveries, prepare refund due notices, and forward the notices to the Department for processing.

d. Timely Identification of Claims

The Contractor shall perform monthly eligibility data matches to identify legally liable third-party resources. All identified coverage shall be incorporated into the Contractor's monthly claim selection and recovery processes for both the FFS and encounter claim populations.

e. Recovery Sources

The Contractor shall provide direct billing of carrier claims including Medicare crossovers, inpatient, outpatient, professional, drug, behavioral health, home health, nursing home, durable medical equipment, dental, transportation, EPSDT, and others. The Contractor shall monitor and provide follow-up on the recovery of unsuccessful billed claims to pursue the recovery of payment for the Department.

f. TRICARE Recovery

The Contractor shall perform an annual data match of the Connecticut Defense Enrollment Eligibility Reporting System (DEERS), to obtain real time eligibility verification queries of newly eligible Medicaid beneficiaries to identify TRICARE identification, billing, and recovery capabilities.

g. Recovery Activity Schedule

The Contractor shall identify, select and initiate the recovery of claims with third-party coverage on a monthly basis.

The Contractor shall submit direct billings and provider disallowance cycles on a monthly basis. Provider disallowance cycles will last 60 days before recovery is initiated.

h. Medicaid-Only Recovery

The Contractor shall track amounts on received claims where the paid amount is more than the Medicaid paid amount. The Contractor shall provide a monthly report to the Department that identifies the amount not invoiced by the Contractor.

i. Customer Services for Disallowance

The Contractor's Provider Relations unit shall communicate regularly with providers to ensure that they receive the required information and understand the disallowance process. The Contractor's Provider Relations staff members shall be thoroughly trained on customer service-related etiquette and techniques, Medicare and commercial insurance billing and reimbursement methodologies, and Department-specific requirements.

The Contractor shall allow providers 60 days to respond to the disallowance notice. Provider Relations Representatives shall contact the provider two times during the 60-day period to confirm that the report was received, answer any questions, and remind the provider when the cycle is closing. This 60-day provider response period may be modified at the Department's discretion.

J. Medicaid Managed Care Recovery

In recovering Medicaid Managed Care cost of care - encounter claims from legally liable third parties, the Contractor shall follow the third party liability procedures and requirements specified in Section 3.37 of the State of Connecticut Department of Social Services Medicaid Managed Care - HUSKY A, SCHIP Managed Care - HUSKY B, and Charter Oak Managed Care Request for Proposal.

2) *Recover from client health insurance or Medicare those Medicaid paid claims not cost avoided when a client's eligibility record contains third party liability information*

The Contractor shall perform Medicaid benefit recovery of claims not cost avoided for which client third party liability is available including recovery of Medicaid claims associated with prenatal, postnatal care, and EPSDT, and Recovery of Medicaid paid claims in which the provider either by commission, omission, or error by-passed the Department's third party liability requirements and instead sought Medicaid reimbursement.

To identify claims for which the provider either by commission, omission, or error by-passed the Department's Third Party Liability requirements and received Medicaid payment, the Contractor shall interrogate the DSS client TPL file and Medicaid paid claims files on a monthly basis to identify these Medicaid paid claims for clients who have commercial insurance in force for that claim service period, and perform Medicaid benefit recovery of that claim.

The Contractor shall identify prenatal, postnatal care, and EPSDT claims by the following criteria:

a. Prenatal and postnatal services:

   i. Services performed by a physician or nurse practitioner with the specialty of obstetrics and gynecology or services performed by a nurse midwife

   ii. Diagnosis code on the claim falls in the range of 630-634.92, 640-676.92, V22-V259, V263, or V28-V289.

   iii. Procedure on the claim is in the list in Exhibit 2.

   iv. Client gender is female.

b EPSDT services:

   i. Services performed by a physician or nurse practitioner with the specialty of pediatrics or family practice.

   ii. Procedure on the claim is in the list in Exhibit 3.

   iii. Client is less than twenty-one years of age.

This criteria may change to reflect changes in Departmental billing procedures or changes in federal regulations.

Identify new or expanded TPL information on the client's eligibility record and then recover the client's Medicaid paid claims from health insurance or Medicare

The Contractor shall utilize current DSS Client Eligibility and TPL Information files with its own TPL information for creating quality benefit recovery of Medicaid paid claims. The Contractor shall:

a. Obtain from the Department the DSS Client Eligibility and TPL Information files to identify those clients that have new or expanded third party liability coverage.

b. Extract and reformat client information obtained from DSS Client Eligibility, TPL Information, Paid and Encounter Claims files to generate Medicaid paid claims for submission to third parties.

c. Interrogate Department EMS client eligibility data every thirty days to identify new and / or expanded client health insurance and / or Medicare information.

d. Identify claims that should be selected for benefit recovery either by a direct billing or provider adjustment.

e. Correct and perfect a claim to diminish the likelihood of rejection by the liable third party.

f. Follow up on, correct, and perfect claims billed to and denied by a third party.

g. Follow up on aged and outstanding claims billed to third parties.

h. Select and bill claim to liable third parties and / or perform a Medicaid claim provider adjustment process in a frequency to be determined by the state agency but not greater than sixty days after the end of the month in which the triggering third party information was entered on the Department's EMS file.

i. Select and generate claims either in paper or electronic format, whichever is acceptable by the liable third party.

2. Electronic Claims Submission Pursuant to HIPAA compliance specified at 45 CFR Part 162, Health Insurance

Reform: Standards for Electronic Transactions, the Contractor shall generate HIPAA compliant Health care claims or equivalent encounter information using the following standards:

a. For Professional Health Care Claims: the ASC X12N 837 - Health Care Claim:Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 (incorporated by reference in §162.920).

b. For Institutional Health Care Claims: the ASC X12N 837 - Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 (incorporated by reference in §162.920).

c. For Retail Pharmacy Drug Claims: the National Council for Prescription Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 0, February 1, 1996 (incorporated by reference in §162.920).

d. For Dental Health Care Claims: the ASC X12N 837 -Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 (incorporated by reference in §162.920).

3. Accounting and Reporting

a. The Contractor shall establish and maintain financial controls that account for all third party liability cash recoveries, denied Medicaid claims, and provider recoupment / disallowed claims, and generate reporting that encompasses all benefit recovery of Medicaid claims activity.

The Contractor shall:

i. Meet all Department of Social Services benefit recovery accounting and reporting requirements.

ii. Report recoveries in a format, frequency, and manner that will support the Department of Social Services' required CMS reporting.

iii. Establish financial controls for transmitting to the Department recovered third party liability dollars or claims information necessary to affect a recovery through provider disallowance.

iv. Report its Medicaid paid claim benefit recovery experience in media and frequency specified by the Department.

v. Report detail and summary information for the results of its benefit recovery process.

b. Supporting Client's GAAP
The Contractor shall maintain accounting practices according to generally accepted accounting principles (GAAP). The Contractor shall provide the Department with 3 yearly GAAP reports in August, September and October, or as needed by the Department.

c. Accounts Receivable System
The Contractor's Accounts Receivable system and cash management process shall be used to post, track, and reconcile billings and payments from initial receipt through monthly invoicing.

d. Bank Lock-Box Account
The Contractor shall establish and maintain a bank lock-box account for the deposit of all recovery checks. All deposits shall be made within twenty-four (24) hours of receipt. The Contractor shall:

i. Secure a lockbox account service for the Department to receive recoveries from third-party resources.

ii. Be responsible for all costs of the lockbox throughout the duration of the contract.

iii. Establish financial controls to ensure that all Department recoveries are appropriately deposited to this account.

iv. Revert all Interest received on this account to the Department.

v. Schedule monthly transfers to the Department's lockbox account and provide lockbox reconciliation reports that include deposits, transfers, and interest accrual.

vi. Provide copies of the bank statement and other check information to the Department.

e. Medicaid Recovery Reporting

The Contractor shall provide the Department with the following Medicaid benefit recovery reporting on a monthly basis.

i. Provider Disallowance Projects: Recoupments and refunds processed during the month.

ii. Long-Term Care Recovery Projects: Recoveries for work on Long-Term Care provider audits, AIDP Audit Project, AIDP Claims Audit recoveries, and Long-Term Care Self Reporting.

iii. Carrier Recovery Report: Gross and net recoveries by carrier.

iv. Lockbox Summary: Gross deposits received through the lockbox, netted by refunds, overpayments, refunds, and "Not Founds."

v. Summary of Payments Not Identified by HMS (Not Founds): Listing of each carrier check received where claims could not be located on the Contractor's accounts receivable system.

vi. Carrier Refunds: Refunds approved and forwarded to DSS for processing.

vii. Program Indicator Report: Recoveries by different DSS programs (Title XIX, Connecticut AIDS Drugs Assistance Program (CADAP), State Administered General Assistance Program (SAGA), etc.).

viii. Any additional reports as required by the Department

F. Transmission of Adjustment Data to DSS

The Contractor shall transmit monthly provider adjustment Medicaid paid claim file information to the Department for both Medicare and commercial adjustments through the following interChange files:

I. Medicare A/B file (hmsmed_ab.dat.zip): Contains information on claims to be adjusted/voided as a result of HMS's Medicare disallowance projects.

II. Financial Transaction Payouts/Recoupments/Adjustment File (hmsfin.dat.zip): Identifies provider overpayments and underpayments.

G. Recovery Activity Reporting Requirements

The Contractor shall provide the following Third Party Liability Benefit Recovery Project (TPLBRP) recovery activity reports:

i. TPLBRP110 - Detail Level Reporting of Claims Selected and Billed to Health Insurance Carriers (See Exhibits 5a- Detail Level Reporting of Claims Selected and Billed to Health Insurance Carriers, and 5b-Data Descriptors for Detail Level Reporting of Claims Selected and Billed to Health Insurance Carriers. This monthly report provides claim-level detail of claims selected for billings to carriers. The report includes the detail level of originally billed claims as well as claims selected for re-bill in that reporting month.

ii. TPLBRP120 - Detail Level Report of Claims Selected for Recoupment From Providers (See Exhibits 6a-Detail Level Report of Claims Selected for Recoupment from Providers, 6b-Data Descriptors for Detail Level Report of Claims Selected for Recoupment from Providers). This monthly report provides detail claim level reporting of claims selected for provider recoupments.

iii. TPLBRP210 Detail Level Report of Claims Recouped From Provider (See Exhibits 7a-Detail Level Report of Claims Recouped from Providers, 7b-Data Descriptors for Detail Level Report of Claims Recouped from Providers,)This monthly report will be provided at the end of a recoupment cycle after the claims have been processed and recouped directly from the provider. It provides claim level detail to report the total dollar amount recouped and claim count by provider.

iv. TPLBRP100, TPLBRP101 - Summary and Detail Level Reporting of Claims Excluded From Benefit Recovery (See Exhibits 8a-Detail Level Report of Claims Excluded from Benefit Recovery, 8b-Data Descriptors for Detail Level Report of Claims Excluded from Benefit Recovery, 8c-Summary Report of Claims Excluded from Benefit Recovery.)This two-part monthly report provides claim-level detail on claims that are excluded from each billing cycle as a result of contractor and DSS-required edits. The summary report will list the reporting month, edit description, number of claims and DSS Paid Amount. Detailed information on all claims originally selected in the contractor's "hits" process, but which were dropped, or edited, during the claims processing portion will be provided as well.

v. TPLBRP420, TPLBRP400, TPLBRP410 - Summary and Detail Level Reporting of Outstanding Claims (See Exhibits 9a-Detail Level Report of Outstanding Claims, 9b-Data Descriptors for Detail Level Report of Outstanding Claims, 9c-Summary Report of Aged Accounts Receivable by Carrier, 9d-Data Descriptors for Summary Report of Aged Accounts Receivable by Carrier, 9e-Summary Report of Outstanding Accounts Receivable by Carrier from Bill Month, 9f-Data Descriptors for Summary Report of Outstanding Accounts Receivable by Carrier from Bill Month.).

These monthly reports provide claim-level detail on claims outstanding from previous billings. The summary reports list the aged accounts receivable by carrier, totaling the number of claims outstanding and the billed amount.

vi. TPLBRP220 Detail Level Reporting of Denied Claims (See Exhibit 10a-Detail Level Report of Account Receivables Denied, 10b-Data Descriptors for Detail Level Report of Account Receivables Denied) This monthly report that supplies detail of claims that were denied by the carrier for the reporting month, and why the claim was denied.

vii. TPLBRP200, TPLBRP201, TPLBRP300 - Summary and Detail Level Reporting of Health Insurance Recoveries (See Exhibit 11a-Detail Level Report of Paid Claims with Variance, 11b-Data Descriptors for Detail Level Report of Paid Claims with Variance, 11c-Summary Report of Claims Recovered From Health Insurance Carriers, 11d-Recoveries by Deposit Month, 11e-Data Descriptors for Recoveries by Deposit Month.)These Monthly reports detailing and summarizing claim counts and recovered dollar amounts by carrier code by month and summary by state fiscal year. Details whether the claim was a Commercial Insurance direct bill, Medicare Part A or B recoupment.

h. Reporting Requirements

i. The contractor is required to be consistent in its TPLBRP reporting practice

ii. The contractor shall provide sample electronic test data and file layouts of the TPLBRP reports in order for CTDSS to determine if the data is suitable for its import needs.

iii. The contractor will be required to make any necessary format, file structure or other changes essential for CTDSS import of data.

iv. The contractor will be required to notify CTDSS and get prior approval if it contemplates any subsequent format, file structure or other changes to the TPLBRP reports.

i. Other Reports

i. The Contractor shall provide any additional TPLBRP reports required by the Department .

B. THIRD PARTY LIABILITY VERIFICATION

The Contractor shall receive unverified TPL information obtained either by the Department during a client's initial application and subsequent re-determinations for Connecticut Medical Assistance eligibility or through other referral sources. The Contractor shall identify legally liable third party resources and incorporate the third party liability data into the Department's client eligibility case file so that either the state agency or a Medicaid Managed Care Organization may process claims under its third party liability payment and recovery procedures. The Contractor shall:

1. Build and implement a Third Party Liability Verification System based on receiving third party liability referrals from a variety of sources.

2. Be responsible for the costs associated with obtaining referral information from the Department.

3. Establish a protocol to handle emergency situations to ensure that the client's third party liability record on the EMS is updated the same business day in situations where a client's access to care is adversely affected by the potential of erroneous third party liability information on the Department's eligibility file.

4. Verify health insurance coverage for all Connecticut Medical Assistance clients covered under a Department's Medical Assistance Unit.

5. Correct previously reported health insurance information, which is subsequently determined to be erroneous.

6. Manually update the client TPL information on the EMS, as needed.

7. From the date of receipt of a referral, perform the TPL verification and update the Department's eligibility file in a timeframe to be determined by the Department but not greater than thirty (30) business days.

8. Report to the Department any referrals that are not updated to the Department's eligibility file within the required period.

9. Ensure that its TPL verification system is compatible with the EMS and MMIS, as needed.

10. Provide a file of any changes, corrections, or deletions needed to be performed on a client's existing TPL record subsequent to its verification of new client health insurance information in a manner, frequency, and format to be specified by the Department.

11. Provide the verified TPL information to the Department in a personal computer-based software, if the Department so requests.

12. Report to the Department summary and detail information on its completed referrals by referral type, as required.

13. Actively assist the Department in correcting any discrepancies or errors in its transmitted data including working with the Department to identify modifications and enhancements to the Department's process of updating the EMS.

14. Provide detailed information on long-term care/skilled nursing coverage including, but not limited to:

    a. Whether or not the policy requires a hospital stay before entry into the long-term care facility

    b. How the policy coordinates benefits with Medicare

    c. Whether the plan covers in-network only or will cover out-of-network care

    d. Whether or not pre-authorization is required

    e. The number of days covered and whether the coverage is per calendar year or contract

    f. The amount per day the policy covers

    g. Whether or not there is a lifetime maximum

    h. Other pertinent information about the insurance

C. THIRD PARTY LIABILITY HEALTH INSURANCE SUSPECT REPORTING

The Contractor shall verify the suspect client third party liability and forward new information to the Department for inclusion in its eligibility file. The Contractor shall develop a working process of analyzing the Department's interchange health insurance suspect report to identify and determine if a client has or had third party liability coverage. The Contractor shall:

1. Build and implement a suspect third party liability health insurance verification and reporting program that succeeds the Department of Social Services' current process.

2. Correct its previously reported health insurance information, which is subsequently determined to be erroneous.

3. Manually update the client third party liability information on the EMS, as needed.

4. Ensure that its third party liability verification system is compatible with the EMS and MMIS, as needed.

5. Provide a file of any changes, corrections, or deletions needed to be performed on a client's existing third party liability record subsequent to its verification of new client health insurance information in a manner, frequency, and format to be specified by the Department.

6. Provide the verified third party liability information to the Department in a personal computer-based software, if the Department so requests.

7. Report to the Department summary and detail information on its completed referrals by referral type, as required.

8. Actively assist the Department in correcting any discrepancies or errors in its transmitted data including working with the Department to identify modifications and enhancements to the Department's process of updating the EMS.

9. Provide output reports to the Department that identify and track the clients for which health insurance coverage was verified as not applicable and reported to the Department for deletion from the EMS.

10. Receive a deliverable from the Department identifying the suspect carrier code and carrier name associated with the information contained in Potential Third Party Liability for Follow-Up Report.

11. Receive the Potential Third Party Liability for Follow-Up Report, perform the third party liability verification, and return the information back to the Department within fifteen business days of receipt.

12. Provide detailed information on long-term care/skilled nursing coverage including, but not limited to:

    a. Whether or not the policy requires a hospital stay before entry into the long-term care facility

    b. How the policy coordinates benefits with Medicare

    c. Whether the plan covers in-network only or will cover out-of-network care

    d. Whether or not pre-authorization is required

    e. The number of days covered and whether the coverage is per calendar year or contract

    f. The amount per day the policy covers

    g. Whether or not there is a lifetime maximum

    h. Other pertinent information about the insurance

13. Provide any additional Third Party Liability Health Insurance Suspect reporting as required by the Department

D. THIRD PARTY LIABILITY INFORMATION FORM

The Contractor shall implement a process to receive, verify and report to the Department any previously unknown TPL, changes, corrections or deletions of client health insurance information received from the Connecticut Medicaid Program Provider Community. Information results shall be reported to the Department to update the TPL database corrections, and to the referring Medicaid provider to coordinate benefits between Medicaid and client TPL. The Contractor shall:

1. Implement a Third Party Liability Information Form - provider reporting process.

2. Provide a file of any changes, corrections, or deletions needed to be performed on a client's existing third party liability record subsequent to its verification of new client health insurance information in a manner, frequency, and format to be specified by the Department.

3. Provide the verified third party liability information to the Department in a personal computer-based software, if the Department so requests.

4. Report to the Department summary and detail information on its completed referrals by referral type, as required.

5. Actively assist the Department in correcting any discrepancies or errors in its transmitted data including working with the Department to identify modifications and enhancements to the Department's process of updating the EMS.

6. Transmit necessary commercial health insurance information to the Department for inclusion on the EMS.

7. Provide customer service to the Medicaid provider in communicating the status and result of the TPL Information Form.

8. Provide detailed information on long-term care/skilled nursing coverage including, but not limited to:

    a. Whether or not the policy requires a hospital stay before entry into the long-term care facility

    b. How the policy coordinates benefits with Medicare

    c. Whether the plan covers in-network only or will cover out-of-network care

    d. Whether or not pre-authorization is required

    e. The number of days covered and whether the coverage is per calendar year or contract

    f. The amount per day the policy covers

    g. Whether or not there is a lifetime maximum

    h. Other pertinent information about the insurance

9. Provide any additional Third Party Liability Information Form reporting as required by the Department

E. THIRD PARTY LIABILITY DATA MATCH AND IDENTIFICATION

1. The Contractor shall secure agreements for the purpose of performing government and commercial health insurance data matches with the following organizations:

   a. The State Workers' Compensation or Industrial Accident Commission: To obtain file information that identifies Medicaid recipients and absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses.

   b. Department of Motor Vehicles: To obtain Motor Vehicle accident report files information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

   c. The State wage information collection agency and Social Security Administration: To obtain wage and earnings files data information that identifies Medicaid recipients that are employed and their employers, employed absent or custodial parents of recipients, and their employers to determine the legal liability of third parties.

   d. Health insurers including a self-insured plan, group health plan, as defined in §607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, and which may or may not be financially at risk for the cost of a health care item or service.

2. The Contractor shall perform a broad scope data match operation encompassing commercial health insurance, and Tricare for identifying Connecticut Medical Assistance Client third party liability. The Contractor shall:

   a. Perform commercial insurance data matches with the DSS Client Eligibility File universe on a monthly basis.

   b. Perform the Tricare commercial insurance data match with the DSS Client Eligibility File universe on an annual basis or as required under regulation.

c. Provide from the data match operation and any additionally needed verification processes accurate and high-quality client health insurance information suitable for performing Medicaid paid claim benefit recovery, and cost avoidance of both Medicaid FFS and Medicaid Managed Care at-risk encounter claims.

d. Maintain the most accurate third party liability database by concurrently matching and identifying new client health insurance information and then verifying any matched client's existing health insurance data to determine additional changes, corrections, or deletions that need to be made to the third party liability record.

e. Transmit electronically to the Department verified health insurance information for automatic updating the EMS.

f. Jointly identify recovery opportunities with the Department and conduct data exchanges and recoveries for agreed upon health plans.

g. Establish and maintain the necessary data exchange agreements with health plans, third party benefit managers, or administrators. Copies of such agreements shall be provided to the Department upon request.

h. Contact organizations and arrange for the data matches.

i. Correct its previously reported health insurance information, which is subsequently determined to be erroneous.

j. Manually update the client third party liability information on the EMS, as needed.

k. Ensure that its third party liability verification system is compatible with the EMS and MMIS, as needed.

l. Provide a file of any changes, corrections, or deletions needed to be performed on a client's existing third party liability record subsequent to its verification of new client health insurance information in a manner, frequency, and format specified by the Department.

m. Provide the verified third party liability information to the Department in a personal computer-based software.

n. Report to the Department summary and detail information on completed referrals by referral type, as required.

o. Actively assist the Department in correcting any discrepancies or errors in its transmitted data including working with the Department to identify modifications and enhancements to the Department's process of updating the EMS.

p. Provide the Department with matched third party information in a format acceptable for electronic submission on the EMS and/or manually update the EMS.

q. Provide the Department with timely third party liability information consistent with a Department defined schedule of data transmission.

r. Correct, quantify, and clarify any TPL information that did not get captured on the EMS due to a discrepancy between the TPL information provided by the Contractor and the TPL information already captured on the EMS, or by other interface problems that result in matched TPL information not getting captured on the EMS.

s. Organize data exchanges regularly to identify client third party and seek Medicaid paid claims recovery from the largest number of liable third parties in Connecticut.

t. Provide detailed information on long-term care/skilled nursing coverage including, but not limited to:

i. Whether or not the policy requires a hospital stay before entry into the long-term care facility

ii. How the policy coordinates benefits with Medicare

iii. Whether the plan covers in-network only or will cover out-of-network care

iv. Whether or not pre-authorization is required

v. The number of days covered and whether the coverage is per calendar year or contract

vi. The amount per day the policy covers

vii. Whether or not there is a lifetime maximum

viii. Other pertinent information about the insurance

ix. Provide any Third Party Liability Data Match and Identification reporting as required by the Department

F. TRAUMA RECOVERY

The Department is required to identify Medicaid clients that have been involved in an accident or trauma to determine if any legally liable third parties may be responsible for paying the cost of health care. In the State of Connecticut, DAS is the agency that recovers from lawsuit settlements and causes of action on behalf of the Department of Social Services. DAS liens the potential settlements and makes Medicaid recoveries.

The Contractor shall implement a process to identify clients not initially determined by DAS as being involved in an accident or trauma. The Contractor may identify if a client has an attorney or has otherwise initiated a cause of action.

The Contractor may uncover potential accident or trauma third party liability and forward this information to DAS for follow up. The Contractor shall:

1. Perform the State agency's required diagnosis and trauma code editing of Medicaid FFS and Managed Care at-risk encounter claim experience under Title 42 CFR, Part 433 Subpart D, Third Party Liability and Connecticut General Statutes 17b 93. Identify Medicaid claims where the claim diagnosis codes are within the range defined for accident/trauma (800.00-999.9), or where the claim diagnosis codes are within the range defined as the supplementary classification of external causes of injury and poisoning found in diagnosis code range E800-E999, inclusive.

2. Supplement the Department's trauma recovery procedures by identifying and referring to DAS for recovery potential casualty insurance recoveries or recoveries from other liable parties where the client does not initiate a lawsuit or where the trauma-related recovery is otherwise not detected by the Department of Social Services or DAS (The basis for this recovery project will be claims identified through standard trauma identification codes in the Department of Social Services' MMIS System. Lawsuits filed by clients who have been identified by DAS are excluded from this recovery project.)

3. Develop and implement an accident and trauma identification and case development process by leveraging its own claims editing methods, interChange Third Party Liability Accident Trauma Report information, and establishing the existence of an attorney, a cause of action, and/or a legally liable third party.

4. Coordinate its accident trauma work with and refer to DAS to avoid duplication of effort and refer its developed case to DAS who will then follow up on the recovery.

5. Follow through with recovery on cases that DAS chooses not to pursue.

6. Perform a match with the State of Connecticut Department of Motor Vehicles and/or police accident files to identify Medicaid clients who were involved in an automobile or traffic accident.

7. Perform a match with medical malpractice files to identify Medicaid clients who have filed medical malpractice claims in Connecticut.

8. Perform a match with Connecticut court systems to identify clients who files civil personal injury lawsuits.

9. Periodically inform providers of their role in TPL/trauma recovery pursuant to Federal regulation 42 CFR 433.138.

10. Provide any Trauma Recovery reporting as required by the Department

G. CHILD SUPPORT MEDICAL INSURANCE IDENTIFICATION

The Connecticut Support Enforcement Services (SES) and the Bureau of Child Support Enforcement (BCSE) enforce child support orders including the medical support component. If medical insurance is available through employment, the noncustodial parent is required to enroll his/her children in this medical insurance unless certain exceptions apply. The Contractor shall research and recover existing medical insurance for dependents that have a child support medical order, whether or not these dependents are on Medicaid, and regardless of who the policyholder is; discover potential medical insurance for children covered under a medical support order; and verify the medical insurance and employer. The Contractor shall:

1. Accept a monthly file from the Connecticut Child Support Enforcement System (CCSES), containing dependents covered under a medical support order and their noncustodial parents, cross match with the Contractor's insurance eligibility information to find potential health insurance for the dependents and/or their noncustodial parents, then verify the potential health insurance.

2. Cross match the verified insurance found via the child support medical insurance match to the Department's client eligibility file and provide the verified insurance for update to the EMS, electronically or manually, for individuals who are Medicaid recipients.

3. Correct its previously reported health insurance information, which is subsequently determined to be erroneous.

4. Manually update the client third party liability information on the EMS, as needed.

5. Ensure that its third party liability verification system is compatible with the EMS and MMIS, as needed.

6. Jointly identify recovery opportunities with the Department and conduct data exchanges and recoveries for agreed upon health plans.

7. Establish and maintain the necessary data exchange agreements with health plans, third party benefit managers, or administrators. (Copies of such agreements will be provided to the Department, when requested. Any expenses charged by health plans, third party benefit managers or administrators for supplying eligibility information or other files to the Contractor will be borne by the Contractor.)

8. Contact organizations and arrange for the data matches. The Contractor shall be responsible for payment of any and all costs incurred in securing necessary files from the Department and the Department's MMIS contractor, performing the data matches, ensuring the third party liability billings do not duplicate those generated by the MMIS contractor, and returning the output of data matches to the Department for input on the EMS.)

9. Provide the Department with matched third party information in a format acceptable for electronic submission on the EMS and/or manually update the EMS.
10. Provide the Department with timely third party liability information consistent with a Department's defined schedule of data transmission.

11. Correct, quantify, and clarify any third party liability information that did not get captured on the EMS due to a discrepancy between the third party liability information provided by the

Contractor and the third party liability information already captured on the EMS, or by other interface problems that result in matched third party liability information not getting captured on the EMS.

12. Organize data exchanges regularly to identify client third party and seek Medicaid paid claims recovery from the largest number of liable third parties in Connecticut.

13. Compare its insurance eligibility database to the noncustodial parent data available from the Department to locate insurance coverage for noncustodial parents.

14. Conduct a data match with its carrier eligibility data to identify noncustodial parents who have active health insurance but their dependents do not.

15. Identify health care coverage available to noncustodial parents including managed care plan insurance.

16. Perform the match with a new child support file at least monthly and provide deliverables at least semi-monthly. The Department will determine the approximate number of records that should be included in the file. The Contractor shall limit the records invoiced to the number of records requested by the Department of Social Services. The Department reserves the right to change the frequency of the match and the number of hits to be included on the file.

17. Electronically provide a file containing the verified third party liability information in the frequency, format, and manner requested by the Department for update to the EMS including providing the Department with coverage type codes identified on Exhibit 4.

18. Actively assist the Department in correcting any discrepancies or errors in its transmitted data including working with the Department to identify modifications and enhancements to the Department process of updating the EMS.

19. At a minimum, report the date of the deliverable, the number of records where the Contractor identified and verified insurance, and the number of unique policies identified.

20. Report the number of verified insurance it found for dependents, separately identifying those dependents that are also receiving medical assistance.

21. Issue a National Medical Support Notice (NMSN), Part A, (Notice to Withhold for Health Care Coverage) and follow up with the employer if requested by the Department.

22. Report the number of existing insurance found for a noncustodial parent where there is no insurance for the dependent and, if appropriate, the number of NMSNs issued and successfully implemented.

23. Issue a National Medical Support Notice (NMSN), Part A, (Notice to Withhold for Health Care Coverage) and follow up with the employer if requested by the Department.

24. If the individual is a Medicaid client, provide detailed information on long-term care/skilled nursing coverage including, but not limited to:

    a. Whether or not the policy requires a hospital stay before entry into the long-term care facility

    b. How the policy coordinates benefits with Medicare

    c. Whether the plan covers in-network only or will cover out-of-network care

    d. Whether or not pre-authorization is required

    e. The number of days covered and whether the coverage is per calendar year or contract

    f. The amount per day the policy covers

    g. Whether or not there is a lifetime maximum

    h. Other pertinent information about the insurance

25. Provide any Child Support Medical Insurance Identification reporting as required by the Department

H. ACUTE CARE HOSPITAL AND SKILLED NURSING FACILITY CREDIT BALANCE/OVERPAYMENT AUDITS, APPLIED INCOME PROJECT, MAINTENANCE OF ONLINE CREDIT BALANCE REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES, AND RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM

The Contractor shall perform credit balance/overpayment audits of skilled nursing facilities and acute care hospitals, process Applied Income Disposition Project (AIDP) claims, maintain a provider overpayment self-reporting program and perform a Recovery Audit Contractor (RAC) Program. The Contractor shall:

1. Develop and implement an audit program that identifies inappropriate/erroneous payments and credit balances owed to the Department by long-term care facilities and hospitals.

2. Process AIDP claims not processed by the Department and develop and maintain a self-reporting program which allows long-term care providers to self-report provider identified Medicaid overpayments directly to the Contractor.

3. Identify potential overpayments through retrospective onsite audits of paid claims data. (All potential overpayments identified shall be thoroughly researched and presented to the appropriate provider representative for review and concurrence.)

4. Meet with providers for exit conferences and to discuss audit results, as necessary.

5. Conduct an onsite overpayment compliance audit of financial records of all Medicaid Long-term Care providers every two years to identify and recover Medicaid overpayments not reported by providers through the program.

6. Process identified IADP claims not processed by the Department where there is no record of a W-9 Medicare clearance form.

7. Identify and recover any credit balances due the Department by hospitals in Connecticut. (All credit balances identified shall be researched and presented to the appropriate provider representative for review and approval.)

8. Ensure that all long-term care providers are accurate, complete, and timely when reporting Medicaid overpayments to the Department by establishing a provider self-reporting program to allow long-term care providers to self-report provider identified Medicaid overpayments directly to the Contractor.

9. Develop and implement appropriate provider reporting mechanisms, educate providers on policies and procedures of the program, review all provider identified overpayments for accuracy, research all identified overpayments with incomplete information, process reported Medicaid overpayments, and submit deliverables for recoupment.

10. Perform the above requirements on a supplemental basis and not duplicate any efforts performed by the Department.

11. Provide the Department with a monthly status report showing year-to-date and project-to-date overpayments (recovered and identified for recovery) by provider.

12. Detail the recoveries by claims payments and applied income payments.

13. Provide the Department with audit schedules and audit procedures.

14. Provide individual provider and recipient reports detailing overpaid claims as requested by the Department.

15. Be available by telephone and site visits to provide the Department with an oral status report on request.

16. Update the EMS directly as needed for changes.

17. Process identified overpayments directly through EDS for recoveries when requested by the Department .

18. Provide additional reports that the Department reasonably requests.

19. The Contractor shall implement and perform a comprehensive RAC program for the Department as required under Section 641 of the Patient Protection and Affordable Care Act (PPACA) P.L. 111 -148, The Contractor shall:

a. Identify underpayments and overpayments made by the Department and recoup any overpayments;

b. Create a process for organizations to appeal adverse decisions made by the Contractor;

c. Coordinate recovery efforts with other governmental entities performing audits:

d. Perform a complete review of the Department's program regulations, policies, manuals, state codes, administrative rules, provider manuals and bulletins, Medicaid publications, Code of Federal Regulations (CFR 42) and the Office of Inspector General (OIG) Exclusion database;

e. Meet with internal and external stakeholders identified by the Department to ensure that the Contractor meets the DSS program goals and guidelines, provide specific education on the RAC program requirements/processes, coordinate with other audit efforts and identify exclusions;

f. Utilize the Contractor's existing database to implement the RAC program;

g. Perform data mining and analysis to identify and target improper payments;

h. Utilize advanced data modeling tools to perform statistical data analysis to target claims and providers for audit, or to bring new issues to the attention of the Department for potential development and auditing

i. Following the identification of the overpayments the Contractor shall audit and validate the overpayment. The Contractor shall conduct an automated audit or a complex audit of:

   i. Improperly paid claims identified from claim data elements alone, with no review of provider documentation, are validated through an automated audit; and
   ii. Claims that require further audits/reviews of medical records or billing/financial records to validate that an improper payment exists and the amount of the improper payment, are validated through the complex audit/review process.

j. The Contractor shall utilize an electronic recoupment file protocol which processes provider offsets electronically through the provider's remittances. The Contractor shall submit these files to DSS' MMIS vendor. In addition, the Contractor may accept payments from Providers through the DSS lockbox and reconcile payments monthly.

k. The Contractor shall provide the Department with a list of targeted providers and claims prior to the start of the audit to ensure the providers are not currently being pursued by DSS;

l. The Contractor shall report on a monthly basis, identified underpayments identified through both complex and automated reviews. Identified underpayments will only be reported when it is found that a claim was incorrectly billed at a lower level of payment than appropriate, not in situations where the provider failed to include a provided services on a claim.

m. The Contractor shall continue to develop methods to electronically target and review potential overpayments that occur when Medicaid and another payor reimburse a provider for the same claim.

n. The Contractor shall continue the development of an expanded Payment Integrity provider portal through which overpayments can be reported and tracked. The provider portal will streamline self- disclosure process for all providers, automate refund data aggregation, and be used as a delivery vehicle for Desk Reviews and eReviews. The portal will include an historical database of DSS paid claims (5 years) and providers will have the ability to search and locate claims and use data entry functions to report overpayments.

o. The Contractor shall work with the Department and provide outreach aud education to providers and provider associations to educate them on the RAC process and ways to prevent overpayments from occurring.

p. The Contractor shall make efforts to address all provider concerns and disputes prior to initiating recoveries. If, however a provider disagrees with a recovery they may request an administrative hearing to contest an adverse determination. In such cases, the Contractor shall continue to assist the Department until resolution is obtained.

q. The Contractor shall track every claim selected for audit and manage those cases using the Contractor's proprietary case management system, TRAC, which details the findings and results related to the identification, verification, and recovery of overpayments.

r. The Contractor shall participate in monthly status meetings with the Department during which the Contractor shall update the Department on progress and results, evaluate any issues and discuss immediate next steps.

s. The Contractor shall provide the following .reports to meet both DSS and CMS reporting requirements:

   i. A monthly overpayment report- Includes all information necessary to identify and track reported overpayments on a claim level.
   ii. A monthly underpayment report- Includes all identified underpayments on a claim level.
   iii. A quarterly reason code recovery report-The distribution of all identified overpayments/recoveries by type of overpayment.
   iv. A quarterly provider-level recovery report-provider and provider type distribution of overpayments and underpayments.
   v. A quarterly provider appeal report -A claim level report of all provider appeals and status.
   vi. A quarterly summary of provider education activities -Includes meetings with providers and provider associations, newsletters and other education activities.

vii. A Suspected Fraud Report-Reported as suspected cases are discovered. This report includes case documentation that supports potential provider or member fraud identified through analysis or audits.

viii. Provide any Additional RAC program reporting as required by the Department

I. WORKERS' COMPENSATION RECOVERY

1. The Department is required to establish or make attempts to establish data exchange agreements with the State Workers' Compensation or Industrial Accident Commission. Each commission files information in which to identify Medicaid recipients and absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses. In addition to performing the Workers' Compensation Data Match requirements specified at E.1.a of the contract, the Contractor shall:

   a. Maintain the Contractor's current Workers' Compensation effort as described in its July 18, 2008 Project Scope of Work.

   b. Perform a comprehensive Medicaid workers compensation identification and case management program, which includes large volume data matching and processing.

   c. Process workers compensation referrals received from, but not limited to: DSS Assignment of Interest in Claim or Cause of Action, attorney correspondence, SAGA Administrative Service Organizations, Potential Lawsuit Notification Form referrals, State of Connecticut Workers Compensation Commission referrals.

   d. Employ Connecticut-specific Workers' Compensation Caseworkers if necessary.

   e. Establish a post office box receipt of project-related correspondence.

   f. Establish a dedicated DSS project telephone number to field the calls from project stakeholders such as: attorneys, Workers' Compensation carriers, and clients.

   g. Manage and organize data requirements related to workers compensation through the use of its Maestro proprietary case management system.

   h. Review and obtain approval of system-generated correspondence. The Contractor shall provide DSS with Connecticut-specific sample correspondence that is generated from its Maestro system.

2. The Contractor shall implement the following specific works steps necessary to perform the above noted service requirements:

a. Process Paper Referrals. The Contractor shall enter all existing leads into the Maestro case management system and verify basic key information, including:

   i. Client information. Name, date of birth, Social Security Number, Medicaid identification number, and address of the injured Medicaid client.

   ii. Attorney information. Name, firm association, address, telephone number, facsimile number, and e-mail address.

   iii. Accident information. Date of accident, type of accident, first date of medical treatment, last date of medical treatment.

   iv. Case information. Referral/identification source, case type, case open date.

   v. Insurance information. Insurance company name, address, telephone number, facsimile number, insurance adjuster name, and claim number.

   vi. Employer information. Name, address, EIN, contact name, contact phone number, contact email address.

   vii. Type of injuries/body parts injured. Type and source of injury and the related body parts injured.

b. Investigation and Case Valuation. The Contractor shall load DSS claims data into its claim data warehouse. The Contractor's Workers' Compensation caseworkers shall use the DSS claims data to relate and value Medicaid payments.

c. Analyze case data including: nature of the injury, body parts injured, source of the injury, medical notes and records, and any documentation the client's attorney (or representative) submits.

d. Select claims related to accident/incident.

e. Verify that payments made by Medicaid were not duplicated. The Contractor shall review claims data received from the various sources and compare them to claims paid by Workers' Compensation insurers/employers.

f. Total all claims related to accident/incident. The Contractor shall select related claims and verify the claims were not duplicated by the Workers' Compensation insurer/employer, The Contractor shall use the International Classification of Diseases (ICD-9) and evaluate the related claims and accumulate the expenses to the accident in question.

g. Lien Notice and Claim Billing. For every case valued at $250 or more, the Contractor shall serve written notice to the employee at his last-known address, the insurance company at its principal place of business or the employer, if self-insured, at its principal place of business, and the workers' compensation commissioner, at the district office.

h. Perform any method of claim or lien filing format including paper and electronic, and create standard lien/claim statements necessary for a workers' compensation carrier to process, and, as required, in specific UB92 and/or HCFA 1500 claim forms.

i. Re-Valuation. To ensure that cases are current, the Contractor shall re-value each case every ninety (90) days or when the Contractor is notified that a settlement is pending.

j. File claim/lien with Commission Compensation Review Board (CRB). If there is a dispute in a worker's compensation case, the Worker's Compensation Commission will hold a hearing in one of the eight District Offices located throughout Connecticut. The Contractor shall ensure that DSS's claim is filed with the appropriate CRB district office.

k. Process Claims Payments and Release Lien. The Contractor shall direct interested parties to mail checks (made payable to DSS) to its post office box. Once the Contractor verifies check amount is complete and there is no language that would prevent deposit (e.g., "payment in full" language when the check does not constitute payment in full), the Contractor shall forward payments to DSS as part of the monthly deposit in accordance with DSS banking procedures. The Contractor shall record each workers compensation payment both on Maestro and the physical case file with the appropriate payment code (full, partial, negotiated, etc.). The Contractor shall file any lien release necessary before closing the case in both Maestro and the physical case file.

l. Information Updates. The Contractor shall generate daily reports to manage the correspondence process. The Contractor shall communicate with WC insurance carriers and agents, and attorneys/ paralegals to inquire about the status of cases, request payment, or provide detailed case information. The Contractor shall supplement mailed correspondence with telephone contact and inquire about case status and obtain a commitment for payment.

m. Subpoenas. The Contractor shall manage all requests for subpoenas within the allowable period. If the subpoena is served to DSS, the Contractor gathers the necessary documentation and consults in-house legal staff or, if appropriate, local counsel to ensure compliance and response as necessary.

n. Reporting. The Contractor shall generate standard month-end status reports and customizable reports including but not limited to:

- Leads by Source
- Cases Opened
- Cases Closed
- Cases Non-Workable
- Maestro Database Value
- Value by Status
- High Dollar Cases
- Follow-Up Reports
- Quality Control Reports
- Dollars Collected

o. Claims Payment Posting. For those cases for which the Contractor is able to obtain claims payment directly from the Workers Compensation carrier, the Contractor shall use the DSS interChange AR Posting File/TPL Carrier Payments File to report on Medicaid claims that have received full or partial workers compensation payment.

J. CONNECTICUT INSURANCE PREMIUM ASSISTANCE PROGRAM - "CIPA"

1. Under Connecticut General State Statute Section 17b-256 the Department of Social Services administers the Connecticut AIDs Drug Assistance Program (CADAP), which provides payment for the cost of drugs prescribed by a physician for the treatment of acquired immunodeficiency syndrome or human immunodeficiency virus. Also under the statute, the Department, subject to federal approval and within available federal resources, may maintain existing health insurance policies for eligible CADAP clients, including, but not limited to, the coverage of costs associated of with such policies that provide a full range of human immunodeficiency virus treatments and access to comprehensive primary care services. Through the use of federal Ryan White HIV/AIDS Program Part B ADAP Funds, the Department of Social Services will implement the Connecticut Insurance Premium Assistance Program (CIPA) for the purpose of paying the insurance premiums for a group health plan or an individual plan for CADAP participants, if the payment of the premiums would be more cost effective to the State, and the group health or individual insurance plan meets certain criteria described in the U.S Department of Health and Human Services, Health Resources and Services Administration Policy Notice 07-05. The Contractor has directed by the Department and as set forth herein, shall implement and operate the CIPA. By April 1, 2011 under this contract the Contractor shall:

   a. Modify the Contractor's Premium Identification Evaluation and Reimbursement (PIER) tracking system, used by the Contractor to operate HIPP plans in other states, to incorporate the specific needs of CTDSS and its CADAP program, including but not necessarily limited to the addition of a field to identify the client's primary language.

   b. Modify the Contractor's HIPP client correspondence to meet the Department's specifications for CIPA and provide all client correspondence in English and Spanish.

   c. Contact 15-20 of the largest insurance carriers and pharmacy benefit managers, nationwide, to confirm whether the Ryan White Part B Formulary and CADAP formulary drugs are all covered for 80-90% of the Department's insured CADAP clients.

   d. Transition the Department's existing participants in the Connecticut Insurance Assistance Program for AIDS Patients (CIAPAP) into the PIER tracking system for participation in the CIPA program.

   e. Determine the availability of third-party insurance coverage for the Department's existing CADAP clients and where third-party insurance exists, confirm that the Ryan White Part B Formulary and CADAP formulary drugs are covered and are therefore suitable for cost avoidance of CADAP pharmacy claims through CIPA.

   f. Provide access to the PIER system for CTDSS and Connecticut Department of Public Health staff designated by the Manager of the DSS Fraud and Recoveries Unit.

g. Work with the DSS Manager of the DSS Fraud and Recoveries Unit and the DSS Division of Financial Management and Analysis to establish a process through which the Contractor shall be able to access and utilize funds provided by the Department to process the payment of reimbursements of group or individual health plan insurance premiums as directed by the Department. Such processes shall include but may not be limited the reconciliation of reimbursement payments against the funds provided by the Department.

h. Create a CIPA website including links back to PIER for electronic application processing and member web portal access.

i. Establish, maintain and operate a dedicated CIPA member phone-line, toll-free within Connecticut, with Spanish translation available.

2. Following the implementation of CIPA and throughout the remaining term of the contract the Contractor shall perform outreach, ongoing enrollment and verification services for new and continuing participants in CIPA. The Contractor shall:

a. Outreach to CADAP clients and determine if they have health insurance in place or have access to health insurance, and to identify those individuals that might be eligible to participate in the CIPA program.

b. Send an application to CADAP clients to request enrollment in the CIPA program. Receive and process all applications for participation in CIPA and notify the applicant of the determination no later than 30 days after the Contractor has received the completed application and all of the required documentation.

c. Apply the eligibility criteria developed by the Department and provided to the Contractor for application determination.

d. Receive and process requests for premium reimbursement from accepted CIPA participants in accordance with the premium documentation requirements established by the Department and provided to the Contractor. Premium reimbursements shall be processed no more frequently than twice a month.

e. Maintain accurate data on CIPA participants in PIER and assist the Department with the maintenance of health insurance data through the electronic transmission of verified new or changed health insurance information to the Department's Eligibility Management System (EMS).

f. For each CIPA participant, verify the client's continued eligibility to participate in CIPA every six months.

g. If directed by the Department following an identified overpayment to a CIPA participant, attempt to recover the overpayment through an offset to future premium reimbursement and/or overpayment notices.

3. In addition to the Contractor's obligations regarding confidentiality as set forth in Part Two – Mandatory Terms and Conditions, the Contractor shall:

   a. Restrict outreach communication to the CADAP client, their alternate or legal contact.

   b. Train all Contractor's caseworkers in CADAP privacy issues, and follow increased security and data handling requirements.

   c. Restrict information gathering to the CADAP client, or their alternate or legal contact and insurance companies.

   d. Scan all incoming documentation into a secure document workflow system and ensure that only those with secure logins and passwords will have electronic access.

   e. Restrict case maintenance to the CADAP client, their alternate or legal contact. Ensure that no private health information or personally identifiable information will be given on the phone unless caller has the correct passcode.

   f. Maintain and follow all HIV and AIDS privacy and confidentiality guidelines specified under Connecticut General State Statutes 19a-581 – 19a – 599.

4. The Contractor shall provide ad hoc report access to the Department through PIER and shall also be required to provide specific reports in a format and according to a frequency agreed to by the parties. The frequency, content, and format, of all ad hoc reports shall be discussed and mutually agreed upon by the Contractor and the Department. Such reports shall include but may not be limited to:

   a. Reports documenting the cost-effectiveness of CIPA.

   b. A bi-weekly report of premiums actually paid by Contractor.

   c. A Contractor billing report – a monthly report of actual reimbursements of eligible insurance premiums made by the Contractor for each CIPA participant including those reimbursements of eligible insurance premiums made during a prior month if the eligible insurance premium covered the current monthly reporting period. (Eg. A reimbursement for an insurance premium paid on a quarterly basis will be reported in each of the three monthly reports for the quarter).

   d. Quarterly and annual summary reports of unduplicated client numbers.

K. RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM

1. Part One - Section II -Description of Services -Subsection H "Acute Care Hospital and Skilled Nursing Facility Credit Balance/Overpayment Audits, Applied Income Project and Maintenance of Online Credit Balance Reporting System for Long-term Care Facilities" on pages 34 and 35 of the original contract is amended by the addition of the Recovery Audit Contractor (RAC) Program

2. Under Section 641 of the Patient Protection and Affordable Care Act (PPACA) P.L. 111 -148, state Medicaid programs are required to establish a RAC program to reduce Medicaid improper payments through the efficient detection and collection of overpayments and to identify provider underpayments. HMS shall build a comprehensive RAC program for the Department through an expansion of the current contracted overpayment identification and recovery audit services.

3. The Contractor shall implement a RAC program through which the Contractor shall:

i. Identify underpayments and overpayments made by the Department and recoup any overpayments;
ii. Create a process for organizations to appeal adverse decisions made by the Contractor;
iii. Coordinate recovery efforts with other governmental entities performing audits.

4. To provide the services described in the Overview and outlined in number 2 above, the Contractor shall:

i. Perform a complete review of the Department's program regulations, policies, manuals, state codes, administrative rules, provider manuals and bulletins, Medicaid publications, Code of Federal Regulations (CFR 42) and the Office of Inspector General (OIG) Exclusion database;
ii. Meet with internal and external stakeholders identified by the Department to ensure that the Contractor meets the DSS program goals and guidelines, provide specific education on the RAC program requirements/processes, coordinate with other audit efforts and identify exclusions;
iii. Utilize the Contractor's existing database to implement the RAC program;
iv Perform data mining and analysis to identify and target improper payments;
v. Utilize advanced data modeling tools to perform statistical data analysis to target claims and providers for audit, or to bring new issues to the attention of the Department for potential development and auditing.
vi. Following the identification of the overpayments the Contractor shall audit and validate the overpayment. The Contractor shall conduct an automated audit or a complex audit of:

1. Improperly paid claims identified from claim data elements alone, with no review of provider documentation, are validated through an automated audit; and
2. Claims that require further audits/reviews of medical records or billing/financial records to validate that an improper payment exists and the amount of the improper payment, are validated through the complex audit/review process.

vii. Report RAC audit results. The Contractor shall utilize an electronic recoupment file protocol which processes provider offsets electronically through the provider's remittances. The Contractor shall submit these files to DSS' MMIS vendor. In addition, the Contractor may accept payments from Providers through the DSS lockbox and reconcile payments monthly.

4. Additional Tasks related to the RAC program. The Contractor shall:

i. Provide the Department with a list of targeted providers and claims prior to the start of the audit to ensure the providers are not currently being pursued by DSS;

ii. On a quarterly basis, report identified underpayments identified through both complex and automated reviews. Identified underpayments will only be reported when it is found that a claim was incorrectly billed at a lower level of payment than appropriate, not in situations where the provider failed to include a provided services on a claim.

iii. Continue to develop methods to electronically target and review potential overpayments that occur when Medicaid and another payor reimburse a provider for the same claim.

iv. Continue the development of an expanded Payment Integrity provider portal through which overpayments can be reported and tracked. The provider portal will streamline self- disclosure process for all providers, automate refund data aggregation, and be used as a delivery vehicle for Desk Reviews and eReviews. The portal will include an historical database of DSS paid claims (5 years) and providers will have the ability to search and locate claims and use data entry functions to report overpayments.

v. Work with the Department and provide outreach and education to providers and provider associations to educate them on the RAC process and ways to prevent overpayments from occurring.

vi. Make efforts to address all provider concerns and disputes prior to initiating recoveries. If, however a provider disagrees with a recovery they may request an administrative hearing to contest an adverse determination. In such cases, the Contractor shall continue to assist the Department until resolution is obtained.

vii. Track every claim selected for audit and manage those cases using the Contractor's proprietary case management system, TRAC, which details the findings and results related to the identification, verification, and recovery of overpayments.

viii. Participate in monthly status meetings with the Department during which the Contractor shall update the Department on progress and results, evaluate any issues and discuss immediate next steps.

ix. Provide the following .reports to meet both DSS and CMS reporting requirements:

1. A monthly overpayment report- Includes all information necessary to identify and track reported overpayments on a claim level.
2. A monthly underpayment report- Includes all identified underpayments on a claim level.
3. A quarterly reason code recovery report-The distribution of all identified overpayments /recoveries by type of overpayment.
4. A quarterly provider-level recovery report-Provider and provider type distribution of overpayments and underpayments.
5. A quarterly provider appeal report -A claim level report of all provider appeals and status.
6. A quarterly summary of provider education activities -Includes meetings with providers and provider associations, newsletters and other education activities.
7. A Suspected Fraud Report-Reported as suspected cases are discovered. This report includes case documentation that supports potential provider or member fraud identified through analysis or audits.
8. Additional and reasonable reports as requested by the Department.

L. ENHANCED TPL DENIED CLAIM TARGETED FOLLOW-UP PROJECT

1. The contractor shall perform the following enhanced TPL denied claim targeted follow-up recovery work for Medicaid claims billed to, and denied by legally liable third parties including, but not limited to, self-insured plans, group health plans, employers', union plans, Administrative Service Organizations (ASO), Third Party Administrators (TPA's), and Pharmacy Benefit Managers (PBM's).

    i. Invalid ID Denials - Medicaid Denied Claims Due To An Invalid Or Aged Policy ID, Or Invalid/Aged Group Number.

        a. The Department and the contractor shall agree upon a Medicaid denied claim dollar threshold in which the contractor shall use to develop a universe of DSS clients that had a high denial rate of claims for the "Invalid Identification Denial" reason.

        b. The contractor shall perform targeted follow-up with identified legally liable third parties defined above in M.1 to determine policy identification issues.

        c. The contractor shall perform extensive contact with legally liable third parties, as necessary, to validate invalid Identification denial reasons

        d. The contractor shall implement new changes, as required or necessary, in receiving and processing legally liable third party eligibility information in order to eliminate or reduce Medicaid claims denied for the Invalid Identification Denial" reason.

    ii. Group Does Not Allow Third Party Claims - Medicaid denied claim due to a legally liable third party not adjudicating Medicaid third party liability recovery claims.

        a. The contractor shall follow-up with legally liable third parties defined above in M.1 that have determined to not adjudicate Medicaid third party liability recovery claims.

        b. The Department and the contractor shall agree upon a Medicaid denied claim dollar threshold to in which the contractor shall use to develop a universe of DSS clients that had a high denial rate of claims due to a legally liable third party not adjudicating Medicaid third party liability recovery claims.

        c. The contractor shall perform educational follow up with the legally liable third parties above in M.1 in citing and educating them on Connecticut's Third Party Liability statutes

        d. The contractor shall perform health insurance appeals provided under Connecticut General State Statutes Title 38a - Insurance, Section 38a-226c, Title 38a - Insurance, Section. 38a - 478m, and/or Title 38a - Insurance, Section 38a-501, as necessary, or take other legal or operational procedures with the legally liable third parties, defined in ii a. above, that have determined to not adjudicate Medicaid third party liability recovery claims

e. The Contractor shall notify the Department of legally liable third parties that have refused to adjudicate Medicaid third party liability recovery claims

iii. Documentation Needed and No Authorization - Carrier has denied the claim with a request for more information including a copy of the medical record, itemized bill, or claim form.

a. The Department and the contractor shall agree upon a Medicaid denied claim dollar threshold to develop a universe of DSS clients that had a high denial rate of claims for the Documentation Needed and No Authorization reason

b. The Contractor shall obtain from providers required medical documentation or other necessary documentation necessary for a legally liable third party to successfully adjudicate a Medicaid third party liability recovery claim. The contractor shall use this documentation to follow-up and pursue third party payment.

c. The Contractor shall utilize any legally liable third party's appeal process to follow-up and pursue third party payment for Medicaid third party liability recovery claims denied for no prior authorization.

iv. Claim Paid To Provider - legally liable third party has indicated that they have reimbursed the contractor- billed recovery claim directly to the provider of service.

a. The Contractor shall provide information to the Department necessary to recover Medicaid claims from providers

b. At the Department's request, or the contractor shall recover Medicaid claims from providers

v. Payments With Low Remittance Dollars - amount paid by the legally liable third party is less than the DSS paid amount.

a. The Department and the contractor shall agree upon a variance between the legally liable third party payment amount and Medicaid billed-paid amount in which Medicaid claims with low remittance dollars will be reviewed.

b. The Department and the contractor shall agree upon the Medicaid claim dollar threshold for Medicaid claims that meet the variance determined in v. a. above, in order to develop a universe of claims with low remittance dollars for follow-up.

c. The contractor shall contact the legally liable third party to determine and verify if the Medicaid claim was correctly adjudicated. The contractor's determination and verification shall be based upon, but not be limited to, the third party's coverage criteria for the Medicaid service-at-issue, the third party's negotiated rates with the provider of service, and any policy holder cost sharing requirements.

d. The contractor shall pursue additional payment from the legally liable third party in cases where the Medicaid claim was not correctly adjudicated and underpaid,

2. The contractor shall provide any Enhanced TPL Denied Claim Targeted Follow-Up Project reporting as required by the Department.

M. OFFICE OF THE HEALTHCARE ADVOCATE

HMS will be paid $105 per hour for work directly related to the Office of Health Care Advocate.

N. FRAUD, WASTE, AND ABUSE

The following solution components shall be performed for HMS by Allied Management Group - Special Investigation Unit, a wholly owned subsidiary of HMS Holdings Corp (as is HMS) as HMS's subcontractor with HMS providing oversight and project management services:

i. Funding/Advanced Planning Document (APD) Support. HMS shall actively assist and support DSS through the solution planning and CMS Advanced Planning Document (APD) process to obtain expedited approval of enhanced federal funding for predictive modeling related to the MMIS.

ii. Data Integration. HMS shall work with DSS and the DSS MMIS vendor to identify appropriate data sources (MMIS or data warehouse) for the solution, and to develop an extract format that effectively supports FWA analysis. To the extent possible, HMS shall leverage existing data feeds as much as possible to minimize costs and burden to DSS.

iii. Solution Configuration. HMS shall configure the FWA solution to DSS specific data, policies, and priorities during the implementation period, and shall ensure through the life of the project that the system is maintained in accordance with DSS data, policies, and priorities. This includes ongoing monitoring of DSS policy changes for the life of the project. During implementation and regularly throughout the project, HMS policy and data analysts shall meet with DSS to discuss how specific policy and data issues should be implemented, consistent with DSS practice and policies.

iv. Initial and Ongoing Integration with DSS/MMIS. HMS shall ensure that the DSS FWA solution is effectively integrated with the MMIS and other DSS systems, per DSS specification to be developed during the project planning process. This includes:

- **Monthly/weekly data extracts**. HMS shall work with DSS and MMIS vendor to ensure that monthly or weekly data extracts from the MMIS, Data Warehouse, and other systems are thoroughly tested, executed, and reviewed for quality on an ongoing basis.

- **Transaction Files**. HMS shall work with DSS to ensure that transactions and files out of the FWA solution are effectively configured, developed, produced, and reviewed for quality to ensure effective and timely integration of results into the MMIS and/or PI process.

v. Analytics Configuration, Maintenance, and Ongoing Development. HMS shall configure, implement, and continually maintain and enhance their suite of analytics through the project to identify inappropriate claims and to target fraud, waste, and abuse. Analytic layers shall include:

- Regulatory Edits
- National Correct Coding Initiative (NCCI) edits

- Clinical Coding edits and algorithms
- Clinical/Logic based FWA targeting algorithms
- Predictive FWA algorithms
- Provider Risk Scorecards

vi. FWA Portal/Dashboard Access. DSS staff and identified stakeholders shall be given access to the FWA solution through a secure, web-based portal. Access is role-based, and HMS shall administer passwords and access based on DSS requirements. Within the portal, each user shall have a configurable dashboard that can be customized to enable efficient access to solution components, screens, and reports – relative to each user's interests.

vii. Case Tracking System. Access to the HMS FWA solution's integrated case tracking system, AIMS shall be given to DSS. HMS shall work with DSS to configure the case tracking system to be consistent with DSS program integrity requirements and protocols, including the customization of required reporting relative to case tracking, as agreed upon by both parties.

viii. Comprehensive Reporting. HMS shall configure, implement, and maintain a complete library of reports, including activity, status, results, utilization, and regulatory reports according to DSS requirements.

ix. Dedicated SIU/Active Analyst (1 FTE). HMS shall provide a dedicated FWA analyst, located in their Windsor CT office, who shall be dedicated to DSS for the duration of the project. This analyst shall work with DSS staff to actively identify inappropriate payment and fraud identification and ensure that DSS staff are achieving full value from the solution.

x. Initial and Ongoing Training. HMS shall supply full user training on the system, including an annual onsite training session for up to 25 users, and ongoing training calls

xi. Ongoing Technical Support. HMS's FWA solution delivery model is Software as a Services (SaaS), and HMS shall provide ongoing technical support to DSS through the duration of the project.

O. <u>Other Projects As Identified</u>

1. The contractor shall work with the Department on developing and implementing new Third Party Liability recovery projects as they are identified.

2. At the Department's request, the contractor shall provide any additional services required to comply with the Affordable Care Act

SECTION III. BUSINESS COST SECTION

A. PAYMENT PROVISIONS

1. Contingency and verification fees – this is a performance-based contract. The Department shall pay the Contractor a contingency fee in which the Contractor shall reduce the Department's recoveries by a fee that equals a percentage of the money recovered. The Department shall pay the Contractor a verification fee in which the Contractor shall reduce the Department's recoveries by the number of health insurance policy verifications it performs. The Contractors' fees shall be deducted from lock-box account balances and documented with each invoice submitted to the Department assuring a full and complete accounting of the recovery and the fee withheld. Contingency fees for any disallowance recoveries shall be deducted from cash recovery projects and documented. Additionally, monthly fees for the performance of fraud, waste and abuse work shall be deducted from lock-box account balances based on the monthly fee schedule articulated below and shall be documented with each invoice submitted to the Department.

    a. Contingency Fee –The Department shall pay the Contractor a contingency fee based upon the fees specified in items A (1-3), F, H, J and K of the Contractor Payment Schedule of this contract.

    b. Verification Fee – The Department shall pay the Contractor a verification fee based upon the fees specified in items B, C, D, E and G the Contractor Payment Schedule of this contract. The Contractor shall be paid on a per policy basis for each policy verified through a combination of manual and web-based health insurance interrogation, data match, electronic commerce, and other verification processes.

        i. The Contractor shall not be paid on a per client verification basis.

        ii. The Contractor shall not be paid a verification fee for verified policies in which the same client health insurance information already exists on the Department's Eligibility Management System.

        iii. The Contractor shall not be paid the verification fee for the same client and carrier verification performed more than one time. The exception is if the Contractor verifies new client health insurance, and then subsequently at a later time verifies that the client's health insurance terminated. In this exception the Contractor would be able to receive payment for the initial health insurance verification and termed health insurance verification.

    c. Per Member Per Month Fee - The Department shall pay the Contractor a per member per month fee based upon fees specified in item I of 7the Contractor Payment Schedule of this contract

    d. Monthly Fee(s) – The Department shall pay the Contractor a monthly fee based upon the fees specified in item L of the Contractor Payment Schedule of this contract. Such fee shall be deducted from the lock-box balances and documented in monthly invoices.

B. CONTRACTOR PAYMENT SCHEDULE

	FUNCTION	Type of Payment	Cost/Percent
A	BENEFIT RECOVERY OF MEDICAID PAID CLAIMS		
	1) Recover Medicaid paid claims from client health insurance or Medicare when third parties are identified after the Department has paid for the cost of care	Contingency	7.90%
	2) Recover from client health insurance or Medicare those Medicaid paid claims not cost avoided when a client's eligibility record contains third party liability information	Contingency	7.90%
	3) Identify new or expanded TPL information on the client's eligibility record and then recover the client's Medicaid paid claims from health insurance or Medicare	Contingency	6.40%
B	THIRD PARTY LIABILITY VERIFICATION	Per Verification	$28.00
C	THIRD PARTY LIABILITY HEALTH INSURANCE SUSPECT REPORTING	Per Verification	$28.00
D	THIRD PARTY LIABILITY INFORMATION FORM	Per Verification	$28.00
E	THIRD PARTY LIABILITY DATA MATCH AND IDENTIFICATION	Per Verification	$23.00
F	TRAUMA RECOVERY	Contingency	10.90%
G	CHILD SUPPORT MEDICAL INSURANCE IDENTIFICATION	Per Verification	$35.10
H	Acute Care Hospital and Skilled Nursing Facility Credit Balance/Overpayment Audits, Applied Income Project, and Maintenance of Online Credit Balance Reporting System for Long-term Care Facilities	Contingency	5.90%
I	Connecticut Insurance Premium Assistance Program Per Member	Per Month Fee	$28.65
J	Recovery Audit Contractor (RAC) Program		
	1) For the performance of Complex Audits	Contingency	10.5%
	2) For the performance of Automated Audits	Contingency	9.3%
K	Enhanced Benefit Recovery of Third Party-Denied Medicaid Paid Claims	Contingency	14.5%
L	Fraud, Waste and Abuse	Monthly	
	1) From April 1, 2013 to September 30, 2013		$130,000
	2) From October 1, 2013 to September 30, 2017		$106,000

SECTION IV. EXHIBITS

Exhibit 1a:	Claim Selection Logic
Exhibit 1b:	Reference Codes
Exhibit 2:	Prenatal and Postnatal Procedure Codes
Exhibit 3:	Early and Periodic Screening, Diagnosis, and Treatment EPSDT Procedure Codes
Exhibit 4:	Department of Social Services Eligibility Management System Commercial Insurance Coverage Codes
Exhibit 5a:	Detail Level Reporting of Claims Selected and Billed to Health Insurance Carriers
Exhibit 5b:	Data Descriptors of Detail Level Reporting of Claims Selected and Billed to Health Insurance Carriers
Exhibit 6a:	Detail Level Report of Claims Selected for Recoupment from Providers
Exhibit 6b:	Data Descriptors for Detail Level Report of Claims Selected for Recoupment from Providers
Exhibit 7a:	Detail Level Report of Claims Recouped from Providers
Exhibit 7b:	Data Descriptors for Detail Level Report of Claims Recouped from Providers
Exhibit 8a:	Detail Level Report of Claims Excluded from Benefit Recovery
Exhibit 8b:	Data Descriptors for Detail Level Report of Claims Excluded from Benefit Recovery
Exhibit 8c:	Summary Report of Claims Excluded from Benefit Recovery
Exhibit 9a:	Detail Level Report of Outstanding Claims
Exhibit 9b:	Data Descriptors for Detail Level Report of Outstanding Claims
Exhibit 9c:	Summary Report of Aged Accounts Receivable by Carrier
Exhibit 9d:	Data Descriptors for Summary Report of Aged Accounts Receivable by Carrier
Exhibit 9e:	Summary Report of Outstanding Accounts Receivable by Carrier from Bill Month
Exhibit 9f:	Data Descriptors for Summary Report of Outstanding Accounts Receivable by Carrier from Bill Month
Exhibit 10a:	Detail Level Report of Account Receivables Denied
Exhibit 10b:	Data Descriptors for Detail Level Report of Account Receivables Denied
Exhibit 11a:	Detail Level Report of Paid Claims with Variance
Exhibit 11b:	Data Descriptors for Detail Level Report of Paid Claims with Variance
Exhibit 11c:	Summary Report of Claims Recovered from Health Insurance Carriers
Exhibit 11d:	Recoveries by Deposit Month
Exhibit 11e:	Data Descriptors for Recoveries by Deposit Month

Exhibit a CLAIM SELECTION

837P PROVIDER TYPE	HMS PROVIDER TYPE DESCRIPTION	837P PROVIDER SPECIALTY	837P PROVIDER SPECIALTY DESCRIPTION	ID PROVIDER TYPE	ID PROVIDER TYPE DESCRIPTION	ID PROVIDER SPECIALTY	ID PROVIDER SPECIALTY DESCRIPTION	837P TYPE OF CLAIM	ID TYPE OF CLAIM	Claims Selection For Other Insurance(s) HMS Type of Coverage	O.I. Ref.	Claims Selection For Medicare: EDS Carrier Code "MDA" and "MDB"	MDA MDB Ref.	O.I. EXCEPTION	MEDICARE EXCEPTION
01	General Hospital	40	Psychiatric Under 21	01	Hospital	002	Psychiatric/Inpatient Under 21	I	I	1 and/or 2		MDA			X
01	General Hospital	40	Psychiatric Under 21	01	Hospital	002	Psychiatric/Inpatient Under 21	X	A	1 and/or 2		None			
01	General Hospital	41	Psychiatric 21-64	01	Hospital	003	Psychiatric/Inpatient 21-64 (Crossovers)	I	I	1 and/or 2		MDA			X
01	General Hospital	41	Psychiatric 21-64	01	Hospital	003	Psychiatric/Inpatient 21-64 (Crossovers)	X	A	1 and/or 2		None			
01	General Hospital	42	Psychiatric Aged	01	Hospital	004	Psychiatric/Inpatient 65+	I	I	1 and/or 2		MDA			X
01	General Hospital	42	Psychiatric Aged	01	Hospital	004	Psychiatric/Inpatient 65+	X	A	1 and/or 2		None			
01	General Hospital	49	Psychiatric Outpatient	01	Hospital	005	Psychiatric - Outpatient	O	O	1 and/or 2		MDB			X
01	General Hospital	49	Psychiatric Outpatient	01	Hospital	005	Psychiatric - Outpatient	X	C	1 and/or 2		None			
01	General Hospital	71	Dental Clinic	01	Hospital	008	Dental Clinic	L	D	1 and/or 2, and 8		MDB			X
01	General Hospital	71	Dental Clinic	01	Hospital	008	Dental Clinic	X	B	1 and/or 2, and 8		None			
01	General Hospital	75	Inpatient	01	Hospital	001	Inpatient	I	I	1 and/or 2		MDA			
01	General Hospital	76	Inpatient	01	Hospital	001	Inpatient	X	A	1 and/or 2		None			
01	General Hospital	79	Outpatient	01	Hospital	007	Outpatient	O	O	1 and/or 2		DDA and MDB			
01	General Hospital	79	Outpatient	01	Hospital	007	Outpatient	X	C	1 and/or 2		None			
04	State Institution	40	Psychiatric Under 21	02	State Institution	007	Psychiatric/Inpatient Under 21	I	I	1 and/or 2		MDA			X
04	State Institution	40	Psychiatric Under 21	02	State Institution	002	Psychiatric/Inpatient Under 21	X	A	1 and/or 2		None		X	
04	State Institution	41	Psychiatric 21-64	02	State Institution	003	Psychiatric/Inpatient 21-64 (Crossovers)	I	I	1 and/or 2		MDA			X
04	State Institution	41	Psychiatric 21-64	02	State Institution	003	Psychiatric/Inpatient 21-64 (Crossovers)	X	A	1 and/or 2		None		X	
04	State Institution	42	Psychiatric Aged	02	State Institution	004	Psychiatric/Inpatient 65+	I	I	1 and/or 2		MDA			X
04	State Institution	42	Psychiatric Aged	02	State Institution	004	Psychiatric/Inpatient 65+	X	A	1 and/or 2		None		X	
04	State Institution	43	Chronic Inpatient	02	State Institution	005	Chronic - Inpatient	I	I	L		MDA			X
04	State Institution	43	Chronic Inpatient	02	State Institution	005	Chronic - Inpatient	X	A	L		None		X	
04	State Institution	44	Int Ltr	02	State Institution	024	ICF/MR (Non Bed Count Specific)	N	L	Exclude All TOC		Exclude All Medicare			
04	State Institution	44	Int Ltr	02	State Institution	024	ICF/MR (Non Bed Count Specific)	N	L	Exclude All TOC		Exclude All Medicare			
04	State Institution	48	Psychiatric Outpatient	02	State Institution	006	Psychiatric - Outpatient	O	O	1 and/or 2		MDB			X
04	State Institution	49	Psychiatric Outpatient	02	State Institution	006	Psychiatric - Outpatient	X	C	1 and/or 2		None		X	
04	State Institution	70	Mental Health Clinic	02	State Institution	011	Community Mental Health Center (CMHC)	N	O	3,4,5,6, and/or 7		None			X
04	State Institution	70	Mental Health Clinic	02	State Institution	011	Community Mental Health Center (CMHC)	X	O	3,4,5,6, and/or 7		None		X	
04	State Institution	80	Rehabilitation Center	02	State Institution	040	Rehabilitation Facility	M	H	3,4,5,6, and/or 7		MDB			X
04	State Institution	80	Rehabilitation Center	02	State Institution	040	Rehabilitation Facility	X	O	3,4,5,6, and/or 7		None		X	
04	State Institution	73	Alcohol And Drug Abuse Inpatient	02	State Institution	008	Alcohol and Drug Abuse Inpatient	I	I	1 and/or 2		MDA			X
04	State Institution	73	Alcohol And Drug Abuse Inpatient	02	State Institution	008	Alcohol and Drug Abuse Inpatient	X	A	1 and/or 2		None		X	
04	State Institution	74	Alcohol And Drug Abuse Outpatient	02	State Institution	009	Alcohol and Drug Abuse Outpatient	O, H	O	1 and/or 2		MDB			X
04	State Institution	74	Alcohol And Drug Abuse Outpatient	02	State Institution	009	Alcohol and Drug Abuse Outpatient	X	C	1 and/or 2		None		X	
09	State Institution	78	Inpatient	06	State Institution	001	Inpatient	I	I	1 and/or 2		MDA			X
09	State Institution	78	Inpatient	02	State Institution	001	Inpatient	X	A	1 and/or 2		None		X	
04	State Institution	96	Chronic Outpatient	02	State Institution	017	Chronic - Outpatient	O	O	1 and/or 2		MDB			X
04	State Institution	96	Chronic Outpatient	02	State Institution	017	Chronic - Outpatient	X	C	1 and/or 2		None		X	
10	Nursing Home	45	Chronic Inpatient	03	Extended Care Facility	035	Chronic - Inpatient	N	L	L		MDA			X
10	Nursing Home	45	Chronic Inpatient	03	Extended Care Facility	035	Chronic - Inpatient	X	A	1 and/or 2		None		X	
10	Nursing Home	47	Int Hv	03	Extended Care Facility	036	ICF/MR (Non Bed Count Specific)	N	L	Exclude All TOC	1	Exclude All Medicare	1		
10	Nursing Home	44	Int Mo	03	Extended Care Facility	036	ICF/MR (Non Bed Count Specific)	X	A	Exclude All TOC	2	None			
10	Nursing Home	48	Snf	03	Extended Care Facility	035	Skilled Nursing Facility	N	L	L		MDA			X
10	Nursing Home	48	Snf	03	Extended Care Facility	035	Skilled Nursing Facility	X	A	1 and/or 2		None			
10	Nursing Home	46	Icf	03	Extended Care Facility	032	Nursing Facility	M	L	L		MDA			X
10	Nursing Home	46	Icf	03	Extended Care Facility	032	Nursing Facility	X	A	1 and/or 2		None			
10	Nursing Home	47	Icf-2	03	Extended Care Facility	039	ICF-3	N	L	L		MDA			
10	Nursing Home	47	Icf-2	03	Extended Care Facility	038	ICF-2	X	A	1 and/or 2		None			
10	Nursing Home	45	Super Snf	03	Extended Care Facility	041	Super Skilled Nursing Facility	M	L	L		MDA			
10	Nursing Home	49	Super Snf	03	Extended Care Facility	041	Super Skilled Nursing Facility	X	A	1 and/or 2		None			
13	Special Services	12	SBCH - Nurse	12	Special Services	088	SBCH - Nurse	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	13	SBCH - Social Worker	12	Special Services	087	SBCH - Social Worker	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	15	SBCH - Guidance Counselor	12	Special Services	086	SBCH - Guidance Counselor	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	17	SBCH - Psychologist	12	Special Services	089	SBCH - Psychologist	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	35	School-Based Child Health	12	Special Services	729	School Corporation	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3A	Sbch Performing Provider	12	Special Services	097	SBCH School District/Performing Provider	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3B	Sbh Ta 2 Billing Provider	12	Special Services	583	Regional Family Service Corporation Ch (RFSCC)	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3C	Sbh Ta 2 Performing Provider	12	Special Services	084	Sbh Ta Three Performing Provider	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3D	Pvnl Performing Provider	12	Special Services	581	Pvt Non-Medical Institution Performing provider	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3E	Pvnl Billing Provider	12	Special Services	580	Pvt Non-Medical Institution Billing Provider	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3F	Psy Rsn Trad Fac	12	Special Services	530	Psy Rsn Trad Fac	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3G	Community Svcs	12	Special Services	585	Community Services	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
13	Special Services	3H	Mental Health Group Home (Sfhgh)	12	Special Services	511	Mental Health Group Home	M	M	Exclude All TOC	5	Exclude All MDA and MDB	5		
19	Nurse Midwife - Group	66	Nurse Midwife/Cnm	73	Nurse Midwife Group	095	Certified Nurse Midwife	M	M	3,4,5,6, and/or 7		MDB	10		X
19	Nurse Midwife - Group	66	Nurse Midwife/Cnm	73	Nurse Midwife Group	095	Certified Nurse Midwife	X	B	3,4,5,6, and/or 7		None			
19	Nurse Midwife	66	Nurse Midwife/Cnm	30	Nurse Midwife	095	Certified Nurse Midwife	M	M	3,4,5,6, and/or 7		MDB	10		X
19	Nurse Midwife	66	Nurse Midwife/Cnm	32	Nurse Midwife	095	Certified Nurse Midwife	X	B	3,4,5,6, and/or 7		None			
18	Pre-Admission Screening - Cmh	78	Pre-Admission Screening Cmh	57	CT Home Care Program	541	CT Home Care Access Agency	M	M	3,4,5,6, and/or 7	4	None			
18	Pre-Admission Screening - Cmh	46	Assisted Living Service Agency	57	CT Home Care Program	542	Assisted Living	M	M	Exclude All TOC	5	None	4		
18	Pre Performing Provider	58	Pre-Admission Screening/Performing Provider	59	CT Home Care Program Performing Provider	540	CT Home Care Program Performing Provider	M	M	Exclude All TOC	5	Exclude All Medicare	5		
17	Dmr Cam	57	Department Of Mental Retardation - Cam	53	DMR Waiver	530	DMR Waiver	M	M	Exclude All TOC	5	Exclude All Medicare	5		
18	Dmr Cam Performing Provider	58	Dmr Performing Provider	54	DMR Waiver Performing Provider	537	DMR Waiver Performing Provider - State	M	M	Exclude All TOC	5	Exclude All Medicare	5		
20	Physician, M.D.	01	General Practice	31	Physician	310	General Practitioner	M	M	3,4,5,6, and/or 7		MDB			
20	Physician, M.D.	01	General Practice	31	Physician	310	General Practitioner	X	B	3,4,5,6, and/or 7		None			
20	Physician, M.D.	02	General Surgery	31	Physician	319	General Surgery	M	M	3,4,5,6, and/or 7		MDB			
20	Physician, M.D.	02	General Surgery	31	Physician	319	General Surgery	X	B	3,4,5,6, and/or 7		None			
20	Physician, M.D.	03	Allergy	31	Physician	313	Allergy	M	M	3,4,5,6, and/or 7		MDB			
20	Physician, M.D.	03	Allergy	31	Physician	313	Allergy	X	B	3,4,5,6, and/or 7		None			
20	Physician, M.D.	04	Ear, Nose, Throat	31	Physician	332	Otology, Laryngology, Rhinology	M	M	3,4,5,6, and/or 7		MDB			
20	Physician, M.D.	04	Ear, Nose, Throat	31	Physician	332	Otology, Laryngology, Rhinology	X	B	3,4,5,6, and/or 7		None			
20	Physician, M.D.	05	Anesthesiology	31	Physician	311	Anesthesiology	M	M	3,4,5,6, and/or 7		MDB			
20	Physician, M.D.	05	Anesthesiology	31	Physician	311	Anesthesiology	X	B	3,4,5,6, and/or 7		None			
20	Physician, M.D.	06	Cardiovascular Disease	31	Physician	312	Cardiology	M	M	3,4,5,6, and/or 7		MDB			

1 of 6

Exhibit 1 12

Exhibit 3 CLAIM SELECTION

HMS PROVIDER TYPE	State PROVIDER TYPE DESCRIPTION	STATE PROVIDER SPECIALTY	HMS PROVIDER SPECIALTY DESCRIPTION	35 PROVIDER TYPE	ID PROVIDER TYPE DESCRIPTION	ID PROVIDER SPECIALTY	ID PROVIDER SPECIALTY DESCRIPTION	STATE TYPE OF CLAIM	ID TYPE OF CLAIM	Claims Selection For Other Insurance EOB Type of Coverage	O.I. Ref.	Claims Selection For Medicare EOB Coverage Code "MDA" and "MDB"	HMS MRS Ref.	O.I. EXCEPTION	MEDICARE EXCEPTION
30	Physician, M.D.	06	Cardiovascular Disease	31	Physician	312	Cardiology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	07	Dermatology	31	Physician	314	Dermatology	IS	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	07	Dermatology	31	Physician	314	Dermatology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	08	Family Practice	31	Physician	316	Family Practitioner	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	08	Family Practice	31	Physician	316	Family Practitioner	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	10	Multidisciplinary Physician	31	Physician	322	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	10	Multidisciplinary Physician	31	Physician	322	Internal Medicine	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	11	Internal Medicine	31	Physician	322	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	11	Internal Medicine	31	Physician	322	Internal Medicine	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	14	Neurological Surgery/Neurology	31	Physician	328	Neurology	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	14	Neurological Surgery/Neurology	31	Physician	328	Neurology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	16	Obstetrics And Gynecology	31	Physician	326	Obstetrics/Gynecology	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	16	Obstetrics And Gynecology	31	Physician	326	Obstetrics/Gynecology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	18	Ophthalmology	31	Physician	330	Ophthalmology	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	18	Ophthalmology	31	Physician	330	Ophthalmology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	19	Oral Surgery	31	Physician	273	Oral Surgery	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	19	Oral Surgery	31	Physician	272	Oral Surgery	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	20	Orthopedics Or Orthopedic Surgery	31	Physician	334	Orthopedic Surgery	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	20	Orthopedics Or Orthopedic Surgery	31	Physician	334	Orthopedic Surgery	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	22	Pathology/Pathology Surgery	31	Physician	336	Pathology	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	22	Pathology/Pathology Surgery	31	Physician	336	Pathology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	24	Plastic & Reconstructive Surgery	31	Physician	337	Plastic Surgery	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	24	Plastic & Reconstructive Surgery	31	Physician	337	Plastic Surgery	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	26	Physical Medicine & Rehabilitation	31	Physician	338	Physical Medicine and Rehabilitation Practitioner	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	26	Physical Medicine & Rehabilitation	31	Physician	338	Physical Medicine and Rehabilitation Practitioner	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	28	Psychiatry And Neurology	31	Physician	339	Psychiatry	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	28	Psychiatry And Neurology	31	Physician	339	Psychiatry	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	76	Proctology	31	Physician	336	Proctology	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	76	Proctology	31	Physician	336	Proctology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	30	Radiology Therapy & Diagnostic	31	Physician	341	Radiology	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	30	Radiology Therapy & Diagnostic	31	Physician	341	Radiology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	35	Thoracic And Cardiovascular Surgery	31	Physician	343	Thoracic Surgery	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	35	Thoracic And Cardiovascular Surgery	31	Physician	343	Thoracic Surgery	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	34	Urology (Genito - Urinary)	31	Physician	345	Urology	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	34	Urology (Genito - Urinary)	31	Physician	345	Urology	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	35	Homeopathy (All)	31	Physician	383	Homeopath	IS	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	35	Homeopathy (All)	31	Physician	383	Homeopath	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	36	Geriatrics	31	Physician	320	Geriatric Practitioner	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	36	Geriatrics	31	Physician	320	Geriatric Practitioner	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	37	Osteopathy (All)	31	Physician	382	Osteopath	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	37	Osteopathy (All)	31	Physician	382	Osteopath	X	B	3,4,5,6, and/or 7		None			
30	Physician, M.D.	38	Podiatrics	31	Physician	345	General Practitioner	M	M	3,4,5,6, and/or 7		MDB			
30	Physician, M.D.	38	Podiatrics	31	Physician	345	General Practitioner	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	01	General Practice	72	Physician Group	315	General Practitioner	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	01	General Practice	72	Physician Group	315	General Practitioner	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	02	General Surgery	72	Physician Group	316	General Surgery	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	02	General Surgery	72	Physician Group	316	General Surgery	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	03	Allergy	72	Physician Group	310	Allergy	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	03	Allergy	72	Physician Group	310	Allergy	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	04	Ear, Nose, Throat	72	Physician Group	333	Otology, Laryngology, Rhinology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	04	Ear, Nose, Throat	72	Physician Group	332	Otology, Laryngology, Rhinology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	05	Anesthesiology	72	Physician Group	311	Anesthesiology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	05	Anesthesiology	72	Physician Group	311	Anesthesiology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	06	Cardiovascular Disease	72	Physician Group	312	Cardiology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	06	Cardiovascular Disease	72	Physician Group	312	Cardiology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	07	Dermatology	72	Physician Group	314	Dermatology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	07	Dermatology	72	Physician Group	314	Dermatology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	08	Family Practice	72	Physician Group	316	Family Practitioner	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	08	Family Practice	72	Physician Group	316	Family Practitioner	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	10	Multidisciplinary Physician	72	Physician Group	322	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	10	Multidisciplinary Physician	72	Physician Group	322	Internal Medicine	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	11	Internal Medicine	72	Physician Group	322	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	11	Internal Medicine	72	Physician Group	322	Internal Medicine	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	14	Neurological Surgery/Neurology	72	Physician Group	328	Neurology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	14	Neurological Surgery/Neurology	72	Physician Group	328	Neurology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	16	Obstetrics And Gynecology	72	Physician Group	326	Obstetrics/Gynecology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	16	Obstetrics And Gynecology	72	Physician Group	326	Obstetrics/Gynecology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	18	Ophthalmology	72	Physician Group	330	Ophthalmology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	18	Ophthalmology	72	Physician Group	330	Ophthalmology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	19	Oral Surgery	72	Physician Group	272	Oral Surgery	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	19	Oral Surgery	72	Physician Group	272	Oral Surgery	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	20	Orthopedics Or Orthopedic Surgery	72	Physician Group	334	Orthopedic Surgery	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	20	Orthopedics Or Orthopedic Surgery	72	Physician Group	334	Orthopedic Surgery	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	22	Pathology/Pathology Surgery	72	Physician Group	336	Pathology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	22	Pathology/Pathology Surgery	72	Physician Group	336	Pathology	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	24	Plastic & Reconstructive Surgery	72	Physician Group	337	Plastic Surgery	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	24	Plastic & Reconstructive Surgery	72	Physician Group	337	Plastic Surgery	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	26	Physical Medicine & Rehabilitation	72	Physician Group	338	Physical Medicine and Rehabilitation Practitioner	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	26	Physical Medicine & Rehabilitation	72	Physician Group	338	Physical Medicine and Rehabilitation Practitioner	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	28	Psychiatry And Neurology	72	Physician Group	339	Psychiatry	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	28	Psychiatry And Neurology	72	Physician Group	339	Psychiatry	X	B	3,4,5,6, and/or 7		None			
31	Physician, M.D. - Group	76	Proctology	72	Physician Group	336	Proctology	M	M	3,4,5,6, and/or 7		MDB			
31	Physician, M.D. - Group	76	Proctology	72	Physician Group	336	Proctology	X	B	3,4,5,6, and/or 7		None			

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Exhibit a CLAIM SELECTION

HMS PROVIDER TYPE	HMS PROVIDER TYPE DESCRIPTION	MMIS PROVIDER SPECIALTY	HMS PROVIDER SPECIALTY DESCRIPTION	ID PROVIDER TYPE	ID PROVIDER TYPE DESCRIPTION	ID PROVIDER SPECIALTY	ID PROVIDER SPECIALTY DESCRIPTION	HMS TYPE OF CLAIM	ID TYPE OF CLAIM	Claims Selection For Other Insurance: KHA Type of Structure	O.I. Ref.	Claims Selection For Medicare: HMS Claims Code "MDA" and "MDB".	MDA Rel.	O.I. EXCEPTION	MMDCARE EXCEPTION
21	Physician, M.D. - Group	39	Radiology Therapy & Diagnostic	72	Physician Group	340	Radiology	M	M	3,4,5,6, and/or 7		MDB			
21	Physician, M.D. - Group	40	Radiology Therapy & Diagnostic	72	Physician Group	341	Radiology	X	B	3,4,5,6, and/or 7		None			
21	Physician, M.D. - Group	33	Thoracic And Cardiovascular Surgery	72	Physician Group	342	Thoracic Surgery	M	M	3,4,5,6, and/or 7		MDB			
21	Physician, M.D. - Group	33	Thoracic And Cardiovascular Surgery	72	Physician Group	342	Thoracic Surgery	X	B	3,4,5,6, and/or 7		None			
21	Physician, M.D. - Group	34	Urology (Genito - Urinary)	72	Physician Group	343	Urology	M	M	3,4,5,6, and/or 7		MDB			
21	Physician, M.D. - Group	34	Urology (Genito - Urinary)	72	Physician Group	343	Urology	X	B	3,4,5,6, and/or 7		None			
21	Physician, M.D. - Group	35	Homeopathic (All)	72	Physician Group	353	Homeopath	M	M	3,4,5,6, and/or 7		MDB			
21	Physician, M.D. - Group	35	Homeopathic (All)	72	Physician Group	353	Homeopath	X	B	3,4,5,6, and/or 7		None			
21	Physician, M.D. - Group	36	Geriatrics	72	Physician Group	370	Geriatric Practitioner	M	M	3,4,5,6, and/or 7		MDB			
21	Physician, M.D. - Group	36	Geriatrics	72	Physician Group	370	Geriatric Practitioner	X	B	3,4,5,6, and/or 7		None			
21	Physician, M.D. - Group	37	Osteopathic (All)	72	Physician Group	352	Osteopath	M	M	3,4,5,6, and/or 7		MDB			
21	Physician, M.D. - Group	37	Osteopathic (All)	72	Physician Group	352	Osteopath	X	B	3,4,5,6, and/or 7		None			
21	Physician, M.D. - Group	38	Pediatrics	72	Physician Group	345	General Pediatrician	M	M	3,4,5,6, and/or 7		MDB			
21	Physician, M.D. - Group	38	Pediatrics	72	Physician Group	345	General Pediatrician	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	01	General Practice	69	Advance Practice Nurse	083	Nurse Practitioner (Other)	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	01	General Practice	69	Advance Practice Nurse	083	Nurse Practitioner (Other)	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	02	General Surgery	69	Advance Practice Nurse	349	General Surgery	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	02	General Surgery	69	Advance Practice Nurse	349	General Surgery	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	03	Allergy	69	Advance Practice Nurse	310	Allergy	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	03	Allergy	69	Advance Practice Nurse	310	Allergy	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	04	Ear, Nose, Throat	69	Advance Practice Nurse	333	Otology, Laryngology, Rhinology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	04	Ear, Nose, Throat	69	Advance Practice Nurse	333	Otology, Laryngology, Rhinology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	05	Anesthesiology	69	Advance Practice Nurse	694	Certified Registered Nurse Anesthetist (CRNA)	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	05	Anesthesiology	69	Advance Practice Nurse	694	Certified Registered Nurse Anesthetist (CRNA)	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	06	Cardiovascular Diseases	69	Advance Practice Nurse	312	Cardiology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	06	Cardiovascular Diseases	69	Advance Practice Nurse	312	Cardiology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	07	Dermatology	69	Advance Practice Nurse	314	Dermatology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	07	Dermatology	69	Advance Practice Nurse	314	Dermatology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	08	Family Practice	69	Advance Practice Nurse	692	Family Nurse Practitioner	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	08	Family Practice	69	Advance Practice Nurse	692	Family Nurse Practitioner	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	10	Multidisciplinary Physician	69	Advance Practice Nurse	372	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	10	Multidisciplinary Physician	69	Advance Practice Nurse	372	Internal Medicine	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	11	Internal Medicine	69	Advance Practice Nurse	372	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	11	Internal Medicine	69	Advance Practice Nurse	321	Internal Medicine	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	14	Neurological Surgery/Neurology	69	Advance Practice Nurse	328	Neurology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	14	Neurological Surgery/Neurology	69	Advance Practice Nurse	329	Neurology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	19	Obstetrics And Gynecology	69	Advance Practice Nurse	084	Obstetric Nurse Practitioner	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	19	Obstetrics And Gynecology	69	Advance Practice Nurse	084	Obstetric Nurse Practitioner	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	15	Ophthalmology	69	Advance Practice Nurse	350	Ophthalmology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	15	Ophthalmology	69	Advance Practice Nurse	350	Ophthalmology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	18	Oral Surgery	69	Advance Practice Nurse	372	Oral Surgery	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	18	Oral Surgery	69	Advance Practice Nurse	372	Oral Surgery	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	20	Orthopedics Or Orthopedic Surgery	69	Advance Practice Nurse	331	Orthopedic Surgery	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	20	Orthopedics Or Orthopedic Surgery	69	Advance Practice Nurse	331	Orthopedic Surgery	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	22	Pathology/Pathology Surgery	69	Advance Practice Nurse	333	Pathology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	22	Pathology/Pathology Surgery	69	Advance Practice Nurse	333	Pathology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	24	Plastic & Reconstructive Surgery	69	Advance Practice Nurse	337	Plastic Surgery	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	24	Plastic & Reconstructive Surgery	69	Advance Practice Nurse	337	Plastic Surgery	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	26	Physical Medicine & Rehabilitation	69	Advance Practice Nurse	336	Physical Medicine and Rehabilitation Practitioner	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	26	Physical Medicine & Rehabilitation	69	Advance Practice Nurse	336	Physical Medicine and Rehabilitation Practitioner	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	28	Psychiatry And Neurology	69	Advance Practice Nurse	339	Psychiatry	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	28	Psychiatry And Neurology	69	Advance Practice Nurse	339	Psychiatry	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	29	Psychology	69	Advance Practice Nurse	535	Psychology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	29	Psychology	69	Advance Practice Nurse	535	Psychology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	30	Radiology Therapy & Diagnostic	69	Advance Practice Nurse	347	Radiation Therapy	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	30	Radiology Therapy & Diagnostic	69	Advance Practice Nurse	347	Radiation Therapy	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	33	Thoracic And Cardiovascular Surgery	69	Advance Practice Nurse	342	Thoracic Surgery	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	33	Thoracic And Cardiovascular Surgery	69	Advance Practice Nurse	342	Thoracic Surgery	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	34	Urology (Genito - Urinary)	69	Advance Practice Nurse	343	Urology	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	34	Urology (Genito - Urinary)	69	Advance Practice Nurse	343	Urology	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	35	Homeopathic (All)	69	Advance Practice Nurse	353	Homeopath	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	35	Homeopathic (All)	69	Advance Practice Nurse	353	Homeopath	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	36	Geriatrics	69	Advance Practice Nurse	370	Geriatric Practitioner	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	36	Geriatrics	69	Advance Practice Nurse	370	Geriatric Practitioner	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	37	Osteopathic (All)	69	Advance Practice Nurse	352	Osteopath	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	37	Osteopathic (All)	69	Advance Practice Nurse	352	Osteopath	X	B	3,4,5,6, and/or 7		None			
23	Nurse Practitioner	38	Pediatrics	69	Advance Practice Nurse	090	Pediatric Nurse Practitioner	M	M	3,4,5,6, and/or 7		MDB	19		X
23	Nurse Practitioner	38	Pediatrics	69	Advance Practice Nurse	090	Pediatric Nurse Practitioner	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	01	General Practice	70	Advance Practice Nurse Group	083	Nurse Practitioner (Other)	M	M	3,4,5,6, and/or 7		MDB	19		X
24	Nurse Practitioner - Group	01	General Practice	70	Advance Practice Nurse Group	083	Nurse Practitioner (Other)	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	02	General Surgery	70	Advance Practice Nurse Group	349	General Surgery	M	M	3,4,5,6, and/or 7		MDB	19		X
24	Nurse Practitioner - Group	02	General Surgery	70	Advance Practice Nurse Group	349	General Surgery	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	03	Allergy	70	Advance Practice Nurse Group	310	Allergy	M	M	3,4,5,6, and/or 7		MDB	19		X
24	Nurse Practitioner - Group	03	Allergy	70	Advance Practice Nurse Group	310	Allergy	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	04	Ear, Nose, Throat	70	Advance Practice Nurse Group	333	Otology, Laryngology, Rhinology	M	M	3,4,5,6, and/or 7		MDB	19		X
24	Nurse Practitioner - Group	04	Ear, Nose, Throat	70	Advance Practice Nurse Group	333	Otology, Laryngology, Rhinology	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	05	Anesthesiology	70	Advance Practice Nurse Group	694	Certified Registered Nurse Anesthetist (CRNA)	M	M	3,4,5,6, and/or 7		MDB	19		X
24	Nurse Practitioner - Group	05	Anesthesiology	70	Advance Practice Nurse Group	694	Certified Registered Nurse Anesthetist (CRNA)	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	06	Cardiovascular Diseases	70	Advance Practice Nurse Group	312	Cardiology	M	M	3,4,5,6, and/or 7		MDB	19		X
24	Nurse Practitioner - Group	06	Cardiovascular Diseases	70	Advance Practice Nurse Group	312	Cardiology	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	07	Dermatology	70	Advance Practice Nurse Group	314	Dermatology	M	M	3,4,5,6, and/or 7		MDB	19		X
24	Nurse Practitioner - Group	07	Dermatology	70	Advance Practice Nurse Group	314	Dermatology	X	B	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	08	Family Practice	70	Advance Practice Nurse Group	692	Family Nurse Practitioner	M	M	3,4,5,6, and/or 7		MDB	19		X

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Exhibit1a CLAIM SELECTION

MMIS PROVIDER TYPE	MMIS PROVIDER TYPE DESCRIPTION	MMIS PROVIDER SPECIALTY	MMIS PROVIDER SPECIALTY DESCRIPTION	ID PROVIDER TYPE	ID PROVIDER TYPE DESCRIPTION	ID PROVIDER SPECIALTY	ID PROVIDER SPECIALTY DESCRIPTION	MMIS TYPE OF CLAIM	ID TYPE OF CLAIM	Claims Selection For Other Insurance: EMS Type of Coverage	O.I. Ref.	Claims Selection For Medicare: EMS Carrier Code "MMA" and "MDR"	MMA MDR Ref.	O.I. EXCEPTION	MEDICARE EXCEPTION
24	Nurse Practitioner - Group	08	Family Practice	70	Advance Practice Nurse Group	082	Family Nurse Practitioner	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	10	Multidisciplinary Physician	70	Advance Practice Nurse Group	322	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	10	Multidisciplinary Physician	70	Advance Practice Nurse Group	322	Internal Medicine	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	11	Internal Medicine	70	Advance Practice Nurse Group	323	Internal Medicine	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	11	Internal Medicine	70	Advance Practice Nurse Group	322	Internal Medicine	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	14	Neurological Surgery/Neurology	70	Advance Practice Nurse Group	326	Neurology	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	14	Neurological Surgery/Neurology	70	Advance Practice Nurse Group	326	Neurology	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	16	Obstetrics And Gynecology	70	Advance Practice Nurse Group	091	Obstetric Nurse Practitioner	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	16	Obstetrics And Gynecology	70	Advance Practice Nurse Group	091	Obstetric Nurse Practitioner	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	18	Ophthalmology	70	Advance Practice Nurse Group	330	Ophthalmology	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	18	Ophthalmology	70	Advance Practice Nurse Group	330	Ophthalmology	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	19	Oral Surgery	70	Advance Practice Nurse Group	272	Oral Surgery	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	19	Oral Surgery	70	Advance Practice Nurse Group	272	Oral Surgery	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	20	Orthopedics Or Orthopedic Surgery	70	Advance Practice Nurse Group	331	Orthopedic Surgery	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	20	Orthopedics Or Orthopedic Surgery	70	Advance Practice Nurse Group	331	Orthopedic Surgery	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	22	Pathology/Pathology Surgery	70	Advance Practice Nurse Group	333	Pathology	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	22	Pathology/Pathology Surgery	70	Advance Practice Nurse Group	333	Pathology	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	24	Plastic & Reconstructive Surgery	70	Advance Practice Nurse Group	337	Plastic Surgery	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	24	Plastic & Reconstructive Surgery	70	Advance Practice Nurse Group	337	Plastic Surgery	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	25	Physical Medicine & Rehabilitation	70	Advance Practice Nurse Group	336	Physical Medicine and Rehabilitation Practitioner	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	25	Physical Medicine & Rehabilitation	70	Advance Practice Nurse Group	336	Physical Medicine and Rehabilitation Practitioner	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	26	Psychiatry And Neurology	70	Advance Practice Nurse Group	339	Psychiatry	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	26	Psychiatry And Neurology	70	Advance Practice Nurse Group	339	Psychiatry	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	28	Proctology	70	Advance Practice Nurse Group	336	Proctology	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	28	Proctology	70	Advance Practice Nurse Group	336	Proctology	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	30	Radiology Therapy & Diagnostic	70	Advance Practice Nurse Group	347	Radiation Therapy	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	30	Radiology Therapy & Diagnostic	70	Advance Practice Nurse Group	347	Radiation Therapy	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	33	Thoracic And Cardiovascular Surgery	70	Advance Practice Nurse Group	341	Thoracic Surgery	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	33	Thoracic And Cardiovascular Surgery	70	Advance Practice Nurse Group	342	Thoracic Surgery	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	34	Urology (Penile - Urinary)	70	Advance Practice Nurse Group	343	Urology	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	34	Urology (Penile - Urinary)	70	Advance Practice Nurse Group	343	Urology	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	39	Homeopathy (All)	70	Advance Practice Nurse Group	365	Homeopath	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	39	Homeopathy (All)	70	Advance Practice Nurse Group	365	Homeopath	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	36	Geriatrics	70	Advance Practice Nurse Group	370	Geriatric Practitioner	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	36	Geriatrics	70	Advance Practice Nurse Group	370	Geriatric Practitioner	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	37	Osteopathy (All)	70	Advance Practice Nurse Group	372	Osteopath	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	37	Osteopathy (All)	70	Advance Practice Nurse Group	372	Osteopath	X	S	3,4,5,6, and/or 7		None			
24	Nurse Practitioner - Group	38	Pediatrics	70	Advance Practice Nurse Group	090	Pediatric Nurse Practitioner	M	M	3,4,5,6, and/or 7		MDB	10		X
24	Nurse Practitioner - Group	38	Pediatrics	70	Advance Practice Nurse Group	090	Pediatric Nurse Practitioner	X	S	3,4,5,6, and/or 7		None			
27	Personal Care Attendant	27	Personal Care Attendants	28	Personal Care Services	281	Personal Care - Agency	M	M	Exclude All TOC	5	Exclude	9		
20	Podiatrist	81	Podiatrist	14	Podiatrist	146	Podiatrist	M	M	3,4,5,6, and/or 7		MDB	10		X
20	Podiatrist	81	Podiatrist	14	Podiatrist	146	Podiatrist	X	S	3,4,5,6, and/or 7		None			
24	Optometrist	81	Optician/Optometrist	18	Optometrist	183	Optometry	M	M	S		MDB	9		X
24	Optometrist	81	Optician/Optometrist	18	Optometrist	183	Optometry	X	S	3,4,5,6, and/or 7		None			
32	Optician	81	Optician/Optometrist	18	Optician	180	Optician	M	M	S		MDB	9		X
32	Optician	81	Optician/Optometrist	18	Optician	180	Optician	X	S	3,4,5,6, and/or 7		None			
20	Podiatrist - Group	81	Podiatrist	73	Podiatrist Group	140	Podiatrist	M	M	3,4,5,6, and/or 7		MDB	11		X
20	Podiatrist - Group	81	Podiatrist	73	Podiatrist Group	140	Podiatrist	X	S	3,4,5,6, and/or 7		None			
24	Optometrist - Group	81	Optician/Optometrist	74	Optometrist Group	180	Optometry	M	M	S		MDB	9		X
24	Optometrist - Group	81	Optician/Optometrist	74	Optometrist Group	180	Optometry	X	S	3,4,5,6, and/or 7		None			
32	Optician - Group	81	Optician/Optometrist	75	Optician Group	190	Optician	M	M	S		MDB	9		X
32	Optician - Group	81	Optician/Optometrist	75	Optician Group	190	Optician	X	S	3,4,5,6, and/or 7		None			
40	Dentist	70	Dental Oral Surgeon	27	Dentist	272	Oral Surgery	L	D	S		None			
40	Dentist	72	Orthodontist	27	Dentist	273	Orthodontist	L	D	S		None			
40	Dentist	76	Dental Hygienist	27	Dentist	278	Dental Hygienist	L	D	S		None			
40	Dentist	83	Dentist	27	Dentist	271	General Dentistry Practitioner	L	D	S		None			
41	Dentist - Group	70	Dental Oral Surgeon	78	Dentist Group	272	Oral Surgery	L	D	S		None			
41	Dentist - Group	72	Orthodontist	78	Dentist Group	273	Orthodontist	L	D	S		None			
41	Dentist - Group	76	Dental Hygienist	78	Dentist Group	278	Dental Hygienist	L	D	S		None			
41	Dentist - Group	83	Dentist	78	Dentist Group	271	General Dentistry Practitioner	L	D	S		None			
60	Community Clinic	21	Dialysis Center	06	Clinic	210	Free-standing Renal Dialysis Clinic	M	M	3,4,5,6, and/or 7		MDB	10		X
60	Community Clinic	21	Dialysis Center	06	Clinic	210	Free-standing Renal Dialysis Clinic	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	23	Substance Abuse Clinic	06	Clinic	088	Methadone Clinic	M	M	3,4,5,6, and/or 7		MDB	15		X
60	Community Clinic	23	Substance Abuse Clinic	06	Clinic	088	Methadone Clinic	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	33	Ambulatory Surgical Center	06	Clinic	030	Ambulatory Surgical Center (ASC)	M	M	3,4,5,6, and/or 7		MDB	14		X
60	Community Clinic	33	Ambulatory Surgical Center	06	Clinic	030	Ambulatory Surgical Center (ASC)	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	80	Mental Health Clinic	06	Clinic	025	Mental Health Clinic	M	M	3,4,5,6, and/or 7		MDB	16		X
60	Community Clinic	80	Mental Health Clinic	06	Clinic	025	Mental Health Clinic	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	69	Family Planning Clinic	06	Clinic	095	Family Planning Clinic	M	M	3,4,5,6, and/or 7		None			
60	Community Clinic	69	Family Planning Clinic	06	Clinic	095	Family Planning Clinic	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	00	Medical Clinic	06	Clinic	033	Medical Clinic	M	M	3,4,5,6, and/or 7		MDB	10		X
60	Community Clinic	00	Medical Clinic	06	Clinic	033	Medical Clinic	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	01	Rural Clinic	06	Clinic	051	Rural Health Clinic (RHC)	M	M	3,4,5,6, and/or 7		MDB	10		X
60	Community Clinic	01	Rural Clinic	06	Clinic	051	Rural Health Clinic (RHC)	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	08	Rehabilitation Clinic	06	Clinic	040	Rehabilitation Facility	M	M	3,4,5,6, and/or 7		MDB	17		X
60	Community Clinic	08	Rehabilitation Clinic	06	Clinic	040	Rehabilitation Facility	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	71	Dental Clinic	06	Clinic	024	Dental Clinic	M	M	S		None			
60	Community Clinic	71	Dental Clinic	06	Clinic	024	Dental Clinic	M	S	S		None			
60	Community Clinic	2A	Well Child Clinic	06	Clinic	085	Pediatric Clinic	M	M	3,4,5,6, and/or 7		None			
60	Community Clinic	2A	Well Child Clinic	06	Clinic	085	Pediatric Clinic	M	S	3,4,5,6, and/or 7		None			
60	Community Clinic	5A	Tcho Dental	06	Clinic	020	Dental FQHC	M	M	S		None			
60	Community Clinic	5A	Tcho Dental	06	Clinic	020	Dental FQHC	M	S	S		None			
60	Community Clinic	5B	Tcho Medical	06	Clinic	021	Medical FQHC	M		3,4,5,6, and/or 7		MDB	18		X

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Exhibit a CLAIM SELECTION

MMIS PROVIDER TYPE	MMIS PROVIDER TYPE DESCRIPTION	MMIS PROVIDER SPECIALTY	MMIS PROVIDER SPECIALTY DESCRIPTION	IQ PROVIDER TYPE	IQ PROVIDER TYPE DESCRIPTION	IQ PROVIDER SPECIALTY	IQ PROVIDER SPECIALTY DESCRIPTION	MMIS TYPE OF CLAIM	IQ TYPE OF CLAIM	Claims Selection For Other Insurance: EMS Type of Coverage	CLI Rel.	Claims Selection For Medicare: EMS Carrier Code "MMAC" and "MMP"	MMA MDR Yes	O.I. EXCEPTION	MEDICARE EXCEPTION
80	Community Clinic	80	Peha Medical	03	Clinic	531	Medical FQHC	M	B	3,4,5,8, and/or 7		None			
80	Community Clinic	80	Peha Mental Health	04	Clinic	531	Mental Health FQHC	M		3,4,5,8, and/or 7		MDR			
80	Community Clinic	80	Peha Mental Health	05	Clinic	532	Mental Health FQHC	M	B	3,4,5,8, and/or 7		None			
87	Alcohol And Drug Abuse Center	79	Inpatient	03	Drug and Alcohol Abuse Center	001	Inpatient	M	M	1 and/or 2					
87	Alcohol And Drug Abuse Center	79	Inpatient	03	Drug and Alcohol Abuse Center	001	Inpatient	X	B	Exclude		None			
87	Alcohol And Drug Abuse Center	79	Outpatient	03	Drug and Alcohol Abuse Center	007	Outpatient	M	M	3,4,5,6, and/or 7		MDR	12		X
87	Alcohol And Drug Abuse Center	79	Outpatient	03	Drug and Alcohol Abuse Center	007	Outpatient	X	B	3,4,5,6, and/or 7		None			
87	Alcohol And Drug Abuse Center	7A	Half Way House (Rosemont)	03	Drug and Alcohol Abuse Center	510	Halfway House - Reserved for Future Use	Not Yet Available	Yet Availa	Exclude		Exclude MDA and MDR			
87	Alcohol And Drug Abuse Center	7B	Long Term Care (Rosemont)	03	Drug and Alcohol Abuse Center	551	Long Term Care - Reserved for Future Use	Not Yet Available	Yet Availa	Exclude		Exclude MDA and MDR			
96	Home Health Agency	97	Home Health Agency	05	Home Health Agency	056	Home Health Agency	O	H	3,4,5,8, and/or 7	#	MDA and MDR	#		X
96	Home Health Agency	97	Home Health Agency	05	Home Health Agency	056	Home Health Agency	X	B	3,4,5,8, and/or 7		None			
80	Pharmacy	84	Pharmacy	24	Pharmacy	240	Pharmacy	D	P	A		MDR	19		X
80	Pharmacy	84	Pharmacy	24	Pharmacy	240	Pharmacy	D	Q	A		MDR	19		X
92	Medical Equipment Supplier	91	Medical And Surgical Supplies	25	DME/Medical Supply Dealer	245	Medical and Surgical Supplies	M	M	3,4,5,8, and/or 7		MDR			X
92	Medical Equipment Supplier	91	Medical And Surgical Supplies	25	DME/Medical Supply Dealer	245	Medical and Surgical Supplies	X	B	3,4,5,8, and/or 7		None			
92	Medical Equipment Supplier	92	Durable Medical Goods	25	DME/Medical Supply Dealer	248	Durable Medical Goods	M	M	3,4,5,8, and/or 7		MDR			X
92	Medical Equipment Supplier	92	Durable Medical Goods	25	DME/Medical Supply Dealer	248	Durable Medical Goods	X	B	3,4,5,8, and/or 7		None			
92	Medical Equipment Supplier	93	Orthotic And Prosthetic Devices	25	DME/Medical Supply Dealer	277	Orthotic And Prosthetic Devices	M	M	3,4,5,8, and/or 7		MDR			X
92	Medical Equipment Supplier	93	Orthotic And Prosthetic Devices	25	DME/Medical Supply Dealer	220	Hearing Aid Dealer	M	M	3,4,5,8, and/or 7		MDR			X
92	Medical Equipment Supplier	93	Orthotic And Prosthetic Devices	25	DME/Medical Supply Dealer	220	Hearing Aid Dealer	X	B	3,4,5,8, and/or 7		None			
92	Medical Equipment Supplier	93	Orthotic And Prosthetic Devices	25	DME/Medical Supply Dealer	277	Orthotic And Prosthetic Devices	X	B	3,4,5,8, and/or 7		None			
92	Medical Equipment Supplier	94	Medical Supply Company	25	DME/Medical Supply Dealer	250	DME/Medical Supply Dealer	M	M	3,4,5,6, and/or 7		MDR			X
92	Medical Equipment Supplier	94	Medical Supply Company	25	DME/Medical Supply Dealer	250	DME/Medical Supply Dealer	X	B	3,4,5,6, and/or 7		None			
84	Naturopath	85	Naturopath	07	Naturopath	358	Naturopath	M	M	3,4,5,8, and/or 7		None			
85	Naturopath - Group	09	Naturopath	85	Naturopath Group	385	Naturopath	M	M	3,4,5,8, and/or 7		None			
87	Chiropractor	90	Chiropractor	15	Chiropractor	150	Chiropractor	M	M	3,4,5,8, and/or 7		MDR	19		X
87	Chiropractor	90	Chiropractor	15	Chiropractor	150	Chiropractor	X	B	3,4,5,8, and/or 7		None			
05	Chiropractor - Group	90	Chiropractor	69	Chiropractor Group	150	Chiropractor	M	M	3,4,5,8, and/or 7		MDR	19		X
05	Chiropractor - Group	90	Chiropractor	69	Chiropractor Group	150	Chiropractor	X	B	3,4,5,8, and/or 7		None			
70	Independent Laboratory	69	Independent Laboratory	29	Laboratory	293	Independent Lab	M	M	3,4,5,8, and/or 7		MDR			X
70	Independent Laboratory	69	Independent Laboratory	29	Laboratory	293	Independent Lab	X	B	3,4,5,8, and/or 7		None			
71	Independent Radiology	82	Portable Radiology	29	Radiology	291	Portable Radiology	M	M	3,4,5,8, and/or 7		MDR			X
71	Independent Radiology	83	Portable Radiology	29	Radiology	291	Portable Radiology	X	B	3,4,5,8, and/or 7		None			
71	Independent Radiology	83	Non-Portable Radiology	29	Radiology	290	Non-Portable Radiology	M	M	3,4,5,8, and/or 7		MDR			X
71	Independent Radiology	83	Non-Portable Radiology	29	Radiology	290	Non-Portable Radiology	X	B	3,4,5,8, and/or 7		None			
89	Medical Transportation	90	Ambulance	29	Transportation Provider	290	Ambulance	M	M	3,4,5,8, and/or 7		MDR			X
89	Medical Transportation	90	Ambulance	29	Transportation Provider	290	Ambulance	M	X	3,4,5,8, and/or 7		None			
80	Medical Transportation	83	Livery	29	Transportation Provider	294	Common Carrier (Ambulatory)	T	M	Exclude All TOC	5	None			
80	Medical Transportation	83	Livery	29	Transportation Provider	294	Common Carrier (Ambulatory)	T	X	Exclude All TOC	5	None			
80	Medical Transportation	84	Taxi	29	Transportation Provider	293	Taxi	T	M	Exclude All TOC	5	None			
80	Medical Transportation	84	Taxi	29	Transportation Provider	293	Taxi	T	X	Exclude All TOC	5	None			
80	Medical Transportation	85	Invalid Coach	29	Transportation Provider	295	Common Carrier (Non-ambulatory)	T	M	3,4,5,8, and/or 7		MDR			X
80	Medical Transportation	85	Invalid Coach	29	Transportation Provider	295	Common Carrier (Non-ambulatory)	T	X	3,4,5,8, and/or 7		None			
80	Medical Transportation	86	Critical Care Helicopter	29	Transportation Provider	282	Critical Care Helicopter	M	M	3,4,5,8, and/or 7		MDR			X
80	Medical Transportation	80	Critical Care Helicopter	29	Transportation Provider	282	Critical Care Helicopter	X	X	3,4,5,8, and/or 7		None			
80	Medical Transportation	87	Air Ambulance	29	Transportation Provider	281	Air Ambulance	M	M	3,4,5,8, and/or 7		MDR			X
80	Medical Transportation	87	Air Ambulance	29	Transportation Provider	281	Air Ambulance	X	X	3,4,5,8, and/or 7		None			
80	Medical Transportation	88	Travel Agent	29	Transportation Provider	289	Travel Agent	M	M	Exclude All TOC	5	None			
80	Medical Transportation	88	Travel Agent	29	Transportation Provider	289	Travel Agent	X	X	Exclude All TOC	5	None			
81	Behavioral Health Clinician	97	Psychologist	33	Behavioral Health Clinician	112	Psychology	M	M	3,4,5,8, and/or 7		MDR	20,21		X
81	Behavioral Health Clinician	9A	Lic Clin Soc Wrkr	33	Behavioral Health Clinician	116	Clinical Social Worker	M	M	3,4,5,8, and/or 7		MDR	20,21		X
81	Behavioral Health Clinician	9B	Lic Ma & Fam Thp	33	Behavioral Health Clinician	119	Marital and Family Therapist	M	M	3,4,5,8, and/or 7	22	None			
81	Behavioral Health Clinician	9D	Lic/Dir ASD Alc D	33	Behavioral Health Clinician	116	Alcohol & Drug Counselor	M	M	3,4,5,8, and/or 7	22	None			
81	Behavioral Health Clinician	9E	Lic Professional Counselor	33	Behavioral Health Clinician	121	Professional Counselor	M	M	3,4,5,8, and/or 7	22	None			
96	Behavioral Health Clinician Groups	97	Psychologist	86	Behavioral Health Clinician Groups	112	Psychology	M	M	3,4,5,8, and/or 7		MDR	20,21		X
96	Behavioral Health Clinician Groups	9A	Lic Clin Soc Wrkr	86	Behavioral Health Clinician Groups	116	Clinical Social Worker	M	M	3,4,5,8, and/or 7		MDR	20,21		X
96	Behavioral Health Clinician Groups	9B	Lic Ma & Fam Thp	86	Behavioral Health Clinician Groups	119	Marital and Family Therapist	M	M	3,4,5,8, and/or 7	22	None			
96	Behavioral Health Clinician Groups	9D	Lic/Dir ASD Alc D	86	Behavioral Health Clinician Groups	116	Alcohol & Drug Counselor	M	M	3,4,5,8, and/or 7	22	None			
96	Behavioral Health Clinician Groups	9E	Lic Professional Counselor	86	Behavioral Health Clinician Groups	121	Professional Counselor	M	M	3,4,5,8, and/or 7	22	None			
97	Physician Assistant	97	Physician Assistant	10	Mid-Level Practitioner	105	Physician Assistant								
84	Therapists	84	Audiologist/Speech	17	Therapist	173	Audiologist Therapist	M	M	3,4,5,8, and/or 7		MDR			X
84	Therapists	84	Audiologist/Speech	17	Therapist	173	Audiologist Therapist	M	B	3,4,5,8, and/or 7		None			
84	Therapists	84	Audiologist/Speech	17	Therapist	175	Speech Therapist	M	M	3,4,5,8, and/or 7		MDR			X
84	Therapists	84	Audiologist/Speech	17	Therapist	175	Speech Therapist	M	B	3,4,5,8, and/or 7		None			
84	Therapists	85	Physical Therapy	17	Therapist	170	Physical Therapist	M	M	3,4,5,8, and/or 7		MDR			X
84	Therapists	85	Physical Therapy	17	Therapist	170	Physical Therapist	M	B	3,4,5,8, and/or 7		None			
84	Therapists	86	Occupational Therapy	17	Therapist	171	Occupational Therapist	M	M	3,4,5,8, and/or 7		MDR			X
84	Therapists	86	Occupational Therapy	17	Therapist	171	Occupational Therapist	M	B	3,4,5,8, and/or 7		None			
87	Therapist - Group	84	Audiologist/Speech	87	Therapist Group	174	Speech Therapist	M	M	3,4,5,8, and/or 7		MDR			X
87	Therapist - Group	84	Audiologist/Speech	87	Therapist Group	175	Speech Therapist	M	B	3,4,5,8, and/or 7		None			
87	Therapist - Group	85	Physical Therapy	87	Therapist Group	170	Physical Therapist	M	M	3,4,5,8, and/or 7		MDR			X
87	Therapist - Group	85	Physical Therapy	87	Therapist Group	170	Physical Therapist	M	B	3,4,5,8, and/or 7		None			
87	Therapist - Group	86	Occupational Therapy	87	Therapist Group	171	Occupational Therapist	M	M	3,4,5,8, and/or 7		MDR			X
87	Therapist - Group	86	Occupational Therapy	87	Therapist Group			M	B	3,4,5,8, and/or 7		None			
20	Abi - Acquired Brain Injury	20	Abi - Acquired Brain Injury	52	Acquired Brain Injury	029	Acquired Brain Injury Statutory			Exclude All TOC	5	Exclude	5		

Exhibit 1b REFERENCE

REFERENCE CODE	EXPLANATION
2	Claims excluded. Third Party Liability does not pay for Intermediate Care Facilities for the Mentally Retarded.
3	Claims excluded. Procedures are bundled and cannot identify medical services that Third Parties would cover.
4	Claims should be selected that contain only the following paid procedure codes : * For dates of service prior to 8/01/03 procedure codes: 1267Z, 1268Z, 1269Z, 1270Z, 1271Z, 1272Z, 1273Z, 1274Z, 1276Z, 1278Z, 1277Z,1275Z, 1279Z, 1280Z, 1282Z, 1284Z; * For dates of service on or after 8/01/03 procedure codes: S9123, S9124, S9128. S9129, S9131, T1001, T1002, T1003, T1004, 97001,97003, 92506
5	Claims excluded. Majority of ABI procedures are for non-medical home and community based services that commercial Health Insurance and Medicare do not reimburse. The procedure 1548P - Cognitive Behavioral Programs could contain medically-orientated bundled services and the specific clinical modality cannot be discerned.
6	Claims should be selected that contain only the following paid home health procedure or revenue center codes: * For D.O.S Prior to 7/01/03 procedure codes: 1800Z, 1912Z, 1961Z, 1962Z, 1963Z, 1964Z, 1965Z, 1966Z, 1807Z, 1806Z, 1805Z, 1910Z, 1918Z, 1830Z, 1921Z, 1960Z, 1840Z, 1850Z; * For D.O.S on or after 7/01/03 procedure codes: S9123, T1002, S9124, T1003, T1502, T1001, T1004; * For D.O.S on or after 7/01/03 revenue center codes: 421, 424, 434, 431, 444, 441
9	Claims should be selected for eye exams, preventative tests and screenings, eye glasses/contact lenses, glaucoma screenings, treatment of macular degeneration, for a client diagnosis of cataract surgery, macular degeneration, glaucoma, diabetes or other high risk groups.
10	Medicare Part B covered service under Non-Physician Health Care Provider Services
11	Medicare Part B covered service for medically necessary treatment of injuries or diseases of the foot
12	Medicare Part B coverage for outpatient maintenance dialysis treatments
13	Medicare Part B coverage for substance abuse treatment in an outpatient treatment center
14	Medicare Part B coverage for services given in an Ambulatory Surgical Center for a covered surgical procedure.
15	Medicare Part coverage for mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department.
16	Medicare Part B coverage for physician and specially qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, for medically necessary services.
17	Medicare Part B coverage for medically necessary outpatient physical and occupational therapy and speech-language pathology services

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Exhibit 1b REFERENCE

REFERENCE CODE	EXPLANATION
18	Medicare Part B coverage for antigens, injectible osteoporosis drugs for women, injection of erythropoietin (Epogen®) or epoetin alpha for end-stage renal disease (permanent kidney failure) for treating anemia, injection of hemophilia clotting factors, injectable drugs administered by a licensed medical practitioner, immunosuppressive drugs for transplant patients, and the following oral Cancer Drugs: Capecitabine (brand name Xeloda®), Cyclophosphamide (brand name Cytoxan®), Methhotrexate, Temozolomide (brand name Temodar®), Busulfan (brand name Myleran®), Etoposide (brand name VePesid®), and Melphalan (brand name Alkeran®), related oral anti-nausea drugs, and drugs used in infusion pumps and nebulizers if considered reasonable and necessary.
19	Medicare Part B coverage for medically necessary manipulation of spine to correct a subluxation.
20	Medicare Part B coverage for the services of specially qualified non-physician practitioners: clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, as allowed by state and local law for medically necessary services.
21	Medicare Part B coverage for mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department.
22	Exclude procedure code T1016 Case Management - Coordination of health care services
23	Medicare Part B coverage not available for services given by a speech pathologist in private practice.
24	Medicare Part B coverage for medically necessary outpatient physical and occupational therapy provided in a private practice; subject to an an annual financial limitation cap of $1780.

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Exhibit 2
Prenatal and Postnatal Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	OB_GYN	11975	INSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES
1/1/2008	OB_GYN	11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES
1/1/2008	OB_GYN	57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS
1/1/2008	OB_GYN	57410	PELVIC EXAMINATION UNDER ANESTHESIA
1/1/2008	OB_GYN	57420	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT
1/1/2008	OB_GYN	57421	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT; WITH BIOPSY(S) OF VAGINA/CERVIX
1/1/2008	OB_GYN	57455	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE CERVIX
1/1/2008	OB_GYN	57456	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH ENDOCERVICAL CURETTAGE
1/1/2008	OB_GYN	57460	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH LOOP ELECTRODE BIOPSY(S) OF THE CERVIX
1/1/2008	OB_GYN	57461	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH LOOP ELECTRODE CONIZATION OF THE CERVIX
1/1/2008	OB_GYN	58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
1/1/2008	OB_GYN	58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)
1/1/2008	OB_GYN	59000	AMNIOCENTESIS; DIAGNOSTIC
1/1/2008	OB_GYN	59020	FETAL CONTRACTION STRESS TEST
1/1/2008	OB_GYN	59025	FETAL NON-STRESS TEST
1/1/2008	OB_GYN	59050	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE, NON-ATTENDING PHYSICIAN) WITH WRITTEN REPORT; SUPERVISION AND INTERPRETATION
1/1/2008	OB_GYN	59070	TRANSABDOMINAL AMNIOINFUSION, INCLUDING ULTRASOUND GUIDANCE
1/1/2008	OB_GYN	59072	FETAL UMBILICAL CORD OCCLUSION, INCLUDING ULTRASOUND GUIDANCE
1/1/2008	OB_GYN	59074	FETAL FLUID DRAINAGE (EG, VESICOCENTESIS, THORACOCENTESIS, PARACENTESIS), INCLUDING ULTRASOUND GUIDANCE
1/1/2008	OB_GYN	59076	FETAL SHUNT PLACEMENT, INCLUDING ULTRASOUND GUIDANCE
1/1/2008	OB_GYN	59120	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; TUBAL OR OVARIAN, REQUIRING SALPINGECTOMY AND/OR OOPHORECTOMY, ABDOMINAL OR VAGINAL APPROACH
1/1/2008	OB_GYN	59300	EPISIOTOMY OR VAGINAL REPAIR, BY OTHER THAN ATTENDING PHYSICIAN
1/1/2008	OB_GYN	59400	ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITHOUT EPISIOTOMY, AND/OR FORCEPS) AND POSTPARTUM CARE
1/1/2008	OB_GYN	59409	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS)
1/1/2008	OB_GYN	59410	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS); INCLUDING POSTPARTUM CARE
1/1/2008	OB_GYN	59425	ANTEPARTUM CARE ONLY; 4-6 VISITS
1/1/2008	OB_GYN	59426	ANTEPARTUM CARE ONLY; 7 OR MORE VISITS
1/1/2008	OB_GYN	59430	POSTPARTUM CARE ONLY (SEPARATE PROCEDURE)
1/1/2008	OB_GYN	59510	ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, CESAREAN DELIVERY, AND POSTPARTUM CARE
1/1/2008	OB_GYN	59514	CESAREAN DELIVERY ONLY

Exhibit 2
Prenatal and Postnatal Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	OB_GYN	59515	CESAREAN DELIVERY ONLY; INCLUDING POSTPARTUM CARE
1/1/2008	OB_GYN	59525	SUBTOTAL OR TOTAL HYSTERECTOMY AFTER CESAREAN DELIVERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
1/1/2008	OB_GYN	59812	TREATMENT OF INCOMPLETE ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY
1/1/2008	OB_GYN	59820	TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; FIRST TRIMESTER
1/1/2008	OB_GYN	59830	TREATMENT OF SEPTIC ABORTION, COMPLETED SURGICALLY
1/1/2008	OB_GYN	59897	UNLISTED FETAL INVASIVE PROCEDURE, INCLUDING ULTRASOUND GUIDANCE M.P.
1/1/2008	OB_GYN	76801	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, FIRST TRIMESTER (14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION
1/1/2008	OB_GYN	76802	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, FIRST TRIMESTER (14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; EACH ADDITIONAL GESTATION (LIS
1/1/2008	OB_GYN	76805	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, AFTER FIRST TRIMESTER (> OR = 14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST
1/1/2008	OB_GYN	76810	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, AFTER FIRST TRIMESTER (> OR = 14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; EACH ADDITIONAL
1/1/2008	OB_GYN	76811	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION PLUS DETAILED FETAL ANATOMIC EXAMINATION, TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION
1/1/2008	OB_GYN	76812	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION PLUS DETAILED FETAL ANATOMIC EXAMINATION, TRANSABDOMINAL APPROACH; EACH ADDITIONAL GESTATION (LIS
1/1/2008	OB_GYN	76815	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED (EG, FETAL HEART BEAT, PLACENTAL LOCATION, FETAL POSITION AND/OR QUALITATIVE AMNIOTIC FLUID VOLUME), ONE OR MORE FETU
1/1/2008	OB_GYN	76817	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, TRANSVAGINAL
1/1/2008	OB_GYN	76818	FETAL BIOPHYSICAL PROFILE; WITH NON-STRESS TESTING
1/1/2008	OB_GYN	93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; COMPLETE STUDY
1/1/2008	OB_GYN	93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; LIMITED STUDY

Exhibit 2
Prenatal and Postnatal Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	OB_GYN	99201	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAI
1/1/2008	OB_GYN	99202	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXA
1/1/2008	OB_GYN	99203	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISI
1/1/2008	OB_GYN	99204	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL D
1/1/2008	OB_GYN	99205	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL D
1/1/2008	OB_GYN	99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. T
1/1/2008	OB_GYN	99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOC
1/1/2008	OB_GYN	99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN
1/1/2008	OB_GYN	99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATI
1/1/2008	OB_GYN	99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE
1/1/2008	OB_GYN	99383	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	OB_GYN	99384	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA

Exhibit 2
Prenatal and Postnatal Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	OB_GYN	99385	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	OB_GYN	99386	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	OB_GYN	99387	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	OB_GYN	99393	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	OB_GYN	99394	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	OB_GYN	99395	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORYGUIDANCE/RISK FA
1/1/2008	OB_GYN	99396	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORYGUIDANCE/RISK FA
1/1/2008	OB_GYN	99397	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORYGUIDANCE/RISK FA
1/1/2008	OB_GYN	99401	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES
1/1/2008	OB_GYN	99402	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES
1/1/2008	OB_GYN	99403	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 45 MINUTES
1/1/2008	OB_GYN	99404	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES
1/1/2008	OB_GYN	99411	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES

Exhibit 2
Prenatal and Postnatal Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	OB_GYN	99412	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES
1/1/2008	OB_GYN	S0190	MIFEPRISTONE, ORAL, 200 MG
1/1/2008	OB_GYN	S0191	MISOPROSTOL, ORAL, 200 MCG
1/1/2008	OB_GYN	S0199	MEDICALLY INDUCED ABORTION BY ORAL INGESTION OF MEDICATION INCLUDING ALL M.P. ASSOCIATED SERVICES AND SUPPLIES (E.G., PATIENT COUNSELING, OFFICE VISITS, CONFIRMATION OF PREGNANCY BY HCG, ULTRAS

Exhibit 3
EPSDT Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	PEDIATRIC	57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS
1/1/2008	PEDIATRIC	57410	PELVIC EXAMINATION UNDER ANESTHESIA
1/1/2008	PEDIATRIC	58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
1/1/2008	PEDIATRIC	58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)
1/1/2008	MEDICAL	90465	IMMUNIZATION ADMINISTRATION UNDER 8 YEARS OF AGE (INCLUDES PERCUTANEOUS,INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS) WHEN THE PHYSICIANCOUNSELS THE PATIENT/FAMILY; FIRST INJECTION (SINGLE OR COMBINATION VACCINE/TOXOID),PER DAY.
1/1/2008	MEDICAL	90466	IMMUNIZATION ADMINISTRATION UNDER 8 YEARS OF AGE (INCLUDES PERCUTANEOUS,INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS) WHEN THE PHYSICIANCOUNSELS THE PATIENT/FAMILY; EACH ADDITIONAL INJECTION (SINGLE OR COMBINATIONVACCINE/TOXOID), PER DAY.(USE 90466 IN CONJUNCTION WITH 90465 OR 90467)
1/1/2008	MEDICAL	90467	IMMUNIZATION ADMINISTRATION UNDER 8 YEARS OF AGE (INCLUDES INTRANASAL OR ORALROUTES OF ADMINISTRATION) WHEN THE PHYSICIAN COUNSELS THE PATIENT/FAMILY; FIRSTADMINISTRATION (SINGLE OR COMBINATION VACCINE/TOXOID), PER DAY.(DO NOT REPORT 90467 IN CONJUNCTION WITH 90465)
1/1/2008	MEDICAL	90468	IMMUNIZATION ADMINISTRATION UNDER 8 YEARS OF AGE (INCLUDES INTRANASAL OR ORALROUTES OF ADMINISTRATION) WHEN THE PHYSICIAN COUNSELS THE PATIENT/FAMILY; EACHADDITIONAL ADMINISTRATION (SINGLE OR COMBINATION VACCINE/TOXOID), PER DAY.(USE 90468 IN CONJUNCTION WITH 90465 OR 90467)
1/1/2008	MEDICAL	90471	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL,,SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); ONE VACCINE (SINGLE OR COMBINATIONVACCINE/TOXOID).(DO NOT REPORT 90471 IN CONJUNCTION WITH 90473)
1/1/2008	MEDICAL	90472	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL,SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); EACH ADDITIONAL VACCINE (SINGLE ORCOMBINATION VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARYPROCEDURE.(USE 90472 IN CONJUNCTION WITH 90471 OR 90473)
1/1/2008	MEDICAL	90473	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE, ONE VACCINE (SINGLE ORCOMBINATION VACCINE/TOXOID).
1/1/2008	MEDICAL	90474	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE, EACH ADDITIONAL VACCINE(SINGLE OR COMBINATION VACCINE VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TOCODE FOR PRIMARY PROCEDURE).(USE 90474 IN CONJUNCTION WITH 90471 OR 90473)
1/1/2008	MEDICAL	90633	HEPATITIS A VACCINE, PEDIATRIC/ADOLESCENT DOSAGE (2 DOSE SCHEDULE) FORINTRAMUSCULAR USE.
1/1/2008	MEDICAL	90647	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-OMP CONJUGATE (3 DOSE SCHEDULE),FOR INTRAMUSCULAR USE.

Exhibit 3
EPSDT Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	MEDICAL	90649	HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 6, 11, 16, 18 (QUADRIVALENT), 3DOSE SCHEDULE, FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90655	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR CHILDREN 6-35 MONTHS OFAGE, FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90656	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR USE IN INDIVIDUALS 3YEARS AND ABOVE, FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90657	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO CHILDREN 6 - 35 MONTHSOF AGE, FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90658	INFLUENZA VIRUS VACCINE, SPLIT VIRUS FOR USE IN INDIVIDUALS 3 YEARS OF AGE ANDABOVE, FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90660	INFLUENZA VIRUS VACCINE, LIVE, FOR INTRANASAL USE.
1/1/2008	MEDICAL	90669	PNEUMOCOCCAL CONJUGATE VACCINE, POLYVALENT, FOR CHILDREN UNDER 5 YEARS, FORINTRAMUSCULAR USE.
1/1/2008	MEDICAL	90680	ROTAVIRUS VACCINE, PENTAVALENT, 3 DOSE SCHEDULE, LIVE, FOR ORAL USE.
1/1/2008	MEDICAL	90700	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), FOR USE ININDIVIDUALS YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE.
1/1/2008	PEDIATRIC	90702	DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED WHEN ADMINISTERED TO YOUNGER THAN 7YEARS, FOR INTRAMUSCULAR USE
1/1/2008	PEDIATRIC	90704	MUMPS VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS OR JET INJECTION USE
1/1/2008	PEDIATRIC	90705	MEASLES VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS OR JET INJECTION USE
1/1/2008	PEDIATRIC	90706	RUBELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS OR JET INJECTION USE
1/1/2008	MEDICAL	90707	MEASLES, MUMPS AND RUBELLA VIRUS VACCINE (MMR), LIVE FOR SUBCUTANEOUS USE.
1/1/2008	MEDICAL	90710	MEASLES, MUMPS, RUBELLA AND VARICELLA VACCINE (MMRV), LIVE, FOR SUBCUTANEOUSUSE.
1/1/2008	MEDICAL	90713	POLIOVIRUS VACCINE, INACTIVATED, (IPV), FOR SUBCUTANEOUS USE.
1/1/2008	MEDICAL	90714	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHENADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), FOR USE ININDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90716	VARICELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE.
1/1/2008	MEDICAL	90723	DIPHTHERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE, HEPATITIS B, ANDPOLIOVIRUS VACCINE, INACTIVATED (DTAP-HEPBIPV), FOR INTRAMUSCULAR USE.
1/1/2008	MEDICAL	90734	MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS A, C, Y AND W-135(TETRAVALENT), FOR INTRAMUSCULAR USE.

Exhibit 3
EPSDT Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	MEDICAL	90744	HEPATITIS B VACCINE, PEDIATRIC/ADOLESCENT DOSAGE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE.
1/1/2008	PEDIATRIC	99201	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; APROBLEM FOCUSED EXAMINATION; AND STRAI
1/1/2008	PEDIATRIC	99202	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSEDHISTORY; AN EXPANDED PROBLEM FOCUSED EXA
1/1/2008	PEDIATRIC	99203	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; ADETAILED EXAMINATION; AND MEDICAL DECISI
1/1/2008	PEDIATRIC	99204	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; ACOMPREHENSIVE EXAMINATION; AND MEDICAL D
1/1/2008	PEDIATRIC	99205	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; ACOMPREHENSIVE EXAMINATION; AND MEDICAL D
1/1/2008	PEDIATRIC	99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY,THE PRESENTING PROBLEM(S) ARE MINIMAL. T
1/1/2008	PEDIATRIC	99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:A PROBLEM FOCUSED HISTORY; A PROBLEM FOC
1/1/2008	PEDIATRIC	99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:AN EXPANDED PROBLEM FOCUSED HISTORY; AN
1/1/2008	PEDIATRIC	99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:A DETAILED HISTORY; A DETAILED EXAMINATI
1/1/2008	PEDIATRIC	99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:A COMPREHENSIVE HISTORY; A COMPREHENSIVE
1/1/2008	PEDIATRIC	99231	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A PROBLEM FOCUSEDINTERVAL HISTORY; A PROBLEM FOCU

Exhibit 3
EPSDT Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	PEDIATRIC	99232	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEMFOCUSED INTERVAL HISTORY; AN EXP
1/1/2008	PEDIATRIC	99233	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A DETAILED INTERVALHISTORY; A DETAILED EXAMINATION
1/1/2008	PEDIATRIC	99381	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99382	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99383	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99384	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99385	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99391	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99392	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99393	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99394	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA

Exhibit 3
EPSDT Procedure Codes

FEE SCHEDULE DATE	CODE TYPE	CODE	CODE DESCRIPTION
1/1/2008	PEDIATRIC	99395	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA
1/1/2008	PEDIATRIC	99401	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES
1/1/2008	PEDIATRIC	99402	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES
1/1/2008	PEDIATRIC	99403	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 45 MINUTES
1/1/2008	PEDIATRIC	99404	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES
~~1/1/2008~~	~~PEDIATRIC~~	~~99411~~	~~PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING~~ (SEPARATE PROCEDURE); APPROXIMATELY 30MINUTES
1/1/2008	PEDIATRIC	99412	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 60MINUTES
1/1/2008	PEDIATRIC	99433	SUBSEQUENT HOSPITAL CARE, FOR THE EVALUATION AND MANAGEMENT OF A NORMAL NEWBORN, PER DAY

Exhibit 4

CTDSS Eligibility Management System (EMS)
Commercial Insurance Coverage Codes

TYPE OF COVERAGE	DESCRIPTION
1	Hospital Inpatient
2	Hospital Outpatient
3, 4, 5, 6 & 7	Doctor / Professional Services, Major Medical, Outpatient Clinic / Laboratory, X-Ray, Home Health Services (Note: all five codes 3-7 are entered on EMS)
8	Dental
9	Vision (Routine eye care, optometrist and optician services)
A	Drug (Presciption drug coverage; drug coverage contingent upon the client having an inpatient hospital or nursing home experience is excluded.)
L	Long Term Care. Coverage for nursing home room and board services

Exhibit 6a-110-Detail

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLSRP110: DETAIL LEVEL REPORT OF CLAIMS SELECTED AND BILLED TO HEALTH INSURANCE CARRIERS

CARRIER CODE	REPORTING MONTH	BILL DATE	BILL TYPE	CLIENT NAME	CLIENT ID #	FROM DOS	TO DOS	ICN	HMS CLAIM TYPE	FUND PAYER	DSS PAID	PROVIDER #	PROVIDER TYPE	PROVIDER SPECIALTY	BILL MONTH	BILL/REBILL CODE	RE-BILL MONTH	HMS A/R NUMBER	SOURCE INDICATOR
			D= DIRECT BILL P=PROVIDER DISALLOWANCE													B R			

CARRIER TOTAL:

GRAND TOTAL:

SORT: 1. CARRIER CODE 2. CLIENT ID 3. PROVIDER #

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Exhibit 5b-110-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP110, MONTHLY DETAIL OF CLAIMS SELECTED AND BILLED TO HEALTH INSURANCE CARRIERS

A monthly report which provides claim-level detail of claims selected for billing to third party insurance carriers. Includes originally billed claims as well as claims selected for re-bill in that reporting month

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the denied claim	
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
Bill Date	Date	The month/day(approximate)/year that the claim was billed to the carrier	
Bill Type	Text	Indicates whether the bill was a direct bill "D" or provider disallowance "P"	
Client Name	Text	Indicates the Medicaid Client's full name	
Client ID#	Number	Indicates the Medicaid Client's Medicaid ID Number (9 digits)	
From DOS	Date	The first date of service (start date)	
To DOS	Date	The last date of service (end date)	
ICN	Number	The claim's unique internal control number	DSS's value
HMS Claim Type	Number	Indicates the type of claim submitted	I.e., inpatient, outpatient, physician
Fund Payor	Text	The Fund Payor from the claim	I.e., Medicaid, CADAP, SAGA
DSS Paid	Currency	Indicates the total Medicaid Paid amount of the billed claims	
Provider Number	Number	The Provider of service's unique provider identification number	DSS's value
Provider Type	Text	The provider of service's service type	DSS's value
Provider Specialty	Text	The provider of service's service specialty type	DSS's value
Bill Month	Date	Indicates the month and year of the claim's billing	
Bill/Re-bill Code	Text	Indicates whether the claim was an initial billing or a re-billing	Value is "B" for initial billing and "R" for re-bill
Re-Bill Month	Date	Indicates the month and year of the claim's re-bill	
HMS A/R Number	Number	An internal HMS control number for identification on the accounts receivable	
Source Indicator	Text	Indicates source of TPL billing	RS=known TPL, NRS=data match

Exhibit 6e-120-Detail

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLBRP120: DETAIL LEVEL REPORT OF CLAIMS SELECTED FOR RECOUPMENT FROM PROVIDERS

CARRIER CODE	REPORTING MONTH	BILL DATE	BILL TYPE P=PROVIDER DISALLOWANCE	CLIENT NAME	CLIENT ID #	FROM DOS	TO DOS	ICN	HMS CLAIM TYPE	FUND PAYER	DSS PAID	PROVIDER #	PROVIDER TYPE	PROVIDER SPECIALTY	BILL MONTH	BILL/REBILL CODE R	RE-BILL MONTH	HMS A/R NUMBER	SOURCE INDICATOR

CARRIER TOTAL:

GRAND TOTAL:

SORT: 1. CARRIER CODE 2. CLIENT ID 3. PROVIDER #

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Exhibit 6b-120-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP120, DETAIL LEVEL REPORT OF CLAIMS SELECTED FOR RECOUPMENT FROM PROVIDERS

A monthly report which provides claim-level detail of claims selected for recoupment from providers.

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the denied claim	
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
Bill Date	Date	The month/day(approximate)/year that the claim was billed to the carrier	
Bill Type	Text	Indicates whether the bill was a direct bill "D" or provider disallowance "P". Only provider disallowance "P" claims should be selected for this report	
Client Name	Text	Indicates the Medicaid Client's full name	
Client ID#	Number	Indicates the Medicaid Client's Medicaid ID Number (9 digits)	
From DOS	Date	The first date of service (start date)	
To DOS	Date	The last date of service (end date)	
ICN	Number	The claim's unique internal control number	DSS's value
HMS Claim Type	Number	Indicates the type of claim submitted	i.e., inpatient, outpatient, physician
Fund Payer	Text	The Fund Payer from the claim	i.e., Medicaid, CADAP, SAGA
DSS Paid	Currency	Indicates the total Medicaid Paid amount of the billed claims	
Provider Number	Number	The Provider of service's unique provider identification number	DSS's value
Provider Type	Text	The provider of service's service type	DSS's value
Provider Specialty	Text	The provider of service's service specialty type	DSS's value
Bill Month	Date	Indicates the month and year of the claim's billing	
Bill/Re-bill Code	Text	Indicates whether the claim was an initial billing or a re-billing	Value is "B" for initial billing and "R" for re-bill
Re-Bill Month	Date	Indicates the month and year of the claim's re-bill	
HMS A/R Number	Number	An internal HMS control number for identification on the accounts receivable	
Source Indicator	Text	Indicates source of TPL billing	RS=known TPL, NRS=data match

Exhibit 7a-210-Detail

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLDRP210: DETAIL LEVEL REPORT OF CLAIMS RECOUPED FROM PROVIDERS

CARRIER CODE	REPORTING MONTH	BILL DATE	EDS RECOUP DATE	CLIENT NAME	CLIENT ID #	FROM DOS	TO DOS	ICN	HMS CLAIM TYPE	FUND CODE	DSS PAID	RECOUP AMOUNT	PROVIDER #	PROVIDER TYPE	PROVIDER SPECIALTY	HMS A/R NUMBER	SOURCE INDICATOR
MCA																	
MCB																	
BC																	

MC A TOTAL:
MC B TOTAL:
BC
GRAND TOTAL:

SORT: 1. CARRIER CODE 2. CLIENT ID 3. PROVIDER #

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Exhibit 7b-210-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP210, DETAIL LEVEL REPORT OF CLAIMS RECOUPED FROM PROVIDERS

A monthly report which provides claim-level detail of Medicaid paid claims that were recouped directly from a provider of service (i.e., a hospital) for either Anthem BCBS inpatient and outpatient claims or Medicare Part A or Part B claims

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the denied claim	
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
Bill Date	Date	The month/day(approximate)/year that the claim was billed to the carrier	
EDS Recoup Date	Date	The month/day/year that EDS recouped the payment from the provider	
Client Name	Text	Indicates the Medicaid Client's full name	
Client ID#	Number	Indicates the Medicaid Client's Medicaid ID Number (9 digits)	
From DOS	Date	The first date of service (start date)	
To DOS	Date	The last date of service (end date)	
ICN	Number	The claim's unique internal control number	DSS's value
HMS Claim Type	Number	Indicates the type of claim submitted	i.e., inpatient, outpatient, physician
Fund Payer	Text	The Fund Payer from the claim	i.e., Medicaid, CADAP, SAGA
DSS Paid	Currency	Indicates the total Medicaid Paid amount of the recouped claims	
Recoup Amount	Currency	The total amount recouped from the provider by EDS (on the provider's remittance advice)	
Provider Number	Number	The Provider of service's unique provider identification number	DSS's value
Provider Type	Text	The provider of service's service type	DSS's value
Provider Specialty	Text	The provider of service's service specialty type	DSS's value
HMS A/R Number	Number	An internal HMS control number for identification on the accounts receivable	
Source Indicator	Text	Indicates source of TPL billing	RS=known TPL, NRS=data match

Exhibit 8a-100-Detail

MEDICAID PAID CLAIMS RECOVERY PROGRAM
FOR THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLBRP100: DETAIL LEVEL REPORT OF CLAIMS EXCLUDED FROM BENEFIT RECOVERY

ARRIER CODE	REPORTING MONTH	BILL DATE	BILL TYPE D= DIRECT P=PROVIDER	BILL DISALLOWANCE	EXCLUSION REASON	CLIENT NAME	CLIENT ID #	FROM DOS	TO DOS	ICN	HMS CLAIM TYPE	FUND PAYER	DSS PAID	PROVIDER #	PROV TYPE	PROV SPECIALTY	BILL MONTH	SOURCE INDICATOR

CARRIER TOTAL:

GRAND TOTAL:

SORT: 1. CARRIER CODE 2. CLIENT ID 3. PROVIDER #

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Exhibit 8b-100-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP100, DETAIL LEVEL REPORT OF CLAIMS EXCLUDED FROM BENEFIT RECOVERY

A monthly report which summarizes the claims that are excluded from each billing cycle. HMS begins by selecting a full TPL Record Type 06-Paid Claims Match File, and then runs that file through a series of edits which removes unbillable claims from each billing cycle

Field Name	Field Type	Field Description	Comments
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
Edit Description	Text	Describes the type of claim edit applied	See Edits Descriptions below
Number of Claims	Number	Indicates the total number of claim records excluded from the billing cycle	
Medicaid Paid Amount	Currency	Indicates the total Medicaid Paid amount of the excluded claims	

EDITS DESCRIPTIONS

Edit Name	Further Description
Previously billed (on the HMS A/R)	Already billed by HMS on a previous billing cycle. Includes a match-off to auto re-billed claims, archived claims, and excluded project codes.
LTC Edits- Uses age, MA paid, level of care, provider, and carrier	Long term care edits- uses age, Medicaid paid amount, level of care, provider type and specialty and carrier information as measures of whether the claim would get paid by the carrier or not
Claims with Medicaid payment under $5	Claims with a Medicaid payment of under $5 are currently removed from the cycle
Institutional crossover claims	Not billable to third parties
HMO coverage edits	Claims for HMOs which HMS knows will not be reimbursed without prior authorization. HMS bills claims where prior authorization is not required. For instance- emergency room and pharmacy claim types
Person not covered on policy	
Yield management group edits	I.e., bad office codes, old or outdated eligibility. As a result of carrier group follow-up, when HMS receives confirmation that a certain group has termed out of a carrier's system, HMS will update the YM edit to remove that group from the billing
Medicare supplemental policy- claim not covered	Not covered under the policy identified
Beyond Rx timely filing limit	
Medco Rx bad relationship code edit	Removes Medco claims with a relationship code of "09". Medco will not accept any claims with this relationship code.
BCCT Rx recipient is over 65 years of age	HMS does not bill pharmacy claims to BCCT where the recipient is over the age of 65, because almost all of the MediGap plans held by BCCT do not pay for Rx
Champus over age 65	Medicare is prime
Institutional crossover claim invalid type of bill edits	Not billable to third parties
TPL segments that DSS has already identified	Record Type 06- DSS has already identified insurance and is pursuing recovery
Miscellaneous edits	Many of these edits send the claims to a "hold file" where additional analysis is completed. This is the result of claims that hit the edit for missing data or carrier information that is incomplete. The largest group of edited claims here are where HMS confirms that certain carrier code/group number and claim type combinations will not be paid by the carrier. For example, HMS often confirms with carriers that certain groups do not have LTC coverage, so HMS will clean all of those claim types for that group
Duplicate Claim Edits	Sends claims to the provider recoupment process
Medicaid paid amount is $0	
Over the counter drug clean	Removes over the counter drugs not payable by third parties
Provider information incomplete	The claim is missing required provider information, such as servicing provider ID, provider type, provider specialty
Diagnosis code edit	Removes non-reimbursable services (i.e., LTC and "special services/case management) or blank diagnosis codes
CPT4/Procedure code edits, including state-specific procedures	Missing or invalid codes; non-covered state specific procedures-i.e., residential services

Exhibit 8c-101-Summary

MEDICAID PAID CLAIMS RECOVERY PROGRAM
FOR THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLBRP101: SUMMARY REPORT OF CLAIMS EXCLUDED FROM BENEFIT RECOVERY

REPORTING MONTH	EDIT DESCRIPTION	NUMBER OF CLAIMS	MEDICAID PAID AMOUNT
August-05	Previously billed (on the HMS A/R)		
August-05	LTC Edits- Uses age, MA paid, level of care, provider, and carrier		
August-05	Claims with Medicaid payment under $5		
August-05	Institutional crossover claims		
August-05	HMO coverage edits		
August-05	Person not covered on policy		
August-05	Yield mangement group edits- I.e., bad office codes, old eligibility		
August-05	Medicare supplemental policy- claim not covered		
August-05	Beyond Rx timely filing limit		
August-05	Medco Rx bad relationship code edit		
August-05	BCCT Rx recipient is over 65 years of age		
August-05	Champus over age 65		
August-05	Institutional crossover claim invalid type of bill edits		
August-05	TPL segments that DSS has already identified		
August-05	Miscellaneous edits		
August-05	Duplicate Claim Edits		
August-05	Medicaid paid amount is $0		
August-05	Over the counter drug clean		
August-05	Provider information incomplete		
August-05	Diagnosis code edit		
August-05	CPT4/Procedure code edits, including state-specific procedures		
	TOTAL AMOUNT EXCLUDED	**0**	**$0**

Exhibit 9e-420-Detail

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT TPLBRP420: DETAIL LEVEL REPORT OF OUTSTANDING CLAIMS

CARRIER CODE	REPORTING MONTH	BILL MONTH	DAYS IN AGING	BILL TYPE	CLIENT NAME	CLIENT ID #	FROM DOS	TO DOS	ICN	HMS CLAIM TYPE	FUND PAYER	DSS PAID	PROVIDER #	PROVIDER TYPE	PROVIDER SPECIALTY	HMS A/R NUMBER	SOURCE INDICATOR

CARRIER TOTAL:

GRAND TOTAL:

SORT: 1. CARRIER CODE 2. CLIENT ID 3. PROVIDER #

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Exhibit 9b-420-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP420, DETAIL LEVEL REPORT OF OUTSTANDING CLAIMS FROM MONTH 0-24

A monthly report that provides claim-level detail of open claims within a two year (24 month) period. Provides detail on the carrier that each claim was billed to as well as the total number of days that the claim has been aging.

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the outstanding claim	
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
Bill Month	Date	The month/year that the claim was billed to the carrier	By Months 1-12, Month 13-18 and Months 19-24
Days In Aging	Number	The number of days the claim has been aging- starting from bill date	
Bill Type	Text	Indicates the type of claim submitted- paper, electronic, etc.	
Client Name	Text	Indicates the Medicaid Client's full name	
Client ID#	Number	Indicates the Medicaid Client's Medicaid ID Number (9 digits)	
From DOS	Date	The first date of service (start date)	
To DOS	Date	The last date of service (end date)	
ICN	Number	The claim's unique internal control number	DSS's value
HMS Claim Type	Number	Indicates the type of claim submitted	i.e., inpatient, outpatient, physician
Fund Payor	Text	The Fund Payer from the claim	i.e., Medicaid, CADAP, SAGA
DSS Paid	Currency	Indicates the total Medicaid Paid amount of the outstanding claims	
Provider Number	Number	The Provider of service's unique provider identification number	DSS's value
Provider Type	Text	The provider of service's service type	DSS's value
Provider Specialty	Text	The provider of service's service specialty type	DSS's value
HMS A/R Number	Number	An internal HMS control number for identification on the accounts receivable	
Source Indicator	Text	Indicates source of TPL billing	RS=known TPL, NRS=data match

Exhibit 9c-100

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLBRP400: SUMMARY REPORT OF AGED ACCOUNTS RECEIVABLE BY CARRIER

CARRIER CODE	REPORTING MONTH	45-60 DAYS		61-90 DAYS		91-120 DAYS		121-150 DAYS		151 -180 DAYS		181- 365 DAYS		366- 730 DAYS	
		# CLAIMS	BILLED $	# CLAIMS	BILLED $	# CLAIMS	BILLED $	# CLAIMS	BILLED $	# CLAIMS	BILLED $	# CLAIMS	BILLED $	# CLAIMS	BILLED $
TOTAL															

Exhibit 9d-400-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP400, SUMMARY REPORT OF AGED ACCOUNTS RECEIVABLE BY CARRIER

A monthly report which provides summary information of unadjudicated claims and their associated dollar values.
Broken down by date spans- 45-60 days, 61-90 days, 91-120 days, 121-150 days, 151-180 days, 181-365 days and 366-730 days outstanding (from bill date)

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the outstanding claim	
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
# Claims	Number	The number of claims billed	By 45-60 days, 61-90 days, 91-120 days, 121-150 days, 151-180 days, 181-365 days and 366-730 days
Billed $	Currency	The total amount billed	By 45-60 days, 61-90 days, 91-120 days, 121-150 days, 151-180 days, 181-365 days and 366-730 days

Exhibit 9e-410-Summary

HEALTH MANAGEMENT SYSTEMS, INC.

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLBRP410: SUMMARY REPORT OF OUTSTANDING CLAIMS BY CARRIER FROM BILL MONTH
MONTH: AUGUST 2005

CARRIER CODE	MONTH*	SOURCE INDICATOR	# CLAIMS	$ BILLED
	0			
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			
	11			
	12			
	13			
	14			
	15			
	16			
	17			
	18			
SUBTOTAL CARRIER				

* MONTH 0 = BILL DATE CURRENT MONTH, MONTH 1 = CURRENT MONTH -1, MONTH 2 = CURRENT MONTH - 2, etc...

Exhibit 9f-410-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP410, SUMMARY REPORT OF OUTSTANDING CLAIMS BY CARRIER FROM BILL MONTH

A monthly report which provides detail on the unadjudicated claims and their associated dollar values. This report counts the number of months that the claim has been outstanding (from bill month). Grouped by carrier code.

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the outstanding claim	
Month	Number	Indicates the number of months that the claim has been outstanding, from bill month	
# Claims	Number	The number of claims billed	
$ Billed	Currency	The total amount billed	

Exhibit 10a-220-Detail

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLSRP220: DETAIL LEVEL REPORT OF ACCOUNT RECEIVABLES DENIED

CARRIER CODE	REPORTING MONTH	POSTING DATE	BILL DATE	BILL TYPE	CLIENT NAME	CLIENT ID #	FROM DOS	TO DOS	ICN	HMS CLAIM TYPE	FUND CODE	DSS PAID	PROVIDER #	PROVIDER TYPE	PROVIDER SPECIALTY	DENIAL REASON CODE	HMS A/R NUMBER	SOURCE INDICATOR

CARRIER TOTAL:

GRAND TOTAL:

SORT: 1. CARRIER CODE 2. CLIENT ID 3. PROVIDER #

PAGE BREAK ON CARRIER

Exhibit 10b-220-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP220, DETAIL LEVEL REPORT OF ACCOUNT RECEIVABLES DENIED

A monthly report which provides claim-level detail of claims that were denied by the third party insurer for the reporting month. Includes information on why the claim was denied.

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the denied claim	
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
Posting Date	Date	The month/day/year that the payment was posted to the HMS accounts receivable system	A/R Update Date
Bill Date	Date	The month/day(approximate)/year that the claim was billed to the carrier	
Bill Type	Text	Indicates the type of claim submitted- paper, electronic, etc.	
Client Name	Text	Indicates the Medicaid Client's full name	
Client ID#	Number	Indicates the Medicaid Client's Medicaid ID Number (9 digits)	
From DOS	Date	The first date of service (start date)	
To DOS	Date	The last date of service (end date)	
ICN	Number	The claim's unique internal control number	DSS's value
HMS Claim Type	Number	Indicates the type of claim submitted	i.e., Inpatient, outpatient, physician
Fund Payer	Text	The Fund Payer from the claim	i.e., Medicaid, CADAP, SAGA
DSS Paid	Currency	Indicates the total Medicaid Paid amount of the denied claims	
Provider Number	Number	The Provider of service's unique provider identification number	DSS's value
Provider Type	Text	The provider of service's service type	DSS's value
Provider Specialty	Text	The provider of service's service specialty type	DSS's value
Denial Reason Code	Text	The HMS reason code for the claim's denial, cross walked from the carrier's denial code	
HMS A/R Number	Number	An internal HMS control number for identification on the accounts receivable	
Source Indicator	Text	Indicates source of TPL billing	RS=known TPL, NRS=data match

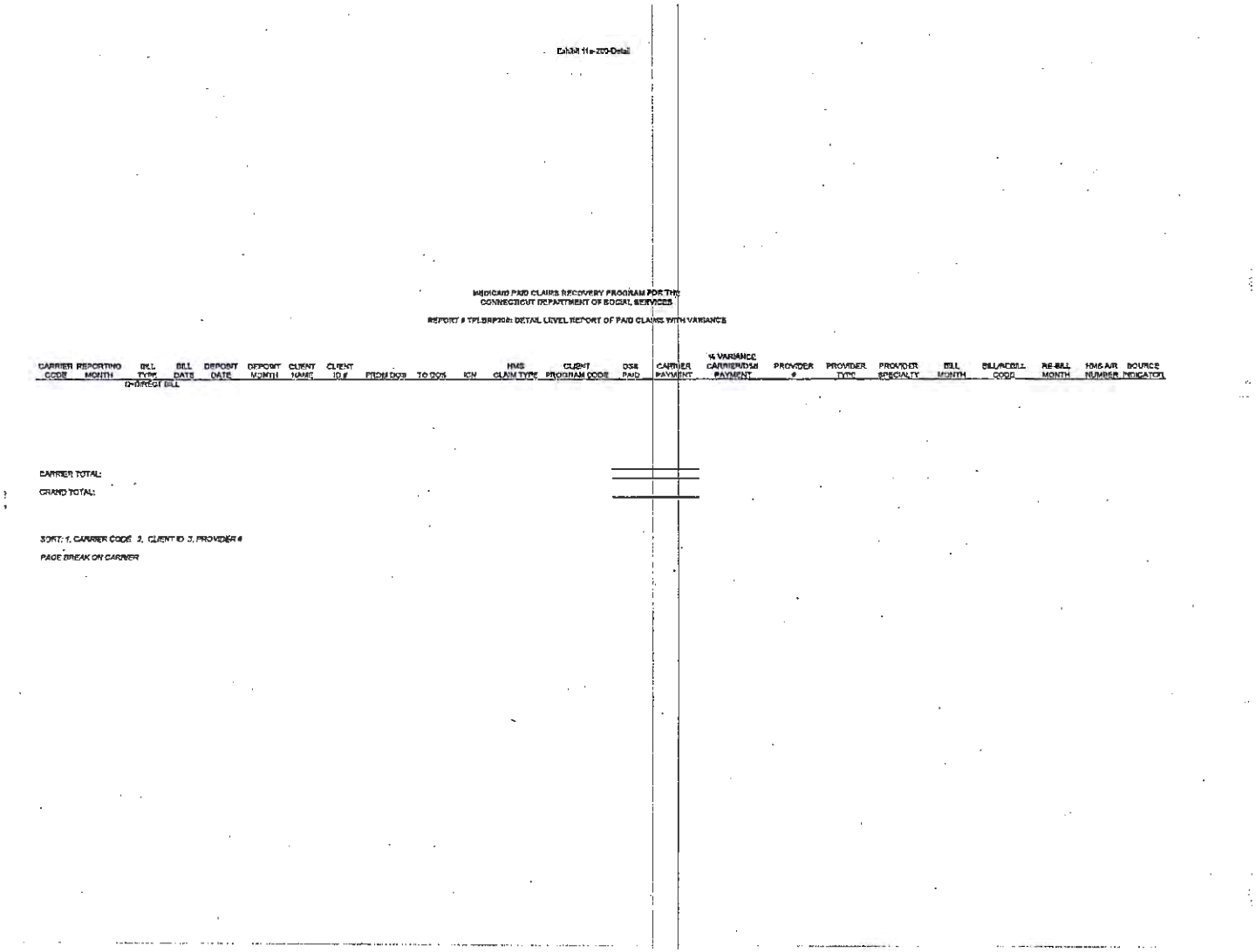

Exhibit 11-e-200-Detail

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLDRP30A: DETAIL LEVEL REPORT OF PAID CLAIMS WITH VARIANCE

CARRIER CODE	REPORTING MONTH	INCL TYPE (D=DIRECT BILL	BILL DATE	DEPOSIT DATE	DEPOSIT MONTH	CLIENT NAME	CLIENT ID #	FROM DOS	TO DOS	ICN	HMS CLAIM TYPE	CLIENT PROGRAM CODE	DSS PAID	CARRIER PAYMENT	% VARIANCE CARRIER/DSS PAYMENT	PROVIDER #	PROVIDER TYPE	PROVIDER SPECIALTY	BILL MONTH	BILL/RECBILL CODE	RE-BILL MONTH	HMS A/R NUMBER	SOURCE INDICATOR

CARRIER TOTAL:

GRAND TOTAL:

SORT: 1. CARRIER CODE 2. CLIENT ID 3. PROVIDER #

PAGE BREAK ON CARRIER

Exhibit 11b-200-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP200, DETAIL LEVEL REPORT OF PAID CLAIMS WITH VARIANCE

A monthly report which details all third party paid claims for the reporting month. Further details the variance between the amount paid on the claim by DSS versus the amount paid by the carrier (by percentage)

Field Name	Field Type	Field Description	Comments
Carrier Code	Number	Indicates the three byte DSS carrier code associated with the denied claim	
Reporting Month	Date	Indicates the reporting month and year- is always the invoice month	
Bill Date	Date	The month/day(approximate)/year that the claim was billed to the carrier	
Deposit Date	Date	The month/day/year that the carrier's payment was deposited to the lockbox account	
Deposit Month	Date	The month and year that the carrier's payment was deposited to the lockbox account	
Client Name	Text	Indicates the Medicaid Client's full name	
Client ID#	Number	Indicates the Medicaid Client's Medicaid ID Number (9 digits)	
From DOS	Date	The first date of service (start date)	
To DOS	Date	The last date of service (end date)	
ICN	Number	The claim's unique internal control number	DSS's value
HMS Claim Type	Number	Indicates the type of claim submitted	i.e., inpatient, outpatient, physician
Fund Payer	Text	The Fund Payer from the claim	i.e., Medicaid, CADAP, SAGA
DSS Paid	Currency	Indicates the total Medicaid Paid amount of the paid claim	
Carrier Payment	Currency	The total amount paid by the carrier for the associated claim	
% Variance Carrier/DSS	Percentage	Indicates the variance between the DSS Medicaid Paid amount and the amount paid by the carrier	
Provider Number	Number	The Provider of service's unique provider identification number	DSS's value
Provider Type	Text	The provider of service's service type	DSS's value
Provider Specialty	Text	The provider of service's service specialty type	DSS's value
HMS A/R Number	Number	An internal HMS control number for identification on the accounts receivable	
Source Indicator	Text	Indicates source of TPL billing	RS=known TPL, NRS=data match

Exhibit11c-201-Summary

MEDICAID PAID CLAIMS RECOVERY PROGRAM FOR THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

REPORT # TPLBRP201: SUMMARY REPORT OF CLAIMS RECOVERED FROM HEALTH INSURANCE CARRIERS

DEPOSIT REPORTING MONTH	CARRIER CODE	SOURCE INDICATOR	NUMBER OF CLAIMS	MEDICAID PAID AMOUNT	CARRIER PAYMENT
CARRIER TOTAL:					
GRAND TOTAL:					

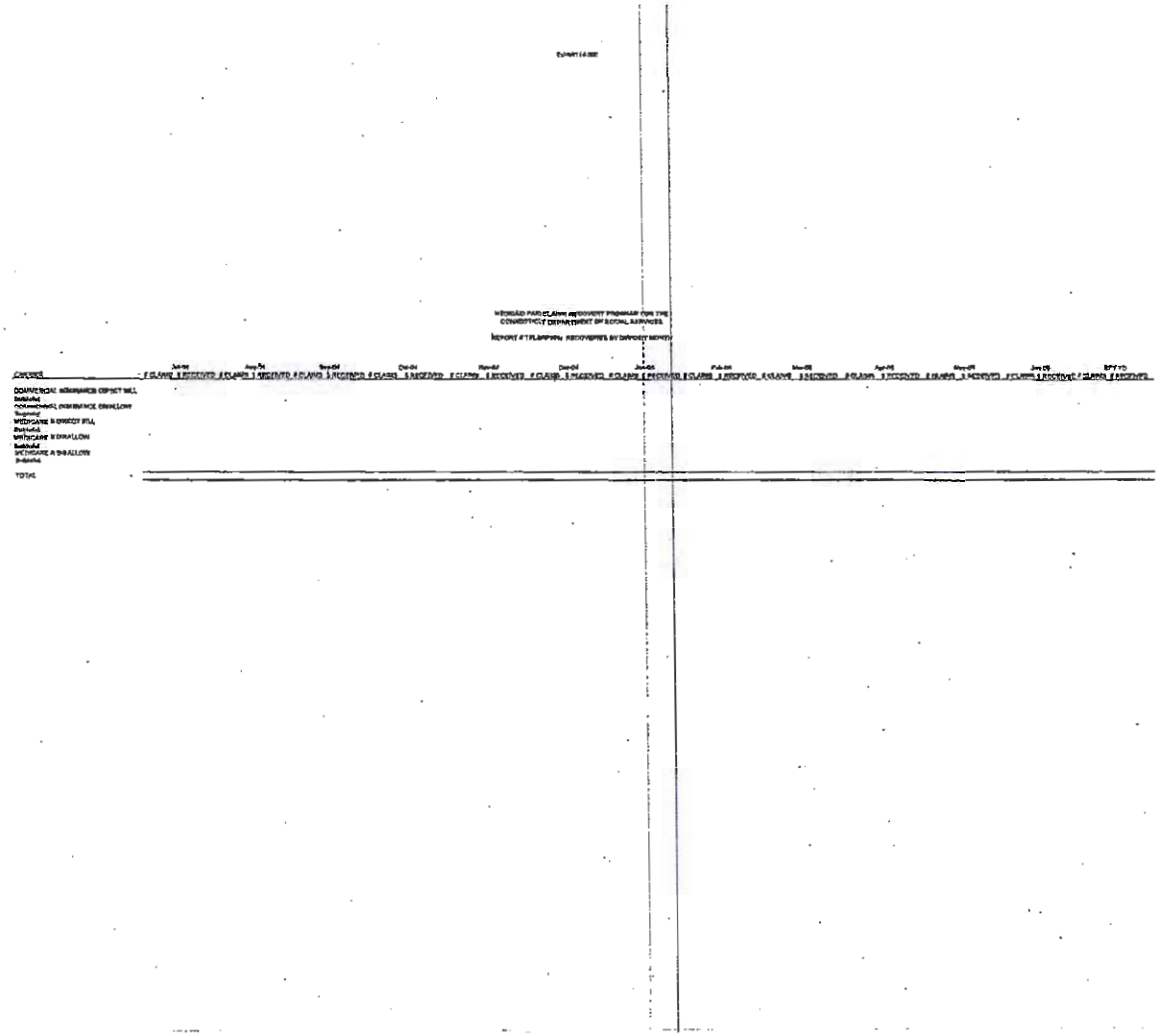

Exhibit11e-300-Description

MEDICAID PAID CLAIMS RECOVERY PROJECT- DATA DESCRIPTORS FOR REPORT TPLBRP300, RECOVERIES BY DEPOSIT MONTH

A monthly report which provides claim counts and recovered $ amounts by carrier code. Further broken down by whether the claim was a Commercial Insurance direct bill, a Commercial Insurance Disallowance (claims listing sent to the provider of service rather than the insurance carrier), Medicare Part B Direct bill, Medicare Part B disallowance, or Medicare Part A disallowance.

Field Name	Field Type	Field Description	Comments
Carrier	Text	The DSS carrier code for the insurance carrier the claim was recovered from	Broken out by CI Direct Bill, CI Disallowed, Medicare B Direct Bill, Medicare B Disallow, and Medicare A Disallow
# Claims	Number	The number of claims recovered	By month
$ Received	Currency	The total amount recovered	By month

PART II. TERMS AND CONDITIONS

The Contractor shall comply with the following terms and conditions.

A. Definitions. Unless otherwise indicated, the following terms shall have the following corresponding definitions:

1. "Bid" shall mean a bid submitted in response to a solicitation.

2. "Breach" shall mean a party's failure to perform some contracted-for or agreed-upon act, or his failure to comply with a duty imposed by law which is owed to another or to society.

3. "Cancellation" shall mean an end to the Contract affected pursuant to a right which the Contract creates due to a Breach.

4. "Claims" shall mean all actions, suits, claims, demands, investigations and proceedings of any kind, open, pending or threatened, whether mature, unmatured, contingent, known or unknown, at law or in equity, in any forum.

5. "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.

6. "Confidential Information Breach" shall mean, generally, an instance where an unauthorized person or entity accesses Confidential Information in any manner, including but not limited to the following occurrences: (1) any Confidential Information that is not encrypted or protected is misplaced, lost, stolen or in any way compromised; (2) one or more third parties have had access to or taken control or possession of any Confidential Information that is not encrypted or protected without prior written authorization from the State; (3) the unauthorized acquisition of encrypted or protected Confidential Information together with the confidential process or key that is capable of compromising the integrity of the Confidential Information; or (4) if there is a substantial risk of identity theft or fraud to the client, the Contractor, the Department or State.

7. "Contract" shall mean this agreement, as of its effective date, between the Contractor and the State for Services.

8. "Contractor Parties" shall mean a Contractor's members, directors, officers, shareholders, partners, managers, principal officers, representatives, agents, servants, consultants, employees or any one of them or any other person or entity with whom the Contractor is in privity of oral or written contract (e.g. subcontractor) and the Contractor intends for such other person or entity to perform under the Contract in any capacity. For the purpose of this Contract, vendors of support services, not otherwise known as human service providers or educators, shall not be considered subcontractors, e.g. lawn care, unless such activity is considered part of a training, vocational or educational program.

9. "Data" shall mean all results, technical information and materials developed and/or obtained in the performance of the Services hereunder, including but not limited to all reports, survey and evaluation tools,

surveys and evaluations, plans, charts, recordings (video and/or sound), pictures, curricula, electronically prepared presentations, public awareness or prevention campaign materials, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents, whether finished or unfinished, which result from or are prepared in connection with the Services performed hereunder.

10. "Day" shall mean all calendar days, other than Saturdays, Sundays and days designated as national or State of Connecticut holidays upon which banks in Connecticut are closed.

11. "Expiration" shall mean an end to the Contract due to the completion in full of the mutual performances of the parties or due to the Contract's term being completed.

12. "Force Majeure" shall mean events that materially affect the Services or the time schedule within which to perform and are outside the control of the party asserting that such an event has occurred, including, but not limited to, labor troubles unrelated to the Contractor, failure of or inadequate permanent power, unavoidable casualties, fire not caused by the Contractor, extraordinary weather conditions, disasters, riots, acts of God, insurrection or war.

13. "Records" shall mean all working papers and such other information and materials as may have been accumulated and/or produced by the Contractor in performing the Contract, including but not limited to, documents, data, plans, books, computations, drawings, specifications, notes, reports, records, estimates, summaries and correspondence, kept or stored in any form.

14. "Services" shall mean the performance of Services as stated in Part I of this Contract.

15. "State" shall mean the State of Connecticut, including any agency, office, department, board, council, commission, institution or other executive branch agency of State Government.

16. "Termination" shall mean an end to the Contract affected pursuant to a right which the Contract creates, other than for a Breach.

B. Contractor Obligations.

1. 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.

2. 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.

i. Contractor acknowledges that it has received a copy of said policy and shall comply with its terms, as amended, and with all applicable state and federal laws, regulations and rules. Contractor shall provide said policy to subcontractors and shall require compliance with the terms of the policy. Failure to abide by the terms of the policy, as determined by the Agency, shall constitute a Breach of this Contract and may result in cancellation or termination of this Contract.

ii. This section applies if, under this Contract, the Contractor or Contractor Parties furnishes, or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the Agency.

(c) Contractor represents that it is not excluded, debarred, suspended or otherwise incligible to participate in federal health care programs.

(d) Contractor shall not, for purposes of performing the Contract with the Agency, knowingly employ or contract with, with or without compensation: (A) any individual or entity listed by a federal agency as excluded, debarred, suspended or otherwise ineligible to participate in federal health care programs; or (B) any person or entity who is excluded from contracting with the State of Connecticut or the federal government (as reflected in the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, Department of Health and Human Services, Office of Inspector General (HHS/OIG) Excluded Parties list and the Office of Foreign Assets Control (OFAC) list of Specially Designated Nationals and Blocked Persons List). Contractor shall immediately notify the Agency should it become subject to an investigation or inquiry involving items or services reimbursable under a federal health care program or be listed as ineligible for participation in or to perform Services in connection with such program. The Agency may cancel or terminate this Contract immediately if at any point the Contractor, subcontractor or any of their employees are sanctioned, suspended, excluded from or otherwise become ineligible to participate in federal health care programs.

3. Annual Financial Audit; Audit and Inspection of Plants and Places of Business; and Records.

a. Financial Audit Requirements. For purposes of this paragraph, the word "contractor" shall be deemed to mean "nonstate entity," as that term is defined in Section 4-230 of the Connecticut General Statutes. The Contractor shall provide for an annual financial audit acceptable to the Department for any expenditure of state-awarded funds made by the Contractor. Such audit shall include management letters and audit recommendations. The State Auditors of Public Accounts shall have access to all records and accounts for the fiscal year(s) in which the award was made. The Contractor will comply with federal and state singe audit standards as applicable.

b. Audits and Inspections.

i. The State and its agents, including, but not limited to, the Connecticut Auditors of Public Accounts, Attorney General and State's Attorney and their respective agents, may, at reasonable hours, inspect and examine all of the parts of the Contractor's and Contractor Parties' plants and places of business which, in any way, are related to, or involved in, the performance of this Contract.

ii. All audits and inspections described in sections b through h of this section shall be at the State's expense.

iii. 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.

iv. The State shall make all requests for any audit or inspection in writing and shall provide the Contractor with at least twenty-four (24) hours' notice prior to the requested audit and inspection date. If the State suspects fraud or other abuse, or in the event of an emergency, the State is not obligated to provide any prior notice

v. The Contractor shall incorporate this entire Section verbatim into any contract or other agreement that it enters into with any Contractor Party.

c. Records.

i. The Contractor shall maintain, and shall require each of the Contractor Parties to maintain, accurate and complete Records. The Contractor shall make all of its and the Contractor Parties' Records available at all reasonable hours for audit and inspection by the State and its agents.

ii. The Contractor shall keep and preserve or cause to be kept and preserved all of its and Contractor Parties' Records until three (3) years after the latter of (i) final payment under this Agreement, or (ii) the expiration or earlier termination of this Agreement, as the same may be modified for any reason. The State may request an audit or inspection at any time during this period. If any Claim or audit is started before the expiration of this period, the Contractor shall retain or cause to be retained all Records until all Claims or audit findings have been resolved.

4. 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.

5. 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.

6. Related Party Transactions. The Contractor shall report all related party transactions, as defined in this section, to the Agency on an annual basis in the appropriate fiscal report as specified in Part I of this Contract. "Related party" means a person or organization related through marriage, ability to control, ownership, family or business association. Past exercise of influence or control need not be shown, only the potential or ability to directly or indirectly exercise influence or control. "Related party transactions" between a Contractor or Contractor Party and a related party include, but are not limited to:

a. Real estate sales or leases;

b. leases for equipment, vehicles or household furnishings;

c. Mortgages, loans and working capital loans; and

d. Contracts for management, consultant and professional services as well as for materials, supplies and other services purchased by the Contractor or Contractor Party.

7. Suspension or Debarment. In addition to the representations and requirements set forth in Section D.4:

a. The Contractor certifies for itself and Contractor Parties involved in the administration of federal or state funds that they:

i. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any governmental agency (federal, state or local);

ii. 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;

iii. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the above offenses; and

iv. 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. 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.

9. 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.

10. Sovereign Immunity. The parties acknowledge and agree that nothing in the Solicitation or 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.

11. Indemnification; Insurance.

a. The Contractor shall indemnify, defend and hold harmless the State 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 obligations under this section. 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 Contractor's bid, proposal or any Records, any intellectual property rights, other proprietary 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.

b. The Contractor shall not be responsible for indemnifying or holding the State harmless from any liability arising due to the negligence of the State or any third party acting under the direct control or supervision of the State.

c. 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.

d. 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.

e. Insurance. The Contractor shall carry and maintain at all times during the term of the Contract, and during the time that any provisions 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. The Agency shall be entitled to recover under the insurance policy even if a body of competent jurisdiction determines that the Agency or the State is contributorily negligent.

f. This section shall survive the Termination of the Contract and shall not be limited by reason of any insurance coverage.

12. 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.

13. 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.

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. Protection of Confidential Information

a. 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.

b. 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.

c. The Contractor and Contractor Parties shall notify the Department and the Connecticut Office of the Attorney General as soon as practical, but no later than twenty-four (24) hours, after they become aware of or suspect that any 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, present a credit monitoring and protection plan to the Commissioner of Administrative Services, the Department and the Connecticut Office of the Attorney General, for review and approval. Such credit monitoring or protection plan shall be made available by the Contractor at its own cost and expense to all individuals affected by the Confidential Information Breach. Such credit monitoring or protection plan shall include, but is not limited to reimbursement for the cost of placing and lifting one (1) security freeze per credit file pursuant to Connecticut General Statutes § 36a-701a. Such credit monitoring or protection plans shall be approved by the State in accordance with this Section and shall cover a length of time commensurate with the circumstances of the 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.

d. The Contractor shall incorporate the requirements of this Section in all subcontracts requiring each Contractor Party to safeguard Confidential Information in the same manner as provided for in this Section.

e. Nothing in this Section shall supersede in any manner Contractor's or Contractor Party's obligations pursuant to HIPAA or the provisions of this Contract concerning the obligations of the Contractor as a Business Associate of the Department.

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 OAG.

(b) The Agency may amend this Contract to reduce the contracted amount of compensation if:

(1) the total amount budgeted by the State for the operation of the Agency or Services provided under the program is reduced or made unavailable in any way; or

(2) federal funding reduction results in reallocation of funds within the Agency.

(c) If the Agency decides to reduce the compensation, the Agency shall send written Notice to the Contractor. Within twenty (20) Days of the Contractor's receipt of the Notice, the Contractor and the Agency shall negotiate the implementation of the reduction of compensation unless the parties mutually agree that such negotiations would be futile. If the parties fail to negotiate an implementation schedule, then the Agency may terminate the Contract effective no earlier than sixty (60) Days from the date that

the Contractor receives written notification of Termination and the date that work under this Contract shall cease.

2. Contractor Changes and Assignment.

(a) The Contractor shall notify the Agency in writing:

(1) at least ninety (90) days prior to the effective date of any fundamental changes in the Contractor's corporate status, including merger, acquisition, transfer of assets, and any change in fiduciary responsibility;

(2) no later than ten (10) days from the effective date of any change in:

(A) its certificate of incorporation or other organizational document;

(B) more than a controlling interest in the ownership of the Contractor; or

(C) the individual(s) in charge of the performance.

(b) No such change shall relieve the Contractor of any responsibility for the accuracy and completeness of the performance. The Agency, after receiving written Notice from the Contractor of any such change, may require such contracts, releases and other instruments evidencing, to the Agency's satisfaction, that any individuals retiring or otherwise separating from the Contractor have been compensated in full or that allowance has been made for compensation in full, for all work performed under terms of the Contract. The Contractor shall deliver such documents to the Agency in accordance with the terms of the Agency's written request. The Agency may also require, and the Contractor shall deliver, a financial statement showing that solvency of the Contractor is maintained. The death of any Contractor Party, as applicable, shall not release the Contractor from the obligation to perform under the Contract; the surviving Contractor Parties, as appropriate, must continue to perform under the Contract until performance is fully completed.

(c) Assignment. The Contractor shall not assign any of its rights or obligations under the Contract, voluntarily or otherwise, in any manner without the prior written consent of the Agency.

(1) The Contractor shall comply with requests for documentation deemed to be appropriate by the Agency in considering whether to consent to such assignment.

(2) The Agency shall notify the Contractor of its decision no later than forty-five (45) Days from the date the Agency receives all requested documentation.

(3) The Agency may void any assignment made without the Agency's consent and deem such assignment to be in violation of this Section and to be in Breach of the Contract. Any cancellation of this Contract by the Agency for a Breach shall be without prejudice to the Agency's or the State's rights or possible claims against the Contractor.

3. Breach.

(a) If either party Breaches this Contract in any respect, the non-breaching party shall provide written notice of the Breach to the breaching party and afford the breaching party an opportunity to cure within ten (10) Days from the date that the breaching party receives the notice. In the case of a Contractor Breach, the Agency may modify the ten (10) day cure period in the notice of Breach. The right to cure period shall be extended if the non-breaching party is satisfied that the breaching party

is making a good faith effort to cure, but the nature of the Breach is such that it cannot be cured within the right to cure period. The Notice may include an effective Contract cancellation date if the Breach is not cured by the stated date and, unless otherwise modified by the non-breaching party in writing prior to the cancellation date, no further action shall be required of any party to effect the cancellation as of the stated date. If the notice does not set forth an effective Contract cancellation date, then the non-breaching party may cancel the Contract by giving the breaching party no less than twenty four (24) hours' prior written Notice after the expiration of the cure period.

(b) If the Agency believes that the Contractor 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.

(c) The Contractor shall return all unexpended funds to the Agency no later than thirty (30) calendar days after the Contractor receives a demand from the Agency.

(d) In addition to the rights and remedies granted to the Agency by this Contract, the Agency shall have all other rights and remedies granted to it by law in the event of Breach of or default by the Contractor under the terms of this Contract.

(e) The action of the Agency shall be considered final. If at any step in this process the Contractor fails to comply with the procedure and, as applicable, the mutually agreed plan of correction, the Agency may proceed with Breach remedies as listed under this section.

(f) Non-enforcement Not to Constitute Waiver of Breach. 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.

4. Ending the Contractual Relationship; Termination.

a. This Contract shall remain in full force and effect for the duration of its entire term or until such time as it is terminated earlier by either party or cancelled.

b. If this Contract is terminated for any reason, cancelled or it expires in accordance with its term, the Contractor shall do and perform all things which the Agency determines to be necessary or appropriate to assist in the orderly 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.

c. Termination.

i. Notwithstanding any provisions in this Contract, the Agency, through a duly authorized employee, may Terminate the Contract whenever the Agency makes a written determination that such Termination is in the best interests of the State. The Agency shall notify the Contractor in writing of Termination pursuant to this section, which notice shall specify the effective date of Termination and the extent to which the Contractor must complete its Performance under the Contract prior to such date.

ii. The Agency may terminate the Contract at any time without prior notice when the funding for the Contract is no longer available.

iii. Notwithstanding any provisions in this Contract, the Agency, through a duly authorized employee, may, after making a written determination that the Contractor has breached the Contract, Terminate the Contract in accordance with the provisions in the Breach section of this Contract.

iv. Notwithstanding any provisions in this Contract, 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.

v. Such Notice of Termination shall be sent in accordance with the Notice provision contained on page 1 of this Contract. Upon receiving the notice from the Agency, the Contractor shall immediately discontinue all services affected in accordance with the notice, undertake all commercially reasonable efforts to mitigate any losses or damages, and deliver to the Agency all Records. The 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 Records. 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.

vi. Upon receipt of a written notice of Termination from the Agency, the Contractor shall cease operations as the Agency directs in the notice, and take all actions that are necessary or appropriate, or that the Agency may reasonably direct, for the protection, and preservation of the Goods and any other property. Except for any work which the Agency directs the Contractor to Perform in the notice prior to the effective date of Termination, and except as otherwise provided in the notice, the Contractor shall terminate or conclude all existing subcontracts and purchase orders and shall not enter into any further subcontracts, purchase orders or commitments.

vii. The Contractor shall return to the Agency any funds not expended in accordance with the terms and conditions of the Contract and, if the Contractor fails to do so upon demand, the Agency may recoup said funds from any future payments owing under this Contract or any other contract between the State and the Contractor. Allowable costs, as detailed in audit findings, incurred until

the date of termination or cancellation for operation or transition of program(s) under this Contract shall not be subject to recoupment.

viii. The Agency shall, within forty-five (45) days of the effective date of Termination, reimburse the Contractor for its Performance rendered and accepted by the Agency in accordance with Part I in addition to all actual and reasonable costs incurred after Termination in completing those portions of the Performance which the notice required the Contractor to complete. However, the Contractor is not entitled to receive and the Agency is not obligated to tender to the Contractor any payments for anticipated or lost profits. Upon request by the Agency, the Contractor shall assign to the Agency, or any replacement contractor which the Agency designates, all subcontracts, purchase orders and other commitments, deliver to the Agency all Records and other information pertaining to its Performance, and remove from State premises, whether leased or owned, all of Contractor's property, equipment, waste material and rubbish related to its Performance, all as the Agency may request.

ix. For breach or violation of any of the provisions in the section concerning Representations and Warranties, the Agency may Terminate the Contract in accordance with its terms and revoke any consents to assignments given as if the assignments had never been requested or consented to, without liability to the Contractor or Contractor Parties or any third party.

x. Upon Termination of the Contract, all rights and obligations shall be null and void, so that no party shall have any further rights or obligations to any other party, except with respect to the sections which survive Termination. All representations, warranties, agreements and rights of the parties under the Contract shall survive such Termination to the extent not otherwise limited in the Contract and without each one of them having to be specifically mentioned in the Contract.

xi. Termination of the Contract pursuant to this section shall not be deemed to be a breach of contract by the Agency.

d. Transition after Termination or Expiration of Contract.

i. 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 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.

ii. 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. Americans with Disabilities Act. The Contractor shall be and remain in compliance with the Americans with Disabilities Act of 1990 (http://www.ada.gov/) as amended from time to time ("Act") to the extent applicable, during the term of the Contract. The Agency may cancel or terminate this Contract if the Contractor fails to comply with the Act. The Contractor represents that it is familiar with the terms of this Act and that it is in compliance with the law. The Contractor warrants that it shall hold the State harmless from any liability which may be imposed upon the state as a result of any failure of the Contractor to be in compliance with this Act. As applicable, the Contractor shall comply with section 504 of the Federal Rehabilitation Act of 1973, as amended from time to time, 29 U.S.C. § 794 (Supp. 1993), regarding access to programs and facilities by people with disabilities.

2. 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.

3. 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.

4. Executive Orders. This Contract is subject to the provisions of Executive Order No. Three of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices, Executive Order No. Seventeen of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings and Executive Order No. Sixteen of Governor John G. Rowland promulgated August 4, 1999, concerning violence in the workplace, all of which are incorporated into and are made a part of the Contract as if they had been fully set forth in it. The Contract may also be subject to the applicable parts of Executive Order No. 7C of Governor M. Jodi Rell, promulgated July 13, 2006, concerning contracting reforms and Executive Order No. 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. If Executive Orders 7C and 14 are applicable, they are deemed to be

incorporated into and are made a part of the Contract as if they had been fully set forth in it. At the Contractor's request, the Department shall provide a copy of these orders to the Contractor. .

5. 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 reproduced below:
http://www.ct.gov/seec/lib/seec/forms/contractor_reporting_/seec_form_11_notice_only.pdf

CONNECTICUT STATE ELECTIONS ENFORCEMENT COMMISSION
Rev. 1/11
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Notice to Executive Branch State Contractors and Prospective State Contractors of Campaign Contribution and Solicitation Limitations

This notice is provided under the authority of Connecticut General Statutes §9-612(g)(2), as amended by P.A. 10-1, and is for the purpose of informing state contractors and prospective state contractors of the following law (italicized words are defined on the reverse side of this page).

CAMPAIGN CONTRIBUTION AND SOLICITATION LIMITATIONS

No *state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor*, with regard to a *state contract* or *state contract solicitation* with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall make a contribution to (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee (which includes town committees).

In addition, no holder or principal of a holder of a valid prequalification certificate, shall make a contribution to (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of State senator or State representative, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

On and after January 1, 2011, no state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor, with regard to a state contract or state contract solicitation with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall knowingly *solicit* contributions from the state contractor's or prospective state contractor's employees or from a *subcontractor* or *principals of the subcontractor* on behalf of (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

DUTY TO INFORM

State contractors and prospective state contractors are required to inform their principals of the above prohibitions, as applicable, and the possible penalties and other consequences of any violation thereof.

PENALTIES FOR VIOLATIONS

Contributions or solicitations of contributions made in violation of the above prohibitions may result in the following civil and criminal penalties:

Civil penalties—Up to $2,000 or twice the amount of the prohibited contribution, whichever is greater, against a principal or a contractor. Any state contractor or prospective state contractor which fails to make reasonable efforts to comply with the provisions requiring notice to its principals of these prohibitions and the possible consequences of their violations may also be subject to civil penalties of up to $2,000 or twice the amount of the prohibited contributions made by their principals.

Criminal penalties—Any knowing and willful violation of the prohibition is a Class D felony, which may subject the violator to imprisonment of not more than 5 years, or not more than $5,000 in fines, or both.

CONTRACT CONSEQUENCES

In the case of a state contractor, contributions made or solicited in violation of the above prohibitions may result in the contract being voided.

In the case of a prospective state contractor, contributions made or solicited in violation of the above prohibitions shall result in the contract described in the state contract solicitation not being awarded to the prospective state contractor, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

The State shall not award any other state contract to anyone found in violation of the above prohibitions for a period of one year after the election for which such contribution is made or solicited, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

Additional information may be found on the website of the State Elections Enforcement Commission, www.ct.gov/seec. Click on the link to "Lobbyist/Contractor Limitations."

6.

DEFINITIONS

"State contractor" means a person, business entity or nonprofit organization that enters into a state contract. Such person, business entity or nonprofit organization shall be deemed to be a state contractor until December thirty-first of the year in which such contract terminates. "State contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Prospective state contractor" means a person, business entity or nonprofit organization that (i) submits a response to a state contract solicitation by the state, a state agency or a quasi-public agency, or a proposal in response to a request for proposals by the state, a state agency or a quasi-public agency, until the contract has been entered into, or (ii) holds a valid prequalification certificate issued by the Commissioner of Administrative Services under section 4a-100. "Prospective state contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a state contractor or prospective state contractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a state contractor or prospective state contractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a state contractor or prospective state contractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a state contractor or prospective state contractor, which is not a business entity, or if a state contractor or prospective state contractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any state contractor or prospective state contractor who has *managerial or discretionary responsibilities with respect to a state contract*, (v) the spouse or a *dependent child* who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the state contractor or prospective state contractor.

"State contract" means an agreement or contract with the state or any state agency or any quasi-public agency, let through a procurement process or otherwise, having a value of fifty thousand dollars or more, or a combination or series of such agreements or contracts having a value of one hundred thousand dollars or more in a calendar year, for (i) the rendition of services, (ii) the furnishing of any goods, material, supplies, equipment or any items of any kind, (iii) the construction, alteration or repair of any public building or public work, (iv) the acquisition, sale or lease of any land or building, (v) a licensing arrangement, or (vi) a grant, loan or loan guarantee. "State contract" does not include any agreement or contract with the state, any state agency or any quasi-public agency that is exclusively federally funded, an education loan, a loan to an individual for other than commercial purposes or any agreement or contract between the state or any state agency and the United States Department of the Navy or the United States Department of Defense.

"State contract solicitation" means a request by a state agency or quasi-public agency, in whatever form issued, including, but not limited to, an invitation to bid, request for proposals, request for information or request for quotes, inviting bids, quotes or other types of submittals, through a competitive procurement process or another process authorized by law waiving competitive procurement.

"Managerial or discretionary responsibilities with respect to a state contract" means having direct, extensive and substantive responsibilities with respect to the negotiation of the state contract and not peripheral, clerical or ministerial responsibilities.

"Dependent child" means a child residing in an individual's household who may legally be claimed as a dependent on the federal income tax of such individual.

"Solicit" means (A) requesting that a contribution be made, (B) participating in any fund-raising activities for a candidate committee, exploratory committee, political committee or party committee, including, but not limited to, forwarding tickets to potential contributors, receiving contributions for transmission to any such committee or bundling contributions, (C) serving as chairperson, treasurer or deputy treasurer of any such committee, or (D) establishing a political committee for the sole purpose of soliciting or receiving contributions for any committee. Solicit does not include: (i) making a contribution that is otherwise permitted by Chapter 155 of the Connecticut General Statutes; (ii) informing any person of a position taken by a candidate for public office or a public official, (iii) notifying the person of any activities of, or contact information for, any candidate for public office, or (iv) serving as a member in any party committee or as an officer of such committee that is not otherwise prohibited in this section.

"Subcontractor" means any person, business entity or nonprofit organization that contracts to perform part or all of the obligations of a state contractor's state contract. Such person, business entity or nonprofit organization shall be deemed to be a subcontractor until December thirty first of the year in which the subcontract terminates. "Subcontractor" does not include (i) a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or (ii) an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a subcontractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a subcontractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a subcontractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a subcontractor, which is not a business entity, or if a subcontractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any subcontractor who has managerial or discretionary responsibilities with respect to a subcontract with a state contractor, (v) the spouse or a dependent child who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the subcontractor.

7. Health Insurance Portability and Accountability Act of 1996.

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

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

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

(d) The Contractor, on behalf of the Agency, performs functions that involve the use or disclosure of "individually identifiable health information," as that term is defined in 45 C.F.R. § 160.103; and

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

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

(g) Definitions

(1) "Breach" shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. § 17921(1)).

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) "Unsecured protected health information" shall have the same meaning as the term as defined in section 13402(h)(1)(A) of HITECH. Act. (42 U.S.C. §17932(h)(1)(A)).

(h) Obligations and Activities of Business Associates.

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

(2) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for in this Section of the Contract.

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

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

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

(6) Business Associate agrees to insure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate, on behalf of the Covered Entity, agrees to the same restrictions and conditions that apply through this Section of the Contract to Business Associate with respect to such information.

(7) Business Associate agrees to provide access, at the request of the Covered Entity, and in the time and manner agreed to by the parties, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524.

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

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

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

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

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

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

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

(A) restrict disclosures of PHI;

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

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

(D) the Business Associate agrees to notify the covered entity, in writing, within five (5) business days of the request.

(15) Business Associate agrees that it shall not, directly or indirectly, receive any remuneration in exchange for PHI of an individual without

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

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

(16) Obligations in the Event of a Breach.

(A) The Business Associate agrees that, following the discovery of a breach of unsecured protected health information, it shall notify the Covered Entity of such breach in accordance with the requirements of section 13402 of HITECH (42 U.S.C. § 17932(b)) and this Section of the Contract.

(B) Such notification shall be provided by the Business Associate to the Covered Entity without unreasonable delay, and in no case later than 30 days after the breach is discovered by the Business Associate, except as otherwise instructed in writing by a law enforcement official pursuant to section 13402(g) of HITECH (42 U.S.C. § 17932(g)). A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate. The notification shall include the identification and last known address, phone number and email address of each individual (or the next of kin of the individual if the individual is deceased) whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

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

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

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

3. The steps the Business Associate recommends that individuals take to protect themselves from potential harm resulting from the breach.

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

5. Whether a law enforcement official has advised either verbally or in writing the Business Associate that he or she has determined that notification or notice to individuals or the posting required under section 13402 of the HITECH Act would impede a criminal investigation or cause damage to national security and; if so, include contact information for said official.

(D) Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed by the Covered Entity of a breach by the Business Associate have the opportunity to ask questions and contact the Business Associate for additional information regarding the breach. Such procedures shall include a toll-free telephone number, an e-mail address, a posting on its Web site or a postal address. For breaches involving ten or more individuals whose contact information is insufficient or out of date to allow written notification under 45 C.F.R. § 164.404(d)(1)(i), the Business Associate shall notify the Covered Entity of such persons and maintain a toll-free telephone number for ninety (90) days after said notification is sent to the Covered Entity. Business Associate agrees to include in the notification of a breach by the Business Associate to the Covered Entity, a written description of the procedures that have been established to meet these requirements. Costs of such contact procedures will be borne by the Contractor.

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

(i) Permitted Uses and Disclosure by Business Associate.

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

(2) Specific Use and Disclosure Provisions

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

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

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

(j) Obligations of Covered Entity.

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

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

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

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

(l) Term and Termination.

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

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

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

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

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

(3) Effect of Termination.

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

(B) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon documentation by Business Associate that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Section of the Contract to such PHI and limit further uses and disclosures of PHI to those purposes that make return or destruction infeasible, for as

long as Business Associate maintains such PHI. Infeasibility of the return or destruction of PHI includes, but is not limited to, requirements under state or federal law that the Business Associate maintains or preserves the PHI or copies thereof.

(m) Miscellaneous Sections.

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

(2) Amendment. The Parties agree to take such action as is 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.

8. Disclosure of Records. This Contract may be subject to the provisions of section 1-218 of the Connecticut General Statutes. In accordance with this statute, each contract in excess of two million five hundred thousand dollars between a public agency and a person for the performance of a governmental function shall (a) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function, and (b) indicate that such records and files are subject to FOIA and may be disclosed by the public agency pursuant to FOIA. No request to inspect or copy such records or files shall be valid unless the request is made to the public agency in accordance with FOIA. Any complaint by a person who is denied the right to inspect or copy such records or files shall be brought to the Freedom of Information Commission in accordance with the provisions of sections 1-205 and 1-206 of the Connecticut General Statutes.

9. 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.

10. 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.

[X] Original Contract
[ ] Amendment #____
(For Internal Use Only)

SIGNATURES AND APPROVALS

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

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

CONTRACTOR – HEALTH MANAGEMENT SYSTEMS, INC.

Maria Perrin, Chief Marketing Officer — Date 3 / 6 / 13

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, Commissioner — Date 3/15/2013

OFFICE OF THE ATTORNEY GENERAL

ASST. / ASSOC. ATTORNEY GENERAL *(Approved as to form & legal sufficiency)* — Date 3/12/13

Joseph Rubin