State of Connecticut
Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

EIGHTH Addendum

RELEASE DATE - 040308

The following information amends the contents of the original RFP issued on January 1, 2008.

A. On pages 2 through 3 of this addendum the Department is providing responses to certain questions related to the FFS rate schedules and other matters pertaining to the Business (Cost) Proposal for this RFP.

This **EIGHTH Addendum to 010308DSS_HUSKY_CO_RFP** is being issued by the Issuing Office on the 3rd day of April, 2008.

This Addendum must be signed and returned with your Business (Cost) proposal submission due by 3:00 pm on Friday, April 11, 2008.

_____ _____
Authorized Signer Company Name

Approved _____
Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

Additional Questions
Managed Care MCO RFP
4/3/2008

	Question/Clarification	RESPONSE
1	Addendum 5 Question 33: The Department's response to this question appears inconsistent with IV-Part Three 5.11 b, 5.16 a and 5.12 e. Please clarify.	The first sentence In Section 5.11 subsection b has been revised to read as follows: "For Charter Oak Members the MCO shall impose (and allow providers to collect) annual deductible amounts. In Section 5.16 subsection a 2 has been revised to read "The MCO's system shall track the Charter Oak (i) co-payments and (ii) co-insurance incurred by Charter Oak Members, including co-payments and co-insurance that Members incur for services provided by the CT BHP ASO." In addition Section 5.16.c.1 has been deleted and replaced with the following:"For Husky B, providers shall neither charge nor collect any co-payments and/or co-insurance from a Member once the Member incurs his or her maximum annual out-of-pocket limit. For Charter Oak, providers shall neither charge nor collect any co-insurance from a Member once the Member incurs his or her maximum annual out-of-pocket limit." and Section 5.16.c.2(b): has been deleted and replaced with the following "For Husky B, the providers and subcontractors shall neither charge nor collect any additional co-payments and/or co-insurance within a
2	Although DSS has provided most of the requested reimbursement information, we are still missing hospital-specific rates. Please provide the specific per diem and cost-to-charge ratio reimbursement rates currently paid to each Connecticut hospital and, if applicable, rates paid to hospitals in bordering states.	The FFS rate schedules have been posted to the Bidders' Library on the Charter Oak page of the DSS website, as an excel workbook with multiple tabs for each provider type.
3	Please clarify. 'When making a "general statement of acceptance for that specific section" does DSS mean that it wants bidders only to make the statement for "The Bidder shall" sections or each and every section of the Scope of Work"?	A responsive proposal will include a response to each "bidder shall" requirement.
4	The Sixth Addendum includes the Connecticut Medicaid Fee for Service Pricing policy, which identifies how certain providers are reimbursed and includes the rates for the ambulatory surgery centers. How can a plan obtain the rate schedules that were not included in the Sixth Addendum, such as Skilled nursing facilities or the hospital-specific inpatient/ outpatient rates?	The FFS rate schedules have been posted to the Bidders' Library on the Charter Oak page of the DSS website, as an excel workbook with multiple tabs for each provider type.
5	Does DSS contemplate increasing the Medicaid fee for service rates during state fiscal year 2009 (e.g., FQHC rates and hospital inpatient rates customarily change in October; physician fees have historically changed in the April/ May timeframe)?	Rate increases for SFY 09 will be determined during the SFY 08 legislative sesssion which is exepcted to conclude in May.
6	How does DSS expect to address any subsequent changes to provider rates in the interim between submission of the cost proposals requiring proof of complying with the minimum Medicaid FFS reimbursement levels in rate-setting and the time of final selection of participating insurers/premium-setting?	Rate increases for SFY 09 will be determined during the SFY 08 legislative sesssion which is exepcted to conclude in May. During the negotiation of the final capitation rates, the Department will apprise bidders of any changes to the SFY 09 rates from those that were posted for this RFP in the Medicaid FFS rate exhibits.

Additional Questions
Managed Care MCO RFP
4/3/2008

7	HUSKY A & B Narratives v. Charter Oak Narratives: Given the 10 page limitation originally specified in RFP and Cost Proposal Instruction providing two potential alternative Charter Oak Proposals (Section 30, page 12, Cost Proposal Instructions), can DSS clarify whether the 10 page limitation can be applied SEPARATELY to the HUSKY and Charter Oak Proposal? Or would DSS consider some overall expansion of page limitation (e.g., 15 pages)?	The 10 page limitation may be applied separately to the HUSKY and Charter Oak Cost Proposals.
8	The dental codes for fluoride treatments and screenings that an MCO will be responsible for reimbursing are not included in the physician fee schedule. Can DSS please identify the specific dental codes that will be used and the corresponding rates for those codes?	DO120 - Periodic Oral Evaluation - $18.00; DO150 - Comprehensive Oral Evaluation - $20.00 D1206 - Flouride Varnish Application (without prophylaxis) - $16.00; D1330 - Oral Hygiene Instruction - $10.00
9	Can DSS explain the basis for variation in pre-2007 claim data such that allowed amounts exceed the paid amounts and other times, the paid amounts exceed the allowed amounts?	For older encounters, claims exist where the allowed amount is greater than the paid amount and the paid amount is greater than the allowed amount. This is an artifact of how claims were submitted to the State. For more recent encounter submissions, a concerted effort was made by the submitting contractors to correct these errors.
10	Do "0" (zero) paid amounts in the claims data indicate these services were provided under capitation arrangements?	Encounters with zero paid amounts could refer to capitated claims, but it may also refer to claims that were submitted for informational purposes only or to claims that are missing paid amounts.

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Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

SEVENTH Addendum

RELEASE DATE - 032408

The following information amends the contents of the original RFP issued on January 1, 2008.

A. In Section II – OVERVIEW OF THE PROCUREMENT PROCESS (RFP Pages 7 – 16) revisions have been made to the following sections: Section 2 – Procurement Schedule (page 7); Section 3 – Bidders' Questions (page 8); and Section 14 – Response Date and Time(page 12)

2. Procurement Schedule – The Department has revised the Procurement Schedule as follows:

Milestones	Ending Dates
Deadline for Questions pertaining to Addendums 1 – 6: 3:00 PM Local Time	**03/26/08**
Responses to Questions (tentative)	**03/28/08**
Technical Proposals – Responses to Parts One, Two and Three - Due by 3:00 PM Local Time	**04/04/08**
Cost Proposal – Response to Part Four - Due by 3:00 PM Local Time	**04/11/08**
Successful Bidder Announced	TBD
Contract Negotiations Begin	TBD
Contract Begins (tentative)	07/01/08

3. Bidders' Questions – The Department has revised the submission date for Bidders' Questions as follows:

The Department will accept written questions and requests for clarification pertaining to Addendums 1 through 6 for this procurement if submitted to and received by the Issuing Office by **3:00 pm on March 26, 2008.** Written questions and requests for clarification may be sent via email or facsimile to meet this deadline. The Department will only respond to those questions and requests submitted and received by the Issuing Office in writing by the stated deadline. Submit questions and requests for clarification to the Issuing Office directed to the attention of Kathleen M. Brennan by facsimile (860-424-4953) or email (Kathleen.Brennan@ct.gov). The Issuing Office will respond to only those questions that meet the deadline and criteria listed above. Official responses to all questions will be posted in an amendment to this RFP in the form of an addendum to this RFP, posted on the Charter Oak page on the Department's website at www.ct.gov/dss/charteroak and the State Procurement/Contracting Portal www.das.state.ct.us/Purchase/Portal/Portal_home.asp. The tentative posting date for the addendum is March 28, 2008. In addition to the posting of the questions and Department responses, the addendum will include the Department's anticipated date for the announcement of the successful bidder and the schedule of contract negotiations. It is solely the Bidder's responsibility to access the Charter Oak page on the Department's website or the State Procurement/ Contracting Portal to obtain any and all addendums or official announcements pertaining to this RFP. **A responsive proposal must include a signed acknowledgment of the receipt of each the addendums to this RFP that are posted to the Charter Oak page on the Department's website or the State Contracting Portal prior to the Proposal submission date.**

14. Response Date and Time

The Issuing Office must receive the Bidders' response to the proposal requirements for the Technical Proposal (Part One: Transmittal Communications, Forms and Acceptances; Part Two: Organization, Key Personnel and Experience; and Part Three: Scope of Work) no later than **3:00 p.m. local time on Friday April 4, 2008.**

The Issuing Office must receive the Bidders' response to the proposal requirements for the Cost Proposal (Part Four: Price and Financial Information) no later than **3:00 p.m. local time on Friday April 11, 2008.**

The Department will not consider a postmark date as the basis for meeting any submission deadline. Bidders should not interpret or otherwise construe receipt of a proposal after the closing date and time as stated herein as acceptance of the proposal, since the actual receipt of the document is a clerical function. The Department suggests the bidder use certified or registered mail to deliver the proposal when the bidder is not able to deliver the proposal by courier or in person. Bidders that are hand-delivering proposals will not be granted access to the building without photo identification and should allow extra time for security procedures. Bidders must address all RFP communications to the Issuing Office.

B. On pages 4 through 9 of this addendum the Department is providing responses to certain questions raised in accordance with the provisions of the RFP.

This **SEVENTH Addendum to 010308DSS_HUSKY_CO_RFP** is being issued by the Issuing Office on the 24th day of March, 2008.

This Addendum must be signed and returned with your submission.

_____ _____

Authorized Signer Company Name

Approved _____

Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

	Source	Paragraph Cite (s)	Page Number	Question	Response
1	RFP	II.7	9	In order for bidders to prepare a proposal that is organized in a concise and logical manner for the reviewers' ease of evaluation, it would be helpful if the State would elaborate on the scoring process used to select a vendor (e.g., the number of points assigned to each section of the RFP that will be scored).	70% of the total points available will be assigned to the evaluation of the Organizational Capacity, Structure and Scope of Work (Phase Two). The remaining 30% will be assigned to the evaluation of the Business (Cost) Proposal (Phase Three). 70% of the total points available for Phase Three will be weighted towards the Bidders' Business (Cost) submission. The remaining 30% will be weighted towards the best and final offer.
2	RFP	IV - Part Two - 4B	26	Our company has contracts with other state agencies who have indicated that, as a matter of policy, they do not provide a ranking among their contracted providers. May we ask those state agencies to provide a summary of our performance with relevant measures, without the explicit reference to ranking each area?	Yes.
3	RFP	IV - Part Three - 3.09a and 3.09b	46	Please clarify how it will calculate the ratios it refers to in sections 3.09a and 3.09b regarding network adequacy? Please provide the equation it will use or sample calculations?	The ratio of members to physicians was determined based on the Fee-For-Service data prior to the implementationof managed care. The ratios are applied to each county for each type of provider category cited (Adult, Children and Women) as explained in 3.09b and compared to the number of HUSKY members in that county.
4	RFP	IV - Part Three - 3.09a and 3.09b	46	How is this methodology applied to the State's Medicaid fee for service population?	This question does not pertain to a requirement of the RFP or the resultant contract.
5	RFP	IV - Part Three - 3.09a and 3.09b	46	Please provide the non-hospital reimbursement schedules and the hospital-specific payment rates in excel format.	This sixth addendum includes the Department's updated fee schedules and a narrative summary of the same.

6	RFP	IV - Part Three - 3.34 b 3	91	This section implies for a report due 12/31/08 including utilization data for the quarter ending 9/30/08, the State will have provided specifications for that report on or before 10/1/08. How will you provide the MCO assurance that the data elements of such reports requested are already required to be captured in the MCO's reporting system? To ensure that MCOs are capturing and reporting all data elements needed by the State, would the State consider providing the specifications for reports 90 days prior to the data capture period?	Specifications for required reports are posted to the Bidders' Library. If additional reports are required the resultant Contractor(s) would have ninety (90) days to implement.
7	RFP	IV - Part Three - 3.39	101	For Members who lose eligibility and then regain it within 60 days, we understand that they will be re-enrolled retroactively so that there is no break in coverage. For a claim incurred and submitted to the MCO after the Member lost eligibility but before the Member regained eligibility, the MCO would (appropriately) deny the claim initially. Then, when the DEPARTMENT notifies the MCO that the Member has regained eligibility and that there is no break in coverage, the provider may resubmit the claim and the MCO would pay it. Please confirm that the MCO would not owe the provider an interest payment in this situation, provided that the MCO pays the claim within 45 days of receipt of resubmission.	Section 3.39 refers to timely processing of a clean claim. If the claim processes within the forty-five (45) days of receipt and the client is not eligible, the claim should be denied and should appear in the Denied Claims report. If the Contractor receives a subsequent retro-enrollment transaction for that previously ineligible date of service, the contractor may reprocess the originally denied claims due to "member not eligible on date of service" as a service to their in-network providers or reprocess the claim upon resubmitall from the provider. Under the former scenario the count of the 45 days for timely filing would begin with notification of the re-enrollment. Under the latter scenario, the 45 days would start with the resubmittal date.

8	RFP	IV - Part Three - 5.16 a 1 & 2	138	Please describe how the co-payment and co-insurance information for services provided by the CT BHP ASO, the dental ASO and pharmacy services managed by the DEPARTMENT will be transmitted to the MCO.	There are no co-pays for HUSKY B CT BHP services. Pharmacy co-pay data will either be included in the pharmacy file the Department plans to make available to contractors for Quality Assurance and Case Management purposes or in a separate file combined with Dental co-payment data for HUSKY B and Behavioral Health co-payment data for Charter Oak.
9	RFP	V	193	What are the available points for Phases Two and Three?	Phase Two - Evaluation of the Organizational Capacity, Structure and Scope of work - 70%. Evaluation of the Business Cost Proposal - 30%.
10	RFP	General Question	N/A	When there is not a "bidder shall" requirement in a contract section, do we need to make a general statement of acceptance for each section?	"Bidder shall" sections require a response. If the bidder is asked to provide specific information, the bidder must respond with the requested information. If specific information is not asked for the bidder should make a general statement of acceptance for that specific section.
11	Addendum 3, Appendix A	Item 15	19-20	This amendment clarifies the MCOs responsibilities for payment of J codes. The amendment also includes in a. Covered Services, Subsection i a reference to the MCO's formulary. The RFP and specific questions related to pharmacy reference the Department's Preferred Drug List. Please verify that it is the Department's intent that MCOs use the Department's PDL as stated in Section 3.16 page 56 of the RFP and not the MCO's own formulary?	MCO providers are required to utilize the Department's PDL when prescribing medications to be filled at retail pharmacies. The Department's PDL does not apply to injectibles or J-code drugs administered at a provider's office, hospital or facility.
12	Addendum 3, Attachment F	3	N/A	Attachment F includes a third page labeled "Consulting Agreement Affidavit" which is not addressed in the RFP. Are Bidders required to complete this form in addition to the gift and campaign affidavits?	**YES**

13	Addendum 4, Procurement Schedule	Item 2		DSS has moved the due date of the technical proposal to 3/28.2008 and the due date of the cost proposal to 4/11/2008. What amount of time does DSS estimate it will take for review of the proposals, contract negotiation and contract execution? And, given that estimate, what amount of time does DSS estimate it will take to review and approve member marketing materials that may be used by the contracted providers during open enrollment, scheduled to begin May 1, 2008? Will DSS review all member education materials at the same time as it is reviewing the marketing materials so that the MCOs may have them available for distribution to new members upon enrollment?	DSS will be working to review all materials in order to have them available for distribution tonew members upon enrollment.
14	Bidder's Conference	N/A	N/A	Mercer stated that the rate range projections would be based on a combination of encounter data and financial data. Will the same financial data be made available to prospective bidders?	As stated in the Fifth Addendum to the RFP, the Department is preparing a data book for the Bidders' use in developing its Business (Cost) Proposal. The data book will be posted as an addendum to this RFP, will be posted to the Bidders' Library and will provide a summary of the HUSKY financial and encounter data reporting. The data book is expected to be posted the week of March 31, 2008.
15	Bidder's Conference	N/A	N/A	Reference was made to the future release demographic and FPL data for Charter Oak eligibles. Is this still the intent and what is the estimated time of delivery for the data?	Information on estimated enrollment by FPL levels was provided in the Prospectus (released 10/07, page 49). Additional estimated enrollment by age/gender should be available by 3/14/08.
16	Bidder's Conference	N/A	N/A	The initial design of Charter Oak has one rate regardless of age/gender. Please confirm that age/gender rates will be allowed for Charter Oak.	Age/gender rates will not be allowed in the Base Plan design as outlined in the RFP. The Alternative Plan design proposed by the bidder may suggest rates by age/gender.
17	Bidder's Conference	N/A	N/A	Do the "actuarially sound" rate ranges for Charter Oak include a factor for the higher-than-average risk members this plan will attract?	Yes, acuity and adverse selection adjustments will be included in the rate ranges.
18	Bidder's Conference	N/A	N/A	Please confirm that the State considers a 2% target return on a three-year rolling basis appropriate.	The information, if available, will be released during contract negotiations with the selected contractor(s).
19	Bidder's Conference	N/A	N/A	Please confirm that the State will release a target administrative percentage in a future addendum.	The information, if available, will be released during contract negotiations with the selected contractor(s).

20	Bidder's Conference	N/A	N/A	Please confirm that premium billing and collection will be performed by the State or another Vendor and will not be an MCO responsibility for HUSKY B and Charter Oak members. If so, please confirm that Bidders do not have to respond to the **bidders shall** in Section 5 of the Scope of Work (5.10 and 5.18) related to premium billing. How will the MCO receive premium billing and collection information from the State for purposes of accumulating premiums for maximum cost-sharing and determining whether overpayments have occurred?	The premium billing and collection will be performed by the Department or its agent and will not be the responsibility of the MCO for HUSKY B and Charter Oak. The Fifth Addendum to the RFP deleted the bidder's obligation to respond to Sections 5.03, 5.04, 5.05, 5.06, 5.08, 5.09 and 5.10 does not have to respond to Sections 5.10. The bidder is also NOT required to respond to Section 5.18, related to premium tracking. The Department or its agent will track premium billing and make this information available to the MCO on the same file as pharmacy, dental and behavioral health co-payment information. See Q & A number 8.
21	RFP	4.b, IV.3.10 Definitions, and 8.0-Standard Terms and Conditions	26, 38, 180	Given the State's definitions of "subcontractors", please provide clarification on the type of service providers that are considered to be a subcontractor for purposes of responding to Part 2 of this RFP. For example, do Bidder's need to identify and provide references and background information for subcontractors who provide interpretive services or a segment of the credentialing process (e.g. third party verification) or the claims process (e.g. document management)?	For purposes of responding to Part 2 of this RFP a Subcontractor shall be any service provider who is managing or providing a medical service required under the terms of the contract.
22	RFP	5.12	135	For the Charter Oak CRCS, should we assume that just MCO claims count toward the deductible (including claims from another MCO if the member was enrolled in that MCO during the same eligibility period)? Or, should we assume that CT ASO and pharmacy claims also count toward the deductible. Both behavioral health and pharmacy have co-payments and coinsurance that should not apply until the deductible is met."	For Charter Oak, only coinsurance counts towards the deductible or out-of-pocket maximums. Also, Charter Oak members will be locked-in for 12 months into their selected MCO. Pharmacy and BH (with the exception of BH inpatient) have copays, which will not need to be counted towards the deductible or out-of-pocket maximums. For BH inpatient, the co-insurance will need to be included in the deductible and/or out-of-pocket maximums.

23	RFP, Addendum 3, Attachment B, and Attachment C	N/A	N/A	Where should Bidders address Affirmative Action Plan requirements? -Part 1- Section 1.6 narrative -In Attachment C as an appendix, or -On the second page of Attachment B	As an appendix to Attachment C.
24	Appendix A	1		Appendix A states: "The Behavioral Health Partnership ("BHP") is responsible for providing services for behavioral health conditions. The Department is responsible for Dental and Pharmacy services." Should this be interpreted as meaning that all costs associated with these services (BH, Dental & pharmacy) be excluded from the capitation rate? If not, then which specific services will remain the financial responsibility of the MCO?	This RFP defines when an MCO may be responsible for CT BHP, Dental and Pharmacy services. Bidders are responsible for factoring the costs for which it will be responsible in its proposed capitation rate.
25	Appendix A	1		If pharmacy services are not included in the capitation payment, the following clarification is requested. Are claims associated with all pharmaceutical products, including both legend drugs and over-the-counter drugs, I.e., any pharmaceutical product having an NDC number, indeed not the responsibility of the MCO, regardless of whether submitted as a pharmacy claim or medical claim?	The responsible party for paying pharmacy claims will be determined by the point of service. The MCO will be responsible for medical claims including those claims for pharmacy products administered by a doctor or other qualified provider in his or her office. These drugs may include specialty drugs that have a limited shelf life and require coordination between the supplier and the doctor and are not typically available through a pharmacy. This exception does not apply to immunizations that are avaiable free from the CT Department of Public Health. The Department will be responsible for those services (pharmacy products) delivered by a pharmacist.

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REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

SIXTH Addendum

RELEASE DATE - 032008

Through this addendum the Department has posted the Connecticut Medicaid Fee For Service Pricing Policy. Bidders' may submit questions pertaining to this Policy in writing directed to the Issuing Office through 3:00 pm on Wednesday, March 26, 2008.

Bidders may submit questions pertaining to the information set forth in addendums 1 through 5 in writing directed to the Issuing Office through 3:00 pm on Wednesday, March 26, 2008.

This **SIXTH Addendum to 010308DSS_HUSKY_CO_RFP** is being issued by the Issuing Office on the 20th day of March, 2008.

This Addendum must be signed and returned with your submission.

_____ Authorized Signer

_____ Company Name

Approved _____
Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

Connecticut Medicaid Fee for Service Pricing Policy

Ambulatory Surgery Centers

Currently, ambulatory surgery centers bill procedure code T1015 for any procedure performed (with the exception of family planning clinic procedures which must be billed with the appropriate CPT code) and the Department pays a provider specific rate regardless of the procedure or service.

Effective July 1, 2008, the Department intends to change its reimbursement methodology for ambulatory surgery centers. Reimbursement for ambulatory surgery centers will be 100% of the 2007 Medicare ambulatory surgery fee. Medicare maintains a list of approximately 2500 procedure codes that may be billed by an ambulatory surgery center and sets a fee for each depending on the complexity of the procedure. Reimbursement is based on the procedure code and does not vary from one ambulatory surgery center to another.

Consolidated Labs Reimbursement

The consolidated lab fee schedule contains fees for three types of labs: independent labs, physician labs and hospital labs. Billing is limited to tests for which the provider has a CLIA certificate. Reimbursement for multi-panel tests based on automated test panels (ATP) codes billed for the same client, the same date of service and by the same provider, will be subject to combined panel rate as shown on the spreadsheet. Lab fees are reimbursed at approximately 95% of the Medicare.

Family Planning Clinics

Family planning services are reimbursed at approximately 80% of the 2007 Medicare physician fee schedule (participating, non-facility). Abortion and other surgical procedures performed by family planning clinics are priced at 57.5% of the Medicare price for the facility and professional components combined. Codes that are listed without a fee are reviewed and priced individually by the department.

With the exception of J-codes and vaccinations, the above fees are not typically updated to reflect changes in Medicare pricing.

For additional details on Family Planning Clinic services policy please refer to the Freestanding Clinic Services Policy available on the department's website at www.ctdssmap.com. Go to "Publications", "Provider Manuals"; scroll down to Chapter 7 and select "Clinic" . See the section on Family Planning"

Federally Qualified Health Centers (FQHC)

In order to enroll with Connecticut Medicaid as an FQHC, a provider must provide primary care services to underserved communities and be designated by CMS as an FQHC. Each FQHC receives a provider specific fee for an encounter that is all-inclusive of the services provided on that date of service. The encounter must be face to face.

The Department establishes separate provider specific FQHC rates for medical, behavioral, and dental services. The rates included in this exhibit are for medical services only.

Freestanding Dialysis Clinics

Dialysis services are reimbursed at approximately 100% of the 2007 Medicare physician fee schedule (participating, non-facility) with the exception of HCPCS code J3490, unclassified drug, which is individually priced by the department based on the National Drug Code (NDC).

The professional component performed by physicians and physician groups is reimbursed under the physician fee schedule in addition to the payment to the dialysis clinic.

With the exception of J-codes and vaccinations, the above fees are not typically updated to reflect changes in Medicare pricing.

Note that the dialysis clinic fee schedule applies to freestanding dialysis clinics only; fees for hospital based clinics are described in outpatient fee schedules of the individual hospitals.

For additional details on Dialysis services policy please refer to the Freestanding Clinic Services Policy available on the department's website at www.ctdssmap.com. Go to "Publications", scroll down to "Provider Manuals", Chapter 7 and select Clinic from the drop down menu and locate the section on dialysis.

Freestanding Medical Clinics (i.e., school based health centers)

School based health center services are reimbursed at approximately 80% of the 2007 Medicare physician fee schedule (participating, non-facility).

Other general medical clinics are enrolled as federally qualified health centers (FQHC) and do not bill off of the medical clinic fee schedule.

With the exception of J-codes and vaccinations, the above fees are not typically updated to reflect changes in Medicare pricing.

For additional details on medical clinic policy please refer to the Freestanding Clinic Services Policy available on the department's website at www.ctdssmap.com. Go to "Publications", scroll down to "Provider Manuals", Chapter 7 and select Clinic from the drop down menu. Go to the chapter on Medical Clinics.

General Hospital

Inpatient

Payment for hospital inpatient services will be reimbursed based on a per diem, all-inclusive rate. The per diem reimbursement rate is considered payment in full for all hospital services when the client is an inpatient. Unlike the Medicaid FFS program, the per diem rates paid under managed care are not cost settled. Physician services may or may not be included in the per diem rate. Community physicians may bill separately for their services; hospital-based physicians may not. Please refer to the Department's Provider Enrollment Regulation posted in chapter 2 of Provider Manuals available on the website for a definition of a hospital based provider.

Outpatient

Hospital Outpatient services are limited to one (1) visit per day to the same outpatient clinic. The clinic fee includes the professional component.

An ED visit may not be billed on the same day that a client is admitted to the hospital. Clients who present in the ED are considered to be inpatient when the client is present for more than 23 hours or is present on an inpatient floor for the midnight census. A hospital professional fee (RCC 981) may be billed in conjunction with the ED visit, with the exception of three hospitals who have

arranged for a group of community physicians to provide and bill separately for the professional component of the ED service.

Laboratory tests and pharmaceuticals may be billed in addition to the clinic or ED visit charge.

Border hospitals and out of state hospitals are paid a percentage of the charges billed, typically 42.9%.

Home Health

Fees for home health agencies are provider specific, although most are uniform. A handful of agencies have add-ons to the general rate in accordance with Sec. 17b-242 of the Connecticut General Statutes.

Extended nursing services are services that extend beyond two hours for any given visit. They are billed with the nursing visit code and modifier TG (complex visit). When modifier TG is billed with a procedure code, the claim pays 45.70% of the fee on file for the code.

When more than one client is receiving nursing services in the same household, the nursing service for the second and any other additional clients are billed with modifier TT (individualized service for more than one patient). When modifier TT is billed with the procedure code, the claim pays 50% of the fee on file for the code.

A nursing visit for the purpose of medication administration only is paid at the fee for medication administration, not at the fee for a skilled nursing visit. Medication administration is defined as the administration of oral, intramuscular or subcutaneous medication and also those procedures used to assess the client's medical or behavioral health status as ordered by the prescribing practitioner. Such procedures include, but are not limited to, glucometer readings, pulse rate checks, blood pressure checks or brief mental health assessments. Medication administration visits include the administration of medication(s) while the nurse is present as well as the pre-pouring of additional doses, less than a one week supply, that the client will self administer at a later time and the teaching of self administration of the medication that has been pre-poured.

Home health services are not available to a client who is in a hospital, nursing facility, chronic disease hospital or ICF/MR.

For additional details on home health policy please refer to the Regulations on Home Health Agency services available on the department’s website at www.ctdssmap.com. Go to “Publications”, “Provider Manuals” and scroll down to Chapter 7. Choose “Home Health” from the drop down menu in chapter 7.

Independent Radiology and Ultrasound Centers

The Department reimburses Independent Radiology and Ultrasound Centers for the procedures listed in the Independent Radiology fee schedule at the fee listed.
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For additional details on Independent Radiology and Ultrasound Centers policy please refer to the Independent Radiology and Ultrasound Centers Regulation available on the department's website at www.ctdssmap.com. Go to "Publications", scroll down to "Provider Manuals", Chapter 7 and select "Independent Radiology and Ultrasound" from the drop down menu.

Independent Therapists

The Department reimburses Independent therapists (audiologists, physical therapists and speech pathologists) for the procedures listed in the audiology or physical therapy fee schedule, as appropriate, at the fee listed.
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For additional details on Independent Therapy services policy please refer to the Independent Therapy Regulation available on the department's website at www.ctdssmap.com. Go to "Publications", scroll down to "Provider Manuals", Chapter 7 and select "Independent therapy" from the drop down menu.

MEDS

DURABLE MEDICAL EQUIPMENT

Type of Service
A = fee for purchase
T = rental fee
0 = repair max fee; bill at list – 15%

Fees for durable medical equipment are procedure code specific. The DME fee schedule has 5 columns: Purchase New, Purchase Used, Rental New, Rental Used and Repair/Modifications. The fee for a purchase is shown as TOS A; the fee for repair is shown as TOS 0; and the fee for rental is shown as TOS T. Used equipment is billed with modifier UE and pays at 75% of the purchase or rental fee.

Repairs and items without a fee listed are priced at list minus 15% based on an appropriate published manufacturer's suggested retail price or Medicare price if available.

Medicaid will pay for only three items of durable medical equipment for clients in nursing facilities and or ICF/MR's. The items that may be covered if medically necessary are: Customized wheelchairs, Group 2 Support Surfaces and Ventilators, each of these items require prior authorization. All other DME is part of the facility's per diem rate. The department does not provide DME for clients in hospitals.

Items that are not listed on the fee schedule may be requested under the generic code, E1399 and require prior authorization.

PROSTHETIC and ORTHOTIC DEVICES

Fees for prosthetic and orthotic devices are HCPCS procedure code specific. The O & P fee schedule has 3 columns which are the following: Purchase, Rental and Repair/Modifications. Purchased equipment appears as TOS A; repairs as TOS 0; rentals as TOS T.

Repairs are priced at list minus 15% based on an appropriate published manufacturer's suggested retail price or Medicare price if available.

Medicaid will pay for many prosthetic and orthotic devices for clients in nursing facilities and or ICF/MR's.

HEARING AIDS/PROSTHETIC EYES

Procedure code V5090 is the dispensing fee code used when billing for digital hearing aids. The department pays the fee on file ($500) for a monaural, digital hearing aid and 150% of the fee on file ($750) for a binaural, digital hearing aid.

Procedure codes V5256, V5257, V5260 and V5261 (digital hearing aids) are only billable for clients under age 21.

Hearing aids are covered for clients in all settings.

OXYGEN

Oxygen is available to clients in all settings. However, procedure codes E1390-E1392 and K0738 are available only to clients who live at home.

If the prescribed amount of oxygen is less than 1 liter per minute, the department pays 65% of the fee listed; if the prescribed amount of oxygen exceeds 4 liters per minute (LPM) the claims pays at 196.00 % of the fee listed.

For additional details on MEDS policy please refer to the Regulations on MEDS available on the department's website at www.ctdssmap.com. Go to "Publications", "Provider Manuals" and scroll down to Chapter 7. Choose "MEDS" from the drop down menu in chapter 7.

Physicians

The physician fee schedule has six categories as follows:

TOS	Category
1	General medical
2	Surgical
E	Radiology
G	Anesthesiology
L	OB/GYN
K	Pediatric services billed by a physician

In general, TOS 1 fees are set at approximately 57.5% of the 2007 Medicare physician fee schedule (participating, non-facility). Exceptions include dialysis at approximately 92-94% of Medicare and J-codes and vaccinations at 100% of Medicare. When billed with professional component modifier 26, a claim will pay at 50% of the fee schedule price.

TOS2 and TOS E fees are set at approximately 57.5% of Medicare. When billed with professional component modifier 26, a claim will pay at 50% of the fee schedule price.

TOS G fees are the product of the conversion factor and relative value for each fee as established on the fee schedule.

TOS L fees are set higher than Medicare, averaging about 160% of Medicare. TOS K fees are set at approximately 85% of Medicare, while the well child visits are set at a fixed uniform fee. Payment at the TOS L or K fees is based on the billing provider type and specialty, as well as client age and gender. A claim is paid as a pediatric procedure if:

- The client is under the age of 21 and
- The specialty of the provider is pediatric or family practice.

A claim is paid as an obstetrical procedure if:

- The client is female
- The provider specialty is ob/gyn, family practice or nurse-midwife and
- The diagnosis is related to pregnancy, childbirth or contraceptive management (diagnosis codes 630-63499, 640-67699, V22-V259, V263, V28-V289)

With the exception of J-codes and vaccinations, the above fees are not typically updated to reflect changes in Medicare pricing.

The following provider types pay 90% of the physician fee schedule within their scope of practice:

- Advanced Practice Nurse and Advanced Practice Nurse Groups
- Nurse Midwife and Nurse Midwife Group
- Naturopath and Naturopath Group
- Optometrist and Optometrist Group
- Podiatrist and Podiatrist Group

Podiatry and naturopath services are available only to clients under the age of 21.

For additional details on physician policies please refer to the Regulations on "Requirements for Payment of Physicians' Services which can be found on the Department of Social Services' website at www.ctdssmap.com under "Publications" > "Provider Manuals" > Chapter 7 under "Physician" in the drop down menu.

Rehabilitation Clinic

Rehabilitation clinic fees are set at approximately 110% of 2007 Medicare physician fee schedule (participating, non-facility). Fees are not updated to reflect changes in Medicare pricing. The codes contained in the department's fee schedule have uniform rates of reimbursement; however it is important to note that each provider may bill only the codes approved for their site.

Services may be billed by the provider clinic only; there is no additional, separate payment to the practitioner.

For additional details on Rehabilitation Clinic services policy please refer to the Freestanding Clinic Services Policy available on the department's website at www.ctdssmap.com. Go to "Publications", "Provider Manuals"; scroll down to Chapter 7 and select "Clinic". See the section on "Rehabilitation Clinics"

Skilled Nursing Facilities

Nursing homes are paid a provider specific, per diem rate that includes all services provided. Providers must hold a client's bed for up to 15 days each time the client is admitted to a hospital. They may bill for the days the client is in the hospital provided certain criteria are met. They may also bill up to 21 days of bed hold for therapeutic/home leave per calendar year. See section 19a-537 of the CGS for details of when the provider may bill.

Vision Care

Vision care services are reimbursed through uniform established fees posted on the department's fee schedule with the exception of HCPCS code V2799 which is billed at acquisition cost.

The vision fee schedule includes all vision hardware that may be billed by an optician, optometrist or ophthalmologist as well as professional services billed by an optician only. Professional services performed by optometrists are reimbursed at 90% of the physician fee schedule.

For additional details on Vision Care services policy please refer to the Vision Care Regulation available on the department's website at www.ctdssmap.com. Go to "Publications", scroll down to "Provider Manuals", Chapter 7 and select Vision Care from the drop down menu.

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
10121	Remove foreign body	02	$446.00
10180	Complex drainage, wound	02	$446.00
11010	Debride skin, fx	37	$251.52
11011	Debride skin/muscle, fx	37	$251.52
11012	Debride skin/muscle/bone, fx	37	$251.52
11042	Debride skin/tissue	28	$164.42
11043	Debride tissue/muscle	28	$164.42
11044	Debride tissue/muscle/bone	52	$423.10
11404	Exc tr-ext b9+marg 3.1-4 cm	01	$333.00
11406	Exc tr-ext b9+marg > 4.0 cm	02	$446.00
11424	Exc h-f-nk-sp b9+marg 3.1-4	02	$446.00
11426	Exc h-f-nk-sp b9+marg > 4 cm	02	$446.00
11444	Exc face-mm b9+marg 3.1-4 cm	01	$333.00
11446	Exc face-mm b9+marg > 4 cm	02	$446.00
11450	Removal, sweat gland lesion	02	$446.00
11451	Removal, sweat gland lesion	02	$446.00
11462	Removal, sweat gland lesion	02	$446.00
11463	Removal, sweat gland lesion	02	$446.00
11470	Removal, sweat gland lesion	02	$446.00
11471	Removal, sweat gland lesion	02	$446.00
11604	Exc tr-ext mlg+marg 3.1-4 cm	51	$418.49
11606	Exc tr-ext mlg+marg > 4 cm	02	$446.00
11624	Exc h-f-nk-sp mlg+marg 3.1-4	02	$446.00
11626	Exc h-f-nk-sp mlg+mar > 4 cm	02	$446.00
11644	Exc face-mm malig+marg 3.1-4	02	$446.00
11646	Exc face-mm mlg+marg > 4 cm	02	$446.00
11770	Removal of pilonidal lesion	03	$510.00
11771	Removal of pilonidal lesion	03	$510.00
11772	Removal of pilonidal lesion	03	$510.00
11960	Insert tissue expander(s)	02	$446.00
11970	Replace tissue expander	03	$510.00
11971	Remove tissue expander(s)	01	$333.00
12005	Repair superficial wound(s)	17	$91.24
12006	Repair superficial wound(s)	17	$91.24
12007	Repair superficial wound(s)	17	$91.24
12016	Repair superficial wound(s)	17	$91.24
12017	Repair superficial wound(s)	17	$91.24
12018	Repair superficial wound(s)	17	$91.24
12020	Closure of split wound	17	$91.24
12021	Closure of split wound	17	$91.24
12034	Layer closure of wound(s)	17	$91.24
12035	Layer closure of wound(s)	17	$91.24
12036	Layer closure of wound(s)	17	$91.24
12037	Layer closure of wound(s)	42	$323.28
12044	Layer closure of wound(s)	17	$91.24
12045	Layer closure of wound(s)	17	$91.24
12046	Layer closure of wound(s)	17	$91.24
12047	Layer closure of wound(s)	42	$323.28
12054	Layer closure of wound(s)	17	$91.24
12055	Layer closure of wound(s)	17	$91.24

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
12056	Layer closure of wound(s)	17	$91.24
12057	Layer closure of wound(s)	42	$323.28
13100	Repair of wound or lesion	42	$323.28
13101	Repair of wound or lesion	42	$323.28
13102	Repair wound/lesion add-on	17	$91.24
13120	Repair of wound or lesion	17	$91.24
13121	Repair of wound or lesion	17	$91.24
13122	Repair wound/lesion add-on	17	$91.24
13131	Repair of wound or lesion	17	$91.24
13132	Repair of wound or lesion	17	$91.24
13133	Repair wound/lesion add-on	17	$91.24
13150	Repair of wound or lesion	42	$323.28
13151	Repair of wound or lesion	42	$323.28
13152	Repair of wound or lesion	42	$323.28
13153	Repair wound/lesion add-on	17	$91.24
13160	Late closure of wound	02	$446.00
14000	Skin tissue rearrangement	02	$446.00
14001	Skin tissue rearrangement	03	$510.00
14020	Skin tissue rearrangement	03	$510.00
14021	Skin tissue rearrangement	03	$510.00
14040	Skin tissue rearrangement	02	$446.00
14041	Skin tissue rearrangement	03	$510.00
14060	Skin tissue rearrangement	03	$510.00
14061	Skin tissue rearrangement	03	$510.00
14300	Skin tissue rearrangement	04	$630.00
14350	Skin tissue rearrangement	03	$510.00
15002	Wnd prep, ch/inf, trk/arm/lg	42	$323.28
15003	Wnd prep, ch/inf addl 100 cm	42	$323.28
15004	Wnd prep ch/inf, f/n/hf/g	42	$323.28
15005	Wnd prep, f/n/hf/g, addl cm	42	$323.28
15040	Harvest cultured skin graft	17	$91.24
15050	Skin pinch graft	42	$323.28
15100	Skin splt grft, trnk/arm/leg	02	$446.00
15101	Skin splt grft t/a/l, add-on	03	$510.00
15110	Epidrm autogrft trnk/arm/leg	02	$446.00
15111	Epidrm autogrft t/a/l add-on	01	$333.00
15115	Epidrm a-grft face/nck/hf/g	02	$446.00
15116	Epidrm a-grft f/n/hf/g addl	01	$333.00
15120	Skn splt a-grft fac/nck/hf/g	02	$446.00
15121	Skn splt a-grft f/n/hf/g add	03	$510.00
15130	Derm autograft, trnk/arm/leg	02	$446.00
15131	Derm autograft t/a/l add-on	01	$333.00
15135	Derm autograft face/nck/hf/g	02	$446.00
15136	Derm autograft, f/n/hf/g add	01	$333.00
15150	Cult epiderm grft t/arm/leg	02	$446.00
15151	Cult epiderm grft t/a/l addl	01	$333.00
15152	Cult epiderm graft t/a/l +%	01	$333.00
15155	Cult epiderm graft, f/n/hf/g	02	$446.00
15156	Cult epidrm grft f/n/hfg add	01	$333.00
15157	Cult epiderm grft f/n/hfg +%	01	$333.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
15200	Skin full graft, trunk	03	$510.00
15201	Skin full graft trunk add-on	42	$323.28
15220	Skin full graft sclp/arm/leg	02	$446.00
15221	Skin full graft add-on	42	$323.28
15240	Skin full grft face/genit/hf	03	$510.00
15241	Skin full graft add-on	42	$323.28
15260	Skin full graft een & lips	02	$446.00
15261	Skin full graft add-on	42	$323.28
15300	Apply skinallogrft, t/arm/lg	42	$323.28
15301	Apply sknallogrft t/a/l addl	42	$323.28
15320	Apply skin allogrft f/n/hf/g	42	$323.28
15321	Aply sknallogrft f/n/hfg add	42	$323.28
15330	Aply acell alogrft t/arm/leg	42	$323.28
15331	Aply acell grft t/a/l add-on	42	$323.28
15335	Apply acell graft, f/n/hf/g	42	$323.28
15336	Aply acell grft f/n/hf/g add	42	$323.28
15400	Apply skin xenograft, t/a/l	42	$323.28
15401	Apply skn xenogrft t/a/l add	42	$323.28
15420	Apply skin xgraft, f/n/hf/g	42	$323.28
15421	Apply skn xgrft f/n/hf/g add	42	$323.28
15430	Apply acellular xenograft	42	$323.28
15431	Apply acellular xgraft add	42	$323.28
15570	Form skin pedicle flap	03	$510.00
15572	Form skin pedicle flap	03	$510.00
15574	Form skin pedicle flap	03	$510.00
15576	Form skin pedicle flap	03	$510.00
15600	Skin graft	03	$510.00
15610	Skin graft	03	$510.00
15620	Skin graft	04	$630.00
15630	Skin graft	03	$510.00
15650	Transfer skin pedicle flap	05	$717.00
15731	Forehead flap w/vasc pedicle	03	$510.00
15732	Muscle-skin graft, head/neck	03	$510.00
15734	Muscle-skin graft, trunk	03	$510.00
15736	Muscle-skin graft, arm	03	$510.00
15738	Muscle-skin graft, leg	03	$510.00
15740	Island pedicle flap graft	02	$446.00
15750	Neurovascular pedicle graft	02	$446.00
15760	Composite skin graft	02	$446.00
15770	Derma-fat-fascia graft	03	$510.00
15775	Hair transplant punch grafts	42	$323.28
15776	Hair transplant punch grafts	42	$323.28
15820	Revision of lower eyelid	03	$510.00
15821	Revision of lower eyelid	03	$510.00
15822	Revision of upper eyelid	03	$510.00
15823	Revision of upper eyelid	05	$717.00
15824	Removal of forehead wrinkles	03	$510.00
15825	Removal of neck wrinkles	03	$510.00
15826	Removal of brow wrinkles	03	$510.00
15828	Removal of face wrinkles	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
15829	Removal of skin wrinkles	05	$717.00
15830	Exc skin abd	03	$510.00
15832	Excise excessive skin tissue	03	$510.00
15833	Excise excessive skin tissue	03	$510.00
15834	Excise excessive skin tissue	03	$510.00
15835	Excise excessive skin tissue	42	$323.28
15836	Excise excessive skin tissue	03	$510.00
15839	Excise excessive skin tissue	03	$510.00
15840	Graft for face nerve palsy	04	$630.00
15841	Graft for face nerve palsy	04	$630.00
15845	Skin and muscle repair, face	04	$630.00
15847	Exc skin abd add-on	03	$510.00
15876	Suction assisted lipectomy	03	$510.00
15877	Suction assisted lipectomy	03	$510.00
15878	Suction assisted lipectomy	03	$510.00
15879	Suction assisted lipectomy	03	$510.00
15920	Removal of tail bone ulcer	37	$251.52
15922	Removal of tail bone ulcer	04	$630.00
15931	Remove sacrum pressure sore	03	$510.00
15933	Remove sacrum pressure sore	03	$510.00
15934	Remove sacrum pressure sore	03	$510.00
15935	Remove sacrum pressure sore	04	$630.00
15936	Remove sacrum pressure sore	04	$630.00
15937	Remove sacrum pressure sore	04	$630.00
15940	Remove hip pressure sore	03	$510.00
15941	Remove hip pressure sore	03	$510.00
15944	Remove hip pressure sore	03	$510.00
15945	Remove hip pressure sore	04	$630.00
15946	Remove hip pressure sore	04	$630.00
15950	Remove thigh pressure sore	03	$510.00
15951	Remove thigh pressure sore	04	$630.00
15952	Remove thigh pressure sore	03	$510.00
15953	Remove thigh pressure sore	04	$630.00
15956	Remove thigh pressure sore	03	$510.00
15958	Remove thigh pressure sore	04	$630.00
16025	Dress/debrid p-thick burn, m	13	$67.11
16030	Dress/debrid p-thick burn, l	18	$99.83
19020	Incision of breast lesion	02	$446.00
19100	Bx breast percut w/o image	34	$240.00
19101	Biopsy of breast, open	02	$446.00
19102	Bx breast percut w/image	34	$240.00
19103	Bx breast percut w/device	48	$395.77
19110	Nipple exploration	02	$446.00
19112	Excise breast duct fistula	03	$510.00
19120	Removal of breast lesion	03	$510.00
19125	Excision, breast lesion	03	$510.00
19126	Excision, addl breast lesion	03	$510.00
19290	Place needle wire, breast	01	$333.00
19291	Place needle wire, breast	01	$333.00
19295	Place breast clip, percut	20	$106.76

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
19296	Place po breast cath for rad	09	$1,339.00
19297	Place breast cath for rad	09	$1,339.00
19298	Place breast rad tube/caths	09	$1,339.00
19300	Removal of breast tissue	04	$630.00
19301	Partical mastectomy	03	$510.00
19302	P-mastectomy w/ln removal	07	$995.00
19303	Mast, simple, complete	04	$630.00
19304	Mast, subq	04	$630.00
19316	Suspension of breast	04	$630.00
19318	Reduction of large breast	04	$630.00
19324	Enlarge breast	04	$630.00
19325	Enlarge breast with implant	09	$1,339.00
19328	Removal of breast implant	01	$333.00
19330	Removal of implant material	01	$333.00
19340	Immediate breast prosthesis	02	$446.00
19342	Delayed breast prosthesis	03	$510.00
19350	Breast reconstruction	04	$630.00
19355	Correct inverted nipple(s)	04	$630.00
19357	Breast reconstruction	05	$717.00
19366	Breast reconstruction	05	$717.00
19370	Surgery of breast capsule	04	$630.00
19371	Removal of breast capsule	04	$630.00
19380	Revise breast reconstruction	05	$717.00
20005	Incision of deep abscess	02	$446.00
20200	Muscle biopsy	02	$446.00
20205	Deep muscle biopsy	03	$510.00
20206	Needle biopsy, muscle	34	$240.00
20220	Bone biopsy, trocar/needle	37	$251.52
20225	Bone biopsy, trocar/needle	51	$418.49
20240	Bone biopsy, excisional	02	$446.00
20245	Bone biopsy, excisional	03	$510.00
20250	Open bone biopsy	03	$510.00
20251	Open bone biopsy	03	$510.00
20525	Removal of foreign body	03	$510.00
20650	Insert and remove bone pin	03	$510.00
20670	Removal of support implant	01	$333.00
20680	Removal of support implant	03	$510.00
20690	Apply bone fixation device	02	$446.00
20692	Apply bone fixation device	03	$510.00
20693	Adjust bone fixation device	03	$510.00
20694	Remove bone fixation device	01	$333.00
20900	Removal of bone for graft	03	$510.00
20902	Removal of bone for graft	04	$630.00
20910	Remove cartilage for graft	03	$510.00
20912	Remove cartilage for graft	03	$510.00
20920	Removal of fascia for graft	04	$630.00
20922	Removal of fascia for graft	03	$510.00
20924	Removal of tendon for graft	04	$630.00
20926	Removal of tissue for graft	04	$630.00
20975	Electrical bone stimulation	10	$37.51

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
21010	Incision of jaw joint	02	$446.00
21015	Resection of facial tumor	03	$510.00
21025	Excision of bone, lower jaw	02	$446.00
21026	Excision of facial bone(s)	02	$446.00
21029	Contour of face bone lesion	02	$446.00
21034	Excise max/zygoma mlg tumor	03	$510.00
21040	Excise mandible lesion	02	$446.00
21044	Removal of jaw bone lesion	02	$446.00
21046	Remove mandible cyst complex	02	$446.00
21047	Excise lwr jaw cyst w/repair	02	$446.00
21050	Removal of jaw joint	03	$510.00
21060	Remove jaw joint cartilage	02	$446.00
21070	Remove coronoid process	03	$510.00
21100	Maxillofacial fixation	02	$446.00
21120	Reconstruction of chin	07	$995.00
21121	Reconstruction of chin	07	$995.00
21122	Reconstruction of chin	07	$995.00
21123	Reconstruction of chin	07	$995.00
21125	Augmentation, lower jaw bone	07	$995.00
21127	Augmentation, lower jaw bone	09	$1,339.00
21181	Contour cranial bone lesion	07	$995.00
21206	Reconstruct upper jaw bone	05	$717.00
21208	Augmentation of facial bones	07	$995.00
21209	Reduction of facial bones	05	$717.00
21210	Face bone graft	07	$995.00
21215	Lower jaw bone graft	07	$995.00
21230	Rib cartilage graft	07	$995.00
21235	Ear cartilage graft	07	$995.00
21240	Reconstruction of jaw joint	04	$630.00
21242	Reconstruction of jaw joint	05	$717.00
21243	Reconstruction of jaw joint	05	$717.00
21244	Reconstruction of lower jaw	07	$995.00
21245	Reconstruction of jaw	07	$995.00
21246	Reconstruction of jaw	07	$995.00
21248	Reconstruction of jaw	07	$995.00
21249	Reconstruction of jaw	07	$995.00
21267	Revise eye sockets	07	$995.00
21270	Augmentation, cheek bone	05	$717.00
21275	Revision, orbitofacial bones	07	$995.00
21280	Revision of eyelid	05	$717.00
21282	Revision of eyelid	05	$717.00
21295	Revision of jaw muscle/bone	01	$333.00
21296	Revision of jaw muscle/bone	01	$333.00
21310	Treatment of nose fracture	27	$150.72
21315	Treatment of nose fracture	27	$150.72
21320	Treatment of nose fracture	02	$446.00
21325	Treatment of nose fracture	04	$630.00
21330	Treatment of nose fracture	05	$717.00
21335	Treatment of nose fracture	07	$995.00
21336	Treat nasal septal fracture	04	$630.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
21337	Treat nasal septal fracture	02	$446.00
21338	Treat nasoethmoid fracture	04	$630.00
21339	Treat nasoethmoid fracture	05	$717.00
21340	Treatment of nose fracture	04	$630.00
21345	Treat nose/jaw fracture	07	$995.00
21355	Treat cheek bone fracture	03	$510.00
21356	Treat cheek bone fracture	03	$510.00
21400	Treat eye socket fracture	02	$446.00
21401	Treat eye socket fracture	03	$510.00
21421	Treat mouth roof fracture	04	$630.00
21445	Treat dental ridge fracture	04	$630.00
21450	Treat lower jaw fracture	27	$150.72
21451	Treat lower jaw fracture	53	$464.15
21452	Treat lower jaw fracture	02	$446.00
21453	Treat lower jaw fracture	03	$510.00
21454	Treat lower jaw fracture	05	$717.00
21461	Treat lower jaw fracture	04	$630.00
21462	Treat lower jaw fracture	05	$717.00
21465	Treat lower jaw fracture	04	$630.00
21480	Reset dislocated jaw	27	$150.72
21485	Reset dislocated jaw	02	$446.00
21490	Repair dislocated jaw	03	$510.00
21497	Interdental wiring	02	$446.00
21501	Drain neck/chest lesion	02	$446.00
21502	Drain chest lesion	02	$446.00
21555	Remove lesion, neck/chest	02	$446.00
21556	Remove lesion, neck/chest	02	$446.00
21600	Partial removal of rib	02	$446.00
21610	Partial removal of rib	02	$446.00
21700	Revision of neck muscle	02	$446.00
21720	Revision of neck muscle	03	$510.00
21725	Revision of neck muscle	16	$88.46
21800	Treatment of rib fracture	19	$103.62
21805	Treatment of rib fracture	02	$446.00
21820	Treat sternum fracture	19	$103.62
21925	Biopsy soft tissue of back	02	$446.00
21930	Remove lesion, back or flank	02	$446.00
21935	Remove tumor, back	03	$510.00
22305	Treat spine process fracture	19	$103.62
22310	Treat spine fracture	19	$103.62
22315	Treat spine fracture	19	$103.62
22505	Manipulation of spine	02	$446.00
22520	Percut vertebroplasty thor	09	$1,339.00
22521	Percut vertebroplasty lumb	09	$1,339.00
22522	Percut vertebroplasty addÆl	09	$1,339.00
22900	Remove abdominal wall lesion	04	$630.00
23000	Removal of calcium deposits	02	$446.00
23020	Release shoulder joint	02	$446.00
23030	Drain shoulder lesion	01	$333.00
23031	Drain shoulder bursa	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
23035	Drain shoulder bone lesion	03	$510.00
23040	Exploratory shoulder surgery	03	$510.00
23044	Exploratory shoulder surgery	04	$630.00
23066	Biopsy shoulder tissues	02	$446.00
23075	Removal of shoulder lesion	02	$446.00
23076	Removal of shoulder lesion	02	$446.00
23077	Remove tumor of shoulder	03	$510.00
23100	Biopsy of shoulder joint	02	$446.00
23101	Shoulder joint surgery	07	$995.00
23105	Remove shoulder joint lining	04	$630.00
23106	Incision of collarbone joint	04	$630.00
23107	Explore treat shoulder joint	04	$630.00
23120	Partial removal, collar bone	05	$717.00
23125	Removal of collar bone	05	$717.00
23130	Remove shoulder bone, part	05	$717.00
23140	Removal of bone lesion	04	$630.00
23145	Removal of bone lesion	05	$717.00
23146	Removal of bone lesion	05	$717.00
23150	Removal of humerus lesion	04	$630.00
23155	Removal of humerus lesion	05	$717.00
23156	Removal of humerus lesion	05	$717.00
23170	Remove collar bone lesion	02	$446.00
23172	Remove shoulder blade lesion	02	$446.00
23174	Remove humerus lesion	02	$446.00
23180	Remove collar bone lesion	04	$630.00
23182	Remove shoulder blade lesion	04	$630.00
23184	Remove humerus lesion	04	$630.00
23190	Partial removal of scapula	04	$630.00
23195	Removal of head of humerus	05	$717.00
23330	Remove shoulder foreign body	01	$333.00
23331	Remove shoulder foreign body	01	$333.00
23395	Muscle transfer,shoulder/arm	05	$717.00
23397	Muscle transfers	07	$995.00
23400	Fixation of shoulder blade	07	$995.00
23405	Incision of tendon & muscle	02	$446.00
23406	Incise tendon(s) & muscle(s)	02	$446.00
23410	Repair rotator cuff, acute	05	$717.00
23412	Repair rotator cuff, chronic	07	$995.00
23415	Release of shoulder ligament	05	$717.00
23420	Repair of shoulder	07	$995.00
23430	Repair biceps tendon	04	$630.00
23440	Remove/transplant tendon	04	$630.00
23450	Repair shoulder capsule	05	$717.00
23455	Repair shoulder capsule	07	$995.00
23460	Repair shoulder capsule	05	$717.00
23462	Repair shoulder capsule	07	$995.00
23465	Repair shoulder capsule	05	$717.00
23466	Repair shoulder capsule	07	$995.00
23480	Revision of collar bone	04	$630.00
23485	Revision of collar bone	07	$995.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
23490	Reinforce clavicle	03	$510.00
23491	Reinforce shoulder bones	03	$510.00
23500	Treat clavicle fracture	19	$103.62
23505	Treat clavicle fracture	19	$103.62
23515	Treat clavicle fracture	03	$510.00
23520	Treat clavicle dislocation	19	$103.62
23525	Treat clavicle dislocation	19	$103.62
23530	Treat clavicle dislocation	03	$510.00
23532	Treat clavicle dislocation	04	$630.00
23540	Treat clavicle dislocation	19	$103.62
23545	Treat clavicle dislocation	19	$103.62
23550	Treat clavicle dislocation	03	$510.00
23552	Treat clavicle dislocation	04	$630.00
23570	Treat shoulder blade fx	19	$103.62
23575	Treat shoulder blade fx	19	$103.62
23585	Treat scapula fracture	03	$510.00
23605	Treat humerus fracture	19	$103.62
23615	Treat humerus fracture	04	$630.00
23616	Treat humerus fracture	04	$630.00
23625	Treat humerus fracture	19	$103.62
23630	Treat humerus fracture	05	$717.00
23650	Treat shoulder dislocation	19	$103.62
23655	Treat shoulder dislocation	01	$333.00
23660	Treat shoulder dislocation	03	$510.00
23665	Treat dislocation/fracture	19	$103.62
23670	Treat dislocation/fracture	03	$510.00
23675	Treat dislocation/fracture	19	$103.62
23680	Treat dislocation/fracture	03	$510.00
23700	Fixation of shoulder	01	$333.00
23800	Fusion of shoulder joint	04	$630.00
23802	Fusion of shoulder joint	07	$995.00
23921	Amputation follow-up surgery	42	$323.28
23930	Drainage of arm lesion	01	$333.00
23931	Drainage of arm bursa	02	$446.00
23935	Drain arm/elbow bone lesion	02	$446.00
24000	Exploratory elbow surgery	04	$630.00
24006	Release elbow joint	04	$630.00
24066	Biopsy arm/elbow soft tissue	02	$446.00
24075	Remove arm/elbow lesion	02	$446.00
24076	Remove arm/elbow lesion	02	$446.00
24077	Remove tumor of arm/elbow	03	$510.00
24100	Biopsy elbow joint lining	01	$333.00
24101	Explore/treat elbow joint	04	$630.00
24102	Remove elbow joint lining	04	$630.00
24105	Removal of elbow bursa	03	$510.00
24110	Remove humerus lesion	02	$446.00
24115	Remove/graft bone lesion	03	$510.00
24116	Remove/graft bone lesion	03	$510.00
24120	Remove elbow lesion	03	$510.00
24125	Remove/graft bone lesion	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
24126	Remove/graft bone lesion	03	$510.00
24130	Removal of head of radius	03	$510.00
24134	Removal of arm bone lesion	02	$446.00
24136	Remove radius bone lesion	02	$446.00
24138	Remove elbow bone lesion	02	$446.00
24140	Partial removal of arm bone	03	$510.00
24145	Partial removal of radius	03	$510.00
24147	Partial removal of elbow	02	$446.00
24155	Removal of elbow joint	03	$510.00
24160	Remove elbow joint implant	02	$446.00
24164	Remove radius head implant	03	$510.00
24201	Removal of arm foreign body	02	$446.00
24301	Muscle/tendon transfer	04	$630.00
24305	Arm tendon lengthening	04	$630.00
24310	Revision of arm tendon	03	$510.00
24320	Repair of arm tendon	03	$510.00
24330	Revision of arm muscles	03	$510.00
24331	Revision of arm muscles	03	$510.00
24340	Repair of biceps tendon	03	$510.00
24341	Repair arm tendon/muscle	03	$510.00
24342	Repair of ruptured tendon	03	$510.00
24345	Repr elbw med ligmnt w/tissu	02	$446.00
24350	Repair of tennis elbow	03	$510.00
24351	Repair of tennis elbow	03	$510.00
24352	Repair of tennis elbow	03	$510.00
24354	Repair of tennis elbow	03	$510.00
24356	Revision of tennis elbow	03	$510.00
24360	Reconstruct elbow joint	05	$717.00
24361	Reconstruct elbow joint	05	$717.00
24362	Reconstruct elbow joint	05	$717.00
24363	Replace elbow joint	07	$995.00
24365	Reconstruct head of radius	05	$717.00
24366	Reconstruct head of radius	05	$717.00
24400	Revision of humerus	04	$630.00
24410	Revision of humerus	04	$630.00
24420	Revision of humerus	03	$510.00
24430	Repair of humerus	03	$510.00
24435	Repair humerus with graft	04	$630.00
24470	Revision of elbow joint	03	$510.00
24495	Decompression of forearm	02	$446.00
24498	Reinforce humerus	03	$510.00
24500	Treat humerus fracture	19	$103.62
24505	Treat humerus fracture	19	$103.62
24515	Treat humerus fracture	04	$630.00
24516	Treat humerus fracture	04	$630.00
24530	Treat humerus fracture	19	$103.62
24535	Treat humerus fracture	19	$103.62
24538	Treat humerus fracture	02	$446.00
24545	Treat humerus fracture	04	$630.00
24546	Treat humerus fracture	05	$717.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
24560	Treat humerus fracture	19	$103.62
24565	Treat humerus fracture	19	$103.62
24566	Treat humerus fracture	02	$446.00
24575	Treat humerus fracture	03	$510.00
24576	Treat humerus fracture	19	$103.62
24577	Treat humerus fracture	19	$103.62
24579	Treat humerus fracture	03	$510.00
24582	Treat humerus fracture	02	$446.00
24586	Treat elbow fracture	04	$630.00
24587	Treat elbow fracture	05	$717.00
24600	Treat elbow dislocation	19	$103.62
24605	Treat elbow dislocation	02	$446.00
24615	Treat elbow dislocation	03	$510.00
24620	Treat elbow fracture	19	$103.62
24635	Treat elbow fracture	03	$510.00
24655	Treat radius fracture	19	$103.62
24665	Treat radius fracture	04	$630.00
24666	Treat radius fracture	04	$630.00
24670	Treat ulnar fracture	19	$103.62
24675	Treat ulnar fracture	19	$103.62
24685	Treat ulnar fracture	03	$510.00
24800	Fusion of elbow joint	04	$630.00
24802	Fusion/graft of elbow joint	05	$717.00
24925	Amputation follow-up surgery	03	$510.00
25000	Incision of tendon sheath	03	$510.00
25020	Decompress forearm 1 space	03	$510.00
25023	Decompress forearm 1 space	03	$510.00
25024	Decompress forearm 2 spaces	03	$510.00
25025	Decompress forearm 2 spaces	03	$510.00
25028	Drainage of forearm lesion	01	$333.00
25031	Drainage of forearm bursa	02	$446.00
25035	Treat forearm bone lesion	02	$446.00
25040	Explore/treat wrist joint	05	$717.00
25066	Biopsy forearm soft tissues	02	$446.00
25075	Removal forearm lesion subcu	02	$446.00
25076	Removal forearm lesion deep	03	$510.00
25077	Remove tumor, forearm/wrist	03	$510.00
25085	Incision of wrist capsule	03	$510.00
25100	Biopsy of wrist joint	02	$446.00
25101	Explore/treat wrist joint	03	$510.00
25105	Remove wrist joint lining	04	$630.00
25107	Remove wrist joint cartilage	03	$510.00
25110	Remove wrist tendon lesion	03	$510.00
25111	Remove wrist tendon lesion	03	$510.00
25112	Reremove wrist tendon lesion	04	$630.00
25115	Remove wrist/forearm lesion	04	$630.00
25116	Remove wrist/forearm lesion	04	$630.00
25118	Excise wrist tendon sheath	02	$446.00
25119	Partial removal of ulna	03	$510.00
25120	Removal of forearm lesion	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
25125	Remove/graft forearm lesion	03	$510.00
25126	Remove/graft forearm lesion	03	$510.00
25130	Removal of wrist lesion	03	$510.00
25135	Remove & graft wrist lesion	03	$510.00
25136	Remove & graft wrist lesion	03	$510.00
25145	Remove forearm bone lesion	02	$446.00
25150	Partial removal of ulna	02	$446.00
25151	Partial removal of radius	02	$446.00
25210	Removal of wrist bone	03	$510.00
25215	Removal of wrist bones	04	$630.00
25230	Partial removal of radius	04	$630.00
25240	Partial removal of ulna	04	$630.00
25248	Remove forearm foreign body	02	$446.00
25250	Removal of wrist prosthesis	01	$333.00
25251	Removal of wrist prosthesis	01	$333.00
25260	Repair forearm tendon/muscle	04	$630.00
25263	Repair forearm tendon/muscle	02	$446.00
25265	Repair forearm tendon/muscle	03	$510.00
25270	Repair forearm tendon/muscle	04	$630.00
25272	Repair forearm tendon/muscle	03	$510.00
25274	Repair forearm tendon/muscle	04	$630.00
25275	Repair forearm tendon sheath	04	$630.00
25280	Revise wrist/forearm tendon	04	$630.00
25290	Incise wrist/forearm tendon	03	$510.00
25295	Release wrist/forearm tendon	03	$510.00
25300	Fusion of tendons at wrist	03	$510.00
25301	Fusion of tendons at wrist	03	$510.00
25310	Transplant forearm tendon	03	$510.00
25312	Transplant forearm tendon	04	$630.00
25315	Revise palsy hand tendon(s)	03	$510.00
25316	Revise palsy hand tendon(s)	03	$510.00
25320	Repair/revise wrist joint	03	$510.00
25332	Revise wrist joint	05	$717.00
25335	Realignment of hand	03	$510.00
25337	Reconstruct ulna/radioulnar	05	$717.00
25350	Revision of radius	03	$510.00
25355	Revision of radius	03	$510.00
25360	Revision of ulna	03	$510.00
25365	Revise radius & ulna	03	$510.00
25370	Revise radius or ulna	03	$510.00
25375	Revise radius & ulna	04	$630.00
25390	Shorten radius or ulna	03	$510.00
25391	Lengthen radius or ulna	04	$630.00
25392	Shorten radius & ulna	03	$510.00
25393	Lengthen radius & ulna	04	$630.00
25400	Repair radius or ulna	03	$510.00
25405	Repair/graft radius or ulna	04	$630.00
25415	Repair radius & ulna	03	$510.00
25420	Repair/graft radius & ulna	04	$630.00
25425	Repair/graft radius or ulna	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
25426	Repair/graft radius & ulna	04	$630.00
25440	Repair/graft wrist bone	04	$630.00
25441	Reconstruct wrist joint	05	$717.00
25442	Reconstruct wrist joint	05	$717.00
25443	Reconstruct wrist joint	05	$717.00
25444	Reconstruct wrist joint	05	$717.00
25445	Reconstruct wrist joint	05	$717.00
25446	Wrist replacement	07	$995.00
25447	Repair wrist joint(s)	05	$717.00
25449	Remove wrist joint implant	05	$717.00
25450	Revision of wrist joint	03	$510.00
25455	Revision of wrist joint	03	$510.00
25490	Reinforce radius	03	$510.00
25491	Reinforce ulna	03	$510.00
25492	Reinforce radius and ulna	03	$510.00
25505	Treat fracture of radius	19	$103.62
25515	Treat fracture of radius	03	$510.00
25520	Treat fracture of radius	19	$103.62
25525	Treat fracture of radius	04	$630.00
25526	Treat fracture of radius	05	$717.00
25535	Treat fracture of ulna	19	$103.62
25545	Treat fracture of ulna	03	$510.00
25565	Treat fracture radius & ulna	19	$103.62
25574	Treat fracture radius & ulna	03	$510.00
25575	Treat fracture radius/ulna	03	$510.00
25605	Treat fracture radius/ulna	19	$103.62
25606	Treat fx distal radial	03	$510.00
25607	Treat fx rad extra-articul	05	$717.00
25608	Treat fx rad intra-articul	05	$717.00
25609	Treat fx radial 3+ frag	05	$717.00
25624	Treat wrist bone fracture	19	$103.62
25628	Treat wrist bone fracture	03	$510.00
25635	Treat wrist bone fracture	19	$103.62
25645	Treat wrist bone fracture	03	$510.00
25660	Treat wrist dislocation	19	$103.62
25670	Treat wrist dislocation	03	$510.00
25671	Pin radioulnar dislocation	01	$333.00
25675	Treat wrist dislocation	19	$103.62
25676	Treat wrist dislocation	02	$446.00
25680	Treat wrist fracture	19	$103.62
25685	Treat wrist fracture	03	$510.00
25690	Treat wrist dislocation	19	$103.62
25695	Treat wrist dislocation	02	$446.00
25800	Fusion of wrist joint	04	$630.00
25805	Fusion/graft of wrist joint	05	$717.00
25810	Fusion/graft of wrist joint	05	$717.00
25820	Fusion of hand bones	04	$630.00
25825	Fuse hand bones with graft	05	$717.00
25830	Fusion, radioulnar jnt/ulna	05	$717.00
25907	Amputation follow-up surgery	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
25922	Amputate hand at wrist	03	$510.00
25929	Amputation follow-up surgery	03	$510.00
26011	Drainage of finger abscess	01	$333.00
26020	Drain hand tendon sheath	02	$446.00
26025	Drainage of palm bursa	01	$333.00
26030	Drainage of palm bursa(s)	02	$446.00
26034	Treat hand bone lesion	02	$446.00
26040	Release palm contracture	04	$630.00
26045	Release palm contracture	03	$510.00
26055	Incise finger tendon sheath	02	$446.00
26060	Incision of finger tendon	02	$446.00
26070	Explore/treat hand joint	02	$446.00
26075	Explore/treat finger joint	04	$630.00
26080	Explore/treat finger joint	04	$630.00
26100	Biopsy hand joint lining	02	$446.00
26105	Biopsy finger joint lining	01	$333.00
26110	Biopsy finger joint lining	01	$333.00
26115	Removal hand lesion subcut	02	$446.00
26116	Removal hand lesion, deep	02	$446.00
26117	Remove tumor, hand/finger	03	$510.00
26121	Release palm contracture	04	$630.00
26123	Release palm contracture	04	$630.00
26125	Release palm contracture	04	$630.00
26130	Remove wrist joint lining	03	$510.00
26135	Revise finger joint, each	04	$630.00
26140	Revise finger joint, each	02	$446.00
26145	Tendon excision, palm/finger	03	$510.00
26160	Remove tendon sheath lesion	03	$510.00
26170	Removal of palm tendon, each	03	$510.00
26180	Removal of finger tendon	03	$510.00
26185	Remove finger bone	04	$630.00
26200	Remove hand bone lesion	02	$446.00
26205	Remove/graft bone lesion	03	$510.00
26210	Removal of finger lesion	02	$446.00
26215	Remove/graft finger lesion	03	$510.00
26230	Partial removal of hand bone	54	$992.95
26235	Partial removal, finger bone	03	$510.00
26236	Partial removal, finger bone	03	$510.00
26250	Extensive hand surgery	03	$510.00
26255	Extensive hand surgery	03	$510.00
26260	Extensive finger surgery	03	$510.00
26261	Extensive finger surgery	03	$510.00
26262	Partial removal of finger	02	$446.00
26320	Removal of implant from hand	02	$446.00
26350	Repair finger/hand tendon	01	$333.00
26352	Repair/graft hand tendon	04	$630.00
26356	Repair finger/hand tendon	04	$630.00
26357	Repair finger/hand tendon	04	$630.00
26358	Repair/graft hand tendon	04	$630.00
26370	Repair finger/hand tendon	04	$630.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
26372	Repair/graft hand tendon	04	$630.00
26373	Repair finger/hand tendon	03	$510.00
26390	Revise hand/finger tendon	04	$630.00
26392	Repair/graft hand tendon	03	$510.00
26410	Repair hand tendon	03	$510.00
26412	Repair/graft hand tendon	03	$510.00
26415	Excision, hand/finger tendon	04	$630.00
26416	Graft hand or finger tendon	03	$510.00
26418	Repair finger tendon	04	$630.00
26420	Repair/graft finger tendon	04	$630.00
26426	Repair finger/hand tendon	03	$510.00
26428	Repair/graft finger tendon	03	$510.00
26432	Repair finger tendon	03	$510.00
26433	Repair finger tendon	03	$510.00
26434	Repair/graft finger tendon	03	$510.00
26437	Realignment of tendons	03	$510.00
26440	Release palm/finger tendon	03	$510.00
26442	Release palm & finger tendon	03	$510.00
26445	Release hand/finger tendon	03	$510.00
26449	Release forearm/hand tendon	03	$510.00
26450	Incision of palm tendon	03	$510.00
26455	Incision of finger tendon	03	$510.00
26460	Incise hand/finger tendon	03	$510.00
26471	Fusion of finger tendons	02	$446.00
26474	Fusion of finger tendons	02	$446.00
26476	Tendon lengthening	01	$333.00
26477	Tendon shortening	01	$333.00
26478	Lengthening of hand tendon	01	$333.00
26479	Shortening of hand tendon	01	$333.00
26480	Transplant hand tendon	03	$510.00
26483	Transplant/graft hand tendon	03	$510.00
26485	Transplant palm tendon	02	$446.00
26489	Transplant/graft palm tendon	03	$510.00
26490	Revise thumb tendon	03	$510.00
26492	Tendon transfer with graft	03	$510.00
26494	Hand tendon/muscle transfer	03	$510.00
26496	Revise thumb tendon	03	$510.00
26497	Finger tendon transfer	03	$510.00
26498	Finger tendon transfer	04	$630.00
26499	Revision of finger	03	$510.00
26500	Hand tendon reconstruction	04	$630.00
26502	Hand tendon reconstruction	04	$630.00
26508	Release thumb contracture	03	$510.00
26510	Thumb tendon transfer	03	$510.00
26516	Fusion of knuckle joint	01	$333.00
26517	Fusion of knuckle joints	03	$510.00
26518	Fusion of knuckle joints	03	$510.00
26520	Release knuckle contracture	03	$510.00
26525	Release finger contracture	03	$510.00
26530	Revise knuckle joint	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
26531	Revise knuckle with implant	07	$995.00
26535	Revise finger joint	05	$717.00
26536	Revise/implant finger joint	05	$717.00
26540	Repair hand joint	04	$630.00
26541	Repair hand joint with graft	07	$995.00
26542	Repair hand joint with graft	04	$630.00
26545	Reconstruct finger joint	04	$630.00
26546	Repair nonunion hand	04	$630.00
26548	Reconstruct finger joint	04	$630.00
26550	Construct thumb replacement	02	$446.00
26555	Positional change of finger	03	$510.00
26560	Repair of web finger	02	$446.00
26561	Repair of web finger	03	$510.00
26562	Repair of web finger	04	$630.00
26565	Correct metacarpal flaw	05	$717.00
26567	Correct finger deformity	05	$717.00
26568	Lengthen metacarpal/finger	03	$510.00
26580	Repair hand deformity	05	$717.00
26587	Reconstruct extra finger	05	$717.00
26590	Repair finger deformity	05	$717.00
26591	Repair muscles of hand	03	$510.00
26593	Release muscles of hand	03	$510.00
26596	Excision constricting tissue	02	$446.00
26605	Treat metacarpal fracture	19	$103.62
26607	Treat metacarpal fracture	19	$103.62
26608	Treat metacarpal fracture	04	$630.00
26615	Treat metacarpal fracture	04	$630.00
26645	Treat thumb fracture	19	$103.62
26650	Treat thumb fracture	02	$446.00
26665	Treat thumb fracture	04	$630.00
26675	Treat hand dislocation	19	$103.62
26676	Pin hand dislocation	02	$446.00
26685	Treat hand dislocation	03	$510.00
26686	Treat hand dislocation	03	$510.00
26705	Treat knuckle dislocation	19	$103.62
26706	Pin knuckle dislocation	19	$103.62
26715	Treat knuckle dislocation	04	$630.00
26727	Treat finger fracture, each	07	$995.00
26735	Treat finger fracture, each	04	$630.00
26742	Treat finger fracture, each	19	$103.62
26746	Treat finger fracture, each	05	$717.00
26756	Pin finger fracture, each	02	$446.00
26765	Treat finger fracture, each	04	$630.00
26776	Pin finger dislocation	02	$446.00
26785	Treat finger dislocation	02	$446.00
26820	Thumb fusion with graft	05	$717.00
26841	Fusion of thumb	04	$630.00
26842	Thumb fusion with graft	04	$630.00
26843	Fusion of hand joint	03	$510.00
26844	Fusion/graft of hand joint	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
26850	Fusion of knuckle	04	$630.00
26852	Fusion of knuckle with graft	04	$630.00
26860	Fusion of finger joint	03	$510.00
26861	Fusion of finger jnt, add-on	02	$446.00
26862	Fusion/graft of finger joint	04	$630.00
26863	Fuse/graft added joint	03	$510.00
26910	Amputate metacarpal bone	03	$510.00
26951	Amputation of finger/thumb	02	$446.00
26952	Amputation of finger/thumb	04	$630.00
26990	Drainage of pelvis lesion	01	$333.00
26991	Drainage of pelvis bursa	01	$333.00
27000	Incision of hip tendon	02	$446.00
27001	Incision of hip tendon	03	$510.00
27003	Incision of hip tendon	03	$510.00
27033	Exploration of hip joint	03	$510.00
27035	Denervation of hip joint	04	$630.00
27040	Biopsy of soft tissues	01	$333.00
27041	Biopsy of soft tissues	51	$418.49
27047	Remove hip/pelvis lesion	02	$446.00
27048	Remove hip/pelvis lesion	03	$510.00
27049	Remove tumor, hip/pelvis	03	$510.00
27050	Biopsy of sacroiliac joint	03	$510.00
27052	Biopsy of hip joint	03	$510.00
27060	Removal of ischial bursa	05	$717.00
27062	Remove femur lesion/bursa	05	$717.00
27065	Removal of hip bone lesion	05	$717.00
27066	Removal of hip bone lesion	05	$717.00
27067	Remove/graft hip bone lesion	05	$717.00
27080	Removal of tail bone	02	$446.00
27086	Remove hip foreign body	01	$333.00
27087	Remove hip foreign body	03	$510.00
27097	Revision of hip tendon	03	$510.00
27098	Transfer tendon to pelvis	03	$510.00
27100	Transfer of abdominal muscle	04	$630.00
27105	Transfer of spinal muscle	04	$630.00
27110	Transfer of iliopsoas muscle	04	$630.00
27111	Transfer of iliopsoas muscle	04	$630.00
27193	Treat pelvic ring fracture	19	$103.62
27194	Treat pelvic ring fracture	02	$446.00
27202	Treat tail bone fracture	02	$446.00
27230	Treat thigh fracture	19	$103.62
27238	Treat thigh fracture	19	$103.62
27246	Treat thigh fracture	19	$103.62
27250	Treat hip dislocation	19	$103.62
27252	Treat hip dislocation	02	$446.00
27257	Treat hip dislocation	03	$510.00
27265	Treat hip dislocation	19	$103.62
27266	Treat hip dislocation	02	$446.00
27275	Manipulation of hip joint	02	$446.00
27301	Drain thigh/knee lesion	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
27305	Incise thigh tendon & fascia	02	$446.00
27306	Incision of thigh tendon	03	$510.00
27307	Incision of thigh tendons	03	$510.00
27310	Exploration of knee joint	04	$630.00
27323	Biopsy, thigh soft tissues	01	$333.00
27324	Biopsy, thigh soft tissues	01	$333.00
27325	Neurectomy, hamstring	02	$446.00
27326	Neurectomy, popliteal	02	$446.00
27327	Removal of thigh lesion	02	$446.00
27328	Removal of thigh lesion	03	$510.00
27329	Remove tumor, thigh/knee	04	$630.00
27330	Biopsy, knee joint lining	04	$630.00
27331	Explore/treat knee joint	04	$630.00
27332	Removal of knee cartilage	04	$630.00
27333	Removal of knee cartilage	04	$630.00
27334	Remove knee joint lining	04	$630.00
27335	Remove knee joint lining	04	$630.00
27340	Removal of kneecap bursa	03	$510.00
27345	Removal of knee cyst	04	$630.00
27347	Remove knee cyst	04	$630.00
27350	Removal of kneecap	04	$630.00
27355	Remove femur lesion	03	$510.00
27356	Remove femur lesion/graft	04	$630.00
27357	Remove femur lesion/graft	05	$717.00
27358	Remove femur lesion/fixation	05	$717.00
27360	Partial removal, leg bone(s)	05	$717.00
27372	Removal of foreign body	07	$995.00
27380	Repair of kneecap tendon	01	$333.00
27381	Repair/graft kneecap tendon	03	$510.00
27385	Repair of thigh muscle	03	$510.00
27386	Repair/graft of thigh muscle	03	$510.00
27390	Incision of thigh tendon	01	$333.00
27391	Incision of thigh tendons	02	$446.00
27392	Incision of thigh tendons	03	$510.00
27393	Lengthening of thigh tendon	02	$446.00
27394	Lengthening of thigh tendons	03	$510.00
27395	Lengthening of thigh tendons	03	$510.00
27396	Transplant of thigh tendon	03	$510.00
27397	Transplants of thigh tendons	03	$510.00
27400	Revise thigh muscles/tendons	03	$510.00
27403	Repair of knee cartilage	04	$630.00
27405	Repair of knee ligament	04	$630.00
27407	Repair of knee ligament	04	$630.00
27409	Repair of knee ligaments	04	$630.00
27418	Repair degenerated kneecap	03	$510.00
27420	Revision of unstable kneecap	03	$510.00
27422	Revision of unstable kneecap	07	$995.00
27424	Revision/removal of kneecap	03	$510.00
27425	Lat retinacular release open	07	$995.00
27427	Reconstruction, knee	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
27428	Reconstruction, knee	04	$630.00
27429	Reconstruction, knee	04	$630.00
27430	Revision of thigh muscles	04	$630.00
27435	Incision of knee joint	04	$630.00
27437	Revise kneecap	04	$630.00
27438	Revise kneecap with implant	05	$717.00
27441	Revision of knee joint	05	$717.00
27442	Revision of knee joint	05	$717.00
27443	Revision of knee joint	05	$717.00
27496	Decompression of thigh/knee	05	$717.00
27497	Decompression of thigh/knee	03	$510.00
27498	Decompression of thigh/knee	03	$510.00
27499	Decompression of thigh/knee	03	$510.00
27500	Treatment of thigh fracture	19	$103.62
27501	Treatment of thigh fracture	19	$103.62
27502	Treatment of thigh fracture	19	$103.62
27503	Treatment of thigh fracture	19	$103.62
27508	Treatment of thigh fracture	19	$103.62
27509	Treatment of thigh fracture	03	$510.00
27510	Treatment of thigh fracture	19	$103.62
27516	Treat thigh fx growth plate	19	$103.62
27517	Treat thigh fx growth plate	19	$103.62
27520	Treat kneecap fracture	19	$103.62
27530	Treat knee fracture	19	$103.62
27532	Treat knee fracture	19	$103.62
27538	Treat knee fracture(s)	19	$103.62
27550	Treat knee dislocation	19	$103.62
27552	Treat knee dislocation	01	$333.00
27560	Treat kneecap dislocation	19	$103.62
27562	Treat kneecap dislocation	01	$333.00
27566	Treat kneecap dislocation	02	$446.00
27570	Fixation of knee joint	01	$333.00
27594	Amputation follow-up surgery	03	$510.00
27600	Decompression of lower leg	03	$510.00
27601	Decompression of lower leg	03	$510.00
27602	Decompression of lower leg	03	$510.00
27603	Drain lower leg lesion	02	$446.00
27604	Drain lower leg bursa	02	$446.00
27605	Incision of achilles tendon	01	$333.00
27606	Incision of achilles tendon	01	$333.00
27607	Treat lower leg bone lesion	02	$446.00
27610	Explore/treat ankle joint	02	$446.00
27612	Exploration of ankle joint	03	$510.00
27614	Biopsy lower leg soft tissue	02	$446.00
27615	Remove tumor, lower leg	03	$510.00
27618	Remove lower leg lesion	02	$446.00
27619	Remove lower leg lesion	03	$510.00
27620	Explore/treat ankle joint	04	$630.00
27625	Remove ankle joint lining	04	$630.00
27626	Remove ankle joint lining	04	$630.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
27630	Removal of tendon lesion	03	$510.00
27635	Remove lower leg bone lesion	03	$510.00
27637	Remove/graft leg bone lesion	03	$510.00
27638	Remove/graft leg bone lesion	03	$510.00
27640	Partial removal of tibia	02	$446.00
27641	Partial removal of fibula	02	$446.00
27647	Extensive ankle/heel surgery	03	$510.00
27650	Repair achilles tendon	03	$510.00
27652	Repair/graft achilles tendon	03	$510.00
27654	Repair of achilles tendon	03	$510.00
27656	Repair leg fascia defect	02	$446.00
27658	Repair of leg tendon, each	01	$333.00
27659	Repair of leg tendon, each	02	$446.00
27664	Repair of leg tendon, each	02	$446.00
27665	Repair of leg tendon, each	02	$446.00
27675	Repair lower leg tendons	02	$446.00
27676	Repair lower leg tendons	03	$510.00
27680	Release of lower leg tendon	03	$510.00
27681	Release of lower leg tendons	02	$446.00
27685	Revision of lower leg tendon	03	$510.00
27686	Revise lower leg tendons	03	$510.00
27687	Revision of calf tendon	03	$510.00
27690	Revise lower leg tendon	04	$630.00
27691	Revise lower leg tendon	04	$630.00
27692	Revise additional leg tendon	03	$510.00
27695	Repair of ankle ligament	02	$446.00
27696	Repair of ankle ligaments	02	$446.00
27698	Repair of ankle ligament	02	$446.00
27700	Revision of ankle joint	05	$717.00
27704	Removal of ankle implant	02	$446.00
27705	Incision of tibia	02	$446.00
27707	Incision of fibula	02	$446.00
27709	Incision of tibia & fibula	02	$446.00
27730	Repair of tibia epiphysis	02	$446.00
27732	Repair of fibula epiphysis	02	$446.00
27734	Repair lower leg epiphyses	02	$446.00
27740	Repair of leg epiphyses	02	$446.00
27742	Repair of leg epiphyses	02	$446.00
27745	Reinforce tibia	03	$510.00
27750	Treatment of tibia fracture	19	$103.62
27752	Treatment of tibia fracture	19	$103.62
27756	Treatment of tibia fracture	03	$510.00
27758	Treatment of tibia fracture	04	$630.00
27759	Treatment of tibia fracture	04	$630.00
27760	Treatment of ankle fracture	19	$103.62
27762	Treatment of ankle fracture	19	$103.62
27766	Treatment of ankle fracture	03	$510.00
27780	Treatment of fibula fracture	19	$103.62
27781	Treatment of fibula fracture	19	$103.62
27784	Treatment of fibula fracture	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
27786	Treatment of ankle fracture	19	$103.62
27788	Treatment of ankle fracture	19	$103.62
27792	Treatment of ankle fracture	03	$510.00
27808	Treatment of ankle fracture	19	$103.62
27810	Treatment of ankle fracture	19	$103.62
27814	Treatment of ankle fracture	03	$510.00
27816	Treatment of ankle fracture	19	$103.62
27818	Treatment of ankle fracture	19	$103.62
27822	Treatment of ankle fracture	03	$510.00
27823	Treatment of ankle fracture	03	$510.00
27824	Treat lower leg fracture	19	$103.62
27825	Treat lower leg fracture	19	$103.62
27826	Treat lower leg fracture	03	$510.00
27827	Treat lower leg fracture	03	$510.00
27828	Treat lower leg fracture	04	$630.00
27829	Treat lower leg joint	02	$446.00
27830	Treat lower leg dislocation	19	$103.62
27831	Treat lower leg dislocation	19	$103.62
27832	Treat lower leg dislocation	02	$446.00
27840	Treat ankle dislocation	19	$103.62
27842	Treat ankle dislocation	01	$333.00
27846	Treat ankle dislocation	03	$510.00
27848	Treat ankle dislocation	03	$510.00
27860	Fixation of ankle joint	01	$333.00
27870	Fusion of ankle joint, open	04	$630.00
27871	Fusion of tibiofibular joint	04	$630.00
27884	Amputation follow-up surgery	03	$510.00
27889	Amputation of foot at ankle	03	$510.00
27892	Decompression of leg	03	$510.00
27893	Decompression of leg	03	$510.00
27894	Decompression of leg	03	$510.00
28002	Treatment of foot infection	03	$510.00
28003	Treatment of foot infection	03	$510.00
28005	Treat foot bone lesion	03	$510.00
28008	Incision of foot fascia	03	$510.00
28011	Incision of toe tendons	03	$510.00
28020	Exploration of foot joint	02	$446.00
28022	Exploration of foot joint	02	$446.00
28024	Exploration of toe joint	02	$446.00
28035	Decompression of tibia nerve	04	$630.00
28043	Excision of foot lesion	02	$446.00
28045	Excision of foot lesion	03	$510.00
28046	Resection of tumor, foot	03	$510.00
28050	Biopsy of foot joint lining	02	$446.00
28052	Biopsy of foot joint lining	02	$446.00
28054	Biopsy of toe joint lining	02	$446.00
28055	Neurectomy, foot	04	$630.00
28060	Partial removal, foot fascia	02	$446.00
28062	Removal of foot fascia	03	$510.00
28070	Removal of foot joint lining	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
28072	Removal of foot joint lining	03	$510.00
28080	Removal of foot lesion	03	$510.00
28086	Excise foot tendon sheath	02	$446.00
28088	Excise foot tendon sheath	02	$446.00
28090	Removal of foot lesion	03	$510.00
28092	Removal of toe lesions	03	$510.00
28100	Removal of ankle/heel lesion	02	$446.00
28102	Remove/graft foot lesion	03	$510.00
28103	Remove/graft foot lesion	03	$510.00
28104	Removal of foot lesion	02	$446.00
28106	Remove/graft foot lesion	03	$510.00
28107	Remove/graft foot lesion	03	$510.00
28108	Removal of toe lesions	02	$446.00
28110	Part removal of metatarsal	03	$510.00
28111	Part removal of metatarsal	03	$510.00
28112	Part removal of metatarsal	03	$510.00
28113	Part removal of metatarsal	03	$510.00
28114	Removal of metatarsal heads	03	$510.00
28116	Revision of foot	03	$510.00
28118	Removal of heel bone	04	$630.00
28119	Removal of heel spur	04	$630.00
28120	Part removal of ankle/heel	07	$995.00
28122	Partial removal of foot bone	03	$510.00
28126	Partial removal of toe	03	$510.00
28130	Removal of ankle bone	03	$510.00
28140	Removal of metatarsal	03	$510.00
28150	Removal of toe	03	$510.00
28153	Partial removal of toe	03	$510.00
28160	Partial removal of toe	03	$510.00
28171	Extensive foot surgery	03	$510.00
28173	Extensive foot surgery	03	$510.00
28175	Extensive foot surgery	03	$510.00
28192	Removal of foot foreign body	02	$446.00
28193	Removal of foot foreign body	51	$418.49
28200	Repair of foot tendon	03	$510.00
28202	Repair/graft of foot tendon	03	$510.00
28208	Repair of foot tendon	03	$510.00
28210	Repair/graft of foot tendon	03	$510.00
28222	Release of foot tendons	01	$333.00
28225	Release of foot tendon	01	$333.00
28226	Release of foot tendons	01	$333.00
28234	Incision of foot tendon	02	$446.00
28238	Revision of foot tendon	03	$510.00
28240	Release of big toe	02	$446.00
28250	Revision of foot fascia	03	$510.00
28260	Release of midfoot joint	03	$510.00
28261	Revision of foot tendon	03	$510.00
28262	Revision of foot and ankle	04	$630.00
28264	Release of midfoot joint	01	$333.00
28270	Release of foot contracture	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
28280	Fusion of toes	02	$446.00
28285	Repair of hammertoe	03	$510.00
28286	Repair of hammertoe	04	$630.00
28288	Partial removal of foot bone	03	$510.00
28289	Repair hallux rigidus	03	$510.00
28290	Correction of bunion	02	$446.00
28292	Correction of bunion	02	$446.00
28293	Correction of bunion	03	$510.00
28294	Correction of bunion	03	$510.00
28296	Correction of bunion	03	$510.00
28297	Correction of bunion	03	$510.00
28298	Correction of bunion	03	$510.00
28299	Correction of bunion	05	$717.00
28300	Incision of heel bone	02	$446.00
28302	Incision of ankle bone	02	$446.00
28304	Incision of midfoot bones	02	$446.00
28305	Incise/graft midfoot bones	03	$510.00
28306	Incision of metatarsal	04	$630.00
28307	Incision of metatarsal	04	$630.00
28308	Incision of metatarsal	02	$446.00
28309	Incision of metatarsals	04	$630.00
28310	Revision of big toe	03	$510.00
28312	Revision of toe	03	$510.00
28313	Repair deformity of toe	02	$446.00
28315	Removal of sesamoid bone	04	$630.00
28320	Repair of foot bones	04	$630.00
28322	Repair of metatarsals	04	$630.00
28340	Resect enlarged toe tissue	04	$630.00
28341	Resect enlarged toe	04	$630.00
28344	Repair extra toe(s)	04	$630.00
28345	Repair webbed toe(s)	04	$630.00
28400	Treatment of heel fracture	19	$103.62
28405	Treatment of heel fracture	19	$103.62
28406	Treatment of heel fracture	02	$446.00
28415	Treat heel fracture	03	$510.00
28420	Treat/graft heel fracture	04	$630.00
28435	Treatment of ankle fracture	19	$103.62
28436	Treatment of ankle fracture	02	$446.00
28445	Treat ankle fracture	03	$510.00
28456	Treat midfoot fracture	02	$446.00
28465	Treat midfoot fracture, each	03	$510.00
28476	Treat metatarsal fracture	02	$446.00
28485	Treat metatarsal fracture	04	$630.00
28496	Treat big toe fracture	02	$446.00
28505	Treat big toe fracture	03	$510.00
28525	Treat toe fracture	03	$510.00
28531	Treat sesamoid bone fracture	03	$510.00
28545	Treat foot dislocation	01	$333.00
28546	Treat foot dislocation	02	$446.00
28555	Repair foot dislocation	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
28575	Treat foot dislocation	19	$103.62
28576	Treat foot dislocation	03	$510.00
28585	Repair foot dislocation	03	$510.00
28605	Treat foot dislocation	19	$103.62
28606	Treat foot dislocation	02	$446.00
28615	Repair foot dislocation	03	$510.00
28635	Treat toe dislocation	01	$333.00
28636	Treat toe dislocation	03	$510.00
28645	Repair toe dislocation	03	$510.00
28665	Treat toe dislocation	01	$333.00
28666	Treat toe dislocation	03	$510.00
28675	Repair of toe dislocation	03	$510.00
28705	Fusion of foot bones	04	$630.00
28715	Fusion of foot bones	04	$630.00
28725	Fusion of foot bones	04	$630.00
28730	Fusion of foot bones	04	$630.00
28735	Fusion of foot bones	04	$630.00
28737	Revision of foot bones	05	$717.00
28740	Fusion of foot bones	04	$630.00
28750	Fusion of big toe joint	04	$630.00
28755	Fusion of big toe joint	04	$630.00
28760	Fusion of big toe joint	04	$630.00
28810	Amputation toe & metatarsal	02	$446.00
28820	Amputation of toe	02	$446.00
28825	Partial amputation of toe	02	$446.00
29800	Jaw arthroscopy/surgery	03	$510.00
29804	Jaw arthroscopy/surgery	03	$510.00
29805	Shoulder arthroscopy, dx	03	$510.00
29806	Shoulder arthroscopy/surgery	03	$510.00
29807	Shoulder arthroscopy/surgery	03	$510.00
29819	Shoulder arthroscopy/surgery	03	$510.00
29820	Shoulder arthroscopy/surgery	03	$510.00
29821	Shoulder arthroscopy/surgery	03	$510.00
29822	Shoulder arthroscopy/surgery	03	$510.00
29823	Shoulder arthroscopy/surgery	03	$510.00
29824	Shoulder arthroscopy/surgery	05	$717.00
29825	Shoulder arthroscopy/surgery	03	$510.00
29826	Shoulder arthroscopy/surgery	03	$510.00
29827	Arthroscop rotator cuff repr	05	$717.00
29830	Elbow arthroscopy	03	$510.00
29834	Elbow arthroscopy/surgery	03	$510.00
29835	Elbow arthroscopy/surgery	03	$510.00
29836	Elbow arthroscopy/surgery	03	$510.00
29837	Elbow arthroscopy/surgery	03	$510.00
29838	Elbow arthroscopy/surgery	03	$510.00
29840	Wrist arthroscopy	03	$510.00
29843	Wrist arthroscopy/surgery	03	$510.00
29844	Wrist arthroscopy/surgery	03	$510.00
29845	Wrist arthroscopy/surgery	03	$510.00
29846	Wrist arthroscopy/surgery	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
29847	Wrist arthroscopy/surgery	03	$510.00
29848	Wrist endoscopy/surgery	09	$1,339.00
29850	Knee arthroscopy/surgery	04	$630.00
29851	Knee arthroscopy/surgery	04	$630.00
29855	Tibial arthroscopy/surgery	04	$630.00
29856	Tibial arthroscopy/surgery	04	$630.00
29860	Hip arthroscopy, dx	04	$630.00
29861	Hip arthroscopy/surgery	04	$630.00
29862	Hip arthroscopy/surgery	09	$1,339.00
29863	Hip arthroscopy/surgery	04	$630.00
29870	Knee arthroscopy, dx	03	$510.00
29871	Knee arthroscopy/drainage	03	$510.00
29873	Knee arthroscopy/surgery	03	$510.00
29874	Knee arthroscopy/surgery	03	$510.00
29875	Knee arthroscopy/surgery	04	$630.00
29876	Knee arthroscopy/surgery	04	$630.00
29877	Knee arthroscopy/surgery	04	$630.00
29879	Knee arthroscopy/surgery	03	$510.00
29880	Knee arthroscopy/surgery	04	$630.00
29881	Knee arthroscopy/surgery	04	$630.00
29882	Knee arthroscopy/surgery	03	$510.00
29883	Knee arthroscopy/surgery	03	$510.00
29884	Knee arthroscopy/surgery	03	$510.00
29885	Knee arthroscopy/surgery	03	$510.00
29886	Knee arthroscopy/surgery	03	$510.00
29887	Knee arthroscopy/surgery	03	$510.00
29888	Knee arthroscopy/surgery	03	$510.00
29889	Knee arthroscopy/surgery	03	$510.00
29891	Ankle arthroscopy/surgery	03	$510.00
29892	Ankle arthroscopy/surgery	03	$510.00
29893	Scope, plantar fasciotomy	55	$1,255.56
29894	Ankle arthroscopy/surgery	03	$510.00
29895	Ankle arthroscopy/surgery	03	$510.00
29897	Ankle arthroscopy/surgery	03	$510.00
29898	Ankle arthroscopy/surgery	03	$510.00
29899	Ankle arthroscopy/surgery	03	$510.00
29900	Mcp joint arthroscopy, dx	03	$510.00
29901	Mcp joint arthroscopy, surg	03	$510.00
29902	Mcp joint arthroscopy, surg	03	$510.00
30115	Removal of nose polyp(s)	02	$446.00
30117	Removal of intranasal lesion	03	$510.00
30118	Removal of intranasal lesion	03	$510.00
30120	Revision of nose	01	$333.00
30125	Removal of nose lesion	02	$446.00
30130	Excise inferior turbinate	03	$510.00
30140	Resect inferior turbinate	02	$446.00
30150	Partial removal of nose	03	$510.00
30160	Removal of nose	04	$630.00
30220	Insert nasal septal button	53	$464.15
30310	Remove nasal foreign body	01	$333.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
30320	Remove nasal foreign body	02	$446.00
30400	Reconstruction of nose	04	$630.00
30410	Reconstruction of nose	05	$717.00
30420	Reconstruction of nose	05	$717.00
30430	Revision of nose	03	$510.00
30435	Revision of nose	05	$717.00
30450	Revision of nose	07	$995.00
30460	Revision of nose	07	$995.00
30462	Revision of nose	09	$1,339.00
30465	Repair nasal stenosis	09	$1,339.00
30520	Repair of nasal septum	04	$630.00
30540	Repair nasal defect	05	$717.00
30545	Repair nasal defect	05	$717.00
30560	Release of nasal adhesions	27	$150.72
30580	Repair upper jaw fistula	04	$630.00
30600	Repair mouth/nose fistula	04	$630.00
30620	Intranasal reconstruction	07	$995.00
30630	Repair nasal septum defect	07	$995.00
30801	Ablate inf turbinate, superf	01	$333.00
30802	Cauterization, inner nose	01	$333.00
30903	Control of nosebleed	14	$72.48
30905	Control of nosebleed	14	$72.48
30906	Repeat control of nosebleed	14	$72.48
30915	Ligation, nasal sinus artery	02	$446.00
30920	Ligation, upper jaw artery	03	$510.00
30930	Ther fx, nasal inf turbinate	04	$630.00
31020	Exploration, maxillary sinus	02	$446.00
31030	Exploration, maxillary sinus	03	$510.00
31032	Explore sinus, remove polyps	04	$630.00
31050	Exploration, sphenoid sinus	02	$446.00
31051	Sphenoid sinus surgery	04	$630.00
31070	Exploration of frontal sinus	02	$446.00
31075	Exploration of frontal sinus	04	$630.00
31080	Removal of frontal sinus	04	$630.00
31081	Removal of frontal sinus	04	$630.00
31084	Removal of frontal sinus	04	$630.00
31085	Removal of frontal sinus	04	$630.00
31086	Removal of frontal sinus	04	$630.00
31087	Removal of frontal sinus	04	$630.00
31090	Exploration of sinuses	05	$717.00
31200	Removal of ethmoid sinus	02	$446.00
31201	Removal of ethmoid sinus	05	$717.00
31205	Removal of ethmoid sinus	03	$510.00
31233	Nasal/sinus endoscopy, dx	15	$86.39
31235	Nasal/sinus endoscopy, dx	01	$333.00
31237	Nasal/sinus endoscopy, surg	02	$446.00
31238	Nasal/sinus endoscopy, surg	01	$333.00
31239	Nasal/sinus endoscopy, surg	04	$630.00
31240	Nasal/sinus endoscopy, surg	02	$446.00
31254	Revision of ethmoid sinus	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
31255	Removal of ethmoid sinus	05	$717.00
31256	Exploration maxillary sinus	03	$510.00
31267	Endoscopy, maxillary sinus	03	$510.00
31276	Sinus endoscopy, surgical	03	$510.00
31287	Nasal/sinus endoscopy, surg	03	$510.00
31288	Nasal/sinus endoscopy, surg	03	$510.00
31300	Removal of larynx lesion	05	$717.00
31320	Diagnostic incision, larynx	02	$446.00
31400	Revision of larynx	02	$446.00
31420	Removal of epiglottis	02	$446.00
31510	Laryngoscopy with biopsy	02	$446.00
31511	Remove foreign body, larynx	15	$86.39
31512	Removal of larynx lesion	02	$446.00
31513	Injection into vocal cord	15	$86.39
31515	Laryngoscopy for aspiration	01	$333.00
31525	Dx laryngoscopy excl nb	01	$333.00
31526	Dx laryngoscopy w/oper scope	02	$446.00
31527	Laryngoscopy for treatment	01	$333.00
31528	Laryngoscopy and dilation	02	$446.00
31529	Laryngoscopy and dilation	02	$446.00
31530	Laryngoscopy w/fb removal	02	$446.00
31531	Laryngoscopy w/fb & op scope	03	$510.00
31535	Laryngoscopy w/biopsy	02	$446.00
31536	Laryngoscopy w/bx & op scope	03	$510.00
31540	Laryngoscopy w/exc of tumor	03	$510.00
31541	Larynscop w/tumr exc + scope	04	$630.00
31545	Remove vc lesion w/scope	04	$630.00
31546	Remove vc lesion scope/graft	04	$630.00
31560	Laryngoscop w/arytenoidectom	05	$717.00
31561	Larynscop, remve cart + scop	05	$717.00
31570	Laryngoscope w/vc inj	02	$446.00
31571	Laryngoscop w/vc inj + scope	02	$446.00
31576	Laryngoscopy with biopsy	02	$446.00
31577	Remove foreign body, larynx	33	$236.42
31578	Removal of larynx lesion	02	$446.00
31580	Revision of larynx	05	$717.00
31582	Revision of larynx	05	$717.00
31588	Revision of larynx	05	$717.00
31590	Reinnervate larynx	05	$717.00
31595	Larynx nerve surgery	02	$446.00
31603	Incision of windpipe	01	$333.00
31611	Surgery/speech prosthesis	03	$510.00
31612	Puncture/clear windpipe	01	$333.00
31613	Repair windpipe opening	02	$446.00
31614	Repair windpipe opening	02	$446.00
31615	Visualization of windpipe	01	$333.00
31620	Endobronchial us add-on	01	$333.00
31622	Dx bronchoscope/wash	01	$333.00
31623	Dx bronchoscope/brush	02	$446.00
31624	Dx bronchoscope/lavage	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
31625	Bronchoscopy w/biopsy(s)	02	$446.00
31628	Bronchoscopy/lung bx, each	02	$446.00
31629	Bronchoscopy/needle bx, each	02	$446.00
31630	Bronchoscopy dilate/fx repr	02	$446.00
31631	Bronchoscopy, dilate w/stent	02	$446.00
31635	Bronchoscopy w/fb removal	02	$446.00
31636	Bronchoscopy, bronch stents	02	$446.00
31637	Bronchoscopy, stent add-on	01	$333.00
31638	Bronchoscopy, revise stent	02	$446.00
31640	Bronchoscopy w/tumor excise	02	$446.00
31641	Bronchoscopy, treat blockage	02	$446.00
31643	Diag bronchoscope/catheter	02	$446.00
31645	Bronchoscopy, clear airways	01	$333.00
31646	Bronchoscopy, reclear airway	01	$333.00
31656	Bronchoscopy, inj for x-ray	01	$333.00
31717	Bronchial brush biopsy	33	$236.42
31720	Clearance of airways	11	$47.32
31730	Intro, windpipe wire/tube	33	$236.42
31750	Repair of windpipe	05	$717.00
31755	Repair of windpipe	02	$446.00
31820	Closure of windpipe lesion	01	$333.00
31825	Repair of windpipe defect	02	$446.00
31830	Revise windpipe scar	02	$446.00
32000	Drainage of chest	32	$222.78
32400	Needle biopsy chest lining	01	$333.00
32405	Biopsy, lung or mediastinum	01	$333.00
32420	Puncture/clear lung	32	$222.78
33010	Drainage of heart sac	32	$222.78
33011	Repeat drainage of heart sac	32	$222.78
33212	Insertion of pulse generator	03	$510.00
33213	Insertion of pulse generator	03	$510.00
33222	Revise pocket, pacemaker	02	$446.00
33223	Revise pocket, pacing-defib	02	$446.00
33233	Removal of pacemaker system	02	$446.00
35188	Repair blood vessel lesion	04	$630.00
35207	Repair blood vessel lesion	04	$630.00
35875	Removal of clot in graft	09	$1,339.00
35876	Removal of clot in graft	09	$1,339.00
36260	Insertion of infusion pump	03	$510.00
36261	Revision of infusion pump	02	$446.00
36262	Removal of infusion pump	01	$333.00
36475	Endovenous rf, 1st vein	09	$1,339.00
36476	Endovenous rf, vein add-on	09	$1,339.00
36478	Endovenous laser, 1st vein	09	$1,339.00
36479	Endovenous laser vein addon	09	$1,339.00
36555	Insert non-tunnel cv cath	01	$333.00
36556	Insert non-tunnel cv cath	01	$333.00
36557	Insert tunneled cv cath	02	$446.00
36558	Insert tunneled cv cath	02	$446.00
36560	Insert tunneled cv cath	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
36561	Insert tunneled cv cath	03	$510.00
36563	Insert tunneled cv cath	03	$510.00
36565	Insert tunneled cv cath	03	$510.00
36566	Insert tunneled cv cath	03	$510.00
36568	Insert picc cath	01	$333.00
36569	Insert picc cath	01	$333.00
36570	Insert picvad cath	03	$510.00
36571	Insert picvad cath	03	$510.00
36575	Repair tunneled cv cath	02	$446.00
36576	Repair tunneled cv cath	02	$446.00
36578	Replace tunneled cv cath	02	$446.00
36580	Replace cvad cath	01	$333.00
36581	Replace tunneled cv cath	02	$446.00
36582	Replace tunneled cv cath	03	$510.00
36583	Replace tunneled cv cath	03	$510.00
36584	Replace picc cath	01	$333.00
36585	Replace picvad cath	03	$510.00
36589	Removal tunneled cv cath	01	$333.00
36590	Removal tunneled cv cath	01	$333.00
36640	Insertion catheter, artery	01	$333.00
36800	Insertion of cannula	03	$510.00
36810	Insertion of cannula	03	$510.00
36815	Insertion of cannula	03	$510.00
36818	Av fuse, uppr arm, cephalic	03	$510.00
36819	Av fuse, uppr arm, basilic	03	$510.00
36820	Av fusion/forearm vein	03	$510.00
36821	Av fusion direct any site	03	$510.00
36825	Artery-vein autograft	04	$630.00
36830	Artery-vein nonautograft	04	$630.00
36831	Open thrombect av fistula	09	$1,339.00
36832	Av fistula revision, open	04	$630.00
36833	Av fistula revision	04	$630.00
36834	Repair A-V aneurysm	03	$510.00
36835	Artery to vein shunt	04	$630.00
36860	External cannula declotting	22	$127.40
36861	Cannula declotting	03	$510.00
36870	Percut thrombect av fistula	09	$1,339.00
37500	Endoscopy ligate perf veins	03	$510.00
37607	Ligation of a-v fistula	03	$510.00
37609	Temporal artery procedure	02	$446.00
37650	Revision of major vein	02	$446.00
37700	Revise leg vein	02	$446.00
37718	Ligate/strip short leg vein	03	$510.00
37722	Ligate/strip long leg vein	03	$510.00
37735	Removal of leg veins/lesion	03	$510.00
37760	Ligation, leg veins, open	03	$510.00
37780	Revision of leg vein	03	$510.00
37785	Ligate/divide/excise vein	03	$510.00
37790	Penile venous occlusion	03	$510.00
38300	Drainage, lymph node lesion	01	$333.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
38305	Drainage, lymph node lesion	02	$446.00
38308	Incision of lymph channels	02	$446.00
38500	Biopsy/removal, lymph nodes	02	$446.00
38505	Needle biopsy, lymph nodes	34	$240.00
38510	Biopsy/removal, lymph nodes	02	$446.00
38520	Biopsy/removal, lymph nodes	02	$446.00
38525	Biopsy/removal, lymph nodes	02	$446.00
38530	Biopsy/removal, lymph nodes	02	$446.00
38542	Explore deep node(s), neck	02	$446.00
38550	Removal, neck/armpit lesion	03	$510.00
38555	Removal, neck/armpit lesion	04	$630.00
38570	Laparoscopy, lymph node biop	09	$1,339.00
38571	Laparoscopy, lymphadenectomy	09	$1,339.00
38572	Laparoscopy, lymphadenectomy	09	$1,339.00
38740	Remove armpit lymph nodes	02	$446.00
38745	Remove armpit lymph nodes	04	$630.00
38760	Remove groin lymph nodes	02	$446.00
40500	Partial excision of lip	02	$446.00
40510	Partial excision of lip	02	$446.00
40520	Partial excision of lip	02	$446.00
40525	Reconstruct lip with flap	02	$446.00
40527	Reconstruct lip with flap	02	$446.00
40530	Partial removal of lip	02	$446.00
40650	Repair lip	53	$464.15
40652	Repair lip	53	$464.15
40654	Repair lip	53	$464.15
40700	Repair cleft lip/nasal	07	$995.00
40701	Repair cleft lip/nasal	07	$995.00
40720	Repair cleft lip/nasal	07	$995.00
40761	Repair cleft lip/nasal	03	$510.00
40801	Drainage of mouth lesion	02	$446.00
40814	Excise/repair mouth lesion	02	$446.00
40816	Excision of mouth lesion	02	$446.00
40818	Excise oral mucosa for graft	27	$150.72
40819	Excise lip or cheek fold	01	$333.00
40831	Repair mouth laceration	01	$333.00
40840	Reconstruction of mouth	02	$446.00
40842	Reconstruction of mouth	03	$510.00
40843	Reconstruction of mouth	03	$510.00
40844	Reconstruction of mouth	05	$717.00
40845	Reconstruction of mouth	05	$717.00
41005	Drainage of mouth lesion	27	$150.72
41006	Drainage of mouth lesion	01	$333.00
41007	Drainage of mouth lesion	01	$333.00
41008	Drainage of mouth lesion	01	$333.00
41009	Drainage of mouth lesion	27	$150.72
41010	Incision of tongue fold	01	$333.00
41015	Drainage of mouth lesion	27	$150.72
41016	Drainage of mouth lesion	01	$333.00
41017	Drainage of mouth lesion	01	$333.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
41018	Drainage of mouth lesion	01	$333.00
41112	Excision of tongue lesion	02	$446.00
41113	Excision of tongue lesion	02	$446.00
41114	Excision of tongue lesion	02	$446.00
41116	Excision of mouth lesion	01	$333.00
41120	Partial removal of tongue	05	$717.00
41250	Repair tongue laceration	27	$150.72
41251	Repair tongue laceration	27	$150.72
41252	Repair tongue laceration	02	$446.00
41500	Fixation of tongue	01	$333.00
41510	Tongue to lip surgery	01	$333.00
41520	Reconstruction, tongue fold	02	$446.00
41800	Drainage of gum lesion	16	$88.46
41827	Excision of gum lesion	02	$446.00
42000	Drainage mouth roof lesion	27	$150.72
42107	Excision lesion, mouth roof	02	$446.00
42120	Remove palate/lesion	04	$630.00
42140	Excision of uvula	02	$446.00
42145	Repair palate, pharynx/uvula	05	$717.00
42180	Repair palate	27	$150.72
42182	Repair palate	02	$446.00
42200	Reconstruct cleft palate	05	$717.00
42205	Reconstruct cleft palate	05	$717.00
42210	Reconstruct cleft palate	05	$717.00
42215	Reconstruct cleft palate	07	$995.00
42220	Reconstruct cleft palate	05	$717.00
42226	Lengthening of palate	05	$717.00
42235	Repair palate	05	$717.00
42260	Repair nose to lip fistula	04	$630.00
42300	Drainage of salivary gland	01	$333.00
42305	Drainage of salivary gland	02	$446.00
42310	Drainage of salivary gland	27	$150.72
42320	Drainage of salivary gland	27	$150.72
42340	Removal of salivary stone	02	$446.00
42405	Biopsy of salivary gland	02	$446.00
42408	Excision of salivary cyst	03	$510.00
42409	Drainage of salivary cyst	03	$510.00
42410	Excise parotid gland/lesion	03	$510.00
42415	Excise parotid gland/lesion	07	$995.00
42420	Excise parotid gland/lesion	07	$995.00
42425	Excise parotid gland/lesion	07	$995.00
42440	Excise submaxillary gland	03	$510.00
42450	Excise sublingual gland	02	$446.00
42500	Repair salivary duct	03	$510.00
42505	Repair salivary duct	04	$630.00
42507	Parotid duct diversion	03	$510.00
42508	Parotid duct diversion	04	$630.00
42509	Parotid duct diversion	04	$630.00
42510	Parotid duct diversion	04	$630.00
42600	Closure of salivary fistula	01	$333.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
42665	Ligation of salivary duct	07	$995.00
42700	Drainage of tonsil abscess	27	$150.72
42720	Drainage of throat abscess	01	$333.00
42725	Drainage of throat abscess	02	$446.00
42802	Biopsy of throat	01	$333.00
42804	Biopsy of upper nose/throat	01	$333.00
42806	Biopsy of upper nose/throat	02	$446.00
42808	Excise pharynx lesion	02	$446.00
42810	Excision of neck cyst	03	$510.00
42815	Excision of neck cyst	05	$717.00
42820	Remove tonsils and adenoids	03	$510.00
42821	Remove tonsils and adenoids	05	$717.00
42825	Removal of tonsils	04	$630.00
42826	Removal of tonsils	04	$630.00
42830	Removal of adenoids	04	$630.00
42831	Removal of adenoids	04	$630.00
42835	Removal of adenoids	04	$630.00
42836	Removal of adenoids	04	$630.00
42860	Excision of tonsil tags	03	$510.00
42870	Excision of lingual tonsil	03	$510.00
42890	Partial removal of pharynx	07	$995.00
42892	Revision of pharyngeal walls	07	$995.00
42900	Repair throat wound	01	$333.00
42950	Reconstruction of throat	02	$446.00
42955	Surgical opening of throat	02	$446.00
42960	Control throat bleeding	14	$72.48
42962	Control throat bleeding	02	$446.00
42972	Control nose/throat bleeding	03	$510.00
43200	Esophagus endoscopy	01	$333.00
43201	Esoph scope w/submucous inj	01	$333.00
43202	Esophagus endoscopy, biopsy	01	$333.00
43204	Esoph scope w/sclerosis inj	01	$333.00
43205	Esophagus endoscopy/ligation	01	$333.00
43215	Esophagus endoscopy	01	$333.00
43216	Esophagus endoscopy/lesion	01	$333.00
43217	Esophagus endoscopy	01	$333.00
43219	Esophagus endoscopy	01	$333.00
43220	Esoph endoscopy, dilation	01	$333.00
43226	Esoph endoscopy, dilation	01	$333.00
43227	Esoph endoscopy, repair	02	$446.00
43228	Esoph endoscopy, ablation	02	$446.00
43231	Esoph endoscopy w/us exam	02	$446.00
43232	Esoph endoscopy w/us fn bx	02	$446.00
43234	Upper GI endoscopy, exam	01	$333.00
43235	Uppr gi endoscopy, diagnosis	01	$333.00
43236	Uppr gi scope w/submuc inj	02	$446.00
43237	Endoscopic us exam, esoph	02	$446.00
43238	Uppr gi endoscopy w/us fn bx	02	$446.00
43239	Upper GI endoscopy, biopsy	02	$446.00
43240	Esoph endoscope w/drain cyst	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
43241	Upper GI endoscopy with tube	02	$446.00
43242	Uppr gi endoscopy w/us fn bx	02	$446.00
43243	Upper gi endoscopy & inject	02	$446.00
43244	Upper GI endoscopy/ligation	02	$446.00
43245	Uppr gi scope dilate strictr	02	$446.00
43246	Place gastrostomy tube	02	$446.00
43247	Operative upper GI endoscopy	02	$446.00
43248	Uppr gi endoscopy/guide wire	02	$446.00
43249	Esoph endoscopy, dilation	02	$446.00
43250	Upper GI endoscopy/tumor	02	$446.00
43251	Operative upper GI endoscopy	02	$446.00
43255	Operative upper GI endoscopy	02	$446.00
43256	Uppr gi endoscopy w/stent	03	$510.00
43257	Uppr gi scope w/thrml txmnt	03	$510.00
43258	Operative upper GI endoscopy	03	$510.00
43259	Endoscopic ultrasound exam	03	$510.00
43260	Endo cholangiopancreatograph	02	$446.00
43261	Endo cholangiopancreatograph	02	$446.00
43262	Endo cholangiopancreatograph	02	$446.00
43263	Endo cholangiopancreatograph	02	$446.00
43264	Endo cholangiopancreatograph	02	$446.00
43265	Endo cholangiopancreatograph	02	$446.00
43267	Endo cholangiopancreatograph	02	$446.00
43268	Endo cholangiopancreatograph	02	$446.00
43269	Endo cholangiopancreatograph	02	$446.00
43271	Endo cholangiopancreatograph	02	$446.00
43272	Endo cholangiopancreatograph	02	$446.00
43450	Dilate esophagus	01	$333.00
43453	Dilate esophagus	01	$333.00
43456	Dilate esophagus	43	$335.41
43458	Dilate esophagus	43	$335.41
43600	Biopsy of stomach	01	$333.00
43653	Laparoscopy, gastrostomy	09	$1,339.00
43750	Place gastrostomy tube	02	$446.00
43760	Change gastrostomy tube	26	$144.98
43761	Reposition gastrostomy tube	01	$333.00
43870	Repair stomach opening	01	$333.00
44100	Biopsy of bowel	01	$333.00
44312	Revision of ileostomy	01	$333.00
44340	Revision of colostomy	03	$510.00
44360	Small bowel endoscopy	02	$446.00
44361	Small bowel endoscopy/biopsy	02	$446.00
44363	Small bowel endoscopy	02	$446.00
44364	Small bowel endoscopy	02	$446.00
44365	Small bowel endoscopy	02	$446.00
44366	Small bowel endoscopy	02	$446.00
44369	Small bowel endoscopy	02	$446.00
44370	Small bowel endoscopy/stent	09	$1,339.00
44372	Small bowel endoscopy	02	$446.00
44373	Small bowel endoscopy	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
44376	Small bowel endoscopy	02	$446.00
44377	Small bowel endoscopy/biopsy	02	$446.00
44378	Small bowel endoscopy	02	$446.00
44379	Sbowel endoscope w/stent	09	$1,339.00
44380	Small bowel endoscopy	01	$333.00
44382	Small bowel endoscopy	01	$333.00
44383	Ileoscopy w/stent	09	$1,339.00
44385	Endoscopy of bowel pouch	01	$333.00
44386	Endoscopy, bowel pouch/biop	01	$333.00
44388	Colonoscopy	01	$333.00
44389	Colonoscopy with biopsy	01	$333.00
44390	Colonoscopy for foreign body	01	$333.00
44391	Colonoscopy for bleeding	01	$333.00
44392	Colonoscopy & polypectomy	01	$333.00
44393	Colonoscopy, lesion removal	01	$333.00
44394	Colonoscopy w/snare	01	$333.00
44397	Colonoscopy w/stent	01	$333.00
45000	Drainage of pelvic abscess	40	$312.07
45005	Drainage of rectal abscess	02	$446.00
45020	Drainage of rectal abscess	02	$446.00
45100	Biopsy of rectum	01	$333.00
45108	Removal of anorectal lesion	02	$446.00
45150	Excision of rectal stricture	02	$446.00
45160	Excision of rectal lesion	02	$446.00
45170	Excision of rectal lesion	02	$446.00
45190	Destruction, rectal tumor	09	$1,339.00
45305	Proctosigmoidoscopy w/bx	01	$333.00
45307	Proctosigmoidoscopy fb	01	$333.00
45308	Proctosigmoidoscopy removal	01	$333.00
45309	Proctosigmoidoscopy removal	01	$333.00
45315	Proctosigmoidoscopy removal	01	$333.00
45317	Proctosigmoidoscopy bleed	01	$333.00
45320	Proctosigmoidoscopy ablate	01	$333.00
45321	Proctosigmoidoscopy volvul	01	$333.00
45327	Proctosigmoidoscopy w/stent	01	$333.00
45331	Sigmoidoscopy and biopsy	38	$299.24
45332	Sigmoidoscopy w/fb removal	38	$299.24
45333	Sigmoidoscopy & polypectomy	01	$333.00
45334	Sigmoidoscopy for bleeding	01	$333.00
45335	Sigmoidoscopy w/submuc inj	38	$299.24
45337	Sigmoidoscopy & decompress	38	$299.24
45338	Sigmoidoscopy w/tumr remove	01	$333.00
45339	Sigmoidoscopy w/ablate tumr	01	$333.00
45340	Sig w/balloon dilation	01	$333.00
45341	Sigmoidoscopy w/ultrasound	01	$333.00
45342	Sigmoidoscopy w/us guide bx	01	$333.00
45345	Sigmoidoscopy w/stent	01	$333.00
45355	Surgical colonoscopy	01	$333.00
45378	Diagnostic colonoscopy	02	$446.00
45379	Colonoscopy w/fb removal	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
45380	Colonoscopy and biopsy	02	$446.00
45381	Colonoscopy, submucous inj	02	$446.00
45382	Colonoscopy/control bleeding	02	$446.00
45383	Lesion removal colonoscopy	02	$446.00
45384	Lesion remove colonoscopy	02	$446.00
45385	Lesion removal colonoscopy	02	$446.00
45386	Colonoscopy dilate stricture	02	$446.00
45387	Colonoscopy w/stent	01	$333.00
45391	Colonoscopy w/endoscope us	02	$446.00
45392	Colonoscopy w/endoscopic fnb	02	$446.00
45500	Repair of rectum	02	$446.00
45505	Repair of rectum	02	$446.00
45560	Repair of rectocele	02	$446.00
45900	Reduction of rectal prolapse	40	$312.07
45905	Dilation of anal sphincter	01	$333.00
45910	Dilation of rectal narrowing	01	$333.00
45915	Remove rectal obstruction	40	$312.07
45990	Surg dx exam, anorectal	40	$312.07
46020	Placement of seton	03	$510.00
46030	Removal of rectal marker	40	$312.07
46040	Incision of rectal abscess	03	$510.00
46045	Incision of rectal abscess	02	$446.00
46050	Incision of anal abscess	40	$312.07
46060	Incision of rectal abscess	02	$446.00
46080	Incision of anal sphincter	03	$510.00
46200	Removal of anal fissure	02	$446.00
46210	Removal of anal crypt	02	$446.00
46211	Removal of anal crypts	02	$446.00
46220	Removal of anal tag	01	$333.00
46230	Removal of anal tags	01	$333.00
46250	Hemorrhoidectomy	03	$510.00
46255	Hemorrhoidectomy	03	$510.00
46257	Remove hemorrhoids & fissure	03	$510.00
46258	Remove hemorrhoids & fistula	03	$510.00
46260	Hemorrhoidectomy	03	$510.00
46261	Remove hemorrhoids & fissure	04	$630.00
46262	Remove hemorrhoids & fistula	04	$630.00
46270	Removal of anal fistula	03	$510.00
46275	Removal of anal fistula	03	$510.00
46280	Removal of anal fistula	04	$630.00
46285	Removal of anal fistula	01	$333.00
46288	Repair anal fistula	04	$630.00
46608	Anoscopy, remove for body	01	$333.00
46610	Anoscopy, remove lesion	01	$333.00
46611	Anoscopy	01	$333.00
46612	Anoscopy, remove lesions	01	$333.00
46615	Anoscopy	02	$446.00
46700	Repair of anal stricture	03	$510.00
46706	Repr of anal fistula w/glue	01	$333.00
46750	Repair of anal sphincter	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
46753	Reconstruction of anus	03	$510.00
46754	Removal of suture from anus	02	$446.00
46760	Repair of anal sphincter	02	$446.00
46761	Repair of anal sphincter	03	$510.00
46762	Implant artificial sphincter	07	$995.00
46917	Laser surgery, anal lesions	01	$333.00
46922	Excision of anal lesion(s)	01	$333.00
46924	Destruction, anal lesion(s)	01	$333.00
46937	Cryotherapy of rectal lesion	02	$446.00
46938	Cryotherapy of rectal lesion	02	$446.00
46946	Ligation of hemorrhoids	01	$333.00
46947	Hemorrhoidopexy by stapling	07	$995.00
47000	Needle biopsy of liver	01	$333.00
47510	Insert catheter, bile duct	02	$446.00
47511	Insert bile duct drain	56	$1,245.85
47525	Change bile duct catheter	01	$333.00
47530	Revise/reinsert bile tube	01	$333.00
47552	Biliary endoscopy thru skin	02	$446.00
47553	Biliary endoscopy thru skin	03	$510.00
47554	Biliary endoscopy thru skin	03	$510.00
47555	Biliary endoscopy thru skin	03	$510.00
47556	Biliary endoscopy thru skin	56	$1,245.85
47560	Laparoscopy w/cholangio	03	$510.00
47561	Laparo w/cholangio/biopsy	03	$510.00
47630	Remove bile duct stone	03	$510.00
48102	Needle biopsy, pancreas	01	$333.00
49080	Puncture, peritoneal cavity	32	$222.78
49081	Removal of abdominal fluid	32	$222.78
49180	Biopsy, abdominal mass	01	$333.00
49250	Excision of umbilicus	04	$630.00
49320	Diag laparo separate proc	03	$510.00
49321	Laparoscopy, biopsy	04	$630.00
49322	Laparoscopy, aspiration	04	$630.00
49402	Remove foreign body, adbomen	02	$446.00
49419	Insrt abdom cath for chemotx	01	$333.00
49420	Insert abdom drain, temp	01	$333.00
49421	Insert abdom drain, perm	01	$333.00
49422	Remove perm cannula/catheter	01	$333.00
49426	Revise abdomen-venous shunt	02	$446.00
49495	Rpr ing hernia baby, reduc	04	$630.00
49496	Rpr ing hernia baby, blocked	04	$630.00
49500	Rpr ing hernia, init, reduce	04	$630.00
49501	Rpr ing hernia, init blocked	09	$1,339.00
49505	Prp i/hern init reduc >5 yr	04	$630.00
49507	Prp i/hern init block >5 yr	09	$1,339.00
49520	Rerepair ing hernia, reduce	07	$995.00
49521	Rerepair ing hernia, blocked	09	$1,339.00
49525	Repair ing hernia, sliding	04	$630.00
49540	Repair lumbar hernia	02	$446.00
49550	Rpr rem hernia, init, reduce	05	$717.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
49553	Rpr fem hernia, init blocked	09	$1,339.00
49555	Rerepair fem hernia, reduce	05	$717.00
49557	Rerepair fem hernia, blocked	09	$1,339.00
49560	Rpr ventral hern init, reduc	04	$630.00
49561	Rpr ventral hern init, block	09	$1,339.00
49565	Rerepair ventrl hern, reduce	04	$630.00
49566	Rerepair ventrl hern, block	09	$1,339.00
49568	Hernia repair w/mesh	07	$995.00
49570	Rpr epigastric hern, reduce	04	$630.00
49572	Rpr epigastric hern, blocked	09	$1,339.00
49580	Rpr umbil hern, reduc < 5 yr	04	$630.00
49582	Rpr umbil hern, block < 5 yr	09	$1,339.00
49585	Rpr umbil hern, reduc > 5 yr	04	$630.00
49587	Rpr umbil hern, block > 5 yr	09	$1,339.00
49590	Repair spigelian hernia	03	$510.00
49600	Repair umbilical lesion	04	$630.00
49650	Laparo hernia repair initial	04	$630.00
49651	Laparo hernia repair recur	07	$995.00
50200	Biopsy of kidney	01	$333.00
50390	Drainage of kidney lesion	01	$333.00
50392	Insert kidney drain	01	$333.00
50393	Insert ureteral tube	01	$333.00
50395	Create passage to kidney	01	$333.00
50396	Measure kidney pressure	23	$131.50
50398	Change kidney tube	01	$333.00
50551	Kidney endoscopy	01	$333.00
50553	Kidney endoscopy	01	$333.00
50555	Kidney endoscopy & biopsy	01	$333.00
50557	Kidney endoscopy & treatment	01	$333.00
50561	Kidney endoscopy & treatment	01	$333.00
50688	Change of ureter tube/stent	01	$333.00
50947	Laparo new ureter/bladder	09	$1,339.00
50948	Laparo new ureter/bladder	09	$1,339.00
50951	Endoscopy of ureter	01	$333.00
50953	Endoscopy of ureter	01	$333.00
50955	Ureter endoscopy & biopsy	01	$333.00
50957	Ureter endoscopy & treatment	01	$333.00
50961	Ureter endoscopy & treatment	01	$333.00
50970	Ureter endoscopy	01	$333.00
50972	Ureter endoscopy & catheter	01	$333.00
50974	Ureter endoscopy & biopsy	01	$333.00
50976	Ureter endoscopy & treatment	01	$333.00
50980	Ureter endoscopy & treatment	01	$333.00
51010	Drainage of bladder	01	$333.00
51020	Incise & treat bladder	04	$630.00
51030	Incise & treat bladder	04	$630.00
51040	Incise & drain bladder	04	$630.00
51045	Incise bladder/drain ureter	49	$399.24
51050	Removal of bladder stone	04	$630.00
51065	Remove ureter calculus	04	$630.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
51080	Drainage of bladder abscess	01	$333.00
51500	Removal of bladder cyst	04	$630.00
51520	Removal of bladder lesion	04	$630.00
51710	Change of bladder tube	01	$333.00
51715	Endoscopic injection/implant	03	$510.00
51726	Complex cystometrogram	31	$209.48
51772	Urethra pressure profile	23	$131.50
51785	Anal/urinary muscle study	12	$66.92
51880	Repair of bladder opening	01	$333.00
51992	Laparo sling operation	05	$717.00
52000	Cystoscopy	01	$333.00
52001	Cystoscopy, removal of clots	49	$399.24
52005	Cystoscopy & ureter catheter	02	$446.00
52007	Cystoscopy and biopsy	02	$446.00
52010	Cystoscopy & duct catheter	49	$399.24
52204	Cystoscopy w/biopsy(s)	02	$446.00
52214	Cystoscopy and treatment	02	$446.00
52224	Cystoscopy and treatment	02	$446.00
52234	Cystoscopy and treatment	02	$446.00
52235	Cystoscopy and treatment	03	$510.00
52240	Cystoscopy and treatment	03	$510.00
52250	Cystoscopy and radiotracer	04	$630.00
52260	Cystoscopy and treatment	02	$446.00
52270	Cystoscopy & revise urethra	02	$446.00
52275	Cystoscopy & revise urethra	02	$446.00
52276	Cystoscopy and treatment	03	$510.00
52277	Cystoscopy and treatment	02	$446.00
52281	Cystoscopy and treatment	02	$446.00
52282	Cystoscopy, implant stent	09	$1,339.00
52283	Cystoscopy and treatment	02	$446.00
52285	Cystoscopy and treatment	02	$446.00
52290	Cystoscopy and treatment	02	$446.00
52300	Cystoscopy and treatment	02	$446.00
52301	Cystoscopy and treatment	03	$510.00
52305	Cystoscopy and treatment	02	$446.00
52310	Cystoscopy and treatment	49	$399.24
52315	Cystoscopy and treatment	02	$446.00
52317	Remove bladder stone	01	$333.00
52318	Remove bladder stone	02	$446.00
52320	Cystoscopy and treatment	05	$717.00
52325	Cystoscopy, stone removal	04	$630.00
52327	Cystoscopy, inject material	02	$446.00
52330	Cystoscopy and treatment	02	$446.00
52332	Cystoscopy and treatment	02	$446.00
52334	Create passage to kidney	03	$510.00
52341	Cysto w/ureter stricture tx	03	$510.00
52342	Cysto w/up stricture tx	03	$510.00
52343	Cysto w/renal stricture tx	03	$510.00
52344	Cysto/uretero, stricture tx	03	$510.00
52345	Cysto/uretero w/up stricture	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
52346	Cystouretero w/renal strict	03	$510.00
52351	Cystouretero & or pyeloscope	03	$510.00
52352	Cystouretero w/stone remove	04	$630.00
52353	Cystouretero w/lithotripsy	04	$630.00
52354	Cystouretero w/biopsy	04	$630.00
52355	Cystouretero w/excise tumor	04	$630.00
52400	Cystouretero w/congen repr	03	$510.00
52402	Cystourethro cut ejacul duct	03	$510.00
52450	Incision of prostate	03	$510.00
52500	Revision of bladder neck	03	$510.00
52510	Dilation prostatic urethra	03	$510.00
52601	Prostatectomy (TURP)	04	$630.00
52606	Control postop bleeding	01	$333.00
52612	Prostatectomy, first stage	02	$446.00
52614	Prostatectomy, second stage	01	$333.00
52620	Remove residual prostate	01	$333.00
52630	Remove prostate regrowth	02	$446.00
52640	Relieve bladder contracture	02	$446.00
52647	Laser surgery of prostate	09	$1,339.00
52648	Laser surgery of prostate	09	$1,339.00
52700	Drainage of prostate abscess	02	$446.00
53000	Incision of urethra	01	$333.00
53010	Incision of urethra	01	$333.00
53020	Incision of urethra	01	$333.00
53040	Drainage of urethra abscess	02	$446.00
53080	Drainage of urinary leakage	03	$510.00
53200	Biopsy of urethra	01	$333.00
53210	Removal of urethra	05	$717.00
53215	Removal of urethra	05	$717.00
53220	Treatment of urethra lesion	02	$446.00
53230	Removal of urethra lesion	02	$446.00
53235	Removal of urethra lesion	03	$510.00
53240	Surgery for urethra pouch	02	$446.00
53250	Removal of urethra gland	02	$446.00
53260	Treatment of urethra lesion	02	$446.00
53265	Treatment of urethra lesion	02	$446.00
53270	Removal of urethra gland	02	$446.00
53275	Repair of urethra defect	02	$446.00
53400	Revise urethra, stage 1	03	$510.00
53405	Revise urethra, stage 2	02	$446.00
53410	Reconstruction of urethra	02	$446.00
53420	Reconstruct urethra, stage 1	03	$510.00
53425	Reconstruct urethra, stage 2	02	$446.00
53430	Reconstruction of urethra	02	$446.00
53431	Reconstruct urethra/bladder	02	$446.00
53440	Male sling procedure	02	$446.00
53442	Remove/revise male sling	01	$333.00
53444	Insert tandem cuff	02	$446.00
53445	Insert uro/ves nck sphincter	01	$333.00
53446	Remove uro sphincter	01	$333.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
53447	Remove/replace ur sphincter	01	$333.00
53449	Repair uro sphincter	01	$333.00
53450	Revision of urethra	01	$333.00
53460	Revision of urethra	01	$333.00
53502	Repair of urethra injury	02	$446.00
53505	Repair of urethra injury	02	$446.00
53510	Repair of urethra injury	02	$446.00
53515	Repair of urethra injury	02	$446.00
53520	Repair of urethra defect	02	$446.00
53605	Dilate urethra stricture	02	$446.00
53665	Dilation of urethra	01	$333.00
54000	Slitting of prepuce	02	$446.00
54001	Slitting of prepuce	02	$446.00
54015	Drain penis lesion	04	$630.00
54057	Laser surg, penis lesion(s)	01	$333.00
54060	Excision of penis lesion(s)	01	$333.00
54065	Destruction, penis lesion(s)	01	$333.00
54100	Biopsy of penis	01	$333.00
54105	Biopsy of penis	01	$333.00
54110	Treatment of penis lesion	02	$446.00
54111	Treat penis lesion, graft	02	$446.00
54112	Treat penis lesion, graft	02	$446.00
54115	Treatment of penis lesion	01	$333.00
54120	Partial removal of penis	02	$446.00
54150	Circumcision w/regionl block	01	$333.00
54160	Circumcision, neonate	02	$446.00
54161	Circum 28 days or older	02	$446.00
54162	Lysis penil circumic lesion	02	$446.00
54163	Repair of circumcision	02	$446.00
54164	Frenulotomy of penis	02	$446.00
54205	Treatment of penis lesion	04	$630.00
54220	Treatment of penis lesion	23	$131.50
54300	Revision of penis	03	$510.00
54304	Revision of penis	03	$510.00
54308	Reconstruction of urethra	03	$510.00
54312	Reconstruction of urethra	03	$510.00
54316	Reconstruction of urethra	03	$510.00
54318	Reconstruction of urethra	03	$510.00
54322	Reconstruction of urethra	03	$510.00
54324	Reconstruction of urethra	03	$510.00
54326	Reconstruction of urethra	03	$510.00
54328	Revise penis/urethra	03	$510.00
54340	Secondary urethral surgery	03	$510.00
54344	Secondary urethral surgery	03	$510.00
54348	Secondary urethral surgery	03	$510.00
54352	Reconstruct urethra/penis	03	$510.00
54360	Penis plastic surgery	03	$510.00
54380	Repair penis	03	$510.00
54385	Repair penis	03	$510.00
54400	Insert semi-rigid prosthesis	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
54401	Insert self-contd prosthesis	03	$510.00
54405	Insert multi-comp penis pros	03	$510.00
54406	Remove muti-comp penis pros	03	$510.00
54408	Repair multi-comp penis pros	03	$510.00
54410	Remove/replace penis prosth	03	$510.00
54415	Remove self-contd penis pros	03	$510.00
54416	Remv/repl penis contain pros	03	$510.00
54420	Revision of penis	04	$630.00
54435	Revision of penis	04	$630.00
54440	Repair of penis	04	$630.00
54450	Preputial stretching	31	$209.48
54500	Biopsy of testis	01	$333.00
54505	Biopsy of testis	01	$333.00
54512	Excise lesion testis	02	$446.00
54520	Removal of testis	03	$510.00
54522	Orchiectomy, partial	03	$510.00
54530	Removal of testis	04	$630.00
54550	Exploration for testis	04	$630.00
54600	Reduce testis torsion	04	$630.00
54620	Suspension of testis	03	$510.00
54640	Suspension of testis	04	$630.00
54660	Revision of testis	02	$446.00
54670	Repair testis injury	03	$510.00
54680	Relocation of testis(es)	03	$510.00
54690	Laparoscopy, orchiectomy	09	$1,339.00
54700	Drainage of scrotum	02	$446.00
54800	Biopsy of epididymis	21	$127.16
54830	Remove epididymis lesion	03	$510.00
54840	Remove epididymis lesion	04	$630.00
54860	Removal of epididymis	03	$510.00
54861	Removal of epididymis	04	$630.00
54865	Explore epididymis	01	$333.00
54900	Fusion of spermatic ducts	04	$630.00
54901	Fusion of spermatic ducts	04	$630.00
55040	Removal of hydrocele	03	$510.00
55041	Removal of hydroceles	05	$717.00
55060	Repair of hydrocele	04	$630.00
55100	Drainage of scrotum abscess	01	$333.00
55110	Explore scrotum	02	$446.00
55120	Removal of scrotum lesion	02	$446.00
55150	Removal of scrotum	01	$333.00
55175	Revision of scrotum	01	$333.00
55180	Revision of scrotum	02	$446.00
55200	Incision of sperm duct	02	$446.00
55250	Removal of sperm duct(s)	02	$446.00
55400	Repair of sperm duct	01	$333.00
55500	Removal of hydrocele	03	$510.00
55520	Removal of sperm cord lesion	04	$630.00
55530	Revise spermatic cord veins	04	$630.00
55535	Revise spermatic cord veins	04	$630.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
55540	Revise hernia & sperm veins	05	$717.00
55550	Laparo ligate spermatic vein	09	$1,339.00
55680	Remove sperm pouch lesion	01	$333.00
55700	Biopsy of prostate	44	$345.83
55705	Biopsy of prostate	44	$345.83
55720	Drainage of prostate abscess	01	$333.00
55725	Drainage of prostate abscess	02	$446.00
55873	Cryoablate prostate	09	$1,339.00
55875	Transperi needle place, pros	09	$1,339.00
56440	Surgery for vulva lesion	02	$446.00
56441	Lysis of labial lesion(s)	01	$333.00
56442	Hymenotomy	01	$333.00
56515	Destroy vulva lesion/s compl	03	$510.00
56620	Partial removal of vulva	05	$717.00
56625	Complete removal of vulva	07	$995.00
56700	Partial removal of hymen	01	$333.00
56740	Remove vagina gland lesion	03	$510.00
56800	Repair of vagina	03	$510.00
56810	Repair of perineum	05	$717.00
57000	Exploration of vagina	01	$333.00
57010	Drainage of pelvic abscess	02	$446.00
57020	Drainage of pelvic fluid	50	$409.33
57023	I & d vag hematoma, non-ob	01	$333.00
57065	Destroy vag lesions, complex	01	$333.00
57105	Biopsy of vagina	02	$446.00
57130	Remove vagina lesion	02	$446.00
57135	Remove vagina lesion	02	$446.00
57155	Insert uteri tandems/ovoids	50	$409.33
57180	Treat vaginal bleeding	29	$178.05
57200	Repair of vagina	01	$333.00
57210	Repair vagina/perineum	02	$446.00
57220	Revision of urethra	03	$510.00
57230	Repair of urethral lesion	03	$510.00
57240	Repair bladder & vagina	05	$717.00
57250	Repair rectum & vagina	05	$717.00
57260	Repair of vagina	05	$717.00
57265	Extensive repair of vagina	07	$995.00
57267	Insert mesh/pelvic flr addon	07	$995.00
57268	Repair of bowel bulge	03	$510.00
57288	Repair bladder defect	05	$717.00
57289	Repair bladder & vagina	05	$717.00
57291	Construction of vagina	05	$717.00
57300	Repair rectum-vagina fistula	03	$510.00
57400	Dilation of vagina	02	$446.00
57410	Pelvic examination	02	$446.00
57415	Remove vaginal foreign body	02	$446.00
57513	Laser surgery of cervix	02	$446.00
57520	Conization of cervix	02	$446.00
57522	Conization of cervix	02	$446.00
57530	Removal of cervix	03	$510.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
57550	Removal of residual cervix	03	$510.00
57556	Remove cervix, repair bowel	05	$717.00
57558	D&c of cervical stump	03	$510.00
57700	Revision of cervix	01	$333.00
57720	Revision of cervix	03	$510.00
58120	Dilation and curettage	02	$446.00
58145	Myomectomy vag method	05	$717.00
58346	Insert heyman uteri capsule	02	$446.00
58350	Reopen fallopian tube	03	$510.00
58353	Endometr ablate, thermal	07	$995.00
58545	Laparoscopic myomectomy	09	$1,339.00
58546	Laparo-myomectomy, complex	09	$1,339.00
58550	Laparo-asst vag hysterectomy	09	$1,339.00
58555	Hysteroscopy, dx, sep proc	01	$333.00
58558	Hysteroscopy, biopsy	03	$510.00
58559	Hysteroscopy, lysis	02	$446.00
58560	Hysteroscopy, resect septum	03	$510.00
58561	Hysteroscopy, remove myoma	03	$510.00
58562	Hysteroscopy, remove fb	03	$510.00
58563	Hysteroscopy, ablation	09	$1,339.00
58565	Hysteroscopy, sterilization	09	$1,339.00
58660	Laparoscopy, lysis	05	$717.00
58661	Laparoscopy, remove adnexa	05	$717.00
58662	Laparoscopy, excise lesions	05	$717.00
58670	Laparoscopy, tubal cautery	03	$510.00
58671	Laparoscopy, tubal block	03	$510.00
58672	Laparoscopy, fimbrioplasty	05	$717.00
58673	Laparoscopy, salpingostomy	05	$717.00
58800	Drainage of ovarian cyst(s)	03	$510.00
58820	Drain ovary abscess, open	03	$510.00
58900	Biopsy of ovary(s)	03	$510.00
58970	Retrieval of oocyte	36	$245.92
58974	Transfer of embryo	36	$245.92
58976	Transfer of embryo	36	$245.92
59160	D& c after delivery	03	$510.00
59320	Revision of cervix	01	$333.00
59812	Treatment of miscarriage	05	$717.00
59820	Care of miscarriage	05	$717.00
59821	Treatment of miscarriage	05	$717.00
59840	Abortion	05	$717.00
59841	Abortion	05	$717.00
59870	Evacuate mole of uterus	05	$717.00
59871	Remove cerclage suture	05	$717.00
60000	Drain thyroid/tongue cyst	01	$333.00
60200	Remove thyroid lesion	02	$446.00
60280	Remove thyroid duct lesion	04	$630.00
60281	Remove thyroid duct lesion	04	$630.00
61020	Remove brain cavity fluid	30	$183.83
61026	Injection into brain canal	30	$183.83
61050	Remove brain canal fluid	30	$183.83

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
61055	Injection into brain canal	30	$183.83
61070	Brain canal shunt procedure	30	$183.83
61215	Insert brain-fluid device	03	$510.00
61790	Treat trigeminal nerve	03	$510.00
61791	Treat trigeminal tract	45	$351.92
61795	Brain surgery using computer	39	$302.04
61885	Insrt/redo neurostim 1 array	02	$446.00
61886	Implant neurostim arrays	03	$510.00
61888	Revise/remove neuroreceiver	01	$333.00
62194	Replace/irrigate catheter	01	$333.00
62225	Replace/irrigate catheter	01	$333.00
62230	Replace/revise brain shunt	02	$446.00
62263	Epidural lysis mult sessions	01	$333.00
62264	Epidural lysis on single day	01	$333.00
62268	Drain spinal cord cyst	30	$183.83
62269	Needle biopsy, spinal cord	01	$333.00
62270	Spinal fluid tap, diagnostic	25	$139.00
62272	Drain cerebro spinal fluid	25	$139.00
62273	Inject epidural patch	01	$333.00
62280	Treat spinal cord lesion	01	$333.00
62281	Treat spinal cord lesion	01	$333.00
62282	Treat spinal canal lesion	01	$333.00
62287	Percutaneous diskectomy	09	$1,339.00
62294	Injection into spinal artery	30	$183.83
62310	Inject spine c/t	01	$333.00
62311	Inject spine l/s (cd)	01	$333.00
62318	Inject spine w/cath, c/t	01	$333.00
62319	Inject spine w/cath l/s (cd)	01	$333.00
62350	Implant spinal canal cath	02	$446.00
62355	Remove spinal canal catheter	02	$446.00
62360	Insert spine infusion device	02	$446.00
62361	Implant spine infusion pump	02	$446.00
62362	Implant spine infusion pump	02	$446.00
62365	Remove spine infusion device	02	$446.00
63600	Remove spinal cord lesion	02	$446.00
63610	Stimulation of spinal cord	01	$333.00
63650	Implant neuroelectrodes	02	$446.00
63660	Revise/remove neuroelectrode	01	$333.00
63685	Insrt/redo spine n generator	02	$446.00
63688	Revise/remove neuroreceiver	01	$333.00
63744	Revision of spinal shunt	03	$510.00
63746	Removal of spinal shunt	02	$446.00
64410	Nblock inj, phrenic	01	$333.00
64415	Nblock inj, brachial plexus	25	$139.00
64417	Nblock inj, axillary	25	$139.00
64420	Nblock inj, intercost, sng	25	$139.00
64421	Nblock inj, intercost, mlt	01	$333.00
64430	Nblock inj, pudendal	25	$139.00
64470	Inj paravertebral c/t	01	$333.00
64472	Inj paravertebral c/t add-on	01	$333.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
64475	Inj paravertebral l/s	01	$333.00
64476	Inj paravertebral l/s add-on	01	$333.00
64479	Inj foramen epidural c/t	01	$333.00
64480	Inj foramen epidural add-on	01	$333.00
64483	Inj foramen epidural l/s	01	$333.00
64484	Inj foramen epidural add-on	01	$333.00
64510	Nblock, stellate ganglion	01	$333.00
64517	Nblock inj, hypogas plxs	25	$139.00
64520	Nblock, lumbar/thoracic	01	$333.00
64530	Nblock inj, celiac pelus	01	$333.00
64553	Implant neuroelectrodes	01	$333.00
64561	Implant neuroelectrodes	03	$510.00
64573	Implant neuroelectrodes	01	$333.00
64575	Implant neuroelectrodes	01	$333.00
64577	Implant neuroelectrodes	01	$333.00
64580	Implant neuroelectrodes	01	$333.00
64581	Implant neuroelectrodes	03	$510.00
64585	Revise/remove neuroelectrode	01	$333.00
64590	Insrt/redo pn/gastr stimul	02	$446.00
64595	Revise/rmv pn/gastr stimul	01	$333.00
64600	Injection treatment of nerve	01	$333.00
64605	Injection treatment of nerve	01	$333.00
64610	Injection treatment of nerve	01	$333.00
64620	Injection treatment of nerve	01	$333.00
64622	Destr paravertebrl nerve l/s	01	$333.00
64623	Destr paravertebral n add-on	01	$333.00
64626	Destr paravertebrl nerve c/t	01	$333.00
64627	Destr paravertebral n add-on	01	$333.00
64630	Injection treatment of nerve	45	$351.92
64680	Injection treatment of nerve	47	$390.95
64681	Injection treatment of nerve	02	$446.00
64702	Revise finger/toe nerve	01	$333.00
64704	Revise hand/foot nerve	01	$333.00
64708	Revise arm/leg nerve	02	$446.00
64712	Revision of sciatic nerve	02	$446.00
64713	Revision of arm nerve(s)	02	$446.00
64714	Revise low back nerve(s)	02	$446.00
64716	Revision of cranial nerve	03	$510.00
64718	Revise ulnar nerve at elbow	02	$446.00
64719	Revise ulnar nerve at wrist	02	$446.00
64721	Carpal tunnel surgery	02	$446.00
64722	Relieve pressure on nerve(s)	01	$333.00
64726	Release foot/toe nerve	01	$333.00
64727	Internal nerve revision	01	$333.00
64732	Incision of brow nerve	02	$446.00
64734	Incision of cheek nerve	02	$446.00
64736	Incision of chin nerve	02	$446.00
64738	Incision of jaw nerve	02	$446.00
64740	Incision of tongue nerve	02	$446.00
64742	Incision of facial nerve	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
64744	Incise nerve, back of head	02	$446.00
64746	Incise diaphragm nerve	02	$446.00
64771	Sever cranial nerve	02	$446.00
64772	Incision of spinal nerve	02	$446.00
64774	Remove skin nerve lesion	02	$446.00
64776	Remove digit nerve lesion	03	$510.00
64778	Digit nerve surgery add-on	02	$446.00
64782	Remove limb nerve lesion	03	$510.00
64783	Limb nerve surgery add-on	02	$446.00
64784	Remove nerve lesion	03	$510.00
64786	Remove sciatic nerve lesion	03	$510.00
64787	Implant nerve end	02	$446.00
64788	Remove skin nerve lesion	03	$510.00
64790	Removal of nerve lesion	03	$510.00
64792	Removal of nerve lesion	03	$510.00
64795	Biopsy of nerve	02	$446.00
64802	Remove sympathetic nerves	02	$446.00
64821	Remove sympathetic nerves	04	$630.00
64831	Repair of digit nerve	04	$630.00
64832	Repair nerve add-on	01	$333.00
64834	Repair of hand or foot nerve	02	$446.00
64835	Repair of hand or foot nerve	03	$510.00
64836	Repair of hand or foot nerve	03	$510.00
64837	Repair nerve add-on	01	$333.00
64840	Repair of leg nerve	02	$446.00
64856	Repair/transpose nerve	02	$446.00
64857	Repair arm/leg nerve	02	$446.00
64858	Repair sciatic nerve	02	$446.00
64859	Nerve surgery	01	$333.00
64861	Repair of arm nerves	03	$510.00
64862	Repair of low back nerves	03	$510.00
64864	Repair of facial nerve	03	$510.00
64865	Repair of facial nerve	04	$630.00
64870	Fusion of facial/other nerve	04	$630.00
64872	Subsequent repair of nerve	02	$446.00
64874	Repair & revise nerve add-on	03	$510.00
64876	Repair nerve/shorten bone	03	$510.00
64885	Nerve graft, head or neck	02	$446.00
64886	Nerve graft, head or neck	02	$446.00
64890	Nerve graft, hand or foot	02	$446.00
64891	Nerve graft, hand or foot	02	$446.00
64892	Nerve graft, arm or leg	02	$446.00
64893	Nerve graft, arm or leg	02	$446.00
64895	Nerve graft, hand or foot	03	$510.00
64896	Nerve graft, hand or foot	03	$510.00
64897	Nerve graft, arm or leg	03	$510.00
64898	Nerve graft, arm or leg	03	$510.00
64901	Nerve graft add-on	02	$446.00
64902	Nerve graft add-on	02	$446.00
64905	Nerve pedicle transfer	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
64907	Nerve pedicle transfer	01	$333.00
65091	Revise eye	03	$510.00
65093	Revise eye with implant	03	$510.00
65101	Removal of eye	03	$510.00
65103	Remove eye/insert implant	03	$510.00
65105	Remove eye/attach implant	04	$630.00
65110	Removal of eye	05	$717.00
65112	Remove eye/revise socket	07	$995.00
65114	Remove eye/revise socket	07	$995.00
65130	Insert ocular implant	03	$510.00
65135	Insert ocular implant	02	$446.00
65140	Attach ocular implant	03	$510.00
65150	Revise ocular implant	02	$446.00
65155	Reinsert ocular implant	03	$510.00
65175	Removal of ocular implant	01	$333.00
65235	Remove foreign body from eye	02	$446.00
65260	Remove foreign body from eye	03	$510.00
65265	Remove foreign body from eye	04	$630.00
65270	Repair of eye wound	02	$446.00
65272	Repair of eye wound	02	$446.00
65275	Repair of eye wound	04	$630.00
65280	Repair of eye wound	04	$630.00
65285	Repair of eye wound	04	$630.00
65290	Repair of eye socket wound	03	$510.00
65400	Removal of eye lesion	01	$333.00
65410	Biopsy of cornea	02	$446.00
65420	Removal of eye lesion	02	$446.00
65426	Removal of eye lesion	05	$717.00
65710	Corneal transplant	07	$995.00
65730	Corneal transplant	07	$995.00
65750	Corneal transplant	07	$995.00
65755	Corneal transplant	07	$995.00
65770	Revise cornea with implant	07	$995.00
65772	Correction of astigmatism	04	$630.00
65775	Correction of astigmatism	04	$630.00
65780	Ocular reconst, transplant	05	$717.00
65781	Ocular reconst, transplant	05	$717.00
65782	Ocular reconst, transplant	05	$717.00
65800	Drainage of eye	01	$333.00
65805	Drainage of eye	01	$333.00
65810	Drainage of eye	03	$510.00
65815	Drainage of eye	02	$446.00
65820	Relieve inner eye pressure	01	$333.00
65850	Incision of eye	04	$630.00
65865	Incise inner eye adhesions	01	$333.00
65870	Incise inner eye adhesions	04	$630.00
65875	Incise inner eye adhesions	04	$630.00
65880	Incise inner eye adhesions	04	$630.00
65900	Remove eye lesion	05	$717.00
65920	Remove implant of eye	07	$995.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
65930	Remove blood clot from eye	05	$717.00
66020	Injection treatment of eye	01	$333.00
66030	Injection treatment of eye	01	$333.00
66130	Remove eye lesion	07	$995.00
66150	Glaucoma surgery	04	$630.00
66155	Glaucoma surgery	04	$630.00
66160	Glaucoma surgery	02	$446.00
66165	Glaucoma surgery	04	$630.00
66170	Glaucoma surgery	04	$630.00
66172	Incision of eye	04	$630.00
66180	Implant eye shunt	05	$717.00
66185	Revise eye shunt	02	$446.00
66220	Repair eye lesion	03	$510.00
66225	Repair/graft eye lesion	04	$630.00
66250	Follow-up surgery of eye	02	$446.00
66500	Incision of iris	01	$333.00
66505	Incision of iris	01	$333.00
66600	Remove iris and lesion	03	$510.00
66605	Removal of iris	03	$510.00
66625	Removal of iris	46	$372.94
66630	Removal of iris	03	$510.00
66635	Removal of iris	03	$510.00
66680	Repair iris & ciliary body	03	$510.00
66682	Repair iris & ciliary body	02	$446.00
66700	Destruction, ciliary body	02	$446.00
66710	Ciliary transsleral therapy	02	$446.00
66711	Ciliary endoscopic ablation	02	$446.00
66720	Destruction, ciliary body	02	$446.00
66740	Destruction, ciliary body	02	$446.00
66821	After cataract laser surgery	41	$312.50
66825	Reposition intraocular lens	04	$630.00
66830	Removal of lens lesion	46	$372.94
66840	Removal of lens material	04	$630.00
66850	Removal of lens material	07	$995.00
66852	Removal of lens material	04	$630.00
66920	Extraction of lens	04	$630.00
66930	Extraction of lens	05	$717.00
66940	Extraction of lens	05	$717.00
66982	Cataract surgery, complex	08	$973.00
66983	Cataract surg w/iol, 1 stage	08	$973.00
66984	Cataract surg w/iol, 1 stage	08	$973.00
66985	Insert lens prosthesis	06	$826.00
66986	Exchange lens prosthesis	06	$826.00
67005	Partial removal of eye fluid	04	$630.00
67010	Partial removal of eye fluid	04	$630.00
67015	Release of eye fluid	01	$333.00
67025	Replace eye fluid	01	$333.00
67027	Implant eye drug system	04	$630.00
67030	Incise inner eye strands	01	$333.00
67031	Laser surgery, eye strands	41	$312.50

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
67036	Removal of inner eye fluid	04	$630.00
67038	Strip retinal membrane	05	$717.00
67039	Laser treatment of retina	07	$995.00
67040	Laser treatment of retina	07	$995.00
67107	Repair detached retina	05	$717.00
67108	Repair detached retina	07	$995.00
67112	Rerepair detached retina	07	$995.00
67115	Release encircling material	02	$446.00
67120	Remove eye implant material	02	$446.00
67121	Remove eye implant material	02	$446.00
67141	Treatment of retina	35	$241.77
67218	Treatment of retinal lesion	05	$717.00
67227	Treatment of retinal lesion	01	$333.00
67250	Reinforce eye wall	03	$510.00
67255	Reinforce/graft eye wall	03	$510.00
67311	Revise eye muscle	03	$510.00
67312	Revise two eye muscles	04	$630.00
67314	Revise eye muscle	04	$630.00
67316	Revise two eye muscles	04	$630.00
67318	Revise eye muscle(s)	04	$630.00
67320	Revise eye muscle(s) add-on	04	$630.00
67331	Eye surgery follow-up add-on	04	$630.00
67332	Rerevise eye muscles add-on	04	$630.00
67334	Revise eye muscle w/suture	04	$630.00
67335	Eye suture during surgery	04	$630.00
67340	Revise eye muscle add-on	04	$630.00
67343	Release eye tissue	07	$995.00
67346	Biopsy, eye muscle	01	$333.00
67400	Explore/biopsy eye socket	03	$510.00
67405	Explore/drain eye socket	04	$630.00
67412	Explore/treat eye socket	05	$717.00
67413	Explore/treat eye socket	05	$717.00
67415	Aspiration, orbital contents	01	$333.00
67420	Explore/treat eye socket	05	$717.00
67430	Explore/treat eye socket	05	$717.00
67440	Explore/drain eye socket	05	$717.00
67445	Explr/decompress eye socket	05	$717.00
67450	Explore/biopsy eye socket	05	$717.00
67550	Insert eye socket implant	04	$630.00
67560	Revise eye socket implant	02	$446.00
67570	Decompress optic nerve	04	$630.00
67715	Incision of eyelid fold	01	$333.00
67808	Remove eyelid lesion(s)	02	$446.00
67830	Revise eyelashes	02	$446.00
67835	Revise eyelashes	02	$446.00
67880	Revision of eyelid	03	$510.00
67882	Revision of eyelid	03	$510.00
67900	Repair brow defect	04	$630.00
67901	Repair eyelid defect	05	$717.00
67902	Repair eyelid defect	05	$717.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
67903	Repair eyelid defect	04	$630.00
67904	Repair eyelid defect	04	$630.00
67906	Repair eyelid defect	05	$717.00
67908	Repair eyelid defect	04	$630.00
67909	Revise eyelid defect	04	$630.00
67911	Revise eyelid defect	03	$510.00
67912	Correction eyelid w/implant	03	$510.00
67914	Repair eyelid defect	03	$510.00
67916	Repair eyelid defect	04	$630.00
67917	Repair eyelid defect	04	$630.00
67921	Repair eyelid defect	03	$510.00
67923	Repair eyelid defect	04	$630.00
67924	Repair eyelid defect	04	$630.00
67935	Repair eyelid wound	02	$446.00
67950	Revision of eyelid	02	$446.00
67961	Revision of eyelid	03	$510.00
67966	Revision of eyelid	03	$510.00
67971	Reconstruction of eyelid	03	$510.00
67973	Reconstruction of eyelid	03	$510.00
67974	Reconstruction of eyelid	03	$510.00
67975	Reconstruction of eyelid	03	$510.00
68115	Remove eyelid lining lesion	02	$446.00
68130	Remove eyelid lining lesion	02	$446.00
68320	Revise/graft eyelid lining	04	$630.00
68325	Revise/graft eyelid lining	04	$630.00
68326	Revise/graft eyelid lining	04	$630.00
68328	Revise/graft eyelid lining	04	$630.00
68330	Revise eyelid lining	04	$630.00
68335	Revise/graft eyelid lining	04	$630.00
68340	Separate eyelid adhesions	04	$630.00
68360	Revise eyelid lining	02	$446.00
68362	Revise eyelid lining	02	$446.00
68371	Harvest eye tissue, alograft	02	$446.00
68500	Removal of tear gland	03	$510.00
68505	Partial removal, tear gland	03	$510.00
68510	Biopsy of tear gland	01	$333.00
68520	Removal of tear sac	03	$510.00
68525	Biopsy of tear sac	01	$333.00
68540	Remove tear gland lesion	03	$510.00
68550	Remove tear gland lesion	03	$510.00
68700	Repair tear ducts	02	$446.00
68720	Create tear sac drain	04	$630.00
68745	Create tear duct drain	04	$630.00
68750	Create tear duct drain	04	$630.00
68770	Close tear system fistula	04	$630.00
68810	Probe nasolacrimal duct	24	$131.86
68811	Probe nasolacrimal duct	02	$446.00
68815	Probe nasolacrimal duct	02	$446.00
69110	Remove external ear, partial	01	$333.00
69120	Removal of external ear	02	$446.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
69140	Remove ear canal lesion(s)	02	$446.00
69145	Remove ear canal lesion(s)	02	$446.00
69150	Extensive ear canal surgery	53	$464.15
69205	Clear outer ear canal	01	$333.00
69300	Revise external ear	03	$510.00
69310	Rebuild outer ear canal	03	$510.00
69320	Rebuild outer ear canal	07	$995.00
69421	Incision of eardrum	03	$510.00
69436	Create eardrum opening	03	$510.00
69440	Exploration of middle ear	03	$510.00
69450	Eardrum revision	01	$333.00
69501	Mastoidectomy	07	$995.00
69502	Mastoidectomy	07	$995.00
69505	Remove mastoid structures	07	$995.00
69511	Extensive mastoid surgery	07	$995.00
69530	Extensive mastoid surgery	07	$995.00
69550	Remove ear lesion	05	$717.00
69552	Remove ear lesion	07	$995.00
69601	Mastoid surgery revision	07	$995.00
69602	Mastoid surgery revision	07	$995.00
69603	Mastoid surgery revision	07	$995.00
69604	Mastoid surgery revision	07	$995.00
69605	Mastoid surgery revision	07	$995.00
69620	Repair of eardrum	02	$446.00
69631	Repair eardrum structures	05	$717.00
69632	Rebuild eardrum structures	05	$717.00
69633	Rebuild eardrum structures	05	$717.00
69635	Repair eardrum structures	07	$995.00
69636	Rebuild eardrum structures	07	$995.00
69637	Rebuild eardrum structures	07	$995.00
69641	Revise middle ear & mastoid	07	$995.00
69642	Revise middle ear & mastoid	07	$995.00
69643	Revise middle ear & mastoid	07	$995.00
69644	Revise middle ear & mastoid	07	$995.00
69645	Revise middle ear & mastoid	07	$995.00
69646	Revise middle ear & mastoid	07	$995.00
69650	Release middle ear bone	07	$995.00
69660	Revise middle ear bone	05	$717.00
69661	Revise middle ear bone	05	$717.00
69662	Revise middle ear bone	05	$717.00
69666	Repair middle ear structures	04	$630.00
69667	Repair middle ear structures	04	$630.00
69670	Remove mastoid air cells	03	$510.00
69676	Remove middle ear nerve	03	$510.00
69700	Close mastoid fistula	03	$510.00
69711	Remove/repair hearing aid	01	$333.00
69714	Implant temple bone w/stimul	09	$1,339.00
69715	Temple bne implnt w/stimulat	09	$1,339.00
69717	Temple bone implant revision	09	$1,339.00
69718	Revise temple bone implant	09	$1,339.00

Procedure Code	Short Description	Pricer Group	07/01/08 Rate
69720	Release facial nerve	05	$717.00
69740	Repair facial nerve	05	$717.00
69745	Repair facial nerve	05	$717.00
69801	Incise inner ear	05	$717.00
69802	Incise inner ear	07	$995.00
69805	Explore inner ear	07	$995.00
69806	Explore inner ear	07	$995.00
69820	Establish inner ear window	05	$717.00
69840	Revise inner ear window	05	$717.00
69905	Remove inner ear	07	$995.00
69910	Remove inner ear & mastoid	07	$995.00
69915	Incise inner ear nerve	07	$995.00
69930	Implant cochlear device	07	$995.00
0176T	Aqu canal dilat w/o retent	09	$1,339.00
0177T	Aqu canal dilat w retent	09	$1,339.00
G0105	Colorectal scrn; hi risk ind	02	$446.00
G0121	Colon ca scrn not hi rsk ind	02	$446.00
G0260	Inj for sacroiliac jt anesth	01	$333.00
G0392	AV fistula or graft arterial	09	$1,339.00
G0393	AV fistula or graft venous	09	$1,339.00

State of Connecticut
Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

FIFTH Addendum

RELEASE DATE - 031708

The following information amends the contents of the original RFP issued on January 1, 2008.

1. Section I – 3 Overview Description of Charter Oak – the third sentence is clarified as follows: If, in the development of its Business (Cost) Proposal the Bidder determines that the total target premium is insufficient to provide each of the Charter Oak covered services, the Bidder MUST propose a premium that includes the provision of each of the Charter Oak covered services and MAY propose **an alternative cost sharing arrangement including changes to co-pays or co-insurance. The benefit package MAY NOT be altered.**

2. Section II – Section 15 J – Personnel and Position Assurances (page 13 - 14) has been revised with the deletion of the last sentence "The Department shall reimburse the Contractor for those staff expenses actually incurred." See Question and Answer #5.

3. Section IV- Proposal Contents Part One: Transmittal Communication, Forms and Acceptances: The Department is changing the order of submission requirements for Part One of the Bidders' response. The Amendment Acknowledgements should precede the Transmittal Letter . The pages of Amendment Acknowledgements do not have to be numbered. Page number requirement Section III – Proposal Format Requirements subsection 6 on page 18) should begin with the Transmittal Letter.

4. Section IV – Part Two – 3B Management Plan has been revised to apply to proposed subcontractors. "The bidder shall, *for the Bidder as the proposed prime Contractor and any proposed subcontractor,* describe a

management plan for the project that includes at a minimum:" See Question and Answer #7.

5. Section IV – Part Two – 4A 1 has been revised with the deletion of "other". See Question and Answer #13.

6. Section IV – Part Three – 3.04 subsection d (page 41) has been deleted and replaced with the following:

> d. A process by which Members may obtain a contract services that the MCO does not provide.

7. Section IV – Part Three – 3.20 (pg 65), subsection b under "The Bidder shall:" has been clarified as follows "Describe its process to provide the care coordination and services outlined in ***3.20 a1 – 8 and b*** above.

8. Section IV-Part Three – 3.30 subsection x (page 85) has been clarified as follows:

> "Expenditures on marketing and marketing related activities shall not exceed one percent (1.0%) of the MCOs administrative expenditures during ***each year for*** the first three years of the resultant contract. Marketing expenditures shall not exceed one half of one percent (0.5%) of administrative expenditures during ***each year for*** the last two years of the resultant contract."

9. Section IV-Part Three- 3.58 Freedom of Information (pages 111 and 112) is deleted in its entirety and replaced with the following section originally set forth in Section II – 15 - M:

3.58 Freedom of Information and Performance of a Governmental Function

a. In performing any acts required or described by this Contract, the Contractor shall be considered to be performing a governmental function for the Department, as that term is defined in section 1-200(11) of the Connecticut General Statutes. Pursuant to section 1-218 of the Connecticut General Statutes, therefore, the Department is entitled to receive a copy of records and files related to the performance of the governmental function, as set forth in this Contract. Such records and files are subject to the Freedom of Information Act and may be disclosed by the Department pursuant to the Freedom of Information Act. Requests to inspect or copy such records or files shall be made to DSS in accordance with the Freedom of Information Act. Accordingly, if the Contractor is in receipt of a request made pursuant to the Freedom of Information Act to

inspect or copy such records or files, the Contractor shall forward that request to DSS.

b. Upon receipt of a Freedom of Information Act request by the Department that seeks records or files related to the performance of the governmental function performed by the Contractor for the Department, the Department shall send such request to the Contractor. The Contractor shall review the request and, with reasonable promptness, search its records and files for documents that are responsive to the request. The Contractor shall promptly notify the Department if any clarification of the request is needed in order to proceed with the search for responsive records or files. The Contractor shall send to the Department a copy of those documents that are responsive to the request or otherwise notify the Department that it has no documents responsive to the request. Upon the completion of the Contractor's search for responsive documents, the Contractor shall notify the Department in writing that the search and production of documents is complete. If, upon review of the request, the Contractor determines that it will require more than fourteen (14) days to search for and provide copies of responsive documents to the Department, the Contractor shall contact the Department within seven (7) days of the receipt of the request from the Department.

c. If the Contractor concludes that any of the responsive documents fits within any of the subdivisions of subsection (b) of section 1-210 of the Connecticut General Statutes, and that the Department should not disclose such documents, the Contractor shall mark said documents accordingly prior to sending them to the Department and shall explain the basis for its conclusion. The Department shall review the Contractor's conclusion and explanation and, as necessary, discuss said conclusion with the Contractor. If the Department agrees that any of the marked documents should not be disclosed, the Department shall not release those documents in its response to the Freedom of Information request If, however, the Department disagrees in good faith, with the conclusion by the Contractor that said documents should not be disclosed, the Department shall notify the Contractor, in writing, that it intends to release the documents fourteen (14) days from the date of the notice. The Contractor shall notify the Department of its intention to file any legal action in response to the Department's notification that it will release said documents, at least 24 hours in advance of filing such action.

d. If the Contractor concludes that a document is protected by attorney-client or work product privilege, the Contractor may decline to produce the documents and must specifically assert the privilege by identifying the nature of the document and claiming the privilege, the date of the document, the author of the document and to whom it was written.

e. If the Contractor asserts an exemption under paragraph c or a privilege under paragraph d of this section, and the Department honors said claim, the

Contractor shall seek to intervene in order to defend the claim for an exemption or privilege in any subsequent Freedom of Information Commission proceeding challenging the Department's refusal to disclose said documents.

10. Section IV-Part Three- 5.02 Maximum Annual Out-of-Pocket Limits for Certain Types of Cost-Sharing subsections a1 and a2 are corrected as follows:

1. The HUSKY B Income Band 1 limit shall be **$760.**
2. The HUSKY B Income Band 1 limit shall be **$1350.**

11. Section IV-Part Three- 5.03 Premium Billing and Collection; 5.04 Notification of Premium Payments Due; 5.05 Non-payment of the Premium Payments; 5.06 Premium Payments Received after Member Disenrollment; 5.08 Member Premium Paid by Another Entity or Individual; 5.09 Partial Premium Payments and 5.10 Tracking Premium Payments are DELETED IN THEIR ENTIRETY.

12. Pages 5 through 10 of this addendum provides the Department's responses to certain questions raised in accordance with the provisions of the RFP.

13. The Department is preparing a data book for the Bidders' use in developing its Business (Cost) Proposal. The data book will be posted as an addendum to this RFP, will be posted to the Bidders' Library and will provide a summary of the HUSKY financial and encounter data reporting. The data book is expected to be posted the week of March 31, 2008.

This **FIFTH Addendum to 010308DSS_HUSKY_CO_RFP** is being issued by the Issuing Office on the 17th day of March, 2008.

This Addendum must be signed and returned with your submission.

_____ _____

Authorized Signer Company Name

Approved _____

Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

Managed Care MCO RFP Questions Addendum 5

	Section Number	Page Number	Question	Response
1	I.2	3	This paragraph states... "In accordance with the timetable specified in this RFP, the Department will build on this established infrastructure to and through this procurement will utilize an existing, known implementation process to transition the existing HUSKY A & B program into the plans contracted with through this selection process." Please define *known implementation process* .	Since the initial implementation of the HUSKY program the Department has worked with an enrollment broker to facilitate the enrollment of eligible members into participating HUSKY plans. The Department will continue to work with the enrollment broker and the plans selected through this RFP to enroll members into participating plans .
2	1.2	3-4	In the description for type of enrollment for HUSKY A, HUSKY B & Charter Oak, it states "Mandatory, Managed Care (through December 31, 2007.) Will it be mandatory enrollment through the entire contract period?	Yes
3	3	4	Under type of enrollment for Charter Oak it says "Individuals without health insurance for the last six (6) months or those who meet certain qualifying criteria to exempt them from the unisured requirement" Please provide details on what certain qualifying criteria is.	Charter Oak will follow the exemption criteria established for HUSKY B (refer to Section 17b-299 (c) of the Connecticut General Statutes) with the exception of the length of time uninsured (Two (2) months under HUSKY B; six (6) months under Charter Oak).
4	II.6	9	Under the Procurement Reference Library it says enrollment information is available on the Web site. We are unable to find this. Can you please provide the enrollment information on the HUSKY A & B programs and projected enrollment for the Charter Oak Program?	Access the Bidders' Library on the Charter Oak page of the DSS website - http://www.ct.gov/dss/charteroak
5	II.15 - J.	13	This paragraph states... "DSS may require the removal and replacement of any of the Contractor's personnel who do not perform adequately on the contract, regardless of whether they were previously approved by DSS. The Department shall reimburse the Contractor for those staff expenses actually incurred." Should any changes in key personnel be necessary, how will this process work? Has the State exercised this provision in the past?	Reimbursement to the Contractor under the resultant contract will be in accordance with a capitated risk-based arrangement. The capitated rates proposed by Bidders, accepted by the Department and documented in the resultant contract will include administrative costs including costs associated with staffing and personnel. Therefore, resultant Contractor's bear the responsibility for staffing costs, including costs associated with any replacement of staff required by the Department. The final sentence of Section II - 15 - J on page 14 of the original RFP has been deleted.
6	IV - Part Two - 3	23	Throughout this section, the bidder is required to provide information for "key personnel." What is the Department's definition for "key personnel?" For example, can "key personnel" be considered management?	At a minimum, the individual with primary supervisory authority over the staff and operations of the following functional areas shall be considered as "key personnel" - Member Services and Outreach, Provider Enrollment and Credentialing, Quality Assessment and Performance Improvement, Utilization Management/ Review, Data Systems and Project Manager. Bidders' are also free to identify individuals as Key Personnel or positions within the organizational structure as Key Positions that will be filled by Key Personnel.
7	IV - Part Two - 3 A and B	23	In section 3A (Corporate Project Unit), the bidder is required to provide the information for itself and any proposed subcontractor. Section 3B does not specifically state that the information is required for subcontractors. Is it correct that the bidder only needs to respond to section 3B for itself and not its proposed subcontractors?	Corresponding information IS required for any proposed Subcontractor. Section IV - Part Two - 3B has been revised to clarify this requirement.
8	IV - Part Two - 3C	24	In addition to the Project Manager, can the bidder identify additional staff who will have responsibilities for certain areas of this contract?	YES.

	Section Number	Page Number	Question	Response
9	IV - Part Two - 3D	24	This section requires the bidder to provide job descriptions or resumes for key personnel in certain functional areas. If a staff member has responsibilities in more than one area, should the bidder include that staff person's resume in each area or only once?	Bidders' discretion. A Bidder may provide multiple copies of an individual's resume or direct the Department to the resume in the proposal. The Department must, however, be provided able to review the qualifications of proposed key personnel for each functional area identified in Section IV-Part Two-3D1.
10	IV - Part Two - 3D	24	How many references should a staff person provide on his/her resume?	A minimum of TWO
11	IV - Part Two - 3D	24	Number 2 asks for job descriptions **or** resumes; however, 2.c and d of this question asks for resume-specific items. If we only submit job descriptions, letters c and d will be incomplete. Will the State waive this requirement if we are only submitting job descriptions?	If the Bidder does not have a proposed individual to staff a functional areas identified in Section IV-Part Two-3D1 then they are to include a job description with proposed qualifications of the individual they would seek to fill the position. In such cases the Bidder should identify the type of experience they would require, including relevant education, experience and training but would not be required to address items c and d which are solely related to information that is required to be provided in a resume for a specific individual..
12	IV - Part Two - 4A	25	Please clarify: Shall bidders provide corporate experience for only the last five years relative to each of the items 1-7?	YES
13	IV - Part Two - 4A	25	The bidder is requested to list all sanctions, fines, penalties or letters of non-compliance issued against it. Would this include Mercer audit results?	YES. Bidders must list all sanctions, fines, penalties or letters of non-compliance issued them by any State Agency, including State of Connecticut agencies and/or any commercial vendor in any state, including Connecticut. The word "other" has been removed from Section IV - Part Two 4 - A - 1 to encompass the State of Connecticut.
14	IV - Part Three - 3.02	40	The bidder is requested to "propose written policies regarding member rights." Should the bidder provide actual policies or a narrative?	Bidders' should propose ACTUAL policies.
15	IV - Part Three - 3.04	41	Does the State currently have a vendor in place who is providing Disease Management services for any Medicaid populations? If so, please indicate the current Disease Management Vendor and provide the scope of services rendered. Will these services be assessible to HUSKY A & B members enrolled in managed care?	No. There is currently no separate vendor in place providing Disease Management services.
16	IV - Part Three - 3.04	41	What is the State's intent for the selected MCO to provide a Disease Management program for the Husky A & B and Charter Oak membership, i.e. Asthma, Diabetes, CHF, etc? Would the State accept a care coordination model which integrates disease management as part of the proposed care coordination model?	Contractor must demonstrate a Disease Management program that, at a minimum, covers High Risk Pregnancies, Asthma and Diabetes. It is up to the Contractor to choose how to deliver this disease management program in a variety of ways and should support its chosen business model in its proposal response.
17	IV - Part Three - 3.05h	43	Please clarify the co-payment prohibition as it relates to emergency services and subsequent screening and treatment needed to diagnose the condition. It appears from Part IV: Section IV-Part III 5.14.a-b, the prohibition is on emergency services which, by definition, are only needed to "evaluate or stabilize an emergency medical condition." May the MCO or its providers seek co-payment for post-stabilization services, including screening and treatment needed for diagnosis of the Member's condition?	The Contractor shall not charge a member for emergency services nor "subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member.

	Section Number	Page Number	Question	Response
18	IV - Part Three - 3.16	56	The bidder is requested to propose how it will ensure that its network providers comply with the Department's PDL. What type of monitoring will DSS require in order to ensure compliance?	The Department will work collaboratively with the Contractor to develop and implement an appropriate and effective compliance monitoring strategy.
19	IV - Part Three - 3.16	56	The bidder is requested to propose pharmacy data sharing requirements. Is it the Department's intent to have real-time access to pharmacy data? Will it provide the pharmacy name, provider name and number and dispensing data? If not real time, how frequent and in what format?	The pharmacy data layout is available on the Bidders' Library. The Department will work collaboratively with the Contractor to develop and implement an appropriate and effective compliance monitoring strategy.
20	IV - Part Three - 3.18	59	The MCO shall have the responsibility for reimbursing dental screens and fluoride treatments for HUSKY A & B Members under age three. What are the specific procedure codes providers should use to bill for these services?	The provider will use the procedure codes that are on the Medicaid fee schedule.
21	IV - Part Three - 3.19 Husky A Only - b	61	Does the MCO maintain the right to review and determine medical appropriateness of health care, diagnostic services, and treatments ordered by providers for HUSKY A members under the age of 21using the definition of medical appropriateness identified by the Connecticut RFP on page 35? If not, who makes this determination?	Yes
22	IV - Part Three - 3.20	65	The bidder is required to describe its process to provide the care coordination and services "outlined in (b) through (h) above." However, the contract provisions end at (b). Are there contract requirements (c-h) that were omitted from this section?	Subsection b under "The Bidder shall:" in Section IV - Part Three- 3.20 (page 65 of the original RFP) is deleted and replaced with the following: "b. Describe its process to provide the care coordination and services outlines in section 3.20 a 1 - 8."
23	IV - Part Three - 3.29	79	Does the State's definition of "provider surveys" include soliciting feedback on provider services in an open communication, i.e. Can MCOs solicit members' feedback on providers electronically via an e-mail link so that the MCO can appropriately address a network or Member Services issue?	Yes
24	IV - Part Three - 3.30j	82	What does the State define as "unsolicited personal contact" with potential members? Does this preclude the use of any general marketing intended to educate the Member about the availability of the plan and its services? For example, in many states, plans use billboards and radio ads to provide this information.	The contractor must conform to all the marketing guidelines in 3.30 including but not limited to obtaining the Department's aproval for all MCO marketing materials (a). The marketing guidelines in (J) specifically prohibits any mass media campaign to identify potential members except as prior approved by the Department.
25	IV - Part Three - 3.30x	85	Does the 1.0% limit apply to each of the first three years separately or to the first three-year period in total? Similarly, does the 0.5% limit apply to the fourth and fifth year separately or to that two-year period in total?	The 1% applies to each of the first three years separately. The 0.5% limit applies to the fourth and fifth years separately.
26	IV - Part Three - 3.30	86	The bidder is required to submit an outline of its proposed marketing and outreach plan. How is the Department defining "outreach" in this section?	"Outreach" in the context of marketing refers to any assertive effort by the MCO to primarily attract potential members to enroll in the MCO. "Outreach" in the context of health education, refers to efforts primarily focused on improving health or advancing health awareness to existing members.

	Section Number	Page Number	Question	Response
27	IV - Part Three - 3.53	108	Please provide a full list of required reports.	Within the Bidders' Library, historical financial reporting requirements have been posted. However, modifications are expected to be made to these reports (e.g. changes to reflect the new rate structure). Contractors will be given advance notice to make changes to their reporting systems. Additional reports will be discussed with the selected Contractor's and the Department at the data reporting work group .
28	IV - Part Three - 3.58	111	The language in this section is different than the language the MCOs were required to comply with. Is this correct?	YES. The language in section 3.58 is deleted in its entirety and replaced with the Freedom of Information and Performance of a Governmental Function language that is set forth in Section II - 15- M on pages 14 through 16 of the original RFP.
29	IV - Part Three - 4.04	116	Will the State have a process in place to notify the MCO so that a NOA or Continuation of Benefits can be initiated?	The Department will provide the MCO a NOA template. The MCO will be responsible for issuing the NOA when there is a denial, suspension, termination or reduction of service or good. The guidelines for the continuation of benefits is defined in section 4.04.
30	IV - Part Three - 5.02 a 1 & 2 and Appendix B - page 5	128	The maximum out-of-pocket limits specified in these two sections appear to conflict with each other. Please clarify.	The maximum annual out-of-pocket limits for HUSKY B Income Band 1 and HUSKY B Income Band 2 in section 5.02 a on page 128 of the original RFP are revised as follows: 1. The HUSKY B Income Band 1 limit shall be **$760;** 2. The HUSKY B Income Band 2 limit shall be **$1,350.**
31	IV- Part Three - 5.03	130	To improve the efficiency of billing, would the State consider any of the following options regarding billing members for premiums: 1) requiring employers to collect the Charter Oak premium from the individual's paycheck; 2) requiring Charter Oak members to use credit cards to pay for their premium and that this be via the internet 3) award only one Charter Oak contract in order to minimize the costly aspects of premium collection and processing. The above options would allow for a more efficient and cost effective billing and collection process.	The State is in negotiations with its enrollment broker to handle the billing and collection process. Successful contractor would receive payment in full from the State and would not be involved in the billing or collection process.
32	IV - Part Three - 5.12	135	Are deductibles calculated on a calendar year or rolling year from the Member's effective date with the plan?	Rolling twelve-month period from the Member's effective date with the Plan. See Appendix C: Charter Oak Plan Design Worksheet - Summary.
33	IV - Part Three - 5.12 a	135	For the Charter Oak CRCS, should we assume that just MCO claims count toward the deductible (including claims from another MCO if the member was enrolled in that MCO during the same eligibility period)? Or, should we assume that CT ASO and pharmacy claims also count toward the deductible. Both behavioral health and pharmacy have co-payments and coinsurance that should not apply until the deductible is met."	For Charter Oak, only coinsurance counts towards the deductible or out-of-pocket maximums. Also, Charter Oak members will be locked-in for 12 months into their selected MCO. Pharmacy and BH (with the exception of BH inpatient) have copays, which will not need to be counted towards the deductible or out-of-pocket maximums. For BH inpatient, the co-insurance will need to be included in the deductible and/or out-of-pocket maximums.
34	IV - Part Three - 5.16b(1)	138	Please define family as it applies to this paragraph. How will DSS communicate the family status of HUSKY B Members to the MCO?	Member living in the same household as determined by the Department or its agent. This information will be sent to the MCO in accordance with HIPAA compliant 834 data transaction.
35	IV - Part Three - 5.16b(2)	138	Please define family as it applies to this paragraph. How will DSS communicate the family status of Charter Oak Members to the MCO?	Member living in the same household as determined by the Department or its agent. This information will be sent to the MCO in accordance with HIPAA compliant 834 data transaction.

Managed Care MCO RFP Questions Addendum 5

	Section Number	Page Number	Question	Response
36	IV - Part Three - 5.23	145	Will the MCOs have access to real-time pharmacy claims data in order to track prescription drug utilization limits for Charter Oak? Please describe how an MCO would monitor prescription drug utilization limits given that the Department is proposing to provide MCOs with a monthly file? CHNCT would suggest this RFP section be modified. The State's pharmacy subcontractor should be responsible for monitoring prescription drug utilization and notify the Department, MCO's, etc. when a Member has reached his or her limit.	DSS will monitor the prescription drug utilization and notify the MCO's when a member has reached his or her limit. Specifics will be discussed in the reporting work group.
37	IV - Part Three - 7.04 a 2	159	If a member changes residency to another state on or after the first day of a month, is the MCO responsible for services delivered to that member in another state throughout that month?	The HUSKY A, HUSKY B and Charter Oak programs have a Connecticut residency requirement. With few exceptions, if a member changes residency to another state, they are no longer eligible. HUSKY A, HUSKY B and Charter Oak members may reside out of state temporarily, e.g., to attend school, vacation, or participate in residential treatment, and continue eligibility in the program. The MCO will be responsible for covered services delivered to members while visiting or residing out of state, including necessary transportation services. For those members whose residence changes to that of another state, the MCO is responsible for their member until the MCO receives a disenrollment transaction from the Department. Members who choose to go out of state in order to obtain services are limited to emergency services only, unless the services are prior authorized or provided by a network provider.
38	IV - Part Three - 7.05 a 2	161	Please clarify the start and end date of the 60-day "open enrollment period" for both HUSKY and Charter Oak members. The definition at Sec IV - III.1 for "Open Enrollment Period" says: "A sixty (60) day period, which ends on the fifteenth (15th) of the last month of the lock-in period, during which time the Member has the opportunity to change managed care plans for any reason." However, Section 7.05.a.2 states, "The last sixty (60) days of the lock-in period will be an open enrollment period, during which time Members may change managed care plans."	Open enrollment is the 60-day period of time at the end of an eligibility period during which a member may choose a new MCO for any reason. The open enrollment period shall end on the 15th day of the month in which the member's eligibility ends.
39	IV - Part Four - 3	190	Does the minimum net worth requriement as stated in this section apply to an MCO that is not licensed as an HMO/ health care center by the CT Insurance Department?	The minimum net worth requirement as stated in this section applies unless the MCO meets the requirements under 17b-266(b)(2) of the Connecticut General Statutes.
40	IV - Part Four - 4	190	The MCO is required to obtain a fidelity bond in an amount not less than $100,000.00. Can DSS establish a uniform amount for the fidelity bond across MCOs?	The Department has established a minimum amount toprotect against potential emplyee dishonesty and related consequences. The MCO may choose to examine its potential risks and choose to increase the bond amount.
41	Appendix A	1	If pharmacy services are not included in the capitation payment, the following clarification is requested. Are claims associated with all pharmaceutical products, including both legend drugs and over-the-counter drugs, I.e., any pharmaceutical product having an NDC number, indeed not the responsibility of the MCO, regardless of whether submitted as a pharmacy claim or medical claim?	The responsible party for paying pharmacy claims will be determined by the point of service. The MCO will be responsible for medical claims including those claims for pharmacy products administered by a doctor or other qualified provider in his or her office. These drugs may include specialty drugs that have a limited shelf life and require coordination between the supplier and the doctor and are not typically available through a pharmacy. This exception does not apply to immunizations that are avaiable free from the CT Department of Public Health. The Department will be responsible for those services (pharmacy products) delivered by a pharmacist.
42	Appendix C	N/A	If a bidder submits its proposal without offering a dental or vision rider for Charter Oak, can the bidder add that benefit later in the year?	Yes but only on an annual basis prior to the annual open enrollment period.

Managed Care MCO RFP Questions Addendum 5

	Section Number	Page Number	Question	Response
43	General	General	Is it possible that the DEPARTMENT will contract with a given bidder for only certain programs and/or certain counties?	No - only statewide bids for all three programs will be accepted. To be a DSS will only award contracts to Contractors for all three programs on a statewide basis.
44	General	9	In order to plan our coordination of services with the providers of the carve out benefits, please provide the Value Options contract, the PBM contract, the dental contract, and the four MCO's contracts in its Bidder's Library?	The Department has posted the scopes of work from the Value Options contract and the current HUSKY A and HUSKY B contracts to the Bidders' Library. There is no existing PBM or dental contract. Requests for additional portions of these contracts as well as other contracts should be directed to the Issuing Office.

State of Connecticut
Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

FOURTH Addendum

RELEASE DATE - 022808

The following information amends the contents of the original RFP issued on January 1, 2008.

A. In Section II – OVERVIEW OF THE PROCUREMENT PROCESS (RFP Pages 7 – 16) revisions have been made to the following sections: Section 2 – Procurement Schedule (page 7); Section 3 – Bidders' Questions (page 8); Section 14 – Response Date and Time(page 12); Section 15 N – Set-Aside for Small, Minority or Women's Business Enterprises (page 16)

2. Procurement Schedule – The Department has revised the Procurement Schedule as follows:

Milestones	Ending Dates
Deadline for Questions 3:00 PM Local Time	**03/05/08**
Responses to Questions (tentative)	**03/10/08**
Technical Proposals – Responses to Parts One, Two and Three - Due by 3:00 PM Local Time	**03/28/08**
Cost Proposal – Response to Part Four - Due by 3:00 PM Local Time	**04/11/08**
Successful Bidder Announced	TBD
Contract Negotiations Begin	TBD
Contract Begins (tentative)	07/01/08

3. Bidders' Questions – The Department has revised the submission date for Bidders' Questions as follows:

The Department will accept written questions and requests for clarification pertaining to this procurement if submitted to and received by the Issuing Office by **3:00 pm on March 5, 2008.** Written questions and requests for clarification may be sent via email or facsimile to meet this deadline. The Department will only respond to those questions and requests submitted and received by the Issuing Office in writing by the stated deadline. Submit questions and requests for clarification to the Issuing Office directed to the attention of Kathleen M. Brennan by facsimile (860-424-4953) or email (Kathleen.Brennan@ct.gov). The Issuing Office will respond to only those questions that meet the deadline and criteria listed above. Official responses to all questions will be posted in an amendment to this RFP in the form of an addendum to this RFP, posted on the Charter Oak page on the Department's website at www.ct.gov/dss/charteroak and the State Procurement/Contracting Portal www.das.state.ct.us/Purchase/Portal/Portal_home.asp. The tentative posting date for the addendum is March 10, 2008. In addition to the posting of the questions and Department responses, the addendum will include the Department's anticipated date for the announcement of the successful bidder and the schedule of contract negotiations. It is solely the Bidder's responsibility to access the Charter Oak page on the Department's website or the State Procurement/ Contracting Portal to obtain any and all addendums or official announcements pertaining to this RFP. **A responsive proposal must include a signed acknowledgment of the receipt of each the addendums to this RFP that are posted to the Charter Oak page on the Department's website or the State Contracting Portal prior to the Proposal submission date.**

14. Response Date and Time

The Issuing Office must receive the Bidders' response to the proposal requirements for the Technical Proposal (Part One: Transmittal Communications, Forms and Acceptances; Part Two: Organization, Key Personnel and Experience; and Part Three: Scope of Work) no later than **3:00 p.m. local time on Friday March 28, 2008.**

The Issuing Office must receive the Bidders' response to the proposal requirements for the Cost Proposal (Part Four: Price and Financial Information) no later than **3:00 p.m. local time on Friday April 11, 2008.**

The Department will not consider a postmark date as the basis for meeting any submission deadline. Bidders should not interpret or otherwise construe receipt of a proposal after the closing date and time as stated herein as acceptance of the proposal, since the actual receipt of the document is a clerical function. The Department suggests the bidder use certified or registered mail to deliver the proposal when the bidder is not able to deliver the proposal by courier or in person. Bidders that are hand-delivering proposals will not be granted access to the building without photo identification and should allow extra time for security procedures. Bidders must address all RFP communications to the Issuing Office.

15 N. Set-Aside for Small, Minority or Women's Business Enterprises

There is an incorrect statutory reference in subsection 2 **replace Section 32-9e with Section 4a-60g** of the Connecticut General Statutes.

B. In Section IV – PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template – 3.47 Provider Compensation subsection g (page 106) is deleted and replaced with:

g. Reimbursement by the MCO to **all providers** shall be at no less than the DEPARTMENT's Medicaid fee schedule.

C. In Section V – PROPOSAL EVALUATION (RFP Pages 192 – 193) the following sections have been replaced: PHASE FOUR: EVALUATION OF THE BUSINESS COST PROPOSEL (PAGE 193) AND PHASE FIVE: RANKING OF THE PROPOSALS (PAGE 193), as follows:

PHASE THREE: EVALUATION OF THE BUSINESS COST PROPOSAL

Each Business Cost Proposal received in accordance with the terms of this RFP shall be reviewed and evaluated. However, the score for the Business Cost Proposal will only be factored into the total score (Technical and Business) for the complete proposal for the bidders who achieved a minimum of seventy-five percent of the total available points for their Technical submission (Phases Two and Three).

PHASE FOUR: RANKING OF THE PROPOSALS

Upon completion of Phases One and Two, it is possible that Evaluation Team members will interview the finalists. After the Evaluation Team has scored the proposals, the points awarded will be totaled to determine the ranking. Recommendations, along with pertinent supporting materials, will then be conveyed to the Commissioner of Social Services. The Commissioner of Social Services, at his discretion, reserves the right to approve or reject the recommendations of the Evaluation Team

C. The Department is providing responses to certain questions raised in accordance with the provisions of the RFP:

1. QUESTION: RFP Section II.15-N (Page 16) Is a resultant contractor required to set aside 25% of its average total of all contracts for each of the previous three fiscal years OR is the resultant contractor required only to make a good faith effort to set aside a portion of this contract?

RESPONSE: The Department is obligated to set aside 25% of its average total of all contracts for each of the previous three fiscal years. To assist the Department in meeting its set-aside goals, resultant contractors are required, at a minimum, to make a good faith effort to set aside a portion of its contract for a small, minority or women's business enterprise as a subcontractor. Bidders are strongly encouraged to access the website (www.das.state.ct.us/Purchase/SetAside/SAPVendor.asp) to identify potential subcontractors. Resultant contractors will be obligated to report, no more frequently than quarterly, on its efforts.

2. QUESTION: RFP Section II.15-N (Page 16) This section indicates the bidder shall make a "good faith effort" to set aside a portion of this contract for a small,

minority, or women's business enterprise as a subcontractor. Such subcontractors may supply goods or services. Do bidder's enterprise-wide supplier diversity commitments meet the requirements, or do certified minority or women's business enterprises have to be located and certified in the State of Connecticut?

RESPONSE: To be meet the "good-faith" requirements, the minority or women's business enterprises used as a subcontractor must be located and certified in the State of Connecticut.

3. **QUESTION: RFP Section IV - Part Three - 9.09 a 1(Page 187)** Please provide the form OMB Standard From 424B.

RESPONSE: ATTACHED.

4. **QUESTION: General -** In order to plan our coordination of services with the providers of the carve out benefits, please provide the Value Options contract, the PBM contract, the dental contract, and the four MCO's contracts in its Bidder's Library?

RESPONSE: The Department will post the scopes of work from the Value Options contract and the current HUSKY A and HUSKY B contracts to the Bidders' Library by **March 4, 2008.** There is no existing PBM or dental contract. Requests for additional portions of these contracts as well as other contracts should be directed to the Issuing Office.

This **FOURTH Addendum to 010308DSS_HUSKY_CO_RFP** is being issued by the Issuing Office on the 28th day of February, 2008.

This Addendum must be signed and returned with your submission.

_____ _____

Authorized Signer Company Name

Approved _____

Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE

APPLICANT ORGANIZATION	DATE SUBMITTED
	May 2, 2017

State of Connecticut
Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

THIRD Addendum

RELEASE DATE – 022108

Clarifications and Attachments A – G

The following information amends the contents of the original RFP issued on January 3, 2008.

1. Delete the reference to Appendix L: Charter Oak Plan Design Worksheet in the Preface to the Request for Proposals. The information is contained in Appendix C: Charter Oak Plan Design Worksheet.

2. Section II 6 Procurement Reference Library – page 9 of the RFP may also be identified as the "Bidders' Library" which may be accessed through the Charter Oak page of the DSS website at http://www.ct.gov/dss/charteroak

3. Section III 4 Proposal Construction Requirements (page 18), delete subsection A – Binding of Proposals and replace with:

A. Binding of Proposal:

Bidders must submit proposals that correspond with the RFP Table of Contents in a format, such as a 3 – ring loose leaf notebook, that will allow updated pages to be easily incorporated into the original proposal. An original (clearly marked – "**Managed Care MCO RFP")** and eight (8) exact, legible copies of the separate Proposal Parts One through Four must be submitted. The official name of the organization must appear on the outside front cover of each notebook and on each page of the proposal. Location of the name is at the bidder's discretion.

4. Delete section III 7 Page Limitation (page 18) and replace with:

7. Page Limitation

Part One has no page limitations. All forms shown as Appendices in this RFP and submitted in Part One of the proposal are not subject to page limitations. Part Two is limited to 150 pages, not including resumes or job descriptions. Part Three is limited to 200 pages not including documents that the Bidder is required to provide as Attachments such as examples of policies, written plans, etc. Part Four is limited to 10 pages not including audit information and corporate disclosure information.

5. Subsection 8 in Section IV PROPOSAL CONTENTS Part One: Transmittal Communication, Forms and Acceptances was intentionally omitted.

6. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template subsection 3.01 Provision of Services DELETE subsection f (page 40) and delete requirement "b" under **The Bidder shall (page 40).**

7. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template subsection 3.10 Geographic Coverage subsection b under "**The Bidder shall"** (page 50) – the HUSKY A and HUSKY B enrollment by town information is provided in the Bidders' Library NOT in Attachment X.

8. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template subsection 3.35 Utilization Management and Prior Authorization Requirements (pages 93 – 95). There was a formatting error that resulted in the omission of subsection "c". Bidders' are instructed to identify the subsections in 3.35 as a through i.

9. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template subsection 3.42 Limited Coverage of Some Benefits, delete subsection a (page 103) and replace with the following:

a. Some contract services are covered only up to a specified dollar or quantity limit, as set forth in Section 5.21, Service Limits and Exclusions, Appendix A (HUSKY A), Appendix B (HUSKY B) and Appendix C (Charter Oak Plan Design Worksheet). This dollar or quantity limit is the allowance for which the MCO shall be responsible. If the Member decides to access these contract services, the MCO shall cover them up to the specified allowance.

10. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template subsection 5.15 Coinsurance, delete subsection b 2 (page 137) and replace with the following:

2. The MCO shall impose the specific co-insurance requirements described in Appendix C -Charter Oak Plan Design Worksheet.

11. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template subsection 5.21 Service Limits and Exclusions, delete subsections a and b (page 143) and replace with the following:

a. Consistent with Section 3.42, Limited Coverage of Some Benefits , the MCO shall impose the service limitations and exclusions for HUSKY B and Charter Oak as described in Appendices A, B, and C.

b. For Charter Oak Members, the MCO shall impose the following coverage limitations:

1. Outpatient Rehabilitation (speech therapy, physical therapy, and occupational therapy) shall be limited to 30 visits per year for all therapy combined;

2. Primary Care Behavioral Health visits shall be limited to 30 visits per year and shall be subject to prior authorization;

3. Durable Medical Equipment (DME) coverage shall be limited to $4,000 per year;

4. Prescription drug and pharmacy services coverage shall be limited to $7,500 per year; and

5. Inpatient Rehabilitation/Skilled Nursing Facility coverage shall be limited to fourteen (14) days per year unless it is documented to be a cost-effective alternative in lieu of hospitalization. The MCO shall submit documentation of cost-effectiveness to the DEPARTMENT, which shall have sole discretion to make this determination for each case. The MCO and Member shall abide by the DEPARTMENT's decision.

12. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template subsection 7.05 Lock-In/Open Enrollment, delete subsection a 1 (page 160) and replace with the following:

1. The first ninety (90) days of enrollment into a new managed care plan for HUSKY A and HUSKY B members and the first thirty (30) days of enrollment into a new managed care plan for Charter Oak members will be designated as the free-look period during which time the Member may change managed care plans.

13. The references to Appendix M, Capitation Payment Amount in Section IV PROPOSAL CONTENTS Part Three: Scope of Work Contract Template section 7.06 Capitation Payments to the MCO subsections a and b (pages 161 and 162) should be revised to Appendix L, Capitation Payment Amount.

14. Section IV PROPOSAL CONTENTS Part Three: Scope of Work – Contract Template section 8 Standard Terms and Conditions (including declarations and miscellaneous provisions) section 8.03 subsection C – Statutory and Regulatory Compliance is amended by the addition of the following provisions:

6 d. Executive Order No. 7C: Contracting Standards Board. This Contract is subject to provisions of Executive Order No. 7C of Governor M. Jodi Rell, promulgated on July 13, 2006. The Parties to this Contract, as part of the consideration hereof, agree that:

(1) The State Contracting Standards Board ("Board") may review this Contract and recommend to the state Contracting agency termination of

this Contract for cause. The State Contracting agency shall consider the recommendations and act as required or permitted in accordance with the Contract and applicable law. The Board shall provide the results of its review, together with its recommendations, to the state Contracting agency and any other affected party in accordance with the notice provisions in the Contract not later than fifteen (15) days after the Board finalizes its recommendation. For the purposes of this Section, "for cause" means: (A) a violation of the State Ethics Code (Chap. 10 of the general statutes) or section 4a-100 of the general statutes or (B) wanton or reckless disregard of any state Contracting and procurement process by any person substantially involved in such Contract or state Contracting agency.

(2) For purposes of this Section, "Contract" shall not include real property transactions involving less than a fee simple interest or financial assistance comprised of state or federal funds, the form of which may include but is not limited to grants, loans, loan guarantees, and participation interests in loans, equity investments and tax credit programs. Notwithstanding the foregoing, the Board shall not have any authority to recommend the termination of a Contract for the sale or purchase of a fee simple interest in real property following transfer of title.

(3) Notwithstanding the Contract value listed in sections 4-250 and 4-252 of the Conn. Gen. Stat. and section 8 of Executive Order Number 1, all State Contracts between state agencies and private entities with a value of $50,000 (fifty thousand dollars) or more in a calendar or fiscal year shall comply with the gift and campaign contribution certification requirements of section 4-252 of the Conn. Gen. Stat. and section 8 of Executive Order Number 1. For purposes of this section, the term "certification" shall include the campaign contribution and annual gift affidavits required by section 8 of Executive Order Number 1.

6e. Executive Order No. 14: Procurement of cleaning products and services. This Agreement is subject to the provisions of Executive Order No. 14 of Governor M. Jodi Rell promulgated April 17, 2006. Pursuant to this Executive Order, the contractor shall use cleaning and/or sanitizing products having properties that minimize potential impacts on human health and the environment, consistent with maintaining clean and sanitary facilities.

14. WHISTLEBLOWING.

This Agreement is subject to the provisions of § 4-61dd of the Connecticut General Statutes. 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 the provisions of subsection (a) of such statute, the Contractor shall be liable for a civil penalty of not more than five thousand dollars for each offense, up to a maximum of twenty per cent of the value of this Agreement.

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 provisions of the statute relating to large state Contractors in a conspicuous place which is readily available for viewing by the employees of the Contractor.

15. CAMPAIGN CONTRIBUTION RESTRICTIONS.

On February 8, 2007, Governor Rell signed into law Public Act 07-1, An Act Concerning the State Contractor Contribution Ban and Gifts to State and Quasi-Public Agencies.

For all State contracts as defined in P.A. 07-1 having a value in a calendar year of $50,000 or more or a combination or series of such agreements or contracts having a value of $100,000 or more, the authorized signatory to this Agreement expressly acknowledges receipt of the State Elections Enforcement Commission's notice advising state contractors of state campaign contribution and solicitation prohibitions, and will inform its principals of the contents of the notice. See SEEC Form 11 – Attachment G.

15. Appendix A – MCO Contract – Summary Description of Benefits – section B – Covered Services Not Included in the Capitation Payment – subsection 6 Pharmacy Services (pages 19 – 20 Appendix A) is deleted and replaced with the following:

6. **Pharmacy Services** - All pharmacy services provided through a retail pharmacy will be managed and reimbursed directly by the Department. The MCO shall be responsible for all physician administered drugs, including injectables and J-codes, that are provided in a professional office setting. A description of pharmacy products covered under HUSKY A is as follows:

a. Covered services

i. Drugs prescribed by a licensed authorized practitioner. The MCO maintains responsibility for all pharmacy services and associated charges, regardless of diagnosis The MCO may use a prescription drug

formulary as is described in Section 3.15, Pharmacy Access of the contract. CT BHP providers are required to follow the MCO's pharmacy program requirements

ii. Over-The-Counter (OTC) Drugs on the State of Connecticut's OTC Formulary, including liquid generic antacids, birth control products, calcium preparations, diabetic-related products, electrolyte replacement products, heratinics, nutritional supplements and vitamins (prenatal, pediatric, high potency).

b. Noncovered Services

i. Drugs included in the Food and Drug Administration's Drug Efficacy Study Implementation Program;

ii. Alcoholic liquors;

iii. Items used for personal care and hygiene or cosmetic purposes;

iv. Drugs solely used to promote fertility;

v. Drugs not directly related to the patient's diagnosis, when diagnosis is required by the DEPARTMENT to be written on the prescription;

vi. Any vaccines and/or biologicals which can be obtained free of charge from the CT. State Department of Health Services. The DEPARTMENT will notify pharmacists of such vaccines or biologicals;

vii. Any drugs used in the treatment of obesity unless caused by a medical condition;

viii. Controlled substances dispensed to HUSKY members that are in excess of the product manufacturer's recommendation for safe and effective use for which there is no documentation of medical justification in the pharmacy's file; and,

ix. Drugs used to promote smoking cessation.

x. Drugs used to treat sexual or erectile dysfunction.

16. Attachments A – F of 010308DSS_HUSKY_CO_RFP were inadvertently omitted when released on January 3, 2008. Through this addendum the Department is providing the following documents originally referenced in the RFP:

Attachment A – Procurement Agreement Signatory Acceptance
Attachment B – Workforce Analysis Form
Attachment C – Affirmative Action – Notification to Bidders Form
Attachment D – Smoking Policy
Attachment E – Lobbying Restrictions
Attachment F – Integrity in State Contracting Policy Affidavits

In addition the Department has added a new Attachment G – Notice to Executive Branch State Contractors and Prospective State Contractors of Campaign Contribution and Solicitation Ban.

This THIRD Addendum to 010308DSS_HUSKY_CO_RFP is being issued by the Issuing Office on the 21st day of February, 2008.

This Addendum must be signed and returned with your submission.

_____ _____

Authorized Signer Company Name

Approved _____

Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

ATTACHMENT A - PROCUREMENT AND CONTRACTUAL AGREEMENTS SIGNATORY ACCEPTANCE

Statement of Acceptance

The terms and conditions contained in this Request for Proposals constitute a basis for this procurement. These terms and conditions, as well as others so labeled elsewhere in this document are mandatory for the resultant contract. The Department is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

Acceptance Statement

On behalf of _____ I, _____ agree to accept the Mandatory Terms and Conditions as set forth in the Department of Social Services' Medicaid Managed Care – HUSKY A; SCHIP Managed Care – HUSKY B and Charter Oak Managed Care Request for Proposals.

Signature

_____ _____

Title Date

ATTACHMENT B - WORKFORCE ANALYSIS FORM

Contractor Name: _____ Total number of CT employees: _____
Address:_____ Full-time_____ Part-time _____

Complete the following Workforce Analysis for employees on Connecticut worksites who are:

Job Categories	Totals for all Columns - Male and Female	White (Not of Hispanic Origin)		Black (Not of Hispanic Origin)		Hispanic		Asian Or Pacific Islander		American Indian Or Alaskan Native		Individuals Disabilities	
		male	female	male	female	male	female	male	female	male	female	male	female
Officials and Managers													
Professionals													
Technicians													
Sales Workers													
Office and Clerical													
Craft Workers (Skilled)													
Operators (Semi Skilled)													
Laborers (Unskilled)													
Totals Above													
Totals One Year Ago													
Formal On-The-Job-Trainees (Enter figures for the same categories as shown above)													
Apprentices													
Trainees													
Employment Figures were obtained from_____Visual Check_____Employment Records_____Other: _____													

Workforce Analysis Form (continued)

1. Have you successfully implemented an Affirmative Action Plan?
   Yes _____ No _____ Date of Implementation _____
   If the answer is No, explain.

1.a. Do you promise to develop and implement a successful Affirmative Action Plan?
   Yes _____ No _____ Not Applicable _____
   Explanation:

2. Have you successfully developed an apprenticeship program complying with §46a-68-1 to 46a-68-17 of the State of Connecticut Department of Labor Regulations, inclusive:
   Yes _____ No _____ Not Applicable _____
   Explanation:

3. According to EEO-1 data, is the composition of your workforce at or near parity when compared with the racial and sexual composition of the workforce in the relevant labor market area?
   Yes _____ No _____ Not Applicable _____
   Explanation:

4. If you plan to subcontract, will you set aside a portion of the contract for legitimate minority business enterprises?
   Yes _____ No _____ Not Applicable _____
   Explanation:

_____ _____

Contractor's Authorized Signature Date [WFA 5/93]

ATTACHMENT C - NOTIFICATION TO BIDDERS FORM

The contract to be awarded in response to this RFP is subject to contract compliance requirements mandated by §4a-60 of the General Statutes of Connecticut, and when the awarding agency is the State, §46a-71(d) of the General Statutes of Connecticut. Contract Compliance Regulations codified at §4a-60 et. seq. of the Regulations of the Connecticut State agencies establish a procedure for the awarding of all contracts covered by §4a-60 and 46a-71(d) of the General Statutes of Connecticut.

According to §4-114a-3(9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance regulations has an obligation to "aggressively solicit participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials." "Minority business enterprise" is defined in §4a-60 of the General Statutes of Connecticut as a business wherein 51 percent or more of the capital stock or assets belong to 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 §32-9n." "Minority" groups are defined in §32-9n of the General Statutes of Connecticut as "(1) Black Americans, (2) Hispanic Americans, (3) Women, (4) Asian Pacific Americans and Pacific Islanders, or (5) American Indians" The above definitions apply to the contract compliance requirements by virtue of §4-114a (10) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder's qualifications under the contract compliance requirements:

1. The bidder's success in implementing an affirmative action plan
2. The bidder's success in developing an apprenticeship program complying with §46a-68-1 to 46a-68-17 of the Regulations of Connecticut State agencies, inclusive
3. The bidder's promise to develop and implement an affirmative action plan
4. The bidder's submission of EEO-1 data indicating that the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market
5. The bidder's promise to set aside a portion of the contract for legitimate minority businesses. See §4-114a3 (10) of the Contract Compliance Regulations

---

INSTRUCTION TO THE BIDDER: The Bidder must sign the acknowledgement below and return it to the Awarding Agency along with the bid proposal. Retain a signed copy in your files.

The undersigned acknowledges receiving and reading a copy of the "Notification to Bidders" form:

_____ _____

Signature Date

On Behalf of: _____

_____

Organization Name

_____

Address

ATTACHMENT D - SMOKING POLICY

General Statutes of Connecticut

Section 31-40q. Smoking in the workplace: Definitions, employers to establish nonsmoking areas, exemptions.

a) As used in this section:

i. "Person" means one or more individuals, partnerships, associations, corporations, limited liability companies, business trusts, legal representatives, or any organized group of persons.

ii. "Employer" means a person engaged in business that has employees including the state and any political subdivision thereof.

iii. "Employee" means any person engaged in service to an employer in the business of his employer.

iv. "Business facility" means a structurally enclosed location or portion thereof at which twenty or more employees perform services for their employer.

v. "Smoking" means the burning of a lighted cigar, cigarette, pipe or any other matter or substance that contains tobacco.

b) Each employer shall establish one or more work areas, sufficient to accommodate nonsmokers who request to utilize such an area, within each business facility under its control, where smoking is prohibited. The employer shall clearly designate the existence and boundaries of each nonsmoking area by posting signs that can be readily seen by employees and visitors. In the areas within the business facility where smoking is permitted, existing physical barriers and ventilation systems shall be used to the extent practicable to minimize the effect of smoking in adjacent nonsmoking areas. Nothing in this section may be construed to prohibit an employer form designating an entire business facility as a nonsmoking area.

c) The State Labor Commissioner may exempt any employer from the provisions of this section if the Commissioner finds that (1) the employer made a good-faith effort to comply with the provisions of this section and (2) any further requirement to so comply would constitute an unreasonable financial burden on the employer.

(P.A. 83-268; P.A. 87-149, S.1, 3; P.A. 91-94; P.A. 95-79, S. 109, 189.)

History: P.A. 87-149 amended Subsection (b) To require employers to establish sufficient nonsmoking areas in business facilities and added Subsection (c) To enable the State Labor Commissioner to exempt certain employers from compliance with those requirements, effective April 1, 1988, P.A. 91-94 amended Subsection (a) By reducing the minimum number of employees from fifty to twenty in Subdiv. (4), P.A. 95-79 amended Subsection (a) To redefine "person" to include limited liability companies, effective May 31, 1995.

Cited. 24C. 666,672-674.
Subsection (b):
Cited. 224C. 666, 674.

ATTACHMENT E - CERTIFICATION REGARDING LOBBYING

Contractor:_____

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federally appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more that $100,000 for each such failure.

_____ _____

Signature Typed Name and Title

_____ _____

Firm/Organization Date

ATTACHMENT F – INTEGRITY IN STATE CONTRACTING POLICY AFFIDAVITS
GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION

STATE OF CONNECTICUT
GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION

Certification to accompany a State contract with a value of $50,000 or more in a calendar or fiscal year, pursuant to C.G.S. §§4-250 and 4-252(c); Governor M. Jodi Rell's Executive Orders No. 1, Para. 8, and No. 7C, Para. 10; and C.G.S. §9-612(g)(2), as amended by Public Act 07-1

INSTRUCTIONS:
Complete all sections of the form. Attach additional pages, if necessary, to provide full disclosure about any lawful campaign contributions made to campaigns of candidates for statewide public office or the General Assembly, as described herein. Sign and date the form, under oath, in the presence of a Commissioner of the Superior Court or Notary Public. Submit the completed form to the awarding State agency at the time of initial contract execution (and on each anniversary date of a multi-year contract, if applicable).

CHECK ONE: ☐ Initial Certification ☐ Annual Update (Multi-year contracts only.)

GIFT CERTIFICATION:
As used in this certification, the following terms have the meaning set forth below:

1) "Contract" means that contract between the State of Connecticut (and/or one or more of it agencies or instrumentalities) and the Contractor, attached hereto, or as otherwise described by the awarding State agency below;
2) If this is an Initial Certification, "Execution Date" means the date the Contract is fully executed by, and becomes effective between, the parties; if this is an Annual Update, "Execution Date" means the date this certification is signed by the Contractor;
3) "Contractor" means the person, firm or corporation named as the contactor below;
4) "Applicable Public Official or State Employee" means any public official or state employee described in C.G.S. §4-252(c)(1)(i) or (ii);
5) **"Gift"** has the same meaning given that term in C.G.S. §4-250(1);
6) "Planning Start Date" is the date the State agency began planning the project, services, procurement, lease or licensing arrangement covered by this Contract, as indicated by the awarding State agency below; and
7) "Principals or Key Personnel" means and refers to those principals and key personnel of the Contractor, and its or their agents, as described in C.G.S. §§4-250(5) and 4-252(c)(1)(B) and (C).

I, the undersigned, am the official authorized to execute the Contract on behalf of the Contractor. I hereby certify that, between the Planning Start Date and Execution Date, neither the Contractor nor any Principals or Key Personnel has made, will make (or has promised, or offered, to, or otherwise indicated that he, she or it will, make) any **Gifts** to any Applicable Public Official or State Employee.

I further certify that no Principals or Key Personnel know of any action by the Contractor to circumvent (or which would result in the circumvention of) the above certification regarding **Gifts** by providing for any other principals, key personnel, officials, or employees of the Contractor, or its or their agents, to make a **Gift** to any Applicable Public Official or State Employee. I further certify that the Contractor made the bid or proposal for the Contract without fraud or collusion with any person.

CAMPAIGN CONTRIBUTION CERTIFICATION:

I further certify that, on or after December 31, 2006, neither the Contractor nor any of its principals, as defined in C.G.S. §9-612(g)(1), has made any **campaign contributions** to, or solicited any contributions on behalf of, any exploratory committee, candidate committee, political committee, or party committee established by, or supporting or authorized to support, any candidate for statewide public office, in violation of C.G.S. §9-612(g)(2)(A). I further certify that **all lawful campaign contributions** that have been made on or after December 31, 2006 by the Contractor or any of its principals, as defined in C.G.S. §9-612(g)(1), to, or solicited on behalf of, any exploratory committee, candidate committee, political committee, or party committee established by, or supporting or authorized to support any candidates for statewide public office or the General Assembly, are listed below:

STATE OF CONNECTICUT
GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION

Lawful Campaign Contributions to Candidates for Statewide Public Office:

Contribution Date	Name of Contributor	Recipient	Value	Description

Lawful Campaign Contributions to Candidates for the General Assembly:

Contribution Date	Name of Contributor	Recipient	Value	Description

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

_____ _____

Printed Contractor Name **Signature of Authorized Official**

Subscribed and acknowledged before me this _____ day of _____, 200__.

_____

Commissioner of the Superior Court (or Notary Public)

For State Agency Use Only

_____ _____

Awarding State Agency Planning Start Date

_____

Contract Number or Description

STATE OF CONNECTICUT
CONSULTING AGREEMENT AFFIDAVIT

Affidavit to accompany a State contract for the purchase of goods and services with a value of $50,000 or more in a calendar or fiscal year, pursuant to General Statutes of Connecticut §§4a-81(a) and 4a-81(b)

INSTRUCTIONS:
If the bidder or vendor has entered into a consulting agreement, as defined by General Statutes of Connecticut §4a-81(b)(1): Complete all sections of the form. If the bidder or vendor has entered into more than one such consulting agreement, use a separate form for each agreement. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public. **If the bidder or vendor has not entered into a consulting agreement, as defined by General Statutes of Connecticut §4a-81(b)(1):** Complete only the shaded section of the form. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public.

Submit completed form to the awarding State agency with bid or proposal. For a sole source award, submit completed form to the awarding State agency at the time of contract execution.

This affidavit must be amended if the contractor enters into any new consulting agreement(s) during the term of the State contract.

AFFIDAVIT: [Number of Affidavits Sworn and Subscribed On This Day: _____]
I, the undersigned, hereby swear that I am the chief official of the bidder or vendor awarded a contract, as described in General Statutes of Connecticut §4a-81(a), or that I am the individual awarded such a contract who is authorized to execute such contract. I further swear that I have not entered into any consulting agreement in connection with such contract, **except for the agreement listed below**:

_____ _____
Consultant's Name and Title Name of Firm (if applicable)

_____ _____ _____
Start Date End Date Cost

Description of Services Provided: _____

_____

_____

Is the consultant a former State employee or former public official? ☐ YES ☐ NO
If YES: _____ _____
Name of Former State Agency Termination Date of Employment

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

_____ _____ _____
Printed Name of Bidder or Vendor **Signature of Chief Official or Individual** **Date**

_____ _____
Printed Name (of above) Awarding State Agency

Sworn and subscribed before me on this _____ day of _____, 200__.

_____
Commissioner of the Superior Court
or Notary Public

SEEC FORM 11

This notice is provided under the authority of General Statutes of Connecticut 9-612(g)(2), as amended by P.A. 07-1, and is for informing state contractors and prospective state contractors of the following law (italicized words are defined below):

Campaign Contribution and Solicitation Ban

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

In addition, no holder or principal of a holder of a valid prequalification certificate, shall make a contribution to, or solicit contributions on behalf of (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of State senator or State representative, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

Duty to Inform

State contractors and prospective state contractors are required to inform their principals of the above prohibitions, as applicable, and the possible penalties and other consequences of any violation thereof.

Penalties for Violations

Contributions or solicitations of contributions made in violation of the above prohibitions may result in the following civil and criminal penalties:

Civil penalties

$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 $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 five years, or $5,000 in fines, or both.

Contract Consequences
Contributions made or solicited in violation of the above prohibitions may result, in the case of a state contractor, in the contract being voided.

Contributions made or solicited in violation of the above prohibitions, in the case of a prospective state contractor, shall result in the contract described in the state contract solicitation not being awarded to the prospective state contractor, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

The State will not award any other state contract to anyone found in violation of the above prohibitions for a period of one year after the election for which such contribution is made or solicited, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

Additional information and the entire text of P.A. 07-1 may be found on the Web site of the State Elections Enforcement Commission, www.ct.gov/seec. Click on the link to “State Contractor Contribution Ban.”

State of Connecticut
Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

SECOND Addendum

RELEASE DATE – 022008

Cost Proposal Requirements and Bidders' Conference

The following information amends the contents of the original RFP issued on January 1, 2008.

1. At the time of the release of 010308DSS_HUSKY_CO_RFP, the Department had not completed its review of certain components within the requirements of the RFP. These included specific requirements for the Cost Proposal. With the release of this second addendum the Department has released instructions for the completion of the cost proposal (pdf file) and cost proposal templates (excel spreadsheets). These documents are reproduced in this addendum in a pdf format but each organization that has provided a Letter of Intent to bid will also receive the excel spreadsheets via e-mail.

2. SECTION II – OVERVIEW OF THE PROCUREMENT PROCESS – SUBSECTION 5. The Bidders' Conference for potential bidders to ask clarifying questions pertaining to the requirements of the RFP shall be held on **FRIDAY, FEBRUARY 22, 2008 from 10:00 am – 12:00 pm** in Mezzanine Conference Room 2 A & B at the State of Connecticut Department of Social Services Central Office located at 25 Sigourney Street, Hartford, CT. **NOTE WELL:** Responses to those questions raised at the Bidders' Conference will not be deemed "OFFICIAL" until they are posted as an amendment to the RFP in a subsequent addendum.

To ensure the availability of adequate space for all interested parties, organizations have been limited to NO MORE than two (2) attendees. For building access and security purposes interested parties were required to submit to the Issuing Office a list of planned attendees by 3:00 PM ON WEDNESDAY, FEBRUARY 20, 2008. **PLEASE NOTE:** Identification will be checked and

access will be granted only to those individuals on the security list provided by the Department to building security.

While the primary purpose of the Bidders' Conference is to allow Bidders' the opportunity to ask clarifying questions pertaining to the requirements of the RFP, the Department will be providing an overview of the Cost Proposal requirements issued through this addendum. As previously stated while the Department may provide tentative responses to questions raised at the Bidders' Conference, the Department's responses will not be deemed OFFICIAL until they are posted as a subsequent addendum to this RFP.

This SECOND Addendum to 010308DSS_HUSKY_CO_RFP is being issued by the Issuing Office on the 20th day of February, 2008.

This Addendum must be signed and returned with your submission.

_____ _____

Authorized Signer Company Name

Approved _____

Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

STATE OF CONNECTICUT HUSKY PROGRAM AND CHARTER OAK PROGRAM

July 1, 2008 – June 30, 2009

INSTRUCTIONS FOR COMPLETING THE COST PROPOSAL AND CAPITATION RATE CALCULATION SHEET (CRCS)

Table of Contents

A. General

This document includes instructions for preparing the capitation cost bids for the State of Connecticut (State) HUSKY Program and Charter Oak Program for the contract period July 1, 2008 through June 30, 2009. The Contractor is advised to review this entire document carefully and follow all instructions.

The information requested in this document is required to support the reasonableness of the capitation cost bids and is for internal Department of Social Services (Department or DSS) use. This information serves as a useful tool for both the Department and Contractor in terms of understanding the Contractor's rationale for its capitation cost bid, facilitating evaluations and negotiations, and serving as a planning and monitoring tool. Any information provided in response to the bid is subject to the Section 1-210 of the Connecticut General Statutes "Access to public records. Exempt records." Bidders in its response to this Request for Proposal (RFP) may declare specific components of their proposal to be proprietary. However, such declarations must comply with the Freedom of Information Act (FOIA) and with Section 1-210 (b) of the Connecticut General Statutes. Bidders making proprietary declarations must clearly identify those sentences or subsections with rationale that complies with FOIA to claim proprietary exemption. The State will not accept blanket declarations. The bidder must explain the rationale for the proprietary claim in terms of the prospective harm to the competitive position of the bidder that would result if the identified material were to be released. The bidder must also state the legal argument for exempting the materials pursuant to the statute cited above. The Proprietary Declaration must be located immediately following the Table of Contents. While the bidder may claim proprietary exemptions, any decision to release information subject to a FOIA request shall remain with the State.

The Department will accept bids from full risk Managed Care Organizations (MCOs). The term "Contractor" throughout this document is intended to refer to the MCO preparing the bid.

Capitation is designed to provide the Contractor with a prospectively determined monthly payment so it may provide services that meet program standards. The Contractor, in these bids, **must** demonstrate that its proposed capitation rates were developed in an actuarially sound manner. The basis of all financial projections **must** be linked to the capitation cost bids. The Contractor may require assistance from an actuary to develop some of the fundamental assumptions for meeting the criteria defined below.

To assist the Contractor with the preparation of its capitation cost bids, the Department will make available, upon request, a data library with relevant historical, financial and eligibility information program changes, and other relevant information necessary to prepare the bid. The data library should not be used as the only source of information in making decisions concerning the capitation cost bids. The Contractor is solely responsible for research, preparation, and documentation of its capitation cost bids.

The capitation cost bids **must** consist of a CRCS for each rating group for each program (HUSKY A, HUSKY B, Charter Oak) for which the Contractor is submitting a bid along with the accompanying schedules. The program Rating Groups, Categories of Services and instructions for the Cost Proposal are described below. The Cost Proposal forms can be found in Attachment 1.

The following **must** be submitted to the Department:

Eight hard copies of the Cost Proposal signed by the responsible individual **and two electronic copies**, using the Excel file provided by the Department in the rate package (Attachment 1).

In the event of a discrepancy between Cost Proposal information submitted electronically and the hard copy version, the hard copy will be utilized for evaluation of the capitation cost bids.

B. Requirements for Submission of Accompanying Narrative
Separate detailed narrative should be provided for both HUSKY and Charter Oak.

B.1. Requirements for Submission of Accompanying HUSKY Narrative

A detailed Narrative must be provided that explains the Contractor's rate-setting methodology. The Contractor should describe in detail the data sources and actuarial assumptions used in developing the July 1, 2008 through June 30, 2009 rates. Attachment 2A provides an example of the specific information to be included in the Narrative. The following should be provided:

a) The data sources used
b) The programmatic changes incorporated and their values
c) Managed care trend rates applied
d) Other utilization assumptions including impact of managed care efforts on the utilization rates
e) Other unit cost assumptions, including identification of provider fee schedule arrangements (including satisfying Section 3.47.g of the RFP), capitation arrangements, reinsurance, risk sharing, withholds or incentive payment arrangements
f) Enrollment projections and assumptions
g) Reinsurance premiums and recovery estimates
h) Pro forma income statements
i) Administrative contracts and related party charges
j) Start-up costs
k) Underwriting gain and risk/contingency margin justification
l) Any other assumptions the Contractor has included in its projections

B.2. Requirements for Submission of Accompanying Charter Oak Narrative

A detailed Narrative must be provided that explains the Contractor's Charter Oak rate-setting methodology. The Contractor should describe in detail the data sources and actuarial assumptions used in developing the July 1, 2008 through June 30, 2009 rates. Attachment 2B provides an example of the specific information to be included in the Narrative. The following should be provided:

a) The data sources used
b) The programmatic changes incorporated and their values
c) Managed care trend rates applied
d) Other utilization assumptions including impact of managed care efforts on the utilization rates
e) Other unit cost assumptions, including identification of provider fee schedule arrangements, capitation arrangements, risk sharing, withholds or incentive payment arrangements
f) Enrollment projections and assumptions
g) Administrative contracts and related party charges
h) Start-up costs
i) Underwriting gain and risk/contingency margin justification
j) Source of age/sex factors
k) Source of family factors
l) Source of Federal Poverty Level (FPL) factors
m) Any other assumptions the Contractor has included in its projections

C. Completing the Cost Proposal

NOTE: The Department will provide an electronic copy of the cost proposal in the rate package that must be used by the Contractor. This file will be in Excel format. Please contact Kathleen Brennan by e-mail at kathleen.brennan@ct.gov or by phone at 860 424 5693 if you encounter problems accessing or utilizing this file. As this workbook has been provided solely to facilitate completing the Cost Proposal, it is the Contractor's responsibility to review all components of the Cost Proposal prior to submission for reasonableness and validity of the amounts resulting from the calculations performed by the formulas provided.

C.1. Completing the HUSKY Cost Proposal

The HUSKY Cost Proposal consists of multiple tabs within the Excel workbook.

1. **Schedule 1:** Includes plan information, contact information and a certification to be signed by the Chief Executive Officer of the Contractor and the actuary, if used, to prepare the bid.

2. CRCS forms for each of seven rating groups in HUSKY A and three rating groups in HUSKY B. Each rating group is Statewide. The Contractor is required to develop and submit separate capitation cost bids for each statewide rating group.

The rating groups for HUSKY A are as follows:

a) Rating Group 1: TANF Less than One Year Old
b) Rating Group 2: TANF Children Age 1–14 M&F
c) Rating Group 3: SSI Children Age 0–20 M&F
d) Rating Group 4: DCF Children Age 0–20 M&F
e) Rating Group 5: TANF Females Age 15–40
f) Rating Group 6: TANF Males Ages 15–40
g) Rating Group 7: TANF Ages 40+ M&F

Supplemental information for HUSKY A is as follows:

h) Supplemental Group 1: Maternity Supplemental
i) Supplemental Group 2: Newborn Supplemental

The rating groups for HUSKY B are as follows:

a) Rating Group 1: HUSKY B Band 1 (185% – 235% FPL) All Ages
b) Rating Group 2: HUSKY B Band 2 (235% – 300% FPL) All Ages
c) Rating Group 3: HUSKY B Band 3 (Over 300% FPL) All Ages

Note that the costs for the maternity and newborn supplemental payments should be included in the appropriate age/sex HUSKY A rating group. The Department may utilize these supplemental costs for maternity and newborns for the development of a maternity and newborn supplemental payment.

3. **Schedule 2:** Includes administrative cost detail by expense classification and department used to support the administrative costs included in the CRCS forms. The total administrative cost from Schedule 2 must be consistent with the administrative per member per month (PMPM) amounts entered on the CRCS forms when converted to a total dollar amount across all rating groups combined.

4. **Schedule 3:** Requests supplemental information on the capitated risk arrangements and how they are reported in the CRCS forms.

The Contractor should begin development of its capitation cost bids by estimating utilization and unit costs for each category of service (COS) within the rating groups described above. Instructions follow regarding the method of calculating the various utilization frequencies and unit costs.

The unit cost estimates should be based on the anticipated reimbursement arrangements negotiated with the subcontractor(s) or provider(s) in the MCO's network, including hospitals, outpatient clinics, physicians, etc. Adjustments should be made to account for the full effect of expected inflation within the contract period. The estimates should reflect expected costs, before the application of any anticipated reinsurance recoveries. Any reinsurance recoveries for claims incurred in the rating period should be included on line 14 and entered as a negative value. Reinsurance premiums are reflected on line 16, if applicable.

The Contractor should take full advantage of its position as a purchaser of health care for HUSKY recipients on behalf of the Department to negotiate as favorable a rate as possible with its providers. However, Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us.

The Contractor should prepare capitation cost bids for the contract period from July 1, 2008 through June 30, 2009.

C.2. Completing the Charter Oak Cost Proposal

The Cost Proposal for the Charter Oak program is similar to that used for the HUSKY program, consisting of multiple tabs within the Excel workbook.

1. **Schedule 1:** Includes plan information, contact information and a certification to be signed by the Chief Executive Officer of the Contractor and the actuary, if used, to prepare the bid and is applicable to the Charter Oak program as well as the HUSKY program.

2. Bid forms for the Charter Oak program. The Contractor is required to develop and submit a single community-rated capitation cost bid for Charter Oak program using the Base Plan Design in the RFP. The intent of the single community-rated bid is to achieve a Target Premium of $250 for individuals with incomes at 300% FPL and above, regardless of age, sex, or geography.

The Contractor should begin development of its capitation cost bids by developing an average PMPM expenditure estimate for individuals with incomes 300% FPL and above upon which to base its capitation estimate. For Charter Oak, DSS has provided 5 categories that the Contractor must provide adjustments for to the average PMPM expenditure estimate. DSS has provided 3 additional columns for any other adjustments the Contractor deems necessary to make the average PMPM expenditure estimate appropriate for individuals with incomes 300% and above. In a later step, DSS provides the Contractor with the ability to vary the rate by FPL by applying a factor to adjust for the varying deductible and out-of-pocket maximums applicable by FPL.

The unit cost estimates should be based on the anticipated reimbursement arrangements negotiated with the subcontractor(s) or provider(s) in the MCO's network, including hospitals, outpatient clinics, physicians, etc. Adjustments should be made to account for the full effect of expected inflation within the contract period. The estimates should reflect expected costs, before the application of any anticipated reinsurance recoveries.

The Contractor should take full advantage of its position as a purchaser of health care for HUSKY recipients on behalf of the Department to negotiate as favorable a rate as possible with its providers for Charter Oak. However, Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us.

The Contractor should prepare capitation cost bids for the contract period from July 1, 2008 through June 30, 2009.

D. Instructions for Completing the CRCS Forms

D.1. Instructions for Completing the HUSKY CRCS Forms

The Contractor is required to input all items highlighted in blue on the CRCS forms.

1. Enter the MCO's estimated member months (MMs). The rating group for which the CRCS is being prepared and the rating period are already identified by the Department.

   For the newborn supplemental information, enter the estimated number of births, including stillborns. Provide the percentage assumption of stillborns and multiples included in the projections.

   For the maternity supplemental information, enter the estimated number of deliveries, including stillborns. Provide the percentage assumption of C-section deliveries compared to the total number of deliveries.

2. Categories of Service – Column one contains the eleven categories of service, which include the following:

   a) Physical Health – Inpatient Hospital
   b) Physical Health – Non-Emergent Outpatient Hospital
   c) Outpatient Hospital – Emergency Room
   d) Physician – Primary Care
   e) Physician – Specialty Care
   f) Emergency Transportation
   g) Non-Emergency Transportation
   h) Lab/Radiology
   i) Durable Medical Equipment
   j) Vision
   k) Other

For a description of the categories of service, please refer to Attachment 3.

3. Unit description – the unit description is provided in column for each category of service listed above. Contractors are expected to use this unit definition when completing the utilization and unit cost information in column 4 and column 5. Units are defined either as days, visits, trips (one-way), procedures, or services.

4. Copay amounts – for certain rating categories and services, Contractor's are expected to collect a copayment from the member. These copayments are listed in column 3. If there is no copayment, the cell is blank.

5. Utilization per 1,000 (lines 1 through 10 and 11a-e) – enter the annual utilization per 1,000 (calculated by multiplying utilization by 12,000 and dividing by the MMs) for each category of service based on the appropriate unit description. For the newborn and maternity supplemental information, note that the utilization is entered per births or per delivery respectively.

6. Unit Cost (lines 1 through 10 and 11a-e) – enter a cost per unit (expressed in dollars and cents) for each category of service, based on the same unit description used for the utilization per 1,000. Unit cost should be expressed net of any copay amounts where applicable.

7. The PMPM is calculated by multiplying the utilization per 1,000 by unit cost and dividing the result by 12,000 (this calculation will be performed automatically by the formula entered in the electronic file provided).

8. Total Medical Expenses (line 12) is calculated by adding PMPM costs for each service (this calculation will be performed automatically by the formula entered in the electronic file provided).

9. Third Party Liability (line 13) should be entered as PMPM amounts. The PMPM amounts should be entered as a negative value since it is expected to reduce the capitation needed. This represents total recoveries related to incurred health care services eligible where Medicaid is not the prime insurance coverage source. The MCO should include all third party recoveries expected to be collected for claims incurred during the contract period.

10. Reinsurance Recoveries (line 14) should be entered as PMPM amounts. The PMPM amounts should be entered as a negative value since it is expected to reduce the capitation needed. This represents total recoveries related to incurred health care services eligible for reinsurance. The MCOs should include all reinsurance recoveries expected to be collected for claims incurred during the contract period.

11. Net Medical Expenses (line 15) is calculated by adding the PMPM costs from Total Medical Expenses (line 12), Third Party Liability (line 13) and Reinsurance Recoveries (line 14) (this calculation will be performed automatically by the formula entered in the electronic file provided).

12. Reinsurance Premium (line 16) includes premium expenditures related to the cost of catastrophic claims insurance. This should be entered as a PMPM amount.

13. Administration (line 17) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. These represent the allocation of the expenditures listed in Schedule 2 and include expenditures associated with the overall management and operation of the MCO. The total administrative cost from Schedule 2 must be consistent with the administrative PMPM amounts entered on the CRCS forms when converted to a total dollar amount across all rating groups combined.

14. Underwriting Gain (line 18) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. This represents the amount of profit included by the Contractor in the cost proposal.

15. Risk/Contingency Margin (line 19) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage.

16. Total Capitation Rate (line 20) is calculated by adding the PMPM costs of the Net Medical Expenses (line 15), Reinsurance Premiums (line 16), Administration (line 17), Underwriting Gain (line 18) and Risk/Contingency (line 19).

17. Medical Loss Ratio (line 21) is calculated by taking the ratio of the Net Medical Expenses (line 15) PMPM plus the Reinsurance Premium (line 16) PMPM over the Total Capitation Rate PMPM (line 20). While the Department currently does not have specific Medical Loss Ratio requirements included as part of this RFP, the

Department reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

18. Preparer **must** sign, date, and enter the name of the organization preparing the CRCS, the name of the actuary used (if any), and the actuary's firm. This is required on Schedule 1.

19. Repeat steps 1 through 17 for each rating group for each program. Note: For the maternity supplemental information, steps 1 through 17 should be performed separately for vaginal delivery types and C-section delivery types. The results of each delivery type are then combined based on the assumed percentage of each delivery type expected by the Contractor.

D.2. Instructions for Completing the Charter Oak CRCS Forms

The Contractor is required to input all items highlighted in blue on the CRCS forms.

1. Confirm Contractor's organization at the top of each bid form.

2. Enter the Contractor's estimated member months (MMs). The rating group for which the CRCS is being prepared and the rating period are already identified by the Department.

3. Provide base data used for the calculations, summarized using the Categories of Service in Column B and noted below:

   a) Physical Health – Inpatient Hospital
   b) Physical Health – Non-Emergent Outpatient Hospital
   c) Outpatient Hospital – Emergency Room
   d) Physician – Primary Care
   e) Physician – Specialty Care
   f) Emergency Transportation
   g) Non-Emergency Transportation (not covered in Charter Oak)
   h) Lab/Radiology
   i) Durable Medical Equipment
   j) Vision
   k) Other
   l) Pharmacy (Carved-out, MCO not at-risk)
   m) Specialty Behavioral Health (Carved-out, MCO not at risk)

   For Charter Oak, although the MCO is not at risk for Pharmacy and Specialty Behavioral Health services, these expenditures are included within the Target Premium of $250. Please include the expected costs for these services at the bottom of the COS listing.

These are the same Categories of Service used to develop the HUSKY Data Book (please also refer to Attachment 3 for more details on how HUSKY claims were summarized). This information will be useful to develop the Charter Oak bid since experience for this population is not yet known.

4. Trend – Supply the trend amount in column D to project the base data used to the SFY09 time period.

5. Copay amounts (Column E) – for certain services, Contractor's are expected to collect a copayment from the member. Supply adjustments for the impact of the copays on all applicable service rows.

6. Deductible (Column F) – All of the participants in Charter Oak must meet a deductible. In this section, please include the value of the full deductible for individuals with income at 300% FPL and above.

7. Out of Pocket Maximum (Column G) – Include any adjustment necessary for the out of pocket maximum for individuals with income at 300% FPL and above.

8. Plan Design (Column H) – Charter Oak's plan design differs from that of the HUSKY program. Please include in this column the value of the differences in covered services between the base data used and the Charter Oak program.

9. Additional Adjustments – Columns I, J, and K are provided to allow the MCO to include additional adjustments to the base data to make it appropriate for the Charter Oak Program. Additional may include, but are not limited to, program changes, additional managed care/education impacts, acuity, pent-up demand, demographic mix, and adverse selection.

10. Total Medical Expenses (line 12) is calculated by adding PMPM costs for each service (this calculation will be performed automatically by the formula entered in the electronic file provided).

11. Unit description – the unit description is provided in column for each category of service listed above. Contractors are expected to use this unit definition when completing the utilization and unit cost information in column N and column O. Units are defined either as days, visits, trips (one-way), procedures, or services.

12. Utilization per 1,000 (lines 1 through 10, 11a-c, Pharmacy, and Specialty Behavioral Health) – enter the annual utilization per 1,000 for SFY09 for each category of service based on the appropriate unit description.

13. Unit Cost (lines 1 through 10 and 11a-c, Pharmacy, and Specialty Behavioral Health) – enter a cost per unit (expressed in dollars and cents) for each category of service, based on the same unit description used for the utilization per 1,000. Unit cost should be expressed net of any copay amounts where applicable.

14. Total Medical Expenses (Column P) is calculated by multiplying the utilization per 1,000 figures in Column N by the unit cost figures in Column O and dividing by 12,000. Column Q is a check to ensure that the PMPM figures calculated in Column P match the PMPM figures calculated in Column L.

15. Third Party Liability (line 13) should be entered as PMPM amounts. The PMPM amounts should be entered as a negative value since it is expected to reduce the capitation needed. This represents total recoveries related to incurred health care services eligible where Charter Oak is not the prime insurance coverage source. The MCO should include all third party recoveries expected to be collected for claims incurred during the contract period.

16. Reinsurance Recoveries (line 14) – For Charter Oak, please bid gross costs. Exclude any recoveries from privately purchased reinsurance policies.

17. Net Medical Expenses (line 15) is calculated by adding the PMPM costs from Total Medical Expenses (line 12), Third Party Liability (line 13) and Reinsurance Recoveries (line 14) (this calculation will be performed automatically by the formula entered in the electronic file provided).

18. Reinsurance Premium (line 16) – For Charter Oak, please bid gross costs. Exclude any private premium expenditures related to the cost of catastrophic claims insurance.

19. Administration (line 17) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. These represent the allocation of the expenditures listed in Schedule 2 and include expenditures associated with the overall management and operation of the MCO. The total administrative cost from Schedule 2 must be consistent with the administrative PMPM amounts entered on the CRCS forms when converted to a total dollar amount across all rating groups combined.

20. Underwriting Gain (line 18) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. This represents the amount of profit included by the Contractor in the cost proposal.

21. Risk/Contingency Margin (line 19) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage.

22. Total Capitation Rate (line 20) is calculated by adding the PMPM costs of the Net Medical Expenses (line 15), Reinsurance Premiums (line 16), Administration (line 17), Underwriting Gain (line 18) and Risk/Contingency (line 19).

23. Medical Loss Ratio (line 21) is calculated by taking the ratio of the Net Medical Expenses (line 15) PMPM plus the Reinsurance Premium (line 16) PMPM over the

Total Capitation Rate PMPM (line 20). While the Department currently does not have specific Medical Loss Ratio requirements included as part of this RFP, the Department reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

24. Implied Age/Sex Factors (Section E) – please provide age/sex factors to be applied to the statewide composite bid. These will be used to calculate the implied age/sex rates in Section F. As Charter Oak is intended to be a community-rated product, these age/sex rates are used only to determine the overall composite using the Contractor's projected enrollment mix by age/sex.

25. Projected Enrollment Mix (Section G) – please provide your estimated distribution of enrollees. This will be used to calculate the statewide composite based on estimated enrollees in the Charter Oak program.

26. Statewide Individual 300% FPL and above Composite Bid (Section H) – this composite bid is calculated by taking the age/sex rates in Section F and multiplying them by the projected enrollment mix in Section G. This premium is targeted to be at $250 PMPM.

27. Statewide Family Size Factor – The Contractor should supply their estimated family size factor to convert the individual rate to a family rate (subscriber + spouse, subscriber + spouse + child(ren) or subscriber + child(ren)).

28. Statewide Family 300% FPL and Above Composite Bid – The family rate is then calculated from the individual rate (H) multiplied by the family factor (I).

29. Statewide Federal Poverty Level Plan Design Factor (if applicable)- The Contractor can then adjust the individual and family rates to reflect the FPL and plan design for those groups under 300% FPL. Factors can be input to address differences in income, enrollee contributions, deductibles, and out of pocket maximums.

30. ONLY IF NECESSARY – Alternative Program/Plan Design – As noted above, Charter Oak is intended to be a community-rated product with a Target Premium of $250 PMPM for all individuals with incomes at 300% FPL and above, regardless of age, sex, or geography. If the Contractor is unable to develop a capitation proposal that achieves a premium of $250 or less, the Contractor is requested to alter the Base Program and Plan Design included within the RFP in such a manner that will achieve the Target Premium of $250 PMPM. All changes are subject to the approval of DSS and may include altering the program's rate structure – age/sex or geographic factors, plan design – covered benefits and cost-sharing, and/or program design – eligibility criteria. There is a section on the Alternative Program/Plan Design bid form to supply adjustments to the program/plan design as a percentage of the capitation rate.

31. For Contractors wishing to participate in the HUSKY program, participation in the Charter Oak program is mandatory. Schedule 1 covers both the HUSKY program and

the Charter Oak program cost proposals. Preparer **must** sign, date, and enter the name of the organization preparing the CRCS, the name of the actuary used (if any), and the actuary's firm.

E. Instructions for Completing HUSKY Schedule 2

Please complete the Administrative Cost Detail by Expense Classification and Department type. Note that we have included different departments that may be within the organization. However, if there are other sectors within the organization, please provide those departments under the available "Department #" column and provide a description of the department. Please provide the total dollar amount of administrative expenses paid to a related/affiliated party. In addition, please provide written explanations of any differences between the total administrative expense reported on Schedule 2 and the amounts shown on the HUSKY CRCS rating sheets. The total administrative cost from Schedule 2 must be consistent with the administrative PMPM amounts entered on the HUSKY CRCS forms when converted to a total dollar amount across all rating groups combined.

F. Instructions for Completing HUSKY Schedule 3

If the MCO contracts with providers on a capitated basis, please complete the supplemental schedule for each service provider that is capitated. Depending on the arrangement with providers, an MCO may either include the entire portion of the capitation payment in a medical expense line, or it may break out a portion of the capitation payment and report that in an administrative expense line. We have included a few services that may be capitated to providers. However, if there are other capitated services, please include these services on the worksheet.

G. Rate Negotiation Process

1. The Department will analyze the Contractor's initial capitation cost bids to determine if clarification is needed and whether rates are within the Department's actuarially sound rate ranges. Rate ranges will not be disclosed. The capitation cost bids are due to the Department on **March 14, 2008**. **The Contractor is advised to provide in its bids clear, precise information, both narrative and quantitative**.

2. The Department will accept capitation cost bids that are within the actuarially sound rate range. For cost bids that are not within the rate ranges, the Department will respond to all Contractors with an "offer rate" and a final rate package that reflects a rate the Department will accept from the Contractor.

3. The Department will schedule a negotiation meeting with all MCOs to discuss the capitation cost bids. The Department anticipates agreement on final rates during negotiation meeting.

4. If agreement on rates cannot be reached during the negotiation meeting, final rates will be sent to the Contractor within two weeks after the negotiation meeting.

5. Notification of the Contractor's intent to accept or reject the offered rate(s) is TBD.

6. The Department will not contract for any rates outside of the Department's actuarially determined rate ranges.

H. Attachments

1. Cost Proposal Excel File
2. Example of Detailed Narrative
3. Category of Service Descriptions
4. Maternity Supplemental Information Description
5. Newborn Supplemental Information Description

Attachment 1 – Cost Proposal Excel File

Schedule 1
Plan Information Worksheet

HUSKY Program and Charter Oak Program
Cost Proposal

Plan Name:	[Plan Name]
Plan Address:	
Address 1:	[Address 1]
Address 2:	[Address 2]
City, State, Zip:	[City, State, Zip]
Plan CEO:	[CEO name]
Proposal contact name:	[Contact name]
Proposal contact title:	[Contact title]
Proposal contact phone #:	[Contact phone]
Proposal contact e-mail:	[Contact e-mail]
Fax Number:	[Contact fax]
Actuary used (if any):	[Actuary name]
Actuary phone #:	[Actuary phone]

Certification Statement:

We hereby affirm that the information in this premium proposal rate application including all schedules and exhibits thereto, has been prepared in accordance with the most recent instructions of the State of Connecticut Department of Social Servic and to the best of our knowledge and belief is accurate and complete.

Signature, Chief Executive Officer	Date
Signature, Actuary (if used)	Date

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – TANF less than 1 year old
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.00%	$ -
18	Underwriting Gain				0.00%	$ -
19	Risk/Contingency				0.00%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – TANF Age 1-14 M&F
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – SSI Age 0-20 M&F
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – DCF Age 0-20 M&F
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – TANF Age 15-40 Female
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – TANF Age 15-40 Male
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – TANF Age 40+ M&F
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY B – Band 1 (185% to 235% FPL) All Ages
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY B – Band 2 (235% to 300% FPL) All Ages
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY B – Band 2 (Over 300% FPL) All Ages
Rating Region:	Statewide
Estimated Member Months:	

	Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost[1]	Rating Period PMPM
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
Rating Period: 7/1/2008 to 6/30/2009
Rating Group: Supplemental Maternity
Rating Region: Statewide
Estimated Number of Deliveries:
Percentage C-Section Deliveries:

	Category of Service	Unit Description	Copay Amount	Vaginal Delivery Type: Units per 1000 Deliveries	Vaginal Delivery Type: Net Unit Cost[1]	Vaginal Delivery Type: Rating Period Cost per Delivery	C-Section Delivery Type: Units per 1000 Deliveries	C-Section Delivery Type: Net Unit Cost[1]	C-Section Delivery Type: Rating Period Cost per Delivery	All Delivery Types: Units per 1000 Deliveries	All Delivery Types: Net Unit Cost[1]	All Delivery Types: Rating Period Cost per Delivery
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
04	Physician – Primary Care	Visits	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
08	Lab/Radiology	Procedures	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
09	Durable Medical Equipment	Services	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
10	Vision	Services	$_____	_____	$ -	$ -	_____	$ -	$ -	-	$ -	$ -
11	Other (Total of a through e)					$ -			$ -			$ -
a)				_____	$_____	$ -	_____	$_____	$ -	-	$ -	$ -
b)				_____	$_____	$ -	_____	$_____	$ -	-	$ -	$ -
c)				_____	$_____	$ -	_____	$_____	$ -	-	$ -	$ -
d)				_____	$_____	$ -	_____	$_____	$ -	-	$ -	$ -
e)				_____	$_____	$ -	_____	$_____	$ -	-	$ -	$ -
12	Total Medical Expenses					$ -			$ -			$ -
Less												
13	Third Party Liability Recovery (enter as a negative value)					$ -			$ -			$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -			$ -			$ -
15	Net Medical Expenses					$ -			$ -			$ -
16	Reinsurance Premium					$ -			$ -			$ -
					% of Premium			% of Premium			% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -		0.0%	$ -		#DIV/0!	$ -
18	Underwriting Gain				0.0%	$ -		0.0%	$ -		#DIV/0!	$ -
19	Risk/Contingency				0.0%	$ -		0.0%	$ -		#DIV/0!	$ -
20	Total Capitation Rate					$ -			$ -			$ -
21	Medical Loss Ratio					#DIV/0!			#DIV/0!			#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	Supplemental Newborn
Rating Region:	Statewide
Estimated Number of Births:	
Percentage Stillborn:	
Percentage Multiples:	

	Category of Service	Unit Description	Copay Amount	Units per 1000 Births	Net Unit Cost[1]	Rating Period Cost per Birth
01	Physical Health – Inpatient Hospital	Days	$_____	_____	$_____	$ -
02	Physical Health – Outpatient Hospital Non-Emergent	Visits	$_____	_____	$_____	$ -
03	Outpatient Hospital – Emergency	Visits	$_____	_____	$_____	$ -
04	Physician – Primary Care	Visits	$_____	_____	$_____	$ -
05	Physician – Specialty Care	Visits	$_____	_____	$_____	$ -
06	Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
07	Non-Emergency Transportation	One-way trips	$_____	_____	$_____	$ -
08	Lab/Radiology	Procedures	$_____	_____	$_____	$ -
09	Durable Medical Equipment	Services	$_____	_____	$_____	$ -
10	Vision	Services	$_____	_____	$_____	$ -
11	Other (Total of a through e)					$ -
a)				_____	$_____	$ -
b)				_____	$_____	$ -
c)				_____	$_____	$ -
d)				_____	$_____	$ -
e)				_____	$_____	$ -
12	Total Medical Expenses					$ -
Less						
13	Third Party Liability Recovery (enter as a negative value)					$ -
14	Reinsurance Recoveries (enter as a negative value)					$ -
15	Net Medical Expenses					$ -
16	Reinsurance Premium					$ -
					% of Premium	
17	Administration (from Schedule 2)[2]				0.0%	$ -
18	Underwriting Gain				0.0%	$ -
19	Risk/Contingency				0.0%	$ -
20	Total Capitation Rate					$ -
21	Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Schedule 2: Administrative Cost Detail
Contract Year 1 - July 1, 2008 through June 30, 2009

ADMINISTRATIVE COST DETAIL																
	Expense Classification	General & Operations	Finance	Claims Processing	Information Systems	Pharmacy Administration	Network Development	Member & Enrollment Services	Case Management	Disease Management	Utilization Management	Other Medical Management	Department #	Department #	Department #	Total
1	Compensation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2	Interest Expense	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3	Occupancy, Depreciation & Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4	Education & Outreach	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5	Marketing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6	Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7	**TOTAL**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	Other Charges Detailed Breakdown Description (insert additional rows if needed)	**General & Operations**	**Finance**	**Claims Processing**	**Information Systems**	**Pharmacy Administration**	**Network Development**	**Member & Enrollment Services**	**Case Management**	**Disease Management**	**Utilization Management**	**Other Medical Management**	**Department #**	**Department #**	**Department #**	**Total**
10	Corporate Overhead Allocations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	Subcontracted/Delegated Admin Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12	Management Fees	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
16		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
17		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
18		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
19		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	**TOTAL**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Total related/affiliated Party expenses: $ -

Notes:

1 Blue highlighted cells denote data input by the MCO

2 Gray highlighted cells denote calculation

3 Other expense allocations must be detailed so that no other expense classification exceeds $250,000

Schedule 3: Capitation Arrangements
Contract Year 1 - July 1, 2008 through June 30, 2009

SUBCAPITATED SERVICES				
Covered Service		Provider at Full-Risk (Yes or No)	Total Amount Reported as Medical Expense	Total Amount Reported as Administrative Expense
1	Global Capitation		$ -	$ -
2	Vision		$ -	$ -
3	Lab/Radiology		$ -	$ -
5	Transportation		$ -	$ -
6	Triage Services/Nurse Hotline		$ -	$ -
7	Primary Care Physicians		$ -	$ -
8	Other #1		$ -	$ -
9	Other #2		$ -	$ -
10	Other #3		$ -	$ -
11	Other #4		$ -	$ -
12	Other #5		$ -	$ -
13	Other #6		$ -	$ -
14	Other #7		$ -	$ -
15	**Total**		**$ -**	**$ -**

Note:

1 Blue highlighted cells denote data input by the MCO

Instructions for filling out Charter Oak Bid Form

PLEASE NOTE: Charter Oak is intended to be a community-rated product with a Target Premium of $250 per member per month (PMPM) for all individuals, regardless of age, sex, or geography.
Family rates will be a single statewide composite rate using a Family Rating Factor provided by the MCO. This template builds the Target Premium Rate for individuals with incomes 300% and Above.
Rates for individuals and families with incomes less than 300% FPL can be adjusted if necessary using FPL factors provided by the Contractor.

Step 1 Be aware that you may enter values only in the light blue highlighted areas (where the text font is also blue). All other areas are locked, whether text or formulas. Since you cannot insert new rows or columns in this file, if you need to provide additional Excel material, you may do so as separate addenda, but note that the bid forms in this file will be the basis of bid evaluation. Also, you are required to submit a **methodology write-up** corresponding to the completed bid forms. This needs to describe your data sources, time periods, nature of each adjustment or estimate, and methodology for calculating each of them.

If the Contractor is unable to provide a Premium rate of $250 using the Base Plan Design provided in the RFP, Contractors are requested to submit a Bid Form based on an alternative program/plan design that achieves the Target Premium of $250. Alternative program/plans designs could include varying the benefits covered, the cost-sharing requirements or the rate structure (age/sex rating and/or geographic rating).
To the extent possible, please describe the alternative program/plan design changes in cells M45-P55. Please provide additional sheets supporting the alternative program/plan design if necessary.

A. Average PMPM Development

Step 2 Confirm your Contractor name in cell C1. Contractor should input estimated member months for this program in cell C4.

Step 3 Enter your base claims experience by Categories of Service (COS) in B9-B24. For ease of bid development, we have included the COS used in the HUSKY development. Please provide further detail, if necessary, for the "Other" categories in lines 11a-c. Although the Contractor is not at risk for Pharmacy or Specialty Behavioral Health, please include Pharmacy and Specialty Behavioral Health in the COS in Step 3, as Pharmacy and Specialty Behavioral Health Services are included within the Target Premium of $250.

Step 4 In cells C9-C24, enter the PMPM claims costs by COS of your starting base data. The date at which these costs are centered should be indicated in cell C7.

Step 5 Use the columns D-K to quantify the PMPM impact (by COS) of separate adjustments (for example: trend, demographics, etc.) to the base data to estimate PMPM claims costs in SFY09 (centered at 01/01/09). Document the nature of each adjustment and their calculation approach in your methodology description. Step #5 will result in an automatic calculation of the Total Medical PMPM (B) in cell L25.

Step 6 In columns M and N, provide the annual utilization per thousand and unit cost components (by COS) of your SFY09 projected PMPM claims costs.

Step 7 If cells P9-P24 do not indicate "OK", please revisit your previous entries to ensure that your SFY09 PMPM projection of utilization and unit cost levels is consistent with the adjustments build-up.

B. Total Medical Expenses

This cell will be automatically calculated as the sum of the medical costs PMPMs in columns L & O.

Step 8 In cell L27, provide the TPL/COB recoveries (as a negative value) expected for Charter Oak.

C. Non-Medical Costs

Step 9 In cells K33-K35, indicate your projected SFY09 PMPM administration, underwriting gain, and risk/contingency loading percentages.

D. Total Capitation Rate (B + C)

This cell will be automatically calculated as the sum of the medical costs PMPMs and admin/gain/risk in columns L.
MLR: Note that while DSS does not currently have an MLR requirement, DSS reserves the right to establish and MLR requirement for the Charter Oak program in the future.

E. Age/Sex Factors

Step 10 In cells C44-C59, provide the age/sex claims cost relativities (relative to the average PMPM claims cost in cell L25), typically referred to as age/sex factors.

F. Implied Age/Sex Bid Rates for SFY09 = (BxE)+C OR **F. Age/Sex Bid Rates for SFY09 = (BxE)+C for Alternative Plan Design**

Note that cells G44-G59 get calculated automatically and are representative ONLY for the Base Program/Plan Design. Charter Oak is intended to be a community rated product using one rate for individuals and one rate for families.
MCOs may propose utilizing this section of the bid form, if necessary, for the submission of an alternative program/plan design to achieve the Target Premium of $250.

G. Projected Enrollment Mix

Step 11 Projected mix of SFY09 enrollment. Please provide your projected enrollment mix by age/sex category based on the program/plan design included within the RFP. If you include an alternative Program/Plan Design, please provide your projected enrollment mix by age/sex category based on the alternative program/plan design.

H. Statewide Individual 300% FPL and Above Composite Bid = sumproduct (FxG)

This cell is automatically calculated and represents the contractor's proposed premium rate for individuals in the Charter Oak program. DSS will compare this figure to the Target Premium of $250 for Charter Oak.

I. Statewide Family Size Factor

Step 12 Please input your Family Size Factor to convert the individual rate to a family rate.

J. Statewide Family 300% FPL and Above Composite Bid = sumproduct (HxI)

This cell is automatically calculated and represents the MCOs proposed premium rate for families in the Charter Oak program.

K. Statewide Federal Poverty Level Plan Design Factor (HxK for Individual and JxK for Family)

Step 13 Due to variances in the deductible and out-of-pocket maximums by FPL level, Contractors may vary their premium requested of DSS by FPL level. Please input your FPL Plan Design Factors in cells K72-K75. The Individual and Family rates will be calculated automatically by FPL.

Final factors and all resulting rates are subject to approval by DSS and may be subject to Federal standards for actuarial soundness.

Contractor Name: [Plan Name]
Rating Period: 7/1/2008 to 6/30/2009
Rating Group: Charter Oak Base RFP Plan Design
Estimated Member Months:

A. Average PMPM Development

	Category of Service	Base Data centered at mm/dd/yy PMPM Cost	Trend	Co-Pay	Ded	OOP Max	Plan Design	Adj x (Describe)	Adj x (Describe)	Adj x (Describe)	PMPM Cost	Unit Description	Annual Utilization per 1,000 members	Unit Cost	PMPM Cost	
		Adjustments (expressed as PMPMs, not %s)										SFY09 centered at 01/01/09				
01	Physical Health – Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Days	-	$ -	$ -	OK
02	Physical Health – Outpatient Hospital Non-Emergent	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
03	Outpatient Hospital – Emergency	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
04	Physician – Primary Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
05	Physician – Specialty Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
06	Emergency Transportation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	One-way trips	-	$ -	$ -	OK
07	Non-Emergency Transportation (Not covered in Charter Oak)											One-way trips				
08	Lab/Radiology	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Procedures	-	$ -	$ -	OK
09	Durable Medical Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Services	-	$ -	$ -	OK
10	Vision	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Services	-	$ -	$ -	OK
11	Other (Total of a through e)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
a)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
b)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
c)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
	Pharmacy (Carved out, MCO not a risk)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Prescriptions	-	$ -	$ -	OK
	Specialty Behavioral Health (Carved out, MCO not at risk)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Services	-	$ -	$ -	OK
12	**B. Total Medical Expenses**										$ -				$ -	
Less																
13	Third Party Liability Recovery (enter as a negative value)										$ -					
14	Reinsurance Recoveries (Not Applicable to Charter Oak)										$ -					
15	Net Medical Expenses										$ -					
16	Reinsurance Premium (Not Applicable to Charter Oak)										$ -					
										% of Premium						
17	Administration (from Schedule 2)									0.0%	$ -					
18	Underwriting Gain									0.0%	$ -					
19	Risk/Contingency									0.0%	$ -					
	C. Non-Medical Costs										$ -					
20	**D. Total Capitation Rate (B + C)**										$ -					
21	Medical Loss Ratio										0%					

E. Age/Sex Factors

	Individual
19-29 M	-
19-29 F	-
30-34 M	-
30-34 F	-
35-39 M	-
30-39 F	-
40-44 M	-
40-44 F	-
45-49 M	-
45-49 F	-
50-54 M	-
50-54 F	-
55-59 M	-
55-59 F	-
60+ M	-
60+ F	-

Notes:

1. Costs are gross and should not include any privately purchased reinsurance
2. Bid does not include costs for additional benefits provided to enrollees (e.g., chiropractic)
3. MCO's will input items in blue highlight and other fields will be calculated.

F. Implied Age/Sex Bid Rates for SFY09 = (BxE)+C

Statewide	Individual
19-29 M	$ -
19-29 F	$ -
30-44 M	$ -
30-44 F	$ -
35-39 M	$ -
30-39 F	$ -
40-44 M	$ -
40-44 F	$ -
45-49 M	$ -
45-49 F	$ -
50-54 M	$ -
50-54 F	$ -
55-59 M	$ -
55-59 F	$ -
60+ M	$ -
60+ F	$ -

G. Projected Enrollment Mix

Statewide	Individual
19-29 M	-
19-29 F	-
30-44 M	-
30-44 F	-
35-39 M	-
30-39 F	-
40-44 M	-
40-44 F	-
45-49 M	-
45-49 F	-
50-54 M	-
50-54 F	-
55-59 M	-
55-59 F	-
60+ M	-
60+ F	-

H. Statewide Individual 300% FPL and Above Composite Bid = sumproduct (FxG)

$ - TARGET PREMIUM = $250

I. Statewide Family Size Factor

0.00

J. Statewide Family 300% FPL and Above Composite Bid = sumproduct (HxI)

$ -

K. Statewide Federal Poverty Level Plan Design Factor (HxK for Individual and JxK for Family)

		Individual	Family
0-150% FPL	0.00	$ -	$ -
151-185% FPL	0.00	$ -	$ -
186-235% FPL	0.00	$ -	$ -
236-300% FPL	0.00	$ -	$ -
300% and Above		$ -	$ -

Contractor Name: [Plan Name]
Rating Period: 7/1/2008 to 6/30/2009
Rating Group: Charter Oak Alternative Program/Plan Design
Estimated Member Months:

A. Average PMPM Development

	Category of Service	Base Data centered at mm/dd/yy PMPM Cost	Adjustments (expressed as PMPMs, not %s) Trend	Co-Pay	Ded	OOP Max	Plan Design	Adj x (Describe)	Adj x (Describe)	Adj x (Describe)	PMPM Cost	SFY09 centered at 01/01/09 Unit Description	Annual Utilization per 1,000 members	Unit Cost	PMPM Cost	
01	Physical Health – Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Days	-	$ -	$ -	OK
02	Physical Health – Outpatient Hospital Non-Emergent	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
03	Outpatient Hospital – Emergency	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
04	Physician – Primary Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
05	Physician – Specialty Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Visits	-	$ -	$ -	OK
06	Emergency Transportation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	One-way trips	-	$ -	$ -	OK
07	Non-Emergency Transportation (Not Covered in Charter Oak)											One-way trips				
08	Lab/Radiology	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Procedures	-	$ -	$ -	OK
09	Durable Medical Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Services	-	$ -	$ -	OK
10	Vision	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Services	-	$ -	$ -	OK
11	Other (Total of a through c)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
a)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
b)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
c)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	$ -	$ -	OK
	Pharmacy (Carved out, MCO not a risk)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Prescriptions	-	$ -	$ -	OK
	Specialty Behavioral Health (Carved out, MCO not at risk)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	Services	-	$ -	$ -	OK
12	**B. Total Medical Expenses**										$ -				$ -	
Less																
13	Third Party Liability Recovery (enter as a negative value)										$ -					
14	Reinsurance Recoveries (Not Applicable to Charter Oak)										$ -					
15	Net Medical Expenses										$ -					
16	Reinsurance Premium (Not Applicable to Charter Oak)										$ -					
										% of Premium						
17	Administration (from Schedule 2)									0.0%	$ -					
18	Underwriting Gain									0.0%	$ -					
19	Risk/Contingency									0.0%	$ -					
	C. Non-Medical Costs										$ -					
20	**D. Total Capitation Rate (B + C)**										$ -					
21	Medical Loss Ratio										0%					

E. Age/Sex Factors

	Individual
19-29 M	-
19-29 F	-
30-34 M	-
30-34 F	-
35-39 M	-
30-39 F	-
40-44 M	-
40-44 F	-
45-49 M	-
45-49 F	-
50-54 M	-
50-54 F	-
55-59 M	-
55-59 F	-
60+ M	-
60+ F	-

Notes:

1. Costs are gross and should not include any privately purchased reinsurance
2. Bid does not include costs for additional benefits provided to enrollees (e.g., chiropractic)
3. MCO's will input items in blue highlight and other fields will be calculated.
4. MCO's may alter the rate structure to achieve a $250 Target Premium and should adjust this sheet accordingly or use an additional spreadsheet.

F. Age/Sex Bid Rates for SFY09 = (BxE)+C

Statewide	Individual
19-29 M	$ -
19-29 F	$ -
30-44 M	$ -
30-44 F	$ -
35-39 M	$ -
30-39 F	$ -
40-44 M	$ -
40-44 F	$ -
45-49 M	$ -
45-49 F	$ -
50-54 M	$ -
50-54 F	$ -
55-59 M	$ -
55-59 F	$ -
60+ M	$ -
60+ F	$ -

G. Projected Enrollment Mix

Statewide	Individual
19-29 M	-
19-29 F	-
30-44 M	-
30-44 F	-
35-39 M	-
30-39 F	-
40-44 M	-
40-44 F	-
45-49 M	-
45-49 F	-
50-54 M	-
50-54 F	-
55-59 M	-
55-59 F	-
60+ M	-
60+ F	-

Proposed Plan Design Changes		Description	Estimated PMPM Impact as a %
1			0.00%
2			0.00%
3			0.00%
4			0.00%
5			0.00%
6			0.00%
7			0.00%
8			0.00%
9			0.00%
10			0.00%

H. Statewide Individual 300% and Above Composite Bid = sumproduct (FxG) (if applicable)

$ - TARGET PREMIUM = $250

I. Statewide Family Size Factor (if applicable)

0.00

J. Statewide Family 300% FPL and Above Composite Bid = sumproduct (HxI) (if applicable)

$ -

K. Statewide Federal Poverty Level Plan Design Factor (HxK for Individual and JxK for Family)(if applicable)

		Individual	Family
0-150% FPL	0.00	$ -	$ -
151-185% FPL	0.00	$ -	$ -
186-235% FPL	0.00	$ -	$ -
236-300% FPL	0.00	$ -	$ -
300% and Above		$ -	$ -

Attachment 2A – Example of HUSKY Detailed Narrative

July 1, 2008 – June 30, 2009 HUSKY Rate-Setting Methodology

Note: If the rates were not developed in the same manner for each rating group, please fill out a separate form for each methodology used.

1. Data Used:
   - Years
   - Encounter, include any adjustments made
   - Financial, include any adjustments made
   - Other Sources (please explain)

2. Programmatic Changes Incorporated

Item	Description	Rating Group	Category of Service (COS)	Value*

*Include any increases/decreases to other COS that would be impacted by this change.

Recent program changes include:

Benefit Design Changes:

- Effective with dates of service January 1, 2006 and forward, the Managed Care Organizations, or their subcontractors, no longer manage or pay claims for behavioral health services
- Behavioral health services are now authorized and managed under an Administrative Services Organization (ASO) contract with Value Options (VO). VO manages the behavioral health services of HUSKY A, HUSKY B and Department of Children and Families (DCF) funded clients under the CT Behavioral Health Partnership (BHP)
- Elimination of coverage for drugs used for treatment of erectile dysfunction effective January 1, 2006
- Premolar dental sealants are now offered as a covered benefit for children, effective January 1, 2007
- Effective with dates of service July 1, 2008 and forward, the Managed Care Organizations, or their subcontractors, will no longer manage or pay claims for dental services
- Effective with dates of service January 25, 2008 and forward, the Managed Care Organizations, or their subcontractors, will no longer manage or pay claims for pharmacy services

Eligibility Expansions:

- Increase eligibility criteria for parents and needy caretaker relatives of children in HUSKY from 150% FPL to 185% FPL, effective July 1, 2007

- HUSKY coverage provided for all uninsured newborns. State coverage of premium costs for first 4 months of life. Effective July 1, 2007
- Expand HUSKY A eligibility for pregnant women from 185% to 250% FPL, effective January 1, 2008

Medicaid Provider Fee Increases for SFY08:

- Physician ($27M)
- Clinics ($10M)
- Dental ($20M)
- Vision ($1M)
- Hospitals ($46M)

3. Managed Care Medical Trend Rate Applied
   - Is this a combined utilization and unit cost trend? If not, please supply the above information for both.
   - Overall trend: _____%
     (from _____ year to 7/1/2008 – 6/30/2009)
   - Overall number of trend months used.
   - Does trend differ by COS? If so, please provide assumptions.
   - Does trend differ by rating group? If so, please provide assumptions.
   - Please list trend sources (e.g., financial and encounter data, commercial market, other states' Medicaid programs, etc.).

4. Other Utilization Assumptions – Includes any projected impact of managed care and educational efforts on the utilization rates.

5. Other Unit Cost Assumptions – The Contractor should discuss the nature of its provider fee schedules and any capitated fee arrangements. Providers accepting captitation should be identified. Also, the Contractor should identify any reinsurance, risk sharing, withholds or incentive payment arrangements.

   Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us . The Contractor should describe plans to satisfy Section 3.47.g. The Contractor should describe the data sources that will provide the Department as evidence that the requirements of Section 3.47.g have been met. If the Contractor has capitated arrangements with physicians or hospitals, the Contractor should explain/demonstrate how these capitation arrangements will be structured in order to satisfy Section 3.47.g. Note that the Medicaid fee schedule contains different reimbursement schedules depending on the rendering location (place of service) and type of provider (pediatricians, clinics, federally qualified health clinics (FQHCs), other community physicians). The Contractor should

describe how it proposes to identify such provider types in the data submitted to the Department to ensure that the requirements of Section 3.47.g have been met.

For the maternity supplemental information, if a global fee is used for prenatal and postpartum care services, describe how the fee is modified to account for low utilization or when the onset of care is begun after the first trimester.

6. Enrollment Projections – Discuss the assumptions underlying the enrollment projections and the projected birth rate and maternity delivery rates for each rating group.

7. Reinsurance Premiums and Recoveries – Please provide a copy of the reinsurance contract and details of the reinsurance recovery and premium calculations included on the CRCS projections. Please indicate if the reinsurance contract is with a related/affiliated party and note that any premiums paid to a related/affiliated party in excess of recoveries may require a pay-back to the State.

8. Pro-forma income statements – Provide three years of pro-forma income statements in a format determined by the Contractor that, at a minimum, show total Medicaid membership, revenue, medical expenses, administration expenses and net income/loss.

9. Administrative Contracts and Related Party Charges – Please provide a copy of all administrative services contracts and management agreements (including price page) delegating administrative functions to a third party, indicating those that are with related/affiliated parties. In addition, please provide all contracts with related or affiliated parties applicable during the contract period, the total expected cost and the amount included in the administrative cost projections (Schedule 2) for the contract period. If the MCO does not wish to send contracts, please provide a detailed list of such contracts, the total costs and the amount included in the administrative cost projections (Schedule 2) for the contract period. This should include, but is not limited to:
   - Management services agreement
   - Provider contract changes effecting cost and utilization within the past year
   - Delegated Care Management (CM)/Disease Management (DM) agreements
   - Delegated member/provider services agreements
   - Claims processing agreements
   - Integrated delivery system agreements
   - Agreements for the administration of vision, transportation claims and/or benefits
   - Any other contract with a related or affiliated party for non-medical services or charges

10. Start-Up Costs – The Department recognizes that additional administrative costs exist when an MCO enters into an agreement with a managed care program such

as HUSKY. Identifying each MCO's one-time, non-recurring start-up costs separately from other administrative expenses will allow the Department to review, and if appropriate, address this issue during the bid review process. Any administrative expenses identified in this section must be reasonable and quantifiable. Please provide the following information as it relates to the administration of the HUSKY program.

- A list of non-recurring equipment acquisitions or conversions, included in the administrative cost projections for FY2009
- A list of any planned system conversions, upgrades or initiatives for FY2009, FY2010 or FY2011 and the budgeted cost impact to HUSKY
- Any other applicable information that will help us to understand the equipment and system changes needed to operate the HUSKY program
- Other start-up and acquisition costs and the amount included in the administrative cost projections for FY2009
- If applicable, the allocation method used to assign these costs to the HUSKY program
- The amortization schedule for each component of the expected start-up costs

11. Underwriting Gain and Risk/Contingency Margin. Provide justification for the requested underwriting gain and risk/contingency margin.

12. Other Assumptions – Any other assumptions or information used to prepare the projections.

Attachment 2B – Example of Charter Oak Detailed Narrative

July 1, 2008 – June 30, 2009 Charter Oak Rate-Setting Methodology

Note: If the Contractor submits an Alternative Program/Plan Design bid, please fill out a separate form for the alternative methodology used.

1. Data Used:
   - Years
   - Encounter, include any adjustments made
   - Financial, include any adjustments made
   - Commercial, Medicaid, blending
   - Other Sources (please explain)

2. Programmatic Changes Incorporated

Item	Description	Rating Group	Category of Service (COS)	Value*

*Include any increases/decreases to other COS that would be impacted by this change.

3. Managed Care Medical Trend Rate Applied
   - Is this a combined utilization and unit cost trend? If not, please supply the above information for both.
   - Overall trend: _____%
     (from _____ year to 7/1/2008 – 6/30/2009)
   - Overall number of trend months used.
   - Does trend differ by COS? If so, please provide assumptions.
   - Does trend differ by rating group? If so, please provide assumptions.
   - Please list trend sources (e.g., financial and encounter data, commercial market, other states' Medicaid programs, etc.).

4. Other Utilization Assumptions. Includes any projected impact of managed care and educational efforts on the utilization rates.

5. Other Unit Cost Assumptions. The Contractor should discuss the nature of its provider fee schedules and any capitated fee arrangements. Providers accepting capitation should be identified. Also, the Contractor should identify any risk sharing, withholds or incentive payment arrangements.

6. Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current

Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us. The Contractor should describe plans to satisfy Section 3.47.g. The Contractor should describe the data sources that will provide the Department as evidence that the requirements of Section 3.47.g have been met. If the Contractor has capitated arrangements with physicians or hospitals, the Contractor should explain/demonstrate how these capitation arrangements will be structured in order to satisfy Section 3.47.g. Note that the Medicaid fee schedule contains different reimbursement schedules depending on the rendering location (place of service) and type of provider (pediatricians, clinics, FQHCs, other community physicians). The Contractor should describe how it proposes to identify such provider types in the data submitted to the Department to ensure that the requirements of Section 3.47.g have been met.

7. Enrollment Projections – Discuss the assumptions underlying the enrollment projections and mix by age/sex category for the Charter Oak program.

8. Administrative Contracts and Related Party Charges – Please provide a copy of all administrative services contracts and management agreements (including price page) delegating administrative functions to a third party, indicating those that are with related/affiliated parties. In addition, please provide all contracts with related or affiliated parties applicable during the contract period, the total expected cost and the amount included in the administrative cost projections (Schedule 2) for the contract period. If the MCO does not wish to send contracts, please provide a detailed list of such contracts, the total costs and the amount included in the administrative cost projections (Schedule 2) for the contract period. This should include, but is not limited to:
   - Management services agreement
   - Provider contract changes effecting cost and utilization within the past year
   - Delegated CM/DM agreements
   - Delegated member/provider services agreements
   - Claims processing agreements
   - Integrated delivery system agreements
   - Agreements for the administration of vision, transportation claims and/or benefits
   - Any other contract with a related or affiliated party for non-medical services or charges

9. Start-Up Costs – The Department recognizes that additional administrative costs exist when an MCO enters into an agreement with a managed care program such as Charter Oak. Identifying each MCO's one-time, non-recurring start-up costs separately from other administrative expenses will allow the Department to review, and if appropriate, address this issue during the bid review process. Any administrative expenses identified in this section must be reasonable and

quantifiable. Please provide the following information as it relates to the administration of the Charter Oak program.

- A list of non-recurring equipment acquisitions or conversions, included in the administrative cost projections for FY2009
- A list of any planned system conversions, upgrades or initiatives for FY2009, FY2010 or FY2011 and the budgeted cost impact to Charter Oak
- Any other applicable information that will help us to understand the equipment and system changes needed to operate the Charter Oak program
- Other start-up and acquisition costs and the amount included in the administrative cost projections for FY2009
- The amortization schedule for each component of the expected start-up costs

10. Underwriting Gain and Risk/Contingency Margin – Provide justification for the requested underwriting gain and risk/contingency margin.

11. Source of Age/Sex Factors – Provide supporting documentation and justification for the factors used to adjust the community rate for individuals with incomes above 300% FPL by age and sex per the age/sex cells provided.

12. Source of Family Factor – Provide supporting documentation and justification for the factor used to adjust the community rate for individuals with incomes above 300% FPL to be applicable to families.

13. Source of FPL Factors – Provide supporting documentation and justification for the factor used to vary the community rate for those individuals and families with incomes under 300% FPL:
    - 0 – 150% FPL
    - 151 – 185% FPL
    - 186 – 235% FPL
    - 236% – 300% FPL

14. Other Assumptions – Any other assumptions or information used to prepare the projections.

Attachment 3 – Category of Service Descriptions

Service Category Descriptions

Categories of service are assigned based on a hierarchy.
Notes about the category of service:

1. The COS is assigned to the entire claim.
2. Physician-related charges are included in inpatient hospital, outpatient hospital, or emergency room COS.
3. The COS were assigned based on a hierarchy, the hierarchy is represented by the order of the table below.
4. Behavioral health, pharmacy and dental services are excluded for HUSKY.

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
1. Physical Health – Inpatient Hospital	Inpatient hospital costs including professional and ancillary services for enrollees while confined to an acute care hospital	**Revenue Codes:** Any claim with at least one line that contains a room and board revenue code Between 0100 and 0219 **Procedure Codes (Professional Services):** 99217-99223 99231-99236 99238-99239 99251-99255 99291-99296 99298-99300 99304-99310 99315-99316 99318 99356-99359 99431-99440 99360	**Utilization** Number of inpatient days per 1,000 members. **Unit Cost** The average cost per day **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from inpatient to outpatient settings**

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
2. Emergency Room	Includes the facility component and the professional component of the emergency room visit. The visit can be free standing or a hospital outpatient department. Professional components that are billed separately are to be included	Any claim not previously categorized **Revenue Codes:** Any claim that has not been categorized as an Inpatient stay and includes revenue codes: Between 0450 – 0452 0456 0459 **Procedure Codes:** G0380 through G0384 S9088 S9083 **Procedure Codes (Professional Services):** 99281-99288	**Utilization** Number of emergency room visits in a hospital setting per 1,000 members. **Unit Cost** Average cost per visit **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from emergency room to outpatient and physician service settings**

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
3. Physician – Primary Care	Includes the costs associated with medical services provided in a community setting (office, clinic, FQHC) by a primary care provider, including physicians and other practitioners. Includes the following providers: Internal Medicine, Family Practice, General Practice, and Pediatricians	Any claim not previously categorized as Inpatient or Emergency Room. For the following providers: Internal Medicine, Family Practice, General Practice and Pediatricians AND **Procedure Codes:** Any claim containing at least one claim line with procedure codes between 90801-90815 99201-99215 99241-99245 99324-99328 99334-99337 99339-99340 99341-99345 99347-99350 99354-99355 99358-99359 99363-99364 99366-99368 99374-99380 99381-99387 99391-99397 99401-99404-99411-99412 99420-99429 99441-99443 99444 99450-99456 99477-99499 G0245 G0246-G0247	**Utilization** Number of clinic, practioner and physician visits per 1,000 members **Unit Cost** Average cost per visit **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from specialty physicians and outpatient hospital and emergency room or other service settings**

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
4. Physician – Specialty Care	Includes all costs associated with medical services provided in a community setting (office, clinic, FQHC) by a physician or other practitioner other than a PCP as identified under #3 above. Excludes the following providers (identified under #3 Physician – Primary Care): Internal Medicine, Family Practice, General Practice, and Pediatricians	Any claim not previously categorized as Inpatient, Emergency Room or Primary Care Physician. For all other providers not identified under PCP: NOT (Internal Medicine, Family Practice, General Practice & Pediatricians) AND **Procedure Codes:** Any claim containing at least one claim line with procedure codes between 90801-90815 99201-99215 99241-99245 99324-99328 99334-99337 99339-99340 99341-99345 99347-99350 99354-99355 99358-99359 99363-99364 99366-99368 99374-99380 99381-99387 99391-99397 99401-99404-99411-99412 99420-99429 99441-99443 99444 99450-99456 99477-99499 G0245 G0246-G0247	**Utilization** Number of physician (other than a PCP) visits per 1,000 members **Unit Cost** Average cost per visit **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from outpatient hospital and emergency room or other service settings**

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
5. Physical Health – Outpatient Hospital Non-Emergent	Includes the facility component and the professional component of the outpatient visit. The visit can be free standing or a hospital outpatient department. Any corresponding professional component that is billed separately is also reported on this service category line item	Any claim not previously categorized as Inpatient, Emergency Room, or Physician **Procedure Codes:** Any claim with a revenue code, not previously categorized as Inpatient, Emergency Room, or Physician or any claim containing at least one claim line within the following procedure code ranges: 54000-60699 90281-99602	**Utilization** Number of non-emergent outpatient hospital visits per 1,000 members **Unit Cost** Average cost per visit **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from inpatient to outpatient settings**
6. Lab/Radiology	The cost of all laboratory and radiology (diagnostic and therapeutic) services which is separately billed	Any claim not previously categorized. **Procedure Codes:** Between Q0111 and Q0115 Between P3000 and P3001 Between 70000 and 79999 Between 80000 and 89999 or Between R0070 and R0076 P7001 Q0091 36415 36416 36400 **Revenue Codes:** Between 0300 and 0314 Between 0320 and 0339 0319	**Utilization** Procedures per 1,000 eligible members **Unit Cost** Average cost per procedure **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from specialty physicians and outpatient hospital and emergency room or other service settings**

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
7. Emergency Transportation	Expenses for all ambulance services with transport to hospitals for emergency medical services	Any claim not previously categorized **Procedure Codes:** A0225 A0427 A0429 A0380 A0390 A0424 A0425 A0430 A0431 A0432 A0433 A0434 A0435 A0436 99289-99290	**Utilization** Number of one way trips per 1,000 eligible members **Unit Cost** Average cost per one way trip **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from emergency transportation to non-emergent transportation services**
8. Non-Emergency Transportation	Expenses for all pre-scheduled services with transport to physician offices, medical clinics, etc. for routine non-emergent medical care	Any claim not previously categorized **Procedure Codes:** Between T2001 and T2007 A0021 A0426 A0428	**Utilization** Number of one way trips per 1,000 eligible members **Unit Cost** Average cost per one way trip **Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from emergency transportation to non-emergent transportation services**

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
9. Durable Medical Equipment	Includes the cost of DME and supplies	Any claim not previously categorized **Procedure Codes:** Between L0000 and L4999 Between E0100 and E9999 Between A4000 and A89999 C1789 C1815 C2622 A procedure code starting with a K	**Utilization** Average utilization of DME equipment per 1,000 eligibles members **Unit Cost** Average cost of DME equipment
10. Vision	The cost of routine exams (by non-physicians) and dispensing glasses to correct eye defects. This category includes the cost of eyeglasses, but excludes ophthalmologist costs related to the treatment of disease or injury to the eye; the latter is to be included in physician specialty	Any claim not previously categorized. **Procedure Codes:** Between S0500 and S0592 Between V2020 and V2799 Between 92002 and 92499 Between 65091 and 68899 S0620 S0621	**Utilization** Average utilization of vision services per 1,000 eligibles members **Unit Cost** Average cost of vision related services

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
11. Other	Any other medical service not specifically described above	Any claim not previously categorized	The anticipated utilization should be only for physical health services not described above and should be expressed as expected utilization per 1,000 members, where applicable**. If "Other" services are entered, the Contractor must itemize these services on lines 11athrough 11e and provide sufficient data to allow examination by the State (including the definition of a unit)**
12. Pharmacy (Charter Oak Only)	Expenses for retail pharmacy, including the ingredient costs and dispensing fees. Carved-out. MCO not at risk	Any retail pharmacy claim with an NDC code	
13. Specialty Behavioral Health (Charter Oak Only)	Includes all inpatient claims where the primary diagnosis is behavioral health-related. For non-inpatient claims, including all claims where the primary diagnosis is behavioral health-related and one of the following factors is behavioral health-related: procedure code, provider and/or facility. MCO not at risk	See Behavioral Health Coverage grid available through the Bidders' library	

Attachment 4 – Maternity Supplemental Information Description

The delivery data will include costs associated with the prenatal period, delivery event and postpartum period. It will also provide the nature of the birth event – live, non-live, multiple, etc.

The prenatal costs should include any pregnancy-related codes found 9 months prior to the month of the delivery event (Example – If the delivery date was August 29, then the prenatal costs should be included for November (month 0) through August (month 9)). All costs should be pulled for the delivery event. The postpartum costs should include all OB costs, up to 2 months past the delivery month (Example – If the delivery date was August 29, then postpartum costs should be included for August (month 0) through October (month 2)).

Include Maternity costs associated with the following codes for still births or live births, excluding elective/induced abortions:

1. ICD9 Diagnosis: 630.x – 674.x: this will pull everything pregnancy- and delivery-related including abortions of all kinds, ectopic pregnancies, etc.
2. ICD9 VCodes: V22.x – 24.x, V27.x - V28.x.
3. ICD9 Procedure: 72.x – 75.x: these are all obstetric procedures including deliveries of all types, fetal monitoring, etc.
4. CPT : 59000 – 59899; these encompass all procedures including abortions and fetal procedures indicating pregnancy exists.
5. Revenue: 720, 721, 722, 724, 729, 0112, 0122, 0132, 0142, 0152, 0232; these include both Labor & Delivery codes as well as Room & Board with OB designation.

The Maternity grouping shall list the number of deliveries, rather than member months.

Attachment 5 – Newborn Supplemental Information Description

Include newborn claims for the partial month of birth and the first four (4) months thereafter. Age shall be determined by counting the child's age as of their last birthday, on the first of the month in which the claim is incurred.

It is expected that there shall be approximately 4.5 newborn member months reported for each delivery as the newborn time period is on average 135 days. Any variation from 4.5 member months may suggest a reporting inconsistency. For counting newborn member months, it is appropriate to group by age (in months) and then sum the first 4 months. As defined above, age should be determined by counting the child's age as of their last birthday, on the first of the month in which the claim was incurred. The following example illustrates the formula for determining a child's age in months:

Example: Date of birth = January 15
- Age on January 1st – 0 months (count of 17/31 is 0 month age)
- Age on February 1st – 0 months (an additional count of 1 goes into 0 month age)
- Age on March 1st – 1 month (count of 1 for 1 month age)
- Age on April 1st – 2 months (count of 1 placed in 2 month age)
- Age on May 1st – 3 months (count of 1 placed in 3 month age)
- Sum = Newborn Member Months (through example expect to have average 4.5 newborn member months per delivery)

If it is easier for the Contractor to count in whole numbers, in the 0 month age cell replace the pro-rated 17/31 with a count of 1. If this logic is utilized, the Contractor must note the counting methodology.

Schedule 1
Plan Information Worksheet

HUSKY Program and Charter Oak Program
Cost Proposal

Plan Name:	[Plan Name]
Plan Address:	
Address 1:	[Address 1]
Address 2:	[Address 2]
City, State, Zip:	[City, State, Zip]
Plan CEO:	[CEO name]
Proposal contact name:	[Contact name]
Proposal contact title:	[Contact title]
Proposal contact phone #:	[Contact phone]
Proposal contact e-mail:	[Contact e-mail]
Fax Number:	[Contact fax]
Actuary used (if any):	[Actuary name]
Actuary phone #:	[Actuary phone]

Certification Statement:

We hereby affirm that the information in this premium proposal rate application including all schedules and exhibits thereto, has been prepared in accordance with the most recent instructions of the State of Connecticut Department of Social Services and to the best of our knowledge and belief is accurate and complete.

Signature, Chief Executive Officer	Date
Signature, Actuary (if used)	Date

State of Connecticut
Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

FIRST Addendum

RELEASE DATE - 020808

The following information amends the contents of the original RFP issued on January 1, 2008.

1. At the time of the release of 010308DSS_HUSKY_CO_RFP, the Department had not completed its review of certain components within the requirements of the RFP. These included specific requirements for the Cost Proposal. The Department anticipated that the review would be completed by January 10, 2008 and that the details of these components would be posted as an addendum to this RFP. The Department's review and development of the necessary addendum has been delayed therefore delaying the posting of the addendum. The Department anticipates a posting date of February 15, 2008. Once posted the Department anticipates allowing for the submission of additional questions up to the date of the Bidders' Conference.

2. SECTION II – OVERVIEW OF THE PROCUREMENT PROCESS – SUBSECTION 5. Bidders' Conference – TENTATIVE – is DELETED in its entirety and replaced with the following:

5. Bidders' Conference

The Department has scheduled a Bidders' Conference for potential bidders to ask clarifying questions pertaining to the requirements of the RFP. The Bidders' Conference shall be held on **FRIDAY, FEBRUARY 22, 2008 from 10:00 am – 12:00 pm** in Mezzanine Conference Room 2 A & B at the State of Connecticut Department of Social Services Central Office located at 25 Sigourney Street, Hartford, CT. **NOTE WELL:** Responses to those questions raised at the Bidders' Conference will not be deemed "OFFICIAL" until they are posted as an amendment to the RFP in a subsequent addendum.

To ensure the availability of adequate space for all interested parties, organizations will be limited to NO MORE than two (2) attendees. For building access and security purposes interested parties **MUST SUBMIT** to the Issuing Office a list of planned attendees. The list of planned attendees must be directed by fax or e-mail to the Issuing Office (860-424-4953 or Kathleen.brennan@ct.gov) **NO LATER THAN 3:00 PM ON WEDNESDAY, FEBRUARY 20, 2008.** Identification will be checked and **access will be granted only to those individuals on the security list provided by the Department to building security. It is the organization's responsibility to confirm the Issuing Office's receipt of the list of planned attendees.**

This FIRST Addendum to 010308DSS_HUSKY_CO_RFP is being issued by the Issuing Office on the 8th day of February, 2008.

This Addendum must be signed and returned with your submission.

_____ _____

Authorized Signer Company Name

Approved _____

Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

State of Connecticut

Department of Social Services

Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care

For the State of Connecticut

REQUEST FOR PROPOSALS

The Connecticut Department of Social Services, the Medicaid and State Children's Health Insurance Program (SCHIP) agency for the State of Connecticut, is requesting proposals from Managed Care Plans to perform managed care for its clients eligible for the Department's HUSKY and Charter Oak programs.

The Department is soliciting proposals from Managed Care Plans that have a strong commitment to education and outreach to help members navigate the health care system and have strong care coordination and disease management capabilities to ensure that when members do access care, they do so in a way that improves the quality of care they receive. All Bidders have an equal opportunity to receive contracts; preference will not be given to existing contractors. The Department anticipates awarding at least three and up to six statewide contracts to ensure adequate network coverage for HUSKY A, HUSKY B, and Charter Oak clients.

A non-binding but MANDATORY letter of intent is required in order to submit and have a proposal considered. The MANDATORY letter of intent must be received by the Issuing Office NO LATER THAN 3:00 PM Local Time Thursday, January 31, 2008.

Sealed responses must be received no later than 3:00 PM Local Time, Friday, March 14, 2008. Any responses received after that date and time might be accepted by DSS as a clerical function but not evaluated. Those responses that are not evaluated shall be retained for thirty (30) days after the resultant contract(s) is executed, after which time the responses will be destroyed.

To download the Request for Proposals (RFP), access the Charter Oak Page on the Department of Social Services' website at www.ct.gov/dss/charteroak or the State Procurement/Contracting Portal at www.das.state.ct.us/Purchase/Portal/Portal_Home.asp or contact the Issuing Office as set forth below:

Kathleen M. Brennan
Department of Social Services
25 Sigourney Street
Hartford, Connecticut 06106
(860) 424-5693 phone, (860) 424-4953 fax
e-mail: Kathleen.Brennan@ct.gov

DSS is an Equal Opportunity/Affirmative Action Employer. Deaf and Hearing impaired individuals may use a TDY by calling 1-800-842-4524. Questions or requests for information in alternative formats must be directed to the DSS Contract Administration Office at (860) 424-5693.

Preface to the Request for Proposals

Connecticut's effort to procure managed care services represents an exciting opportunity to improve the services and expand the delivery of those services to a new population included under the "Charter Oak" plan.

For purposes of this RFP, "the State, "the State of Connecticut," "the Connecticut Department of Social Services," "DSS," or "the Department" have the same meaning and shall be referred to as the "State" or the "Department." The entity that will contract with the Department as a result of this RFP will be referred to as the "Contractor" or the "MCO" or "Managed Care Organization."

At the time of the release of this RFP, the Department had not completed its review of certain components listed below. It is anticipated that the review will be completed by January 10, 2008 and the Department shall post the details of these components as an addendum to this RFP. Any and all addendums to this RFP shall be posted to the Charter Oak Page on the Department of Social Services' website at www.ct.gov/dss/charteroak and the State Contracting Portal at www.das.state.ct.us/Purchase/Portal/Portal_Home.asp It is each bidders' responsibility to access the state contracting portal to receive any and all addendums to this RFP. The specific components that the Department anticipates addressing in an addendum to this RFP are:

1. Cost Proposal Requirements
2. Charter Oak:
   Appendix C: Charter Oak Covered Services
   Appendix L: Charter Oak Plan Design Worksheet
3. Connecticut state insurance quality/service assurances and mandates

Outline of the Request for Proposals

The RFP is divided into the following major sections:

1. Background Information and Program Objectives including information about the Department, HUSKY managed care, and Charter Oak.
2. Overview of the Procurement Process including the sequence and steps in the State's procurement process.
3. Proposal Format Requirements including instructions to prospective bidders on how to submit a proposal.
4. Proposal Contents: Four parts that correspond to the following organization of the bidders' material in binders.
   a. Part One: Transmittal statements and acceptances.
   b. Part Two: Information about the bidder's organization, key personnel and experience

c. Part Three: Scope of Work information.

d. Part Four: Cost proposal, including proposed price and financial information.

5. Evaluation description, the process the State will use to conduct fair evaluations of the proposals.

6. Appendices: The appendices refer to Scope of Work detailed information

7. Attachments: The attachments refer to contract terms, conditions and assurances.

Table of Contents

7. Smoking Policy - Attachment D
8. Lobbying Restrictions – Attachment E
9. Integrity in State Contracting Policy Affidavit – Attachment F

Section IV. PROPOSAL CONTENTS

Part Two: Organization, Key Personnel, Experience

1. Introduction
2. Organization
3. Key Personnel and Staff Resources
4. Corporate Experience
5. Systems Design and Architecture
6. Project Timetable

Section IV PROPOSAL CONTENTS

Part Three: Scope of Work – Contract Template

1. DEFINITIONS
2. DELEGATIONS OF AUTHORITY
3. FUNCTIONS AND DUTIES REQUIRED IN THE RESULTANT CONTRACT

3.01 Provision of Services
3.02 Member Rights
3.03 Gag Rules and Integrity of Professional Advice to Members
3.04 Coordination and Continuation of Care
3.05 Emergency Services
3.06 Acceptance of DSS Rulings
3.07 Choice of Health Professional
3.08 Provider Network
3.09 Network Adequacy and Maximum Enrollment Levels
3.10 Geographic Coverage
3.11 Provider Contracts
3.12 Provider Credentialing and Enrollment
3.13 Second Opinions, Specialist Providers and the Referral Process.
3.14 PCP and Specialist Selection, Scheduling, and Capacity
3.15 Women's Health, Family Planning Access, and Confidentiality
3.16 Pharmacy Access
3.17 Mental Health and Substance Abuse Access
3.18 Dental Services
3.19 Preventive Care and Services for Children
3.20 Prenatal Care
3.21 Other Access Features
3.22 Pre-Existing Conditions
3.23 Acute and Sub-acute Care during a Hospital, Nursing Facility or Chronic Disease Hospital Stay at Time of Enrollment or Disenrollment
3.24 Continuous Enrollment
3.25 Special Disenrollment
3.26 Linguistic Access
3.27 Services for Members
3.28 Content of Member Handbook

SECTION I - BACKGROUND INFORMATION AND PROGRAM OBJECTIVES

1. Overview

A. Department of Social Services

The Department of Social Services provides a broad range of services to elderly persons, disabled persons, families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. It administers approximately ninety (90) legislatively authorized programs and approximately one-third of the State budget. By statute, it is the State Agency responsible for administering human service programs sponsored by federal legislation including the Rehabilitation Act, the Food Stamp Act, the Older Americans Act and Title XIX and XXI of the Social Security Act.

The Commissioner of Social Services and two Deputy Commissioners administer the Department with Regional Administrators and Directors including the Director of Medical Care Administration. Regional Administrators manage the three service regions. Directors or other managers reporting to one of the three Commissioners manage nineteen organizational units within central office. The Connecticut General Statutes requires a statewide advisory council to the Commissioner, and a regional advisory council in each region.

B. Medical Care Administration

The Department's Medical Care Administration Division administers the Medicaid Program, State Children's Health Insurance Program (SCHIP), ConnPACE, CADAP, Alternate Care and SAGA Medical benefits, and, beginning July 1, 2008, the Charter Oak Health Plan. This Division offers and authorizes payment for comprehensive medical coverage to adults, elderly individuals, children and families across the state. Connecticut's Medicaid program covers all of the federal and state mandatory services and thirty-one (31) out of the thirty-three (33) optional services in both fee-for-service and managed care environments. Connecticut's Charter Oak Health Plan will provide access to affordable health insurance to adult Connecticut residents.

The Department serves clients with various needs and includes those individuals who are low-income working families with children, seniors who live in communities and in nursing facilities, adults and children with physical, mental and behavioral health challenges, children under the care of Department of Children and Families, and previously uninsured individuals in need of affordable health insurance. They receive health care services in facilities such as: nursing facilities, federally qualified health centers, chronic disease hospitals, inpatient and outpatient hospitals, clinics, physician offices, dental offices, pharmacies, facilities for individuals with mental retardation, and psychiatric hospitals.

C. Medicaid Managed Care and SCHIP Programs

The Department's managed care program for children and families is called HUSKY (i.e. Healthcare for Uninsured Kids and Youth). The HUSKY program includes Medicaid managed care (HUSKY A) that targets children, pregnant women and families with incomes at or below 185% of the federal poverty level (FPL) and SCHIP (HUSKY B) for children in families with higher incomes (above 185% FPL). Currently, under HUSKY B, families with incomes between 185% - 235% FPL pay no premiums while those between 235% to 300% FPL pay modest monthly premiums, and those families with incomes exceeding 300% FPL pay group premium rates negotiated by the DEPARTMENT.

The HUSKY A covered services are the same as the Medicaid covered services. The HUSKY B program and its co-payment structure is modeled after the Connecticut state employee benefit program. The Department also provides additional coverage for children with special physical and/or behavioral health care needs under the HUSKY Plus program for children who are eligible for HUSKY B. Through December 31, 2007, the Department contracted with four MCOs to administer the health services of the HUSKY A program and three MCOs to administer the health benefits for HUSKY B. Several of the MCOs subcontracted with other organizations to administer some of their benefits including vision, dental and pharmacy benefits. Effective January 1, 2008 through June 30, 2008, HUSKY A and HUSKY B programs were temporarily moved from full risk MCO contracts to Pre-paid Inpatient Health Plan contracts.

Effective January 1, 2006, behavioral health services were carved out of the healthcare package administered by the MCOs. Under the HUSKY program behavioral health services for HUSKY enrolled individuals are managed by an administrative services organization contracted with the Department. The behavioral health program is called the Connecticut Behavioral Health Partnership. By the end of January 2008 the Department will assume the management responsibilities of the pharmacy services in the HUSKY A, HUSKY B, the State Administered General Assistance and future Chart Oak programs. The Department will also conduct a competitive procurement to select an administrative services organization to manage Dental Services for HUSKY A and HUSKY B recipients under a direct contract with the Department. The Charter Oak program will not include a dental benefit package.

Many adult Medicaid recipients, including those that are aged, blind, or disabled, are served in the Medicaid Fee for Service (FFS) program administered and managed by DSS. DSS employees conduct utilization review, with the exception of general hospital inpatient services that are reviewed by a DSS utilization review contractor. All claims for the Medicaid FFS program are paid by the DSS Medicaid Management Information System (MMIS) claims vendor.

2. Overview Description of HUSKY Managed Care

For a minimum period of five-years (7/01/08 – 6/30/13) with the availability of two optional extension years (through 6/30/15), the Department will contract with Contractors to perform the tasks described in this RFP and summarized below.

Since 1995 the Department has a long, proven track record administering the HUSKY program resulting in a successful health care delivery system covering approximately 320,000 lives. In accordance with the timetable specified in this RFP, the Department will build on this established infrastructure to and through this procurement will utilize an existing, known implementation process to transition the existing HUSKY A & B program into the plans contracted with through this selection process.

GENERAL DESCRIPTION:

HUSKY A — Comprehensive health care coverage serving uninsured low-income children and adults

- Includes parents, relative caregivers, and pregnant women
- Traditional Medicaid health coverage

Type of Enrollment

- Mandatory, Managed Care (through December 31, 2007)

  Children up to age 19 with household incomes under 185% FPL, TANF, SOBRA, Pregnant Women, Associated Adults (parents of HUSKY A kids) up to 185% FPL, DCF children (Foster care), SSI children who are not Medicare eligible

HUSKY B — Health coverage for uninsured children in moderate and higher income families, including children with intensive physical or behavioral health needs

- HUSKY Plus — A supplemental program for children with special medical needs available to participants enrolled in HUSKY B. HUSKY Plus benefits are paid on a FFS basis through DSS contracts.

Type of Enrollment

- Voluntary Managed Care (through December 31, 2007)

  Children up to age 19 with household incomes over 185% FPL

- Excluded HUSKY A & B Populations (who may otherwise be eligible)

SSI Adults without Medicare, Duals, General Assistance (State only) Refugees, QMB/SLMB, ConnPACE (State funded Rx only), Connecticut Home Care (CHC) (State funded)

3. Overview Description of Charter Oak

Charter Oak is designed to provide an affordable health insurance product to adults of all incomes. The target total premium for Charter Oak covered services (see Appendix C) is $250 per member per month. If, in the development of its Business (Cost) Proposal the Bidder determines that the total target premium is insufficient to provide each of the Charter Oak covered services, the Bidder MUST propose a premium that includes the provision of each of the Charter Oak covered services and MAY propose an alternative benefit package that, when priced, would not exceed the total target premium of $250 per member per month. Details of this requirement are set forth in the Business (Cost) Proposal section of this RFP.

Charter Oak benefits are based on a commercial health insurance model, with deductibles, co-payments, and coinsurance. To improve access to affordable health insurance for those greatest in need, defined as individuals with incomes less than 300% of the federal poverty level (FPL), premiums will be subsidized by the DEPARTMENT according to a fixed sliding scale.

Type of Enrollment

- Voluntary, Affordable Health Insurance
    - Individuals without health insurance for the last six (6) months or those who meet certain qualifying criteria to exempt them from the uninsured requirement
    - Excluded Populations
        - Individuals currently insured or insured within last six (6) months (exemptions will be similar to the current exemption list for HUSKY B)
        - Individuals eligible but not enrolled in Public Programs (SAGA, HUSKY A and B, etc.)

4. Program Design - HUSKY and Charter Oak Benefits Coordination

- **Specialty Behavioral Health** Benefit Design Carve-out (HUSKY and Charter Oak):

Effective January 1, 2006 the Department and the Managed Care Organizations, in coordination with a new behavioral vendor, carved out specialty behavioral health services for HUSKY A and B. This carve-out will continue for HUSKY A and B and will be applicable to Charter Oak as well.

Specialty behavioral health services are now authorized and managed under an Administrative Services Organization (ASO) contract with Value Options (VO). VO manages the specialty behavioral health services of HUSKY A, HUSKY B and Department of Children and Families (DCF) funded clients under the CT Behavioral Health Partnership (BHP).

- Participating HUSKY MCOs have monthly coordination of care meetings with ValueOptions.
- If there is ever a question of whether medical or behavioral health is primary, either party can refer the issue to DSS for review and resolution (this has occurred fewer than four times in twenty (20) months).
- MCOs and ASO have worked together on primary care education and initiatives to improve ease of referral from primary care to behavioral health network.
- MCOs remain responsible for behavioral health in primary care settings and all behavioral health non-emergent medical transportation (for HUSKY A members only).

- **Dental** Benefit Design Carve-out (HUSKY only)

  Effective with dates of service July 1, 2008 and forward, the participating MCOs will not manage or pay claims for dental services for HUSKY A or B (dental services are not covered under Charter Oak.)

  - The participating MCOs and the dental ASO will work together on primary care education and initiatives to improve ease of referral from primary care to the dental network.
  - Pediatricians will be able to receive reimbursement for provision of dental screens and fluoride treatments to children under 3.
  - Participating MCOs will be responsible for dental non-emergent medical transportation (for HUSKY A members only); hospital Emergency Department services related to dental emergencies, operating room services or same day surgery suites (excluding the dental procedures) and oral surgery services performed by an oral and maxillofacial surgeon.

- **Pharmacy** Benefit Design Carve-out (HUSKY and Charter Oak):

Effective January 25, 2008, participating MCOs will not manage or pay claims for pharmacy services. HUSKY and Charter Oak members will access pharmacy services through the Department's Preferred Drug List (PDL) managed by ACS under contract with the Department.

5. HUSKY and Charter Oak Member Enrollment Procedures

- The Department, or its designee, determines eligibility for HUSKY A, HUSKY B and the Charter Oak program.
- The Department, through a centralized enrollment broker, handles the enrollment, disenrollment and initial selection of the PCP.

  Enrollments and disenrollments are transmitted electronically to each participating MCO each day.

  Enrollment is conducted on a continuous basis as individuals gain HUSKY A, HUSKY B, or Charter Oak eligibility.

6. HUSKY and Charter Oak Benefits

- See Appendix A for a summary of HUSKY A benefits Appendix B for HUSKY B benefits, and Appendix C for Charter Oak benefits.

7. Statutory Authority

The Department of Social Services operates the State's Medicaid Managed Care (HUSKY) program as authorized under Section 1915(b)(1) of the Social Security Act and Section 17b-28 and 17b-289 to 17b-303 inclusive of the Connecticut General Statutes.

Furthermore, the Department operates the State Children's Health Insurance Program (SCHIP) also known as HUSKY B in accordance with Title XXI of the Social Security Act and 17b-289 to 17b-303 of the Connecticut General Statutes as amended. The Department intends, through this RFP, to obtain the services of managed care organizations to arrange, provide and manage medical and vision services to the Department's HUSKY A and HUSKY B clientele.

In 2007, Governor Rell signed legislation authorizing the establishment of the Charter Oak Health Plan (section 23(e)(2),(3) of Public Act 07-02 (June Special Session) (Charter Oak Health Plan).

Section II - OVERVIEW OF THE PROCUREMENT PROCESS

1. Issuing Office

The Department is issuing this Request for Proposals (RFP), through its Contract Procurement Unit. The Contract Procurement Unit is the Issuing Office for this procurement and is the **only** contact in the State of Connecticut (State) for this competitive bidding process. The integrity of the procurement process is based, in part, on ensuring that all potential and intended bidders be afforded the same information and opportunities regarding the terms of the procurement. Therefore, it is incumbent upon the Issuing Office to monitor, control and release information pertaining to this procurement. Potential and intended bidders are advised that they must refrain from contacting any other office within the State of Connecticut or any other state employee with questions or comments related to this procurement. Potential and intended bidders who contact others within the State of Connecticut with questions or issues pertaining to this procurement may risk disqualification from consideration. Decisions regarding such disqualification will be made by the Department's Contract Administrator, within the Issuing Office, after consultation with the Office of the Commissioner. The Contract Administrator and the contact information for the Issuing Office is as follows:

Kathleen M. Brennan
Contract Administrator
Department of Social Services
25 Sigourney Street
Hartford, CT 06106
Phone: (860) 424-5693 - Fax: (860) 424-4953
E-mail: Kathleen.Brennan@ct.gov

All questions, comments, proposals and other communications with the Issuing Office regarding this RFP must be submitted in writing clearly identifying as pertaining to the:

"Managed Care MCO RFP"

Any material received that does not indicate its RFP-related contents will be opened as general mail.

2. Procurement Schedule

Milestones	Ending Dates
RFP Released	01/03/08
Deadline for Questions 3:00 PM Local Time	01/31/08
Deadline for Letter of Intent 3:00 PM Local Time	01/31/08
Bidders' Conference – TENTATIVE	02/11/08
Responses to Questions (tentative)	02/15/08
Proposals Due by 3:00 PM Local Time	03/14/08
Successful Bidder Announced	TBD

Contract Negotiations Begin	TBD
Contract Begins (tentative)	07/01/08

3. Bidders' Questions

The Department will accept written questions and requests for clarification pertaining to this procurement if submitted to and received by the Issuing Office by **3:00 pm on January 31, 2008.** Written questions and requests for clarification may be sent via email or facsimile to meet this deadline. The Department will only respond to those questions and requests submitted and received by the Issuing Office in writing by the stated deadline. Submit questions and requests for clarification to the Issuing Office directed to the attention of Kathleen M. Brennan by facsimile (860-424-4953) or email (Kathleen.Brennan@ct.gov). The Issuing Office will respond to only those questions that meet the deadline and criteria listed above. Official responses to all questions will be posted in an amendment to this RFP in the form of an addendum to this RFP, posted on the Charter Oak page on the Department's website at www.ct.gov/dss/charteroak and the State Procurement/Contracting Portal www.das.state.ct.us/Purchase/Portal/Portal_home.asp. The tentative posting date for the addendum is February 15, 2008. In addition to the posting of the questions and Department responses, the addendum will include the Department's anticipated date for the announcement of the successful bidder and the schedule of contract negotiations. It is solely the Bidder's responsibility to access the Charter Oak page on the Department's website or the State Procurement/ Contracting Portal to obtain any and all addendums or official announcements pertaining to this RFP. **A responsive proposal must include a signed acknowledgment of the receipt of each the addendums to this RFP that are posted to the Charter Oak page on the Department's website or the State Contracting Portal prior to the Proposal submission date.**

4. MANDATORY Letter of Intent

Interested Bidders must submit a MANDATORY Letter of Intent to the Issuing Office to advise the Department of their intention to present a proposal in response to this RFP. The letter of intent MUST be received by the Issuing Office by 3:00 PM Local on Thursday, January 31, 2008.

The LOI may be faxed or emailed to the Issuing Office. While the Letter of Intent is non binding, an interested bidder MUST submit a letter of intent before the date and time set forth herein in order for the Bidders proposal to be reviewed and evaluated. The LOI must include the following information:

1. the name, telephone number, fax number, and email address of the bidder's contact person for matters related to this procurement; and
2. A statement certifying that the bidder's proposal shall address the bidders' ability to perform managed care for its clients eligible for the Department's HUSKY and Charter Oak program on a statewide basis.

A LOI that fails to include the required information and certifications will be considered as unresponsive and not accepted. **It is the bidders' responsibility to confirm the Issuing Office's receipt of a LOI.**

5. Bidders' Conference - TENTATIVE

The Department has TENTATIVELY scheduled a Bidders' Conference to be held on MONDAY, FEBRUARY 11, 2008 from 10:00 – 12:00 in Mezzanine Conference Room 2 A & B at the State of Connecticut Department of Social Services Central Office located at 25 Sigourney Street, Hartford, CT. The decision to hold the Bidders' Conference will be made by the Department on or after 3:00 pm on January 31, 2008 based upon the volume and scope of questions and requests for clarification received in accordance with Section II – OVERVIEW OF THE PROCUREMENT PROCESS, subsection 3 – Bidders' Questions. Those organizations that submit the MANDATORY letter of intent in accordance with the requirements in Section II – OVERVIEW OF THE PROCUREMENT PROCESS, subsection 4 – MANDATORY Letter of Intent shall be contacted by the Department on or before 3:00 pm on Tuesday, February 5, 2008 to confirm or cancel the Bidders' Conference. In addition, the Department shall post an addendum to this RFP on the Charter Oak page on the Department's website and the State Procurement/Contracting Portal www.das.state.ct.us/Purchase/Portal/Portal_home.asp. The tentative posting date for the addendum is February 5, 2008.

To ensure the availability of adequate space for all interested parties, organizations will be limited to NO MORE than two (2) attendees. For building access and security purposes the Issuing Office will require attending organizations to submit a list of planned attendees in advance of the scheduled conference. Identification will be checked and access will be granted only to those individuals on the security list provided by the Department to building security.

6. Procurement Reference Library

Bidders may obtain enrollment and reporting information related to the HUSKY program for use with this procurement at the DSS website http://www.ct.gov/dss

7. Evaluation and Selection

The Department will conduct a comprehensive, fair and impartial evaluation of proposals received in response to this competitive procurement. Only proposals found to be responsive to the RFP will be evaluated and scored. A responsive proposal must comply with all instructions listed in this RFP.

8. Contract Execution

The contract developed as a result of this RFP is subject to State contracting procedures for executing a contract, which may include approval by the Connecticut Office of the Attorney General. If approval by the Office of the Attorney General is required, resulting contracts will become executed upon the signature of the Attorney General and no financial commitments can be made unless and until the Attorney General approves the contract. The Attorney General reviews the contract only after the Commissioners and the Contractor have agreed to the provisions.

Requirements in future Federal and/or State laws that affect the services contemplated in this RFP will be included in amendment(s) to the contract.

9. Acceptance of Proposal Content

If acquisition action ensues, the contents of this RFP and the proposal of the successful bidder will form the basis of contractual obligations in the final contract.

The resulting contract will be a Purchase of Services (POS) contract between the successful bidder and the Department. The standard terms used in the Department's POS contracts and the specific functions pertaining to the scope of work are detailed in the "Scope of Work" section of this RFP and are described in Sections 1 through Section 9. The POS also describes the services to be provided including agreed upon deliverables, outcomes and measures. The resultant contract terms will be based upon the terms and conditions in this RFP and the successful bidder's proposal. The Bidder's proposal must include a Statement of Acceptance (Attachment A) without qualification of all terms and conditions as stated within this RFP including the standard terms. The successful bidder may suggest alternative language to the Standard Terms and Conditions (See Section 8.03 of this RFP). The Department may, after consultation with the Office of the Attorney General and the Office of Policy and Management, agree to incorporate the alternate language in any resultant contract; however the Department's decision will be final.

Any proposal that fails to comply in any way with this requirement may be disqualified as non-responsive. The Department is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

10. Bidder Debriefing

The State will notify all bidders of any award issued as a result of this RFP. Unsuccessful bidders may, within thirty (30) days of the signing of the resultant contract, request a meeting for debriefing and discussion of their proposal by contacting the Contract Administrator in writing at the address previously given.

Debriefing will not include any comparisons of unsuccessful proposals with other proposals.

11. Disposition of Proposals - Rights Reserved

Upon determination that its best interests would be served, the Department shall have the right to the following:

- **A. Cancellation:** Cancel this procurement at any time prior to contract award.
- **B. Amend Procurement**: Amend this procurement at any time prior to contract award.
- **C. Refuse to Accept**: Refuse to accept, or return accepted proposals that do not comply with procurement requirements.
- **D. Incomplete Business Proposal**: Reject any proposal in which the Business proposal is incomplete or in which there are significant inconsistencies or inaccuracies. The State reserves the right to reject all proposals.
- **E. Prior Contract Default**: Reject the proposal of any bidder in default of any prior contract or for misrepresentation of material presented.
- **F. Proposals Received after Due Date**: Reject any bidder's response that is received after the deadline.

G. Written Clarification: Require bidders, at their own expense, to submit written clarification of proposals in a manner or format that the Department may require.

H. Oral Clarification: The Department may require bidders to make oral presentations. Such presentations will be at the bidders' expense and shall conform to the Department's presentation rules and instructions (including time and place) that will be made available should the Department choose to require oral presentations. The Department may invite bidders, but not necessarily all, to make an oral presentation to assist the Department in their determination of award. The Department further reserves the right to limit the number of bidders invited to make such a presentation.

I. On-site Visits/Inspections: Make on-site visits to the operational facilities of bidders to further evaluate the bidder's capacity to perform the duties required in this RFP.

J. No Proposal Changes: Allow no additions or changes to the original proposal after the due date specified herein, except as may be authorized by the Department.

K. Property of the State: Own all proposals submitted in response to this procurement upon receipt by DSS.

L. Separate Service Negotiation: Negotiate separately any service in any manner necessary to serve the best interest of the State.

M. All or Any Portion: Contract for all or any portion of the scope of work or tasks contained within this RFP.

N. One or More Bidders: Contract with one or more bidders.

O. Proposal Most Advantageous: Consider cost and all factors in determining the most advantageous proposal for the Department when awarding a bidder the right to negotiate a contract with the Department. While cost is a factor in determining the bidder to be awarded the right to negotiate a contract with the Department, price alone shall not determine the winning bidder.

P. Technical Defects: Waive technical defects, irregularities and omissions if in its judgment the best interests of the Department will be served.

Q. Privileged and Confidential Communication: Share the contents of any proposal with any of its designees for purposes of evaluating proposals to make an award. The contents of all meetings, including the first, second and any subsequent meetings and all communications in the course of negotiating and arriving at the terms of the Contract shall be privileged and confidential.

R. Best and Final Offers: Seek Best and Final Offers (BFO) on price from Bidders upon review of the scored criteria. In addition, the Department reserves the right to set parameters on any BFOs it receives.

S. Unacceptable Proposals: Reopen the bidding process if the Department determines that all proposals are unacceptable.

12. Electronic Copy of Proposal

One exact electronic copy of the entire proposal in a non-PDF format must be submitted with the original. Those required documents that cannot be converted into electronic format may be excluded from the electronic copy.

13. Proposal Preparation Expenses

The State of Connecticut and DSS assume no liability for payment of expenses incurred by bidders in preparing and submitting proposals in response to this procurement.

14. Response Date and Time

The Issuing Office must receive proposals no later than 3:00 p.m. local time on Friday March 14, 2008. The Department will not consider a postmark date as the basis for meeting any submission deadline. Bidders should not interpret or otherwise construe receipt of a proposal after the closing date and time as stated herein as acceptance of the proposal, since the actual receipt of the document is a clerical function. The Department suggests the bidder use certified or registered mail to deliver the proposal when the bidder is not able to deliver the proposal by courier or in person. Bidders that are hand-delivering proposals will not be granted access to the building without photo identification and should allow extra time for security procedures. Bidders must address all RFP communications to the Issuing Office.

15. Bidder Assurances

By submission of a proposal and through assurances provided by an officer of the bidder with the authority to bind the bidder in its Transmittal Letter and certification forms as applicable, the bidder certifies or agrees that:

A. Independent Price Determination:

1. Costs: The costs proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such process with any other organization or with any competitor;
2. Disclosure: Unless otherwise required by law, the costs quoted have not been knowingly disclosed by the bidder on a prior basis directly or indirectly to any other organization or to any competitor;
3. Competition: No attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition;
4. Prior Knowledge: The bidder had no prior knowledge of the RFP contents prior to actual receipt of the RFP and had no part in the RFP development; and
5. Offer of Gratuities: No elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the State if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the Contractor, the Contractor's agent or the Contractor's employee(s).

B. Valid and Binding Offer:

The proposal represents a valid and binding offer to provide services in accordance with the terms and provisions described in this RFP and any amendments or attachments hereto.

C. Press Releases:

The bidder will obtain prior written consent and approval from the Department for press releases that relate in any manner to this RFP or any resulting contract.

D. Restrictions on Communications with DSS Staff:

It shall not communicate with the Department's staff on matters relating to this RFP except as provided herein through the Issuing Office from the date of release of this RFP until the Department makes an award. Any other communication concerning this RFP with any of the Department's staff may, at the discretion of the Department, result in disqualification of that bidder's proposal.

E. Evidence of a Qualified Entity:

It is qualified to conduct business in Connecticut and is not prohibited by its articles of incorporation, bylaws, or the law under which it is incorporated from performing the services required under any resultant contract.

F. Real or Perceived Conflicts of Interest:

The company, its principals and staff will avoid any and all real or perceived conflicts of interest with Medicaid managed care organizations operating in the State of Connecticut. This assurance shall include, but not be limited to an assurance that organization's principals and staff will have no relationships with Medicaid managed care organizations during the term of the contract that could or do conflict with the goals and intent of this project.

G. Discovery of a Conflict of Interest:

It shall immediately disclose any situation with the Department of Social Services' Contract Administrator where the bidder (if selected as the resultant Contractor) becomes aware of an existing, potential or perceived conflict that may compromise its objective provision of services under the resultant contract. The Department's Contract Administrator will determine the necessary remedy.

H. HIPAA Compliance:

It is compliant with the following parts of the Health Insurance Portability and Accountability Act (HIPAA) pursuant to 45 CFR Part 160 and 164. Privacy and Transaction Code Sets.

I. Confidentiality:

It shall comply with all applicable state and federal laws and regulations pertaining to the confidentiality of all Medicaid applicant/client records and other materials that are maintained in accordance with the resultant contract, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

J. Personnel and Position Assurances

The positions and personnel identified in its response to this RFP will be the positions and persons actually assigned to the project if awarded a contract as a result of this RFP. In any resultant contract the resultant Contractor shall submit to the Department for its

approval, the name and credentials of any person or persons the Contractor proposes to replace existing or previously proposed project management staff, or other key personnel identified by the state. Likewise, the resultant Contractor shall propose to the Department for its approval prior to implementation any changes to positions including adding, deleting or combining functions. Furthermore, the Department must approve any additions, deletions or changes in positions or the personnel assigned in writing in any resultant contract. These changes must not negatively impact the Department or adversely affect the ability of the Contractor to meet any requirement or deliverable set forth in this RFP and/or the resultant contract. Also, at its discretion, DSS may require the removal and replacement of any of the Contractor's personnel who do not perform adequately on the contract, regardless of whether they were previously approved by DSS. The Department shall reimburse the Contractor for those staff expenses actually incurred.

K. Insurance

It will carry insurance, (liability, fidelity bonding, surety bonding and/or other), as specified in a resultant contract, during the term of the contract according to the nature of the work to be performed to "save harmless" the State of Connecticut from any claims, suits or demands that may be asserted against it by reason of any act or omission of the contractor subcontractor or employees in providing services hereunder, including but not limited to any claims or demands of malpractice. Certificates of such insurance shall be filed with the Contract Administrator prior to the performance of services.

L. Suspension or Debarment

The bidder certifies that the bidder or any person (including subcontractors) involved in the administration of Federal or State funds:

1. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and
2. Is not presently indicted for or otherwise criminally or civil charged by a governmental entity with the commission of any of the above offenses; and
3. Has not within a three year period preceding the proposal submission had one or more public transactions terminated for cause or fault; and
4. Will immediately report any change in the above status to the Department.

M. Freedom of Information and Performance of a Governmental Function

The Bidder acknowledges that Resultant Contractors selected through this competitive procurement to provide services under the HUSKY and Charter Oak programs will execute a contract with the Department that will address the rights and responsibilities of each of the parties to the contract. While some terms may be negotiated by and between the Department and the Resultant Contractor the following provisions regarding the Resultant Contractor's performance of a governmental function and the applicability of section 1 – 218 of the Connecticut General Statutes are non-negotiable. Through the

submission of a Transmittal Letter as required through the response to this RFP the Bidder certifies its acceptance of the following language in any contract that may result from this procurement.

a. In performing any acts required or described by this Contract, the Contractor shall be considered to be performing a governmental function for the Department, as that term is defined in section 1-200(11) of the Connecticut General Statutes. Pursuant to section 1-218 of the Connecticut General Statutes, therefore, the Department is entitled to receive a copy of records and files related to the performance of the governmental function, as set forth in this Contract. Such records and files are subject to the Freedom of Information Act and may be disclosed by the Department pursuant to the Freedom of Information Act. Requests to inspect or copy such records or files shall be made to DSS in accordance with the Freedom of Information Act. Accordingly, if the Contractor is in receipt of a request made pursuant to the Freedom of Information Act to inspect or copy such records or files, the Contractor shall forward that request to DSS.

b. Upon receipt of a Freedom of Information Act request by the Department that seeks records or files related to the performance of the governmental function performed by the Contractor for the Department, the Department shall send such request to the Contractor. The Contractor shall review the request and, with reasonable promptness, search its records and files for documents that are responsive to the request. The Contractor shall promptly notify the Department if any clarification of the request is needed in order to proceed with the search for responsive records or files. The Contractor shall send to the Department a copy of those documents that are responsive to the request or otherwise notify the Department that it has no documents responsive to the request. Upon the completion of the Contractor's search for responsive documents, the Contractor shall notify the Department in writing that the search and production of documents is complete. If, upon review of the request, the Contractor determines that it will require more than fourteen (14) days to search for and provide copies of responsive documents to the Department, the Contractor shall contact the Department within seven (7) days of the receipt of the request from the Department.

c. If the Contractor concludes that any of the responsive documents fits within any of the subdivisions of subsection (b) of section 1-210 of the Connecticut General Statutes, and that the Department should not disclose such documents, the Contractor shall mark said documents accordingly prior to sending them to the Department and shall explain the basis for its conclusion. The Department shall review the Contractor's conclusion and explanation and, as necessary, discuss said conclusion with the Contractor. If the Department agrees that any of the marked documents should not be disclosed, the Department shall not release those documents in its response to the Freedom of Information request If, however, the Department disagrees in good faith, with the conclusion by the Contractor that said documents should not be disclosed, the Department shall notify the Contractor, in writing, that it intends to release the documents fourteen (14) days from the date of the notice. The Contractor shall notify the Department of its intention to file any legal action in response to the Department's notification that it will release said documents, at least 24 hours in advance of filing such action.

d. If the Contractor concludes that a document is protected by attorney-client or work product privilege, the Contractor may decline to produce the documents and must specifically assert the privilege by identifying the nature of the document and claiming the privilege, the date of the document, the author of the document and to whom it was written.

e. If the Contractor asserts an exemption under paragraph 3 or a privilege under paragraph 4 of this Contract, and the Department honors said claim, the Contractor shall seek to intervene in order to defend the claim for an exemption or privilege in any subsequent Freedom of Information Commission proceeding challenging the Department's refusal to disclose said documents.

N. Set-Aside for Small, Minority or Women's Business Enterprises

1. The bidder, if awarded a resultant contract shall make a "good-faith effort" to set aside a portion of this contract for a small, minority or women's business enterprise as a subcontractor. Such subcontractors may supply goods or services.
2. Section 32-9e of the Connecticut General Statutes sets forth the requirements of each executive branch agency relative to the Connecticut Small Business Set-Aside program. Pursuant to that statute, twenty-five (25%) of the average total of all contracts let for each of the three previous fiscal years must be set aside.
3. Prospective bidders may obtain a list of firms certified to participate in the Set-Aside program by contacting the Department of Administrative Services at the DAS web site: www.das.state.ct.us/Purchase/SetAside/SAPVendor.asp

16. Incurring Costs

The Department is not liable for any cost incurred by the bidder, including but not limited to the cost of producing a proposal, prior to the effective date of a contract.

17. Declaration and Protection of Proprietary Information

The State of Connecticut shall own all proposals submitted and all materials associated with this RFP and as such they shall be subject to Section 1-210 of the Connecticut General Statutes "Access to public records. Exempt records." Bidders in its response to this RFP may declare specific components of their proposal to be proprietary. However, such declarations must comply with the Freedom of Information Act (FOIA) and with Section 1-210 (b) of the Connecticut General Statutes. Bidders making proprietary declarations must clearly identify those sentences or subsections with rationale that complies with FOIA to claim proprietary exemption. The State will not accept blanket declarations. The bidder must explain the rationale for the proprietary claim in terms of the prospective harm to the competitive position of the bidder that would result if the identified material were to be released. The bidder must also state the legal argument for exempting the materials pursuant to the statute cited above. The Proprietary Declaration must be located immediately following the Table of Contents.

While bidders may claim proprietary exemptions, any decision to release information subject to a FOIA request shall remain with the State.

Section III. PROPOSAL FORMAT REQUIREMENTS

1. General Requirements

Bidders must submit proposals that follow the requirements of this RFP including the requirements of form and format that have been established in order to facilitate the bidder's proposal response and the Department's evaluation process.

The proposal format requirements are listed in this section below and the content requirements are listed in Section IV of this RFP in four parts.

Part One: Transmittal Communications, Forms and Acceptances.

Part Two: Organization, Key Personnel, and Experience: Information about the bidding organization and its qualifications. This Part must describe the background and experience of the bidder's organization and subcontractors (if any) and include details regarding its size and resources, its experience relevant to the functions to be performed under this contract or recent contracts for similar services.

Part Three: Scope of Work: This part will contain the bidder's response to specific requests for information related to specific contractual provisions. The bidder must respond completely to each **"bidder shall"** requirement and those responses must reference the contract citation.

Part Four: Cost proposal: Price and financial information.

2. Delivery Condition – Copies Necessary

The original (clearly marked) and eight (8) exact, legible copies of the proposal must be bound in four (4) separate parts and submitted in properly marked **" Managed Care MCO RFP"** , sealed boxes by the deadline.

3. Proposal Structure – Four Parts

Bidders must observe the separate binding and sealed delivery requirements when they submit their proposals.

A. Four Proposal Parts Separately Bound

The copies of Parts One through Four must be bound in separate binders by proposal part, i.e. Part One: Transmittal Communications, Forms, and Acceptances, Part Two: Organization, Key Personnel, and Experience, Part Three: Scope of Work, and Part Four: Cost Proposal. The bidder must label them as they are described above, e.g., "**Managed Care MCO RFP** – Part Two."

B. Shipping Container Labeling

The cartons or envelopes that contain the separate parts may be incorporated into one or more shipping containers. The shipping containers must be labeled with the following identification information: Name of bidding organization, Name of RFP (**Managed Care MCO RFP)** and the contents of the Shipping container – Part One, Part Two, Part Three, or Part Four.

4. Proposal Construction Requirements

A. Binding of Proposal:

Bidders must submit proposals that correspond with the RFP Table of Contents in a format that will allow updated pages to be easily incorporated into the original proposal. An original (clearly marked – "**Managed Care MCO RFP")** and eight (8) exact, legible copies of the separate Proposal Parts One through Four must be submitted in loose leaf or spiral bound notebooks. The official name of the organization must appear on the outside front cover of each binder and on each page of the proposal. Location of the name is at the bidder's discretion.

B. Tab Sheet Dividers

Bidders must separate each major section of each part of the proposal with a tab sheet keyed to the table of contents. The title of each major section must appear on the tab sheet.

C. Table of Contents

Each proposal must incorporate a complete Table of Contents in Part One.

D. Cross-referencing RFP and Proposal

All responses must correspond to the specific assigned task number in the RFP and shall follow the sequence order found in the RFP. Each section of the proposal must cross-reference the appropriate section of the RFP that is being addressed. Proposal responses to specific task requirements must reference the RFP request citation.

5. Electronic Copy

One exact electronic copy of the entire proposal in a non-PDF format must be submitted with the original. Those required documents that cannot be converted into electronic format may be excluded from the electronic copy.

6. Page Numbers

Each page of each part of the proposal must be numbered consecutively in Arabic numerals from the transmittal page.

7. Page Limitation

Part One has no page limitations. All forms shown as Appendices in this RFP and submitted in Part One of the proposal are not subject to page limitations. Part Two is limited to 150 pages, not including resumes or job descriptions. Part Three is limited to 200 pages. Part Four is limited to 10 pages not including audit information and corporate disclosure information.

8. Page Format

The standard format to be used throughout the proposal is as follows:

A. Text shall be on 8 ½" x 11" paper in the "portrait" orientation.

B. Text shall be single-spaced.

C. Font shall be a minimum of twelve (12) point in Arial (not Arial narrow) or Times New Roman (not Times New Roman Condensed) font as used in Microsoft® Word.

D. The binding edge margin of all pages shall be a minimum of one and one half inches (1 ½"). All other margins shall be 1".

E. Graphics may have a "landscape" orientation, bound along the top (11") side. If oversize, graphics may have a maximum of one (1) fold.

F. Graphics may have a smaller text spacing, pitch, and font size.

G. Resumes are considered text not graphics.

SECTION IV. PROPOSAL CONTENTS

Part One: Transmittal Communication, Forms and Acceptances

Each response must include an original (clearly marked) and eight (8) exact copies submitted in a separate, sealed envelope and properly marked **"Managed Care MCO RFP – Part One"** in the order specified below:

1. Transmittal Letter

The original proposal and all copies must include a Transmittal Letter signed by a corporate officer with the authority to bind the bidder of no more than four pages that addresses:

- **A.** Each of the Bidder assurances (RFP Section II – 15);
- **B.** The identification of any proprietary information (RFP Section II – 17);
- **C.** A statement that any submitted response and cost shall remain valid for one hundred twenty (120) days after the proposed due date or until the contract is approved, whichever comes first; and
- **D.** The following identifying information:
    1. Full Legal name of the corporation and address;
    2. Federal Taxpayer Identification Number
    3. Name, title, telephone number, fax number and e-mail address of the individual with the authority to bind the bidder to sign a contract with the Department; and
    4. Name, title, telephone number, fax number and e-mail address of the bidder's principal contact to receive amendments to the RFP and requests for clarification.

2. Amendment Acknowledgement

The bidder must insert acknowledgement of the receipt of all amendments issued to this RFP.

3. Table of Contents

Part One must include the Table of Contents for the entire Proposal beginning with the Transmittal Letter.

4. Procurement Agreement Signatory Acceptance – Attachment A

The bidder must provide a signed Acceptance Statement, without qualification, of all terms and conditions (Attachment). The bidder may propose alternate language to the Standard Terms and Conditions (See Section 8.03) and the Department may, after consultation with the Office of the Attorney General and the Office of Policy and Management, incorporate the alternate language in any resultant contract. Nonetheless, the Decision of the Department is final.

5. Workforce Analysis Form – Attachment B

Bidders with Connecticut work sites must complete this form.

6. Affirmative Action - Notification to Bidders Form - Attachment C

Regulations of Connecticut State Agencies Section 46a68j-3(10) requires agencies to consider the factors listed below when awarding a contract that is subject to contract compliance requirements

The Bidder shall provide a signed Notification to Bidders Form and must address in writing the following five factors as appropriate to the bidder's particular situation:

- **A.** The bidder's success in implementing an Affirmative Action Plan;
- **B.** The bidder's success in developing an apprenticeship program complying with Sections 46 a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;
- **C.** The bidder's promise to set-aside a portion of the contract for legitimate minority businesses (See Section 4-114a3(10) of the Contract Compliance Regulations) and to provide the Department Set-Aside reports in a format required by Department.
- **D.** The bidder's promise to develop and implement a successful Affirmative Action Plan if no successful Affirmative Action Plan is in place; and
- **E.** The bidder's submission of EEO-1 data indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area.

7. Smoking Policy - Attachment D

(Signed Statement if applicable): If the bidder is an employer subject to the provisions of Section 31-40q (Attachment D) of the Connecticut General Statutes, the bidder agrees to provide the Department with a copy of its written rules concerning smoking. The Department must receive the rules or a statement that the bidder is not subject to the provision of Section 31-40q of the Connecticut General Statutes prior to contract approval.

9. Lobbying Restrictions – Attachment E

The bidder must include a signed statement to the effect that no funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member or Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

10. Integrity in State Contracting Policy Affidavit – Attachment F

The bidder must include a signed and notarized statement regarding the giving of gifts to any state official or employee of the Department of Social Services or any state official or employee of any state agency which has supervisory or appointing authority over DSS including, the Office of the Attorney General and the Office of Policy and Management.

SECTION IV. PROPOSAL CONTENTS

Part Two: Organization, Key Personnel, Experience

1. Introduction

The bidder's responses to the requirements of this Section must describe the background of the bidder's organization and subcontractors (if any). Responses shall also address the details regarding the size and resources of the organization relevant to the functions to be performed under the resultant contract.

2. Organization

A. Governance - Disclosure

The bidder shall provide the following information for the bidder as the proposed prime Contractor and any proposed subcontractor:

1. The name, work address, and percentage of time allocated for this contract for each responsible director.
2. The role of the board of directors in governance and policy-making.
3. A current organizational chart defining levels of ownership, governance and management.

B. Ownership - Disclosure

The bidder shall provide the following information for the bidder as the proposed prime Contractor and any proposed subcontractor:

1. A complete description of percent of ownership by the principals of the company or any other individual or organization that retains 5% or more including: name, work address.
2. The relationship of the persons so identified to any other owner or governor as the individual's spouse, child, brother, sister, or parent.
3. The name of any person with an ownership or controlling interest of five percent (5%) or more, in the bidder, who also has an ownership or control interest of five percent (5%) or more in any other related entity including subcontracting entity or parent entity or wholly owned entity. The bidder shall include the name or names of the other entity.
4. The name and address of any person with an ownership or controlling interest in the disclosing entity or is an agent or employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Title XVIII, XIX, XX or XXI of the Social Security Act, since the inception of such programs.

5. Whether any person identified in subsections (1) through (4) above, has been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, from any program under Titles XVIII, XIX, or XX of the Social Security Act, or has within the last five years been reinstated to participation in any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, and prior to said reinstatement had been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, in such programs.
6. A description of the relationship with other entities including whether the bidder is an independent entity or a subsidiary or division of another company. If the bidder is not an independent entity, the bidder shall describe the organization linkages and the degree of integration/collaboration between the organizations including any roles of the organization's principals.
7. A complete listing and explanation of any financial relationship with any other health management or consulting organization.

3. Key Personnel and Staff Resources

A. Corporate Project Unit:

The bidder shall provide the following information for the bidder as the proposed prime Contractor and any proposed subcontractor:

1. A functional organization chart of the organization detailing how the staffing for the proposed Connecticut project fits within the entire structure of the organization.
2. Describe how the proposed organizational structure will manage and operate the project.
3. The names of personnel proposed for this project and the percentages of time dedicated to this project.
4. Justify its staffing resources to successfully meet its RFP response requirements in light of any other similar obligations for any other entity.

B. Management Plan:

The bidder shall describe a management plan for the project that includes at a minimum:

1. A description of the duties, authority and responsibilities of each of the key personnel, including the number and type of personnel to be supervised by each.

2. The names of key personnel who are not full-time staff of the bidder including a complete description of their employment status with the bidder.
3. An organizational structure of the company indicating lines of authority.
4. A description of any other current or planned contractual obligations that might have an influence on the bidder's capability to perform the work under a contract with the Department.

C. Project Manager:

The bidder shall identify a Project Manager who will be responsible for

1. Implementing and managing the project;
2. Monitoring and ensuring the performance of duties and obligations under a contract;
3. The day-to-day oversight of the project and who will be available to attend all project meetings at the request of the Department; and Responding to the Department's inquiries and other communications related to implementation, operations, and program management of the activities presented in this RFP.

D. Resumes and Job Descriptions

The bidder shall

1. Provide proposed personnel job descriptions or resumes for key personnel for the following functional areas:

   Member Services and Outreach;

   Provider Enrollment and Credentialing;

   Quality Assessment and Performance Improvement;

   Utilization Management/Review;

   Data systems; and

   Project Manager.
2. The resumes or job descriptions shall specify contract-related experience, credentials, education and training, and work experience and shall include:
   a. Experience with bidder (or proposed subcontractor to the bidder);
   b. Relevant education, experience, and training;
   c. Names, positions, titles, and telephone numbers of persons who are able to provide information concerning the individual's experience and competence; and

d. Each project referenced in a resume should include the customer, and a brief description of the responsibility of the individual to the project.

E. Personnel and Tasks

The bidder shall describe the relationship between specific personnel, for whom resumes have been submitted, (or proposed job descriptions when specific individuals have not been employed) and the specific tasks and assignment proposed to accomplish the scope of work and a justification of the individual's function based on the individual's competence; and

4. Corporate Experience

A. Contracts

The bidder shall describe information on its, and any proposed subcontractors, experience and success related to the scope of work for this project including the following information concerning the bidder's and/or proposed subcontractor's experience in other contracts or projects similar to the type of service contemplated by this RFP, whether ongoing or completed:

1. Identify all state agency(s) and commercial vendors in all other states for which the bidder has engaged in similar or related contract work;
2. Describe its contracts or the work performed in the past five years for those agencies or commercial vendors;
3. Provide a signed release allowing the Department to access any evaluative information including but not limited to site reviews conducted by any state agency or commercial entity for which the bidder has performed work in the past five years;
4. Identify contacts for those projects including: name of customer's project officer, title, address, telephone number, fax number and e-mail address;
5. Identify the term for the contracts including the date of contract signing, the date of project initiation, the initial schedule completion date and the actual completion date;
6. List all sanctions, fines, penalties, or letters of non-compliance issued against the bidder by any of the contracting entities listed above. The list shall include a description of the circumstance eliciting the sanction or letter of non-compliance and the corrective action or resolution to the sanction, fine, penalty or letters of non-compliance; and
7. Describe how the bidder contributed innovation and problem solving expertise to a collaborative relationship with the governmental entity or commercial entity for selected contracts listed above.

B. Bidder References (Organization)

The bidder shall supply three external letters of reference, on author's letterhead, from official representatives of organizations, other than the State of Connecticut, who are currently contracting with the Bidder or have contracted with the Bidder within the past three years for work related to the work contemplated in this RFP. If the Bidder is proposing to use subcontractors, the bidder shall supply three external letters of reference for each proposed subcontractor. In addition, the bidder shall obtain references from the State of Connecticut, excluding the Department of Social Services, if the Bidder or any proposed subcontractor is currently or was during the period January 1, 2002 through December 31, 2007 under contract with the State of Connecticut, excluding the Department of Social Services. For purposes of this requirement, subcontractor refers to those entities that provide a function as outlined in the Scope of Work – Part Four. Each letter of reference MUST address and evaluate the bidder's and/or proposed subcontractor's performance regarding the following issues:

1. Performance quality and quality management;
2. Call center performance;
3. Creativity and problem solving;
4. Responsiveness and quality of communication with contracting agency or organization;
5. Responsiveness and quality of communication with consumers (Department clients);
6. Overall project management; and
7. Accuracy and timeliness of work including reports and data submissions to the contracting entity.

The contracting entity should briefly describe the bidder's (or proposed subcontractor's) performance in each area and then rate the performance as Very Poor, Poor, Satisfactory, Good, Very Good in each category.

Each letter of reference MUST include valid contact information including telephone number and e-mail address of each representative providing the reference.

5. Systems Design and Architecture

A. The Contractor shall:

1. Establish and maintain a HIPAA compliant computer system to accommodate all operational and reporting functions required in this contract;
2. Maintain information integrity through controls at appropriate locations within the Contractor's system and process flow and ensure quality control of all operational components impacting Contractors performance of functions required by resultant contract; and

3. Perform all file and system maintenance functions to the Contractor's proprietary system and maintain data processing expertise, data processing equipment, programmers and operators and other related technical support to ensure the continued operation of the functions required by resultant contract.

B. **The Bidder shall** describe and profile the information systems the bidder proposes to use to perform the information management and operational functions required by this RFP.

6. Project Timetable

The bidder shall submit a PERT, Gantt, or Bar Chart, that clearly outlines the task timetable for the implementation process from beginning to end. The chart must display key dates and events relating to the establishment of the project and implementing the protocols. The chart must display the position and title of the responsible party for the events and include the percentage of time allocated for all staff throughout the project.

SECTION IV PROPOSAL CONTENTS

Part Three: Scope of Work – Contract Template

1. DEFINITIONS

As used throughout this contract, the following terms shall have the meanings set forth below.

Abuse:
Provider and/or MCO practices that are inconsistent with sound fiscal, business or medical practices and that result in an unnecessary cost to HUSKY A, HUSKY B, or Charter Oak, or the reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or a pattern of failing to provide medically necessary services required by this contract. Member practices that result in unnecessary cost to HUSKY A, HUSKY B, or Charter Oak also constitute abuse.

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

Administrative Services Organization (ASO):
An organization contracted with DSS to provide administrative and clinically related services, including but not limited to claims payment, utilization management, quality management, and benefit information for a specific health or behavioral health benefit.

Advance Directive:
A written instruction, such as a living will or durable power of attorney for health care, recognized under Connecticut law, relating to the provision of health care when the individual is incapacitated.

Agent:
An entity with the authority to act on behalf of the DEPARTMENT, the federal government, or the MCO.

Allowance:
The amount that the MCO is responsible to pay a provider towards the cost of limited contract services.

American Indian/Alaska Native (AI):

a. A member of a Federally recognized Indian tribe, band, or group;
b. An Eskimo or Aleut other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. § 1601 et seq.; or
c. A person who is considered by the Secretary of HHS to be an Indian for any purpose.

Appeal:
A request to the MCO from a Member for a formal review of an MCO action.

Applicant:
See "HUSKY B Applicant" or "Charter Oak Applicant"

Behavioral Health Partnership ("BHP" or "CT BHP"):
An integrated behavioral health service system for HUSKY Part A, HUSKY Part B, and Charter Oak Members, children enrolled in the Voluntary Services Program operated by the Department of Children and Families and may, at the discretion of the Commissioners of Children and Families and Social Services, include other children, adolescents, and families served by the Department of Children and Families

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

Capitation Payment:
The individualized monthly payment made by the DEPARTMENT to the MCO on behalf of Members.

Capitation Rate:
The amount paid per Member by the DEPARTMENT to the MCO on a monthly basis.

Charter Oak Applicant:
An individual who are applying for coverage under Charter Oak pursuant to § 23 of Public Act No. 07-2.

Charter Oak
A publicly-funded program that, pursuant to § 23 of Public Act No. 07-2, provides access to health insurance coverage for Connecticut residents who have been uninsured for at least six (6) months and who are ineligible for Medicare, HUSKY A, and HUSKY B or other publicly-funded health insurance.

Children with Special Health Care Needs:

Children at elevated risk for (biologic or acquired) chronic physical, developmental, behavioral, or emotional conditions and who also require health and related (not educational or recreational) services of a type and amount not usually required by children of the same age.

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

Clean Claim:
A bill for service(s) or goods, a line item of services or all services and/or goods for a Member contained on one bill which can be processed without obtaining additional information from the provider of service(s) or a third party. A clean claim does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

Client:
A person eligible for services under HUSKY A, HUSKY B, or Charter Oak. For purposes of this contract, the term "client" is synonymous with beneficiary, recipient and enrollee (which are terms used in other jurisdictions).

CMS or Centers for Medicare & Medicaid Services:
A division within the United States Department of Health and Human Services that has primary responsibility for administering federal funding for Medicare and Medicaid. CMS was formerly known as the Health Care Financing Administration (HCFA).

Coinsurance:
The sharing of expenses for specified contract services by the insured and an insurer in a specified ratio.

Cold-Call Marketing:
Any unsolicited personal contact by the MCO with a potential Member for the purpose of marketing.

Commissioner:
The Commissioner of the Department of Social Services, as defined in Conn. Gen. Stat. § 17b-3.

Contract Administrator:
The DEPARTMENT employee responsible for fulfilling the administrative responsibilities associated with this managed care project.

Contract Services:
Those services, goods and items that the MCO shall provide to HUSKY A, HUSKY B, and Charter Oak Members under this contract.

Co-payment:
A payment made by or on behalf of a Member for (1) specified contract services and (2) services, goods or items that are not covered under this contract but that HUSKY A, HUSKY B or Charter Oak covers for that Member.

Cost-sharing:
An arrangement made by or on behalf of a Member to pay a portion of the cost of health services and share costs with the DEPARTMENT and the MCO, which may include co-payments, premiums, deductibles and coinsurance.

CPT Codes or Current Procedure Terminology Codes:
A listing of descriptive terms and identifying codes for reporting medical services and procedures for a variety of uses, including billing of public and private health insurance programs. The codes are developed and published by the American Medical Association.

Day:
Except where the term “business day” is expressly used, all references in this contract will be construed as calendar days.

Deductible:
The amount of out-of-pocket expenses that would be paid for contract services by or on behalf of a Member before becoming payable by the insurer.

DEPARTMENT or DSS:
The Department of Social Services, State of Connecticut (DEPARTMENT) is the state agency responsible for administering a over 90 legislatively-authorized programs (including HUSKY A, HUSKY B, and Charter Oak). These programs also included those authorized under various federal statutes, including the Rehabilitation Act, the Food Stamp Act, the Older Americans Act, and the Social Security Act. The DEPARTMENT is headed by the Commissioner of Social Services. Additional information is available online at http://www.ct.gov/dss/site/default.asp. References to the “DEPARTMENT” shall include its representatives, agents, and subcontractors.

Department of Children and Families or DCF:
Pursuant to Conn. Gen. Stat. § 17a-2, the Connecticut Department of Children and Families (DCF) offers child protection, behavioral health, juvenile justice and prevention

services to (i) abused and neglected children, (ii) children committed to DCF by the juvenile justice system; and (iii) families of these and other at-risk children. Additional information about DCF is available online at http://www.ct.gov/dcf/site/default.asp.

DSM-IV or Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition:
The current listing of descriptive terms and identifying codes for reporting a classification of mental and substance abuse disorders.

DME or Durable Medical Equipment:
Equipment furnished by a supplier or a home health agency that:

a. Can withstand repeated use;
b. Is primarily and customarily used to serve a medical purpose;
c. Generally is not useful to an individual in the absence of an illness or injury; and
d. Is appropriate for use in the home.

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

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

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

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

Effective date of eligibility:
The DEPARTMENT's administrative determination of the date an individual becomes eligible for HUSKY A, HUSKY B or Charter Oak.

Effective date of enrollment:
The DEPARTMENT's administrative determination of the date on which a HUSKY A, HUSKY B or Charter Oak Member is officially enrolled with the MCO, thereby assigning financial and service responsibility to the MCO for that Member.

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

Emergency Services:
Inpatient and outpatient contract services that are: 1) furnished by a provider that is qualified to furnish Medicaid services; and 2) needed to evaluate or stabilize an emergency medical condition. Such services shall include, but not be limited to,

behavioral health and detoxification needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

Enhanced Care Clinics:
Clinics that qualify for fees that are higher than the standard Medicaid fee schedule for outpatient mental health and substance abuse clinics. In order to qualify for such higher fees, clinics must meet special service requirements as determined by the CT BHP.

Enrollment Broker:
The organization contracted by the DEPARTMENT to perform the following administrative and operational functions for the DEPARTMENT's managed care system: HUSKY B and Charter Oak application processing, HUSKY B and Charter Oak eligibility determinations, Charter Oak premium subsidy determinations, passive billing and MCO enrollment processing.

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

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

Fee-For-Service (FFS):

A traditional method of paying for health care services under which the DEPARTMENT pays providers directly for each service that they render to a Member. The providers submit claims for payment to the DEPARTMENT, which reimburses them pursuant to the terms of their provider agreement.

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

Free-look Period:
A specified period of time, occurring from the date of onset of a lock-in period of HUSKY A, HUSKY B, or Charter Oak Member with the earliest date of enrollment in the MCO, during which time the Member's family shall have the opportunity to choose another MCO for all Members in that family. Such period is contingent upon no Members of the family having previously been enrolled in the MCO chosen by the family. For HUSKY A and HUSKY B, the free-look period is ninety (90) days; for Charter Oak, the free-look period is thirty (30) days.

Global Plan of Care:
The treatment plan that integrates contract services with services from the HUSKY Plus Physical Program when a HUSKY B Member is concurrently receiving services from HUSKY B and the HUSKY Plus Physical Program.

Grievance:
An expression of dissatisfaction about the MCO on any matter other than an "action" as defined herein. Possible subjects for grievances include, but are not limited to, the quality of care or services provided by the MCO and aspects of interpersonal

relationships such as rudeness of a provider or an MCO employee, or failure to respect a Member's rights.

Health Employer Data Information Set (HEDIS):
A standardized performance measurement tool that enables users to evaluate the quality of different managed health care plans based on the following categories: effectiveness of care; managed health care plan stability; use of services; cost of care; informed health care choices; and managed health care plan descriptive information.

HHS:
The United States Department of Health and Human Services.

HUSKY B Applicant:
Any of the following individuals who are applying for coverage under HUSKY B on behalf of a child, pursuant to Conn. Gen. Stat. § 17b-290:

a. A natural parent, adoptive parent, legal guardian, caretaker relative, foster parent, or a stepparent who is nineteen (19) years of age or older and who lives with the child for whom he or she is applying;

b. A non-custodial parent who is under order of a court or family support magistrate to provide health insurance for his or her child;

c. A child who is eighteen (18) years of age or younger and who is applying on his or her own behalf or on behalf of a minor dependent with whom he or she lives; and

d. A child who is emancipated in accordance with the provisions of Conn. Gen. Stat. §§46b-150 to 150e, inclusive, who is applying on his or her own behalf or on behalf of a minor dependent with whom he or she lives.

A child is an applicant until the child receives coverage under HUSKY B.

HUSKY Plan, Part A, HUSKY A, or HUSKY A Plan:
For purposes of this contract, HUSKY A includes all those coverage groups previously covered in Connecticut Access, subject to expansion of eligibility groups pursuant to Conn. Gen. Stat. § 17b-266.

HUSKY Plan, Part B, HUSKY B, or HUSKY B Plan:
The health insurance plan for children established pursuant to Title XXI of the Social Security Act, the provisions of Conn. Gen. Stat. § 17b-289 to 17b-303, inclusive, and of the § 16 of Public Act 97-1 of the October special session.

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

ICD9-CM or The International Classification of Disease, 9th Revision, Clinical Modification:
A widely-recognized system of disease classification developed and published by the National Center for Health Statistics.

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

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

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

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

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

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

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

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

In-Network Providers or Network Providers:
Providers who have contracted with the MCO to provide services to Members.

Institution:
An establishment that furnishes food, shelter and some treatment or services to four (4) or more persons unrelated to the proprietor.

Lifetime Benefit Maximum:
The limit on the total amount that an insurer is liable to pay for contract services for the insured during the entire period that the insured is enrolled in Charter Oak. This amount does not include any Charter Oak Member deductibles, co-insurance, or payments for non-contract services.

Limited Benefits:
Contract services that are covered only up to a specified dollar or quantity limit.

Lock-in:
Limitations on Member changes of managed care plans for a period of time, not to exceed twelve (12) months.

Lock-out:
The three-month period during which HUSKY B and Charter Oak Members are not permitted to participate in an MCO due to non-payment of a premium owed to the MCO in which they were enrolled. Conn. Agencies Regs. § 17b-304-11(d) details the policy and procedures related to the lock-out provision for HUSKY B; for purposes of this contract, these regulations shall also apply to Charter Oak.

Managed Care Organization or MCO or Contractor:
The managed care plan signing this agreement/contract with the DEPARTMENT. References to the “MCO” or “the Contractor” shall include its representatives, assignees, agents, and subcontractors.

Managed Care Plan:
An insurer, health care center, or other organization that provides, offers, or arranges for coverage of health services needed by plan members and uses utilization review and a network of participating providers. For purposes of the contract, "managed care plan" refers to a managed care plan that is under contract with the DEPARTMENT to provide contract services to HUSKY A, HUSKY B, and Charter Oak Members.

Marketing:
Any communication from the MCO to a potential Member, that can be reasonably interpreted as intended to influence the potential Member to enroll or reenroll in a managed care plan or either to not enroll in, or disenroll from, another managed care plan.

Marketing Materials:
Any materials produced in any medium, by or on behalf of the MCO that can reasonably be interpreted as intended to influence a potential Member to enroll.

Maximum Annual Aggregate Cost-sharing:
The maximum amount that a Member is required to pay (out-of-pocket) for services under HUSKY B or Charter Oak. For HUSKY B, such payments include co-payments and premiums. For Charter Oak, such payments include deductibles, co-insurance, and co-payments, but they do not include premiums.

Medicaid:
The Connecticut Medical Assistance Program operated by the Connecticut Department of Social Services under Title XIX of the federal Social Security Act and related federal and state regulations.

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

Medical Appropriateness or Medically Appropriate:
Health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities.

Medically Necessary/Medical Necessity:
Health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or prevent a medical condition from occurring.

Member:
a. For the purposes of HUSKY A, a Medicaid client who has been certified by the DEPARTMENT as eligible to enroll under this contract, and whose name appears on the MCO enrollment information that the DEPARTMENT transmits to the MCO in accordance with an established notification schedule. For HUSKY A Members who are minors, the references herein to Member rights, responsibilities and potential liabilities shall be construed to extend to the HUSKY A Members' parents, caretakers, or legal guardians.
b. For the purposes of HUSKY B, a child who has been deemed eligible for HUSKY B pursuant to Conn. Gen. Stat. § 17b-290 and whose name appears on the MCO enrollment information that the DEPARTMENT transmits to the MCO in accordance

with an established notification scheduled. For the purposes of this contract, HUSKY B Members are clients as defined by Conn. Gen. Stat. § 17b-290(11). For HUSKY B Members who are minors, the references herein to Member rights, responsibilities and potential liabilities shall be construed to extend to the HUSKY B Members' parents, caretakers, or legal guardians.

c. For the purposes of Charter Oak, a person who has been determined eligible for the Charter Oak Health Plan and whose name appears on the MCO enrollment information that the DEPARTMENT transmits to the MCO in accordance with an established notification schedule.

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

Open Enrollment Period:
A sixty (60) day period, which ends on the fifteenth (15^{th}) of the last month of the lock-in period, during which time the Member has the opportunity to change managed care plans for any reason.

Out-of-network Provider:
A provider that has not contracted with the MCO.

Passive Billing:
Automatic capitation payments generated by the DEPARTMENT based on enrollment.

Post-Stabilization Services:
Contract services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR § 422.113(c), to improve or resolve the Member's condition.

Potential Member:
A HUSKY A, HUSKY B or Charter Oak client who is subject to mandatory enrollment or may voluntarily enroll in a managed care plan but is not yet a member of a specific managed care plan.

Preferred Drug List:
A list of selected pharmaceuticals determined to be the most useful and cost effective for patient care, developed by the DEPARTMENT's pharmacy and therapeutics committee.

Premium:
Any required payment made by an individual to offset, or pay in full, the capitation rate under HUSKY B or Charter Oak.

Preventive Care and Services for Children:

a. Child preventive care, including periodic and interperiodic well-child visits, routine immunizations, health screenings and routine laboratory tests;
b. Prenatal care, including care of all complications of pregnancy;
c. Care of newborn infants, including attendance at high-risk deliveries and normal newborn care;
d. Women, Infants and Children (WIC) evaluations;
e. Child abuse assessment required under Conn. Gen. Stat. §§17a-106a and 46-b-129a;
f. Preventive dental care for children; and

g. Periodicity schedules and reporting based on the standards specified by the American Academy of Pediatrics.

Preventive Services:
Services provided by a physician or other licensed health practitioner within the scope of his or her practice under State law to: prevent disease, disability, and other health conditions or their progression; treat potential secondary conditions before they happen or at an early remediable stage; prolong life; and promote physical and mental health.

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

Primary Care Services:
The services of licensed health care professionals that are provided on an outpatient basis, including preventive services such as routine well-child and well-care visits; diagnosis and treatment of illness and injury; laboratory tests; diagnostic x-rays; radiation therapy; chemotherapy; and hemodialysis.

Prior Authorization:
The process of obtaining prior approval as to the medical necessity or appropriateness of a service or plan of treatment.

Provider Lock-In:
An optional managed care plan feature, subject to approval by the DEPARTMENT, to restrict certain Members to a specific provider in order to monitor services and reduce unnecessary or inappropriate utilization.

Provider Site:
A physical location where an individual, entity or organization supplies medical, dental, behavioral health services or goods. The definition of provider site also extends to shared waiting rooms and shared inside space in multi-service facilities.

Reinsurance:
A type of protection purchased by managed care plans from insurance companies specializing in underwriting reinsurance policies for a stipulated premium. Typical reinsurance risk coverage may include one or more of the following: (1) individual stop-loss, (2) aggregate stop-loss, (3) out-of-area, and (4) insolvency protection.

Revenue Center Code:
A revenue code identifies a specific billable service type. Facilities must choose the code that most appropriately describes the service to be billed.

Risk:
The possibility of monetary loss or gain by the MCO resulting from service costs exceeding or being less than payments made to it by the DEPARTMENT.

Routine Cases:
A symptomatic situation (such as a chronic back condition) for which the Member is seeking care, but for which treatment is neither of an emergent nor urgent nature.

Solicitation:
Attempts, irrespective of the medium or method or degree of persistence, by MCO representatives to promote or market their managed care plan.

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

Sub-acute care:
Comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long-term conditions and overall situation.

Subcontract:
Any written agreement between the MCO and another party to fulfill any requirements of this contract.

Subcontractor:
The party contracting with the MCO to fulfill any requirements of this contract.

Third Party Resource:
Any individual, entity or program that is or may be liable to pay all or part of the expenditures for contract services.

Title V:
For purposes of this contract, a state and federally funded program for Children with Special Health Care Needs administered by the Department of Public Health, State of Connecticut.

Title XIX:
The provisions of 42 U.S.C. § 1396 et seq., including any amendments thereto. (See Medicaid)

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

Urgent Cases:
Illnesses or injuries of a less serious nature than those constituting emergencies but for which treatment is required to prevent a serious deterioration in the Member's health and for which treatment cannot be delayed without imposing undue risk on the Members' well-being.

Well-child Visits:
See EPSDT.

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

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

2. DELEGATIONS OF AUTHORITY

The State of Connecticut Department of Social Services is the single state agency responsible for administering the Medicaid program, HUSKY B, and the Charter Oak Health Plan. No delegation by either party in administering this contract shall relieve either party of responsibility for carrying out the terms of the resultant contract.

3. FUNCTIONS AND DUTIES REQUIRED OF THE MCO IN THE RESULTANT CONTRACT

The MCO agrees to perform the following contractual obligations including, but not limited to, the specific services for HUSKY A, HUSKY B, or Charter Oak Members. All provisions of the contract apply equally to HUSKY A, HUSKY B, or Charter Oak unless otherwise specified in the text of the provision or in the section title.

3.01 Provision of Services

a. The MCO shall provide Members, directly or through arrangements with others, all of the contract services described in Appendix A for HUSKY A Members, Appendix B for HUSKY B Members, and Appendix C for Charter Oak Members.

b. The MCO shall ensure that the services provided to Members are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the service is provided. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the Member's diagnosis, type of illness or medical condition.

c. The services provided to HUSKY A Members shall be in an amount, duration and scope that is no less than the amount, duration and scope of services for fee-for-service Medicaid clients.

d. The MCO shall ensure that utilization management/review and coverage decisions concerning acute or chronic care services to each Member are made on an individualized basis in accordance with the contractual definitions for Medical Appropriateness or Medically Appropriate and Medically Necessary or Medical Necessity at Section 1, Contract Definitions. As required by 42 CFR § 438.236 and as more fully described in Section E below, the MCO shall adopt practice guidelines as part of its quality improvement program. The MCO shall disseminate the guidelines to affected providers and to Members, upon request. The MCO's utilization management decisions shall be consistent with any applicable practice guidelines adopted by the MCO. In order to operationalize the medical necessity definition, the MCO may use utilization management criteria or guidelines developed by the MCO or a by a subcontractor or a third party. The MCO shall only use such criteria or guidelines in conjunction with the DEPARTMENT's medical necessity and medical appropriateness definitions. The DEPARTMENT's definitions take precedence over any guidelines or criteria and are mandatory and binding on all MCO utilization management decisions. The MCO shall also ensure that its subcontracts and contracts with network providers require that the decisions of subcontractors and network providers affecting the delivery of acute or chronic care services to Members are made on an individualized basis and in accordance with the contractual definitions for Medical Appropriateness or Medically Appropriate and Medically Necessary and Medical Necessity.

e. The MCO shall provide twenty-four (24) hour, seven (7) day a week accessibility to qualified medical personnel for Members in need of urgent or emergency care. The MCO may provide such access to medical personnel through either: 1) a hotline staffed by physicians, physicians on-call or registered nurses or 2) a PCP on-call system. Whether the MCO utilizes a hotline or PCPs on-call, Members shall gain access to medical personnel within thirty (30) minutes of their call. The MCO Member Handbook and MCO taped telephone message shall instruct Members to go directly to an emergency room if the Member needs emergency care. If the Member needs urgent care and has not gained access to medical personnel within thirty (30) minutes, the Member shall be instructed to go to the emergency room. The DEPARTMENT will randomly monitor the availability of such access.

f. The MCO is not required to provide a contract service if the MCO objects to the service on moral or religious grounds. However, the MCO shall furnish information about the services it does not cover as required in 42 CFR § 438.102. The MCO acknowledges that the DEPARTMENT may adjust the capitation rates to reflect services not provided by the MCO pursuant to this provision.

The Bidder shall:

a. Propose a plan outlining how it will meet the requirements of 3.01 a-e.

b. Identify any contract services the MCO will not provide because of an objection on moral or religious grounds.

3.02 Member Rights

a. The MCO shall have written policies regarding member rights. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, subcontractors and network providers consider and respect those rights when providing services to Members.

b. Member rights include, but are not limited to, the following:

   1. The right to be treated with respect and due consideration for the Member's dignity and privacy;

   2. The right to receive information on treatment options and alternatives in a manner appropriate to the Member's condition and ability to understand;

   3. The right to participate in treatment decisions, including the right to refuse treatment;

   4. The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience;

   5. The right to receive a copy of his or her medical records, including, if the HIPAA privacy rule applies, the right to request that the records be amended or corrected as allowed in 45 CFR Part 164; and

   6. Freedom to exercise the rights described herein without any adverse affect on the Member's treatment by the DEPARTMENT, the MCO or the MCO's subcontractors or network providers.

The Bidder shall:

Propose written policies regarding member rights to ensure that the MCO's employees, subcontractors and network providers consider and respect those rights when providing services to Members.

3.03 Gag Rules and Integrity of Professional Advice to Members

a. Subject to the limitations described in 42 U.S.C. § 1396u-2(b)(3)(B) and (C) and Conn. Gen. Stat. § 38a-478k, the MCO shall not prohibit or otherwise restrict a health care provider acting within his or her lawful scope of practice from advising or advocating on behalf of a Member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under this contract, for the following:
    1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
    2. Any information the Member needs in order to decide among relevant treatment options;
    3. The risks, benefits and consequences of treatment or non-treatment; and
    4. The Member's right to participate in decisions regarding his or her health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.
b. The MCO shall comply with the provisions of 42 C.F,R. § 457.985 concerning the integrity of professional advice to Members, including interference with providers' advice to Members and information disclosure requirements related to physician incentive plans.

The Bidder shall:

Propose a plan outlining how it will meet the requirements of 3.03 a & b.

3.04 Coordination and Continuation of Care

The MCO shall implement and maintain, at a minimum, the following patient care management processes to assure that Members receive appropriate patient care according to relevant professional standards and DEPARTMENT requirements:

a. Management and integration of health care through a PCP, gatekeeper or other means.
b. Referral process for medically necessary specialty, secondary and tertiary care.
c. Emergency care process, including Member education and instruction regarding where and how to obtain medically necessary care in emergency situations.
d. A process by which Members may obtain a contract service that the MCO does not provide or for which the MCO does not arrange because it would violate a religious or moral teaching of the religious institution or organization with which the MCO is owned, controlled, sponsored or affiliated.
e. Coordination and provision of EPSDT/well-child screening services in accordance with the schedules for immunizations and periodicity of well-child services as established by the DEPARTMENT and federal regulations.

f. EPSDT/well-child case management services through PCPs for HUSKY A and HUSKY B Members under twenty-one (21) years of age when the Member has a physical or mental health condition that makes the coordination of medical, social, and educational services medically necessary. As necessary, case management services shall include but not be limited to:

   1. Assessment of the need for case management and development of a plan for services;
   2. Periodic reassessment of the need for case management and review of the plan for services;
   3. Referring for related medical, social, and educational services;
   4. Facilitating referrals by providing assistance in scheduling appointments for health and health-related services, and arranging non-emergency medical transportation (for HUSKY A Members only) and interpreter services;
   5. Coordinating and integrating the plan of services through direct or collateral contacts with the family and those agencies and providers providing services to the child;
   6. Monitoring the quality and quantity of services being provided;
   7. Providing health education as needed; and
   8. Advocating to minimize conflict between service providers and to mobilize resources to obtain needed services.

g. Coordination and case management services for HUSKY A and HUSKY B Members who are children with special health care needs.

h. Inclusion and participation of PCPs, when requested, in the review and authorization of Individual Education Plans for HUSKY A and HUSKY B Members receiving School Based Child Health services and Individual Family Service Plans for HUSKY A and HUSKY B Members receiving services from the Birth to Three program.

i. Coordination of Members' care with the CT BHP ASO, as outlined in this contract, including but not limited to section 3.17, Mental health and Substance Abuse Access.

j. Provision of a case manager to the HUSKY Plus Physical Program and the coordination of care for HUSKY B Members who qualify for these services, as outlined in Section 3.19, Preventive Care and Services for Children, of this contract.

The Bidder shall:

Describe the patient care management processes the bidder will implement and maintain to comply with the requirements listed in a-j to achieve professionally acceptable standards of care.

3.05 Emergency Services

a. The MCO shall provide all emergency services twenty-four (24) hours each day, seven (7) days a week or arrange for the provision of said services twenty-four (24) hours each day, seven (7) days a week through its provider network.

b. The MCO shall cover and pay for emergency services without regard to prior authorization and regardless of whether the provider that furnishes the services has a contract with the MCO.

c. The MCO shall be responsible for payment for emergency department visits, including emergent and urgent visits billed by the facility, regardless of the Member's diagnosis. The DEPARTMENT and MCO will jointly develop audit procedures related to emergency department services when Members are admitted to the hospital and the primary diagnosis is behavioral. The CT BHP shall be responsible for payment for the following:

    1. Professional psychiatric services rendered in an emergency department by a community psychiatrist, if the psychiatrist is enrolled in the Medicaid program under either an individual provider or group provider number and bills the DEPARTMENT under that provider number.

d. The MCO shall not limit the number of emergency visits.

e. The MCO shall cover all services necessary to determine whether or not an emergency condition exists, even if it is later determined that the condition was not an emergency medical condition.

    1. If the screening examination leads to a clinical determination by the examining physician that an actual emergency does not exist, then the nature and extent of payment liability will be based on whether the Member had acute symptoms under the prudent layperson standard at the time of presentation.

    2. The MCO shall not base its determinations on what constitutes an emergency medical condition on a list of diagnoses or symptoms. The determination of whether the prudent layperson standard is met shall be made on a case-by-case basis. However, the MCO may determine that the emergency medical condition definition is met, based on a list such as ICD-9 codes.

f. The MCO shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent in nature.

g. If the screening examination leads to a clinical determination by the examining physician that an actual emergency does not exist, then the nature and extent of payment liability will be based on whether the Member had acute symptoms under the prudent layperson standard at the time of presentation.

h. A Member who has an emergency medical condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

i. Once the individual's condition is stabilized, the MCO may require prior authorization for a hospital admission or follow-up care.

j. The MCO shall cover post-stabilization services obtained either within or outside the MCO's provider network, under the following circumstances;

    1. The services were pre-approved by the MCO; or

    2. The services were not pre-approved by the MCO, but administered to maintain the Member's stabilized condition within one hour of a request to the MCO for pre-approval of further post-stabilization care services.

k. The MCO shall cover post stabilization services that were obtained either within or outside the MCO's provider network and not pre-approved, but administered to maintain, improve or resolve the Member's stabilized condition in the following circumstances:

   1. The MCO does not respond to a request for pre-approval of such services within one hour;

   2. The MCO cannot be contacted; or

   3. The MCO and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is not available for consultation. In this circumstance, the MCO shall give the treating physician the opportunity to consult with an MCO physician and the treating physician may continue with care of the patient until an MCO physician is reached or one of the following criteria are met:

      a) An MCO physician with privileges at the treating hospital assumes responsibility for the Member's care;

      b) An MCO physician assumes responsibility for the Member's care through transfer;

      c) The MCO and the treating physician reach an agreement concerning the Member's care; or

      d) The Member is discharged.

l. If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the Member is stable enough for discharge or transfer from the emergency room, the judgment of the attending physician(s) or the provider actually treating the Member prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission. The MCO may establish arrangements with hospitals whereby the MCO may send one of its own physicians or may contract with appropriate physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Member.

m. If a Member receives post-stabilization services from an out-of-network provider, the MCO shall not charge the Member more than he or she would be charged (pursuant to the cost-sharing provisions of this contract) if he or she had obtained the services through a network provider.

n. When a Member's PCP or another MCO representative instructs the Member to seek emergency care in-network or out-of-network, the MCO is responsible for payment for the screening examination and for other medically necessary emergency services, without regard to whether the Member's condition meets the emergency medical condition definition.

o. If a Member believes that a claim for emergency services has been inappropriately denied by the MCO, the Member may seek recourse through the MCO's appeal and the DEPARTMENT's administrative hearing process for HUSKY A members.

p. When the MCO reimburses emergency services provided by an in-network provider, the rate of reimbursement will be subject to the contractual relationship that has been negotiated with said provider.

q. When the MCO reimburses emergency services provided by an out-of-network provider whether within or outside Connecticut, the rate of reimbursement shall be limited to the fees established by the DEPARTMENT for the Medicaid fee-for-service delivery system, less any payments for indirect costs of medical education and direct costs of graduate medical education.

r. The MCO may not make payment for emergency services contingent upon the Member providing the MCO with notification either before or after receiving emergency services. The MCO may, however, enter into contracts with providers or facilities that require, as a condition of payment, the provider or facility to provide notification to the MCO after Members are present at the emergency room, assuming adequate provision is given for such notification.

s. The MCO shall retain responsibility for payment for emergency medical transportation, regardless of diagnosis. The MCO shall also retain responsibility for hospital-to-hospital ambulance transportation of members with a behavioral health condition.

The Bidder shall:

Propose a plan outlining how it will meet the requirements of 3.05 a-s.

3.06 Acceptance of DSS Rulings

In cases where there is a dispute between the MCO and an out-of-network provider about whether a service is an emergency or is an appropriate diagnostic test to determine whether an emergency condition exists, the DEPARTMENT will hear appeals, filed within one year following the date of service and make final determinations. The DEPARTMENT will accept written comments from all parties to the dispute prior to making the decision, and order or not order payment, as appropriate. The MCO shall accept the DEPARTMENT's determinations regarding appeals.

3.07 Choice of Health Professional

The MCO shall inform each Member about the full panel of network providers. To the extent possible and appropriate, the MCO shall offer each Member the opportunity to choose among network providers.

The Bidder shall:

a. Describe its process for allowing members choice of providers.

b. Propose a strategy to inform each Member regarding the panel of network providers in its network. Include the frequency and method used.

3.08 Provider Network

a. The MCO shall maintain a provider network capable of delivering or arranging for the delivery of all contract services to all of its Members.

   1. The MCO’s provider network shall have the capacity to deliver or arrange for the delivery of all the contract services regardless of whether all of the services, goods and items are provided through direct provider contracts.

2. The MCO shall have a single provider network for HUSKY A, HUSKY B, and Charter Oak. The MCO may have a smaller, high-performing network only for Charter Oak Members.

b. The MCO shall consider the following in establishing and maintaining its provider network:
   1. Anticipated enrollment;
   2. Expected utilization of services, taking into consideration the characteristics and health care needs of HUSKY A, HUSKY B, and Charter Oak Members;
   3. The number and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;
   4. The number of network providers who are not accepting new HUSKY A, HUSKY B, or Charter Oak patients; and
   5. The geographic location of providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

c. The MCO shall notify the DEPARTMENT, in a timely manner, of any changes made in the MCO's provider network. The monthly file submitted to the DEPARTMENT shall not contain any providers who are no longer in the MCO's network. The DEPARTMENT will randomly audit the provider network file for accuracy and completeness and will take corrective action if the provider network file fails to meet these requirements.

d. If the MCO declines to include a provider or group of providers in its network, the MCO shall give the affected provider(s) written notice of the reason for its decision.

e. The MCO shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider who is acting within the scope of that provider's license or certification under applicable State law, solely on the basis of the provider's license or certification. This shall not be construed to prohibit the MCO from including providers only to the extent necessary to meet the needs of the MCO's Members or from establishing measures designed to maintain the quality of services and control costs, consistent with its responsibilities. This shall not preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

f. The MCO's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

g. The MCO shall not employ or contract with any provider excluded from participation in a Federal health care program under either Section 1128 or 1128A of the Social Security Act.

3.09 Network Adequacy and Maximum Enrollment Levels

a. The DEPARTMENT will evaluate the adequacy of the MCO's provider network on a quarterly basis, except as otherwise specified by the DEPARTMENT. Such evaluations shall use ratios of Members to specific types of providers and shall not be less than the access ratio based on the Connecticut Medicaid fee-for-service delivery system for a similar population.

b. For primary care providers (PCPs) the ratio shall be as follows:

1. Adult PCPs, including general practice specialists counted at 61%, internal medicine specialists counted at 88%, family practice specialists counted at 67%, and nurse practitioners of the appropriate specialties and physician assistants counted at 67%, 387 adult Members per provider;
2. Children's PCPs, including pediatric specialists counted at 100%, general practice specialists counted at 39%, internal medicine specialists counted at 11%, family practice specialists counted at 33%, nurse practitioners of the appropriate specialties and physician assistants counted at 33%, 301 child (under age 19) Members per provider; and
3. Women's PCPs, including obstetrics and gynecology specialists, nurse midwives, and nurse practitioners of the appropriate specialty at 100%, 835 Members per provider.

c. In the event that the number of Members in a given county equals or exceeds ninety percent (90%) of the established capacity the DEPARTMENT will evaluate the adequacy of the MCO's network on a monthly basis.

d. Maximum Enrollment Levels: Based on the adequacy of the MCO's provider network, the DEPARTMENT may establish a maximum enrollment level for Members in the MCO on a county-specific basis. The DEPARTMENT will provide the MCO with written notification no less than thirty (30) days prior to the effective date of the maximum enrollment level.

e. Subsequent to the establishment of this limit, if the MCO wishes to increase its maximum enrollment level in a specific county, the MCO shall provide the DEPARTMENT with the signature pages from the executed provider contracts of newly enrolled providers. The DEPARTMENT will not accept any other proof or documentation as evidence of a provider's participation in the MCO's provider network. The DEPARTMENT will review the existence of additional capacity for confirmation no later than thirty (30) days following notice by the MCO. An increase will be effective the first of the month after the DEPARTMENT confirms additional capacity exists.

f. In addition to the network adequacy measures described in subsections (a) through (e) above, the DEPARTMENT will measure access to specialists by examining and reviewing confirmed complaints received by the MCO, the Enrollment Broker, the DEPARTMENT, the HUSKY Infoline and taking other steps as more fully described below:

1. For purposes of this section, a "complaint" shall be defined as dissatisfaction expressed by a Member, or their authorized representative, with the Member's ability to obtain an appointment with a specialist that will accommodate the member's medical needs within a reasonable timeframe or within a reasonable distance.
    a) Member requests for information or referrals to specialists within the MCO's network shall not constitute a complaint.
    b) The DEPARTMENT will count more than one complaint to different entities about a Member's inability to access a particular specialist, within the same timeframe, as one complaint.

c) The DEPARTMENT will count as separate complaints when a Member complains about being unable to make appointments with more than one specialist.

2. The DEPARTMENT will refer to the MCO all complaints for resolution.

3. The DEPARTMENT will send the MCO a "Complaint Report" when it receives a certain number of confirmed access complaints from Members during a quarter regarding a particular specialty.

   a) The number of confirmed complaints that will initiate the DEPARTMENT'S sending a "Complaint Report" will be based on the MCO's number of Members factored by the ratio of one complaint per 10,000 members.

   b) For purposes of this section, a "confirmed complaint" means that the DEPARTMENT or another entity has received a complaint and the DEPARTMENT has confirmed that the MCO has not provided a specialist within a reasonable timeframe or within a reasonable distance from the Member's home, or both.

   c) In determining whether a complaint will be confirmed, the DEPARTMENT will consider a number of factors, including but not limited to:

      1) The Member's PCP or other referring provider's medical opinion regarding how soon the Member should be seen by the specialist;

      2) The severity of the Member's condition;

      3) Nationally recognized standards of access, if any, with respect to the particular specialty;

      4) Whether the access problem is related to a broader access or provider availability problem that is not within the MCO's control;

      5) The MCO's diligence in attempting to address the Member's complaint; and

      6) Whether both the Member and the MCO have reasonably attempted to obtain an appointment that will meet the Member's medical needs.

g. The DEPARTMENT may seek to amend these requirements, particularly as they relate to the adequacy of the network of dermatologists, neurologists, orthopedists and other specialty providers.

Sanctions:

a. In the event the DEPARTMENT deems that the MCO's provider network is not capable of accepting additional enrollments and lacks adequate access to providers as described in (a) through (e) above, the DEPARTMENT may exercise its rights under Section 6, Corrective Action And Contract Termination, of this contract, including but not limited to the rights under Section 6.04, Suspension of New Enrollments.

b. In the event the DEPARTMENT determines that it has received sufficient confirmed complaints regarding specialist access problems to initiate a statewide default enrollment freeze, the DEPARTMENT will advise the MCO in the Complaint Report that it has received confirmed complaints and that it will impose a default enrollment

freeze on the MCO in thirty (30) days unless the MCO submits a satisfactory resolution of the access issue in a corrective action plan.

1. The MCO may request an opportunity to meet with the DEPARTMENT prior to the imposition of the default enrollment freeze;
2. The DEPARTMENT will impose a default enrollment freeze statewide, for a minimum of three (3) months. The default enrollment freeze will remain in effect until the DEPARTMENT determines that the access problem has been resolved to the DEPARTMENT'S satisfaction.
3. The MCO shall submit a corrective action plan to the DEPARTMENT when the DEPARTMENT formally notifies the MCO that the number of confirmed specialist complaints has passed the report threshold for that MCO during the reporting period.
4. If, subsequent to the DEPARTMENT's approval of the corrective action plan, the network deficiency is not remedied within the time specified in the corrective action plan, or if the MCO does not develop a corrective action plan satisfactory to the DEPARTMENT, the DEPARTMENT may impose a strike towards a Class A sanction for each month the MCO fails to correct the deficiency, in accordance with Section 6.05, Monetary Sanctions,. This sanction shall be in addition to any enrollment freeze imposed in accordance with (2) above.

3.10 Geographic Coverage

a. The MCO shall serve Members statewide. The MCO shall ensure that its provider network includes access for each Member to PCPs appropriate for his or her age, or Obstetric/Gynecological providers, and at a distance of no more than fifteen (15) miles as measured by the Public Utility Control Authority. The MCO shall ensure that its provider network has the capacity to deliver or arrange to deliver all the contract services available through this contract for Members.

b. If the MCO does not have a network provider that is able to provide medically necessary contract services to a particular Member, the MCO shall adequately and timely cover the services through an out-of-network provider for as long as medically necessary and the MCO's network providers are unable to provide the services. The MCO shall ensure that the cost to the Member is not greater than if the services had been furnished by a network provider.

c. On a monthly basis, the MCO shall provide the DEPARTMENT with a list of all network providers. The list shall be in a format and contain such information as the DEPARTMENT may specify.

Performance Measure: Geographic Access. The DEPARTMENT will randomly monitor geographic access by reviewing the mileage to the nearest town containing a PCP for every town in which the MCO has Members.

Sanction: In any sampling, if more than two percent (2%) of Members reside in towns beyond fifteen (15) miles of a town containing a PCP the DEPARTMENT may impose a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions,.

The Bidder shall (for requirements outlined in sections 3.08, Provider Network; 3.09, Network Adequacy and Maximum Enrollment; and 3.10, Geographic Coverage):

a. Provide an EXCEL spreadsheet file of providers including type and specialty, town, and group affiliation. Identify current network providers and those that have signed letters indicating intent to participate in the event that the bidder contracts with the DEPARTMENT pursuant to this contract.

b. Justify how the number of providers by specialty and geographic area meet the capacity and geographic requirements as specified above for your projected enrollment targets, using the HUSKY A and HUSKY B enrollment by town information provided in Attachment X. Specify enrollment targets and time period for meeting enrollment targets. Explain your assumptions regarding Charter Oak enrollment.

c. Describe its specialty provider network and demonstrate its capacity to deliver all contract services, including specialty services, durable medical equipment and therapies to Members.

d. Describe its strategy to maintain or expand its statewide network.

e. Explain whether it will have a smaller, high-performing network for Charter Oak Members and, if it will, describe that network.

f. The DEPARTMENT is interested in exploring alternative methodologies with the potential contractor to more appropriately measure access than the methodology currently used. The bidder has the option to propose an alternative method to measure access for Members. The bidder must also describe how its proposed methodology provides a better or improved measure of access.

3.11 Provider Contracts

All contracts between the MCO and its in-network providers shall, at a minimum, include the following provisions:

a. Providers shall meet the minimum requirements for participation in the Medicaid program as set forth in the Regulations of Connecticut State Agencies, Section 17b-262-522 to Section 17b-262-533, as applicable;

b. Except for applicable cost-sharing requirements (see Section xxx), Members shall be held harmless for the costs of all contract services provided;

c. Providers must provide evidence of and maintain adequate malpractice insurance. For physicians, the minimum malpractice coverage requirements are $1 million per individual episode and $3 million in the aggregate;

d. Specific terms regarding provider reimbursement as specified in, Section 3.49, Timely Payment of Claims of this contract;

e. Specific terms concerning each party's rights to terminate the contract;

f. That any risk shifted to individual providers does not jeopardize access to care or appropriate service delivery;

g. The exclusion of any provider that has been suspended from the Medicare or Medicaid program in any state;

h. For PCPs, the provision of “on-call” coverage through arrangements with other PCPs; and

i. That the MCO and its subcontractors require in-network providers to participate in the DEPARTMENT's efforts to study access, quality and outcome.

The Bidder shall:

Provide a sample provider contract.

3.12 Provider Credentialing and Enrollment

a. The MCO shall implement and maintain written policies and procedures for the selection and retention of providers.

b. The MCO shall establish minimum credentialing criteria and shall formally re-credential all professional network providers at least once every two (2) years or such other time period as established by the NCQA. The MCO shall create and maintain a credentialing file for each network provider that contains evidence that all credentialing requirements have been met. The file shall include copies of all documentation to support that credentialing criteria have been met, including licenses, Drug Enforcement Agency (DEA) certificates and provider statements regarding lack of impairment. Credentialing files shall be subject to inspection by the DEPARTMENT.

c. MCO credentialing and re-credentialing criteria for professional providers shall include at a minimum:

   1. Appropriate license or certification as required by Connecticut law;
   2. Verification that providers have not been suspended or terminated from participation in Medicare or the Medicaid program in any state;
   3. Verification that providers of contract services meet minimum requirements for Medicaid participation;
   4. Evidence of malpractice or liability insurance, as appropriate;
   5. Board certification or eligibility, as appropriate;
   6. A current statement from the provider addressing:
      a). Lack of impairment due to chemical dependency/drug abuse;
      b). Physical and mental health status;
      c). History of past or pending professional disciplinary actions, sanctions, or license limitations;
      d). Revocation and suspension of hospital privileges; and
      e). A history of malpractice claims; and
      f). Evidence of compliance with Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, 42 U.S.C. § 1395aa et seq. and 42 CFR Part 493 (as amended, 68 Fed. Reg. 3639-3714 (2003)).

d. The MCO may require more stringent credentialing criteria. Any other criteria shall be in addition to the minimum criteria set forth above.

e. Additional MCO credentialing/re-credentialing criteria for PCPs shall include, but not be limited to:

1. Adherence to the principles of Ethics of the American Medical Association, the American Osteopathic Association or other appropriate professional organization;
2. Ability to perform or directly supervise the ambulatory primary care services of Members;
3. Membership on the medical staff with admitting privileges to at least one accredited general hospital or an acceptable arrangement with a PCP with admitting privileges;
4. Continuing medical education credits;
5. A valid DEA certification; and
6. Assurances that any Advanced Practice Registered Nurses (APRN), Nurse Midwives or Physician Assistants are performing within the scope of their licensure.

f. For purposes of credentialing and re-credentialing, the MCO shall perform a check on all PCPs and other network providers by contacting the National Practitioner Data Bank (NPDB). The DEPARTMENT will notify the MCO immediately if a provider under contract with the MCO is subsequently terminated or suspended from participation in the Medicare or Medicaid programs. Upon such notification from the DEPARTMENT or any other appropriate source, the MCO shall immediately act to terminate the provider from participation in its network.

g. The MCO may delegate credentialing functions to a subcontractor. The MCO shall be responsible and accountable to the DEPARTMENT for compliance with the credentialing requirements. The MCO shall demonstrate and document to the DEPARTMENT the MCO's significant oversight of its subcontractors performing any and all provider credentialing, including facility or delegated credentialing. The MCO and any such entity shall be required to cooperate in the performance of financial, quality or other audits conducted by the DEPARTMENT(s). Any subcontracted entity shall maintain a credentialing file for each in-network provider as set forth above.

h. The MCO shall adhere to the additional credentialing requirements set forth in Appendix I, Provider Credentialing and Enrollment Requirements.

Sanction: The DEPARTMENT may impose a Class B sanction pursuant to Section 6.05, Monetary Sanctions, if, upon completion of a performance review, it is established that a network provider fails to meet the minimum credentialing criteria for participation set forth in (a) through (d) above or a network PCP fails to meet the criteria set forth in (e).

The Bidder shall:

a. Describe its credentialing process and credentialing schedule.

b. Indicate its interest in collaborating with the DEPARTMENT and the other managed care plans in pursuing a strategy to reduce the credentialing burden on providers and the credentialing "overlap" among competing managed care plans.

3.13 Second Opinions, Specialist Providers and the Referral Process

The MCO shall:

a. Provide for a second opinion from a qualified health care professional within its provider network, or arrange for the Member to obtain one outside the network, at no cost to the Member.

b. Contract with a sufficient number and mix of specialists so that the anticipated specialty care needs of Members can be substantially met within network providers.

c. Refer Members to out-of-network specialists when appropriate network specialists are not available.

d. Make specialist referrals available to its Members when it is medically necessary and medically appropriate.

e. Assume all financial responsibility for all in-network or out-of-network referrals and ensure that, except for applicable cost-sharing requirements (see Section xxx), the Member shall not incur any costs for such referrals.

f. Implement and maintain policies and procedures for the coordination of care and the arrangement and documentation of all referrals to specialty providers.

g. Coordinate specialty care services and specialty provider referral process with the HUSKY Plus Physical Program to ensure access to care for HUSKY B Members enrolled in HUSKY Plus Physical Program as described in Section 3.19, Preventive Care and Services for Children, of this contract.

The Bidder shall:

a. Provide its policies and procedures related to the coordination of care and the arrangement and documentation of referrals to specialty providers.

b. Describe the circumstances under which the bidder shall inform members of the opportunity to obtain a second opinion.

c. Describe the process to refer Members to out-of-network specialists if appropriate network specialists are not available.

3.14 PCP and Specialist Selection, Scheduling, and Capacity

The MCO shall:

a. Implement procedures to ensure that each Member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the health care services furnished to the Member.

b. Provide Members with the opportunity to select a PCP within thirty (30) days of enrollment. The MCO shall assign a Member to a PCP when a Member fails to choose a PCP within thirty (30) days after being notified to do so. The assignment shall be appropriate to the Member's age, gender and residence.

c. Ensure that network providers adhere to the following scheduling practices:

   1. Emergency cases shall be seen immediately or referred to an emergency facility;
   2. Urgent cases shall be seen within forty-eight (48) hours of PCP notification;
   3. Routine cases shall be seen within ten (10) days of PCP notification;
   4. Well-care visits shall be scheduled within six (6) weeks of PCP notification;

5. Specialists shall provide treatment within the scope of their practice and within professionally accepted promptness standards for providing such treatment;
6. All well-child visits, comprehensive health screens and immunizations shall be scheduled in accordance with the American Academy of Pediatrics' (AAP) periodicity schedule and the Advisory Committee on Immunization Practice's (ACIP) immunization schedules;
7. New Members shall receive an initial PCP appointment in a timely manner; (for those HUSKY A, HUSKY B, and Charter Oak Members who do not access contract services within the first six (6) months of enrollment, the MCO shall conduct outreach to ensure the Member can access services in accordance with the access standards of the contract and to provide scheduling assistance to a HUSKY A and HUSKY B Member); and
8. Waiting times at PCPs are kept to a minimum.

d. Report quarterly on each PCP's panel size, group practice and hospital affiliations in a format specified by the DEPARTMENT. The DEPARTMENT will aggregate reports received from all managed care plans for HUSKY A, HUSKY B, and Charter Oak reported separately. In the event that the DEPARTMENT finds a PCP with more than 1,200 combined Members, the DEPARTMENT will notify the MCO if the PCP is part of the MCO's network. The DEPARTMENT expects that the MCO will take appropriate action to ensure that patient access to the PCP is assured.

e. Maintain a record of each Member's PCP assignments for a period of two (2) years.

f. Track each Member's use of primary care services. In the event that a Member does not regularly receive primary care services from the PCP or the PCP's group other than visits to school based health clinics, the MCO shall contact the Member and offer to assist the Member in selecting a PCP.

g. Offer HUSKY A and HUSKY B Members scheduling assistance for a well-care visit when a Member's last well-care visit was not within the appropriate guidelines for his or her age and gender or if the Member has not received any primary care services.

Performance Measure: Appointment Availability. The DEPARTMENT will routinely monitor appointment availability as measured by (c)(1) through (c)(8) above by using test cases to arrange appointments of various kinds with selected providers:

a. The DEPARTMENT will require the MCO to submit a corrective action plan within thirty (30) days, outlining the steps that the MCO will take to rectify the problem, when the DEPARTMENT determines that:
    1. Less than ninety percent (90%) of the sample of test cases make appointments available within the required time, or
    2. The MCO's provider network is not capable of accepting additional enrollments based on valid complaints received by the MCO, the DEPARTMENT and HUSKY Infoline.

b. If the DEPARTMENT determines that appointment availability is insufficient, the DEPARTMENT may exercise its rights under Section 6, Corrective Action and Contract Termination of this contract, including but not limited to the rights under Section 6.04, Suspension of New Enrollments.

The Bidder shall:

a. Propose procedures to ensure that each Member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the health care services furnished to the Member.

b. Describe the procedures to enable a member to select a PCP including the procedures for assignment when a member fails to chose a PCP within thirty (30) days.

c. Describe its method for ensuring that providers in its network adhere to the scheduling standards.

d. Propose a method to track each member's medical care services and follow-up with the member when the member has not received well-care visits within appropriate guidelines for his or her age and gender.

3.15 Women's Health, Family Planning Access, and Confidentiality

The MCO shall:

a. Provide Members with direct access to a women's health specialist in network for covered care necessary to provide women's routine and preventive health care services. This access shall be in addition to the Member's PCP if that provider is not a women's health specialist.

b. Notify and give each HUSKY A Member, including adolescents, the opportunity to use his or her own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization.

c. Make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act, and shall reimburse providers for all family planning services regardless of whether that provider is a network provider.

d. Reimburse out-of-network providers of family planning services for HUSKY A Members at least the Medicaid fee-for-service rate for the service. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services.

e. Maintain the confidentiality of family planning information and records for each individual Member including those of minor patients.

f. Cover the following family planning services:

   1. Reproductive health exams;
   2. Patient counseling;
   3. Patient education;
   4. Lab tests to detect the presence of conditions affecting reproductive health;
   5. Sterilizations (HUSKY A only);
   6. Screening, testing, and treatment of and pre and post- test counseling for sexually transmitted diseases and HIV; and
   7. Abortions, if the pregnancy is the result of an act of rape or incest or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the

pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

g. Cover all abortions that are described in federal law ("the Hyde Amendment," as reflected in the federal appropriations for Title XIX), 42 CFR Part 441, Subpart E, 42 U.S.C. § 1397ee(c)(1) and (7), 42 CFR § 457.475, and Title XXI of the Social Security Act. The DEPARTMENT may only seek federal funding for those abortions described in (f)(7) above. The MCO shall submit a Form W-484 for any such abortions and comply with the DEPARTMENT's Medical Services Policy concerning abortions and shall neither charge nor allow its providers to collect any co-payments for such procedures.

h. Enter into a separate contract with the DEPARTMENT for all medically necessary abortions that do not qualify for federal matching funds, as described in subsection (f) and (g) above. The MCO shall provide reporting on such abortions in the format required by the DEPARTMENT.

i. Ensure that the provisions of 42 CFR § 441.250 – 259 and Section 173 G of the DEPARTMENT's Medical Services Policy and Provider Bulletin 2004-77 are strictly followed by the MCO in payment for sterilization and hysterectomies. These requirements include, but are not limited to, the submission of a completed W-612 informed consent form (sterilization) or a W-613 information form (hysterectomy) prior to payment for either of these procedures.

Sanction: If the MCO fails to comply with the provisions in subsection (f), and fails to accurately maintain and submit accurate records of those abortions, that meet the federal definition for funding, the DEPARTMENT may impose a Class A sanction, pursuant to Section 6.05, Monetary Sanctions,.

The Bidder shall:

a. Describe its plan to meet the requirements of this section and indicate its intention to enter into a separate contract for abortion services.

3.16 Pharmacy Access

The MCO, or their subcontractors, will not manage or pay claims for pharmacy services. The DEPARTMENT will manage pharmacy services, but will provide pharmacy data to the MCO for purposes of care coordination, health management, tracking of Member cost-sharing, and quality assurance.

a. The MCO shall require its network providers to comply with the DEPARTMENT's Preferred Drug List (PDL) and prior authorization requirements.

b. The MCO shall receive, utilize and analyze pharmacy claims/utilization data to coordinate services to their members and for assessing provider performance, quality measures and member compliance with treatment protocols.

The Bidder shall:

a. Propose how it will ensure that its network providers comply with the DEPARTMENT's PDL;

b. Propose pharmacy data sharing requirements from the DEPARTMENT for the care coordination of its Members;

c. Propose a plan of how the bidder intends to utilize pharmacy data to meet the requirements in subsection b of this section.

3.17 Mental Health and Substance Abuse Access

a. Except as otherwise identified in this section and this contract, mental health and substance abuse services for Members will be managed by the CT BHP ASO and paid for by the DEPARTMENT. The MCO shall coordinate services covered under this contract with the behavioral health services managed by the CT BHP ASO.

b. The MCO shall track utilization, including, but not limited to, primary care behavioral health, laboratory, emergency department, and transportation. The MCO shall report the utilization trend for these services to the DEPARTMENT. At the DEPARTMENT's request, the MCO shall provide a separate report for HUSKY A, HUSKY B and Charter Oak.

c. If there is a conflict between the MCO and the CT BHP ASO regarding whether a Member's medical or behavioral health condition is primary, the MCO's medical director shall work with the CT BHP ASO's medical director to reach a timely and mutually agreeable resolution. If the MCO and BHP ASO are not able to reach a resolution, the DEPARTMENT will make a binding determination. Issues related to whether a Member's medical or behavioral health condition is primary must not delay timely medical necessity determinations. In these circumstances, the MCO shall render a determination within the standard timeframe required under this contract and its policies and procedures.

d. Ancillary Services

   1. The MCO shall retain responsibility for all ancillary services such as laboratory, radiology, and medical equipment, devices and supplies regardless of diagnosis.

   2. The MCO is not responsible for ancillary services that are part of the DEPARTMENT's all-inclusive rate for inpatient behavioral health services.

e. Co-Occurring Medical and Behavioral Health Conditions

   The MCO shall continue programs and procedures designed to support the identification of untreated behavioral health disorders in medical patients at risk for such disorders. The MCO shall:

   1. Contact the CT BHP ASO when co-management of a Member's care by the MCO and the CT BHP ASO is indicated, such as for persons with special physical health and behavioral health needs;

   2. Respond to inquiries by the CT BHP ASO regarding the presence of medical co-morbidities;

   3. Coordinate with the CT BHP ASO, upon request;

   4. Assign a key contact person in order to facilitate timely coordination with the CT BHP ASO; and

   5. Participate in medical/behavioral co-management meetings at least once a month, with the specific frequency to be determined by agreement between the MCO and the CT BHP ASO.

f. Freestanding Primary Care Clinics

The MCO shall be responsible for primary care and other services provided by primary care and medical clinics not affiliated with a hospital, regardless of diagnosis. The only exception is that the MCO shall not be responsible for behavioral health evaluation and treatment services billed under CPT codes 90801-90806, 90853, 90846, 90847 and 90862, when the Member has a primary behavioral health diagnosis and the services are provided by a licensed behavioral health professional.

g. Home Health Services

1. The MCO shall be responsible for management and payment of claims when home health services are required for the treatment of medical diagnoses alone and when home health services are required to treat both medical and behavioral diagnoses, but the medical diagnosis is primary.
2. The MCO shall also be responsible for authorization and payment of the medical component of claims if a Member has both medical and behavioral diagnoses and the Member's medical treatment needs cannot be safely and effectively managed by the psychiatric nurse or aide.
3. The MCO shall manage and pay claims for home health, physical therapy, occupational therapy, and speech therapy, regardless of diagnosis, to the extent such services are otherwise covered under this contract.
4. The MCO shall be responsible for the management and payment of claims for home health services for Members with mental retardation when the Member does not also have a diagnosis of autism.

h. Hospital Inpatient Services.

1. The MCO will share responsibility for inpatient general hospital services with the CT BHP ASO.
2. The MCO shall be responsible for management and payment of claims for inpatient general hospital services when the medical diagnosis is primary. The medical diagnosis is primary if both the Revenue Center Code and primary diagnosis are medical.
3. The MCO shall also be responsible for professional services and other charges associated with primary medical diagnoses during a behavioral stay.
4. The MCO shall also be responsible for ancillary services associated with non-primary behavioral health diagnoses during a medical stay, as described in subsection (a) of this section.
5. The MCO shall not be responsible for ancillary services that are included in the hospital's per diem inpatient behavioral health rate under the CTBHP for clients with a primary behavioral health diagnosis.

i. Hospital Outpatient Clinic Services

The MCO shall be responsible for all primary care and other medical services provided by hospital outpatient clinics, regardless of diagnosis, including all medical specialty services and all ancillary services.

j. Long-term Care

The MCO shall be responsible for all long-term care contract services such as nursing facilities and chronic disease hospitals, regardless of a Member's diagnosis.

k. Primary Care Behavioral Health Services

1. The MCO shall be responsible for all primary care services and all associated charges, regardless of diagnosis. Such responsibilities include:

a) Behavioral health related prevention and anticipatory guidance;

b) Screening for behavioral health disorders;

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

d) Management of psychotropic medications in conjunction with treatment by a CT BHP non-medical behavioral health specialist when necessary; and

2. The CT BHP ASO will develop education and guidance for PCPs related to the provision of behavioral health services in primary care settings. The MCO may participate with the CT BHP ASO in the development of education and guidance or it will be provided the opportunity for review and comment. The education and guidance will address PCP prescribing with support and guidance from the CT BHP ASO or referring clinic. The CT BHP ASO will make telephonic psychiatric consultation services available to primary care providers. Any PCP that is seeking guidance on psychotropic prescribing for a Member may initiate consultation.

3. The MCO will sponsor opportunities for joint training to promote effective coordination and collaboration. MCO policies, procedures and provider contracts must support the provision of behavioral health services by PCPs and entry into coordination agreements with Enhanced Care Clinics established by the DEPARTMENT.

l. School Based Health Center Services

The MCO shall be responsible for services provided by contracted school-based health centers to Members, regardless of diagnosis; however, the MCO will not be responsible for behavioral health assessment and treatment services billed under CPT codes 90801 – 90807, 90853, 90846 and 90847 and provided by licensed behavioral health practitioners.

The Bidder shall:

Describe its method to coordinate services as described above with the CT BHP ASO.

3.18 Dental Services

Except as otherwise identified below, dental services will be the responsibility of the DEPARTMENT.

a. The MCO shall collaborate with the Dental ASO on primary care education and initiatives in order to improve ease of referral from and coordination between PCPs and the dental network.

b. For HUSKY A and B Members under age three (3), the MCO shall have responsibility for reimbursement for provision of dental screens and fluoride treatments.

c. For HUSKY A Members, the MCO shall have responsibility for dental non-emergency medical transportation.

d. The MCO shall have responsibility for:

1. Hospital emergency department services related to dental emergencies;
2. Operating room services or same day surgery suites (excluding the dental procedures); and
3. Oral surgery services performed by an oral and maxillofacial surgeon.

The Bidder shall:

Describe its method to coordinate services as described above with the Dental ASO.

3.19 Preventive Care and Services for Children

General

The MCO shall ensure access to preventive care and services for Members under the age of twenty-one (21) years as follows:

a. The MCO shall provide preventive care and services consisting of the services described in this section and in accordance with the standards and schedules specified in Appendices A and E. Any changes in the standards and schedule subsequent to the effective date of this contract shall be provided to the MCO sixty (60) days before the effective date of the change. The MCO shall not require prior authorization of preventive care and services. Preventive care and services shall at a minimum include:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development and assessment of nutritional status);
2. A comprehensive unclothed or partially draped physical exam;
3. Appropriate immunizations as currently recommended by the Connecticut Department of Public Health;
4. Laboratory tests, as set forth in the periodicity schedule at Appendix E, EPSDT/Well Child Periodicity & Immunization.
5. Vision and hearing screenings as set forth in the periodicity schedule at Appendix E, EPSDT/Well Child Periodicity & Immunization;
6. Dental screens and fluoride treatments for children up to three years of age provided by trained pediatricians and referrals for dental assessments as set forth in the periodicity schedule at Appendix E, EPSDT/Well Child Periodicity & Immunization;
7. Health education, including anticipatory guidance; and
8. For newborns, preventive care includes: inpatient physician visits, routine inpatient and outpatient screenings,

b. Preventive care may also include:

1. WIC evaluations, as applicable; and

2. Child abuse assessments required under Conn. Gen. Stat. §§ 17a-106a and 46b-129a.

c. The MCO shall require PCPs to obtain all available vaccines free of charge from the Department of Public Health under the Vaccines for Children (VFC) program and to provide them to eligible Members. The MCO shall inform specialists, including OB/GYNs that they may enroll in VFC to obtain vaccines without cost for their eligible patients under age nineteen (19). The MCO is responsible for the cost of medically appropriate vaccines not covered by VFC.

d. The MCO shall cooperate with the Connecticut Immunization Registry and Tracking System to track childhood immunizations of its Members.

e. The MCO shall identify children who are overdue for well-child visits, and those who have missed well-child visits. The MCO shall work to develop a plan for ensuring that Members under twenty-one (21) years of age who are overdue or late for screening examinations receive their well-child visits.

f. The MCO shall attain an annual EPSDT/well-child participation ratio and an annual EPSDT/well-child screening ratio of at least eighty percent (80%) for each twelve-month eligibility period from July 1 through June 30. The DEPARTMENT will determine the MCO's participation and screening ratio from the encounter data as reported to the DEPARTMENT(s) in accordance with the methodology established by CMS for the CMS-416 report.

Sanction: Failure to achieve a participation and/or screening ratio of eighty percent (80%) may subject the MCO to a Class B sanction in accordance with the provisions of Section 6.05, Monetary Sanctions,.

HUSKY A Only

In order to meet the requirements of the EPSDT program as set forth in Sections 1902(a)(43) and 1905(r) of the Social Security Act for HUSKY A Members, the MCO shall:

a. Provide interperiodic screening examinations when medically necessary, or in accordance with the provisions of Section 3.19(a), Preventive Care and Services for Children, to determine the existence of a physical or mental illness or condition, or to assist HUSKY A Members in meeting the medical requirements for certification or recertification in WIC. Such interperiodic screens shall include screens for anemia as recommended by the Centers for Disease Control (CDC). The MCO shall not require prior authorization of interperiodic screening examinations;

b. Provide all medically necessary health care, diagnostic services, and treatment for HUSKY A Members under twenty-one (21) covered under the federal Medicaid program and described in Section 1905(a) of the Social Security Act regardless of whether the health care, diagnostic services, and treatment are specified in the list of contract services at Appendix A, HUSKY A Covered Services, of this contract and regardless of any limitations on the amount, duration, or scope of the services that would otherwise be applied.

c. Take all necessary steps to ensure that its HUSKY A Members under the age of twenty-one (21) receive EPSDT screening services and any necessary diagnostic and treatment services, including, but not limited to:

1. Providing assistance in arranging and scheduling appointments;

2. Providing and arranging transportation;
3. Following up on missed appointments; and
4. Providing interpreters to HUSKY A Members with limited English proficiency and HUSKY A Members who are hearing and visually impaired in accordance with Section 3.26, Linguistic Access, and Section 3.27, Services for Members.

d. No later than sixty (60) days after enrollment with the MCO and annually thereafter, the MCO shall use a combination of oral and written methods including methods for communicating with HUSKY A Members with limited English proficiency, HUSKY A Members who cannot read, and HUSKY A Members who are visually or hearing impaired, to inform them:
   1. About the availability of preventive care and services;
   2. About the importance and benefits of preventive care and services;
   3. About how to obtain preventive care and services;
   4. That assistance with scheduling appointments is available about how to obtain this assistance; and
   5. That assistance for transportation is available and about how to obtain this assistance.

e. Coordinate and enhance the services provided to HUSKY A Members under twenty-one (21) through the development and execution of memoranda of understanding (MOUs) with the following programs:
   1. Nurturing Families Network;
   2. Healthy Start;
   3. The Special Supplemental Food Program for Women, Infants, and Children (WIC);
   4. Birth-to-Three;
   5. Head Start;
   6. InfoLine's Maternal and Child Health Project; and
   7. Other programs operated by the Departments of Children and Families, Education, Public Health, Mental Health and Addiction Services and Mental Retardation as designated by the DEPARTMENT.

f. The MCO shall cooperate with the DEPARTMENT and the entities listed above in e. (1)-(7) in the development and execution of the MOUs and any revisions or amendments thereto.

g. The MCO shall include in the MOUs developed and executed under subsection (f) of this section, provisions that specify how the MCO will work with the program, including, but not limited to:
   1. A description of the services provided by the program;
   2. Designation of a liaison at the MCO to work with the program on ensuring the provision of medically necessary and appropriate contract services by the MCO and the coordination of services provided by the MCO and the program;
   3. Protocols for referrals to the program by the MCO;

4. Protocols for communication of information concerning individuals who are Members of the MCO who are receiving services from the program;
5. Protocols for the resolution of any issues that arise concerning the delivery of services to Members who are receiving services from the program;
6. Compliance with HIPAA privacy rules if the agreement includes exchange of members' protected health information; and
7. Any other mutually agreed upon provisions.

HUSKY Plus Physical Program

a. Overview

HUSKY Plus Physical Program is a supplemental health insurance program that provides services to children whose intensive physical health care needs cannot be accommodated within the benefit package offered under HUSKY B.

1. HUSKY Plus Physical Program is administered by the Center for Children with Special Health Care Needs at Connecticut Children's Medical Center.
2. HUSKY Plus Physical Program is available for children with intensive physical health care needs who are enrolled in HUSKY B and fall within Income Bands 1 and 2. HUSKY B Members who fall into Income Band 3 are excluded from the HUSKY Plus Physical Program.
3. The MCO shall have final decision-making authority for those services for which they are at financial risk. The HUSKY Plus Physical Program shall have final decision-making authority for those supplemental services for which they are at financial risk. The HUSKY Plus Physical Program shall be the documented payor of last resort.
4. Any dispute between the MCO and the HUSKY Plus Physical Program concerning the responsibility for reimbursement of a service authorized under the treatment plan shall be referred to the DEPARTMENT for resolution.

b. MCO's Responsibility to Maximize HUSKY Plus Physical Program Services

The MCO shall coordinate care with HUSKY Plus Physical Program so as to maximize the HUSKY B Member's coverage of special health needs. Such coordination shall include, but not be limited to, a monthly conference, either in person or by telephone or other interactive means, between the MCO case manager, the HUSKY Plus Physical Program case manager, and the HUSKY B Member or his or her representative.

c. HUSKY B MCO Case Management Responsibilities

1. The HUSKY Plus Physical Program case management team will develop a global plan of care when a HUSKY B Member is receiving HUSKY Plus Physical Program services. A case manager with appropriate qualifications, credentials and decision-making authority shall be assigned by the MCO to the HUSKY Plus Physical Program case management team.
2. The global plan of care shall be based on the comprehensive diagnostic needs assessment, periodic reassessments, and treatment plans from the MCO and HUSKY Plus Physical Programs providing services to the HUSKY B Member.

3. The global plan of care shall integrate HUSKY B services as set forth in Appendix B, HUSKY B Covered Services, and HUSKY Plus services as set forth in Appendix D, HUSKY Plus Covered Services. The MCO shall be responsible for managing the utilization of HUSKY B services contained in the global plan of care.
4. The MCO case manager shall actively participate with the HUSKY Plus Physical Program case management team to ensure that all medically necessary HUSKY Plus Physical Program services identified in the global plan of care, which are also covered in the HUSKY B benefit package, are exhausted first under HUSKY B.

Sanction: If the MCO fails to have a procedure to identify Members who may be eligible for HUSKY Plus Physical Program or fails to assign a case manager to the HUSKY Plus Physical Program, the DEPARTMENT may impose a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions..

The Bidder shall:

Describe its method to:

1. Provide preventive care and services;
2. Cooperate with the Connecticut Immunization Registry and Tracking System;
3. Attain an annual EPSDT/Well care participation ratio and an annual EPSDT/Well care screening ratio of at least eighty percent (80%);
4. Identify children who are overdue for well-care visits, and those who have missed well-care visits;
5. Meet the requirements of the EPSDT program; and
6. Cooperate with the Center for Children with Special Health Care Needs at Connecticut Children's Medical Center to implement HUSKY Plus Physical Program for children with intensive physical health care needs who are HUSKY B Members and fall within Income Bands 1 and 2.

3.20 Prenatal Care

a. In order to promote healthy birth outcomes, the MCO or its network providers shall:
    1. Identify pregnant Members as early as possible in the pregnancy;
    2. Conduct prenatal risk assessments in order to identify high risk pregnant Members, arrange for specialized prenatal care and support services tailored to risk status, and begin care coordination that will continue throughout the pregnancy and early weeks of postpartum;
    3. Refer pregnant Members to the WIC program;
    4. Offer to pregnant Members case management services for assistance with obtaining prenatal care appointments, transportation, WIC, and other support services as necessary;
    5. Offer to pregnant Members prenatal health education materials and/or programs aimed at promoting healthy birth outcomes;

6. Offer to pregnant Members HIV and other sexually-transmitted disease (STD) testing and counseling and all appropriate treatment;
7. Refer pregnant Members who are actively abusing drugs or alcohol to CT BHP ASO; and
8. Educate Members who are new mothers about the importance of the postpartum visit and well-baby care.

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

Performance Measure: Early access to prenatal care: Percentage of female Members who had a live birth, who were continuously enrolled in the MCO for 280 days prior to delivery who had a prenatal visit on or between 176 to 280 days prior to delivery.

Performance Measure: Adequacy of prenatal care: Percentage of female Members with live births who were continuously enrolled during pregnancy who had more than eighty percent (80%) of the prenatal visits recommended by the American College of Obstetrics and Gynecology, adjusted for gestational age at enrollment and delivery.

The Bidder shall:

a. Describe its process to identify Members who are pregnant as early as possible in the pregnancy.

b. Describe its process to provide the care coordination and services outlined in (b) through (h) above.

c. Describe its method to measure access to prenatal care and the adequacy of prenatal care.

3.21 Other Access Features

a. The MCO shall implement and maintain procedures and processes to ensure that Members have access to medically necessary and medically appropriate well-care. The MCO shall develop procedures to identify access problems and shall take corrective action as problems are identified. These systems and initiatives shall include, but not be limited to:
   1. Monitoring new Members to ensure that a well-care appointment is scheduled within six (6) months of enrollment for those whose last well-care visit does not fall within the recommended age and gender appropriate schedules;
   2. Monitoring and ensuring that Members receive well-care visits based on age and gender appropriate schedules;
   3. Contacting and counseling Members who miss scheduled appointments;
   4. Covering and providing services to newborns from the time of birth;
   5. Assisting Members in accessing and locating linguistically and culturally appropriate services, including but not limited to, appropriate accommodation for Members with hearing disabilities;

6. Assisting disabled Members in accessing and locating services and providers that can appropriately accommodate their needs, for example wheelchair access to provider's office;
7. Developing special initiatives, case management, care coordination, disease management, and outreach to Members with special or multiple medical needs (e.g., for HIV-infected Members);
8. Developing goals and action plans for incremental increases in utilization of services such as postpartum care, adolescent health, and other health care measures agreed upon between the MCO and the DEPARTMENT;
9. Encouraging providers to offer extended business hours and weekend (Saturday) openings; and
10. Monitoring timely access to care as described in Section 3.14.

b. The MCO's access systems will be assessed as part of the annual performance review of the MCO.

The Bidder shall:

Describe its procedures and processes to ensure that Members have access to medically necessary and medically appropriate care.

3.22 Pre-Existing Conditions

a. The MCO shall assume responsibility for all contract services as outlined in Appendix A for each HUSKY A Member, Appendix B for each HUSKY B Member, and Appendix C for each Charter Oak Member as of the effective date of enrollment under the contract regardless of the new Member's health status. There is no exclusion for pre-existing conditions.

b. For HUSKY A, as outlined in Section 3.25, Special Disenrollment, for new Members who have transferred enrollment from another managed care plan, coverage of services other than acute care hospitalization, nursing facility care, or care in a long-term chronic disease hospital shall be the responsibility of the MCO from the beginning of the month during which enrollment becomes effective. Responsibility for acute hospitalization, nursing facility or long-term chronic disease hospital care services at the time of enrollment or disenrollment is described in Section 3.25, Special Disenrollment.

c. For HUSKY B, the MCO shall assume responsibility for all HUSKY B contract services as outlined in Appendix B for each HUSKY B Member as of the effective date of enrollment.

d. For Charter Oak, the MCO shall assume responsibility for all Charter Oak contract services as outlined in Appendix C for each Charter Oak Member as of the effective date of enrollment.

3.23 Acute and Sub-acute Care during a Hospital, Nursing Facility or Chronic Disease Hospital Stay at Time of Enrollment or Disenrollment

a. The following factors affect the financial responsibility for acute and sub-acute care during a continuous inpatient stay in a hospital, nursing facility or chronic disease hospital:

   1. Effective date of eligibility and re-categorization of HUSKY A, HUSKY B or Charter Oak coverage; and

   2. Effective date of enrollment in a specific managed care plan.

b. For HUSKY B and Charter Oak Members, the MCO shall be responsible for inpatient coverage as of the effective date of enrollment.

c. The MCO shall be responsible for the management and payment of a Member's inpatient stay if the Member (i) is enrolled in the MCO at the time at admission and (ii) remains enrolled with the MCO for the entire inpatient stay.

d. For HUSKY A Members, the effective date of enrollment shall not begin during a Member's inpatient stay. Two exceptions apply: Members may enroll during an inpatient stay if they are changing managed care plans or if they are newborns of HUSKY A Members.

   1. The MCO shall notify the DEPARTMENT within three (3) months regarding Members who enrolled in the MCO during an inpatient stay but who did not meet one of the two permissible exceptions. The MCO shall notify the DEPARTMENT only after confirming that the exceptions are inapplicable for each of the cases in question.

   2. The DEPARTMENT will correct the effective date of enrollment to the first of the month after discharge if the MCO notifies the DEPARTMENT within the timeframe specified in subsection (1) above.

   3. The DEPARTMENT will not correct the effective date of enrollment if the MCO fails to notify the DEPARTMENT of the individual's inpatient status within the timeframe specified in subsection (1) above. For such Members, the MCO shall retain all financial and care management responsibility from the unchanged effective date of enrollment.

e. For HUSKY A, HUSKY B, and Charter Oak Members who choose to disenroll from one MCO and enroll with another MCO during an inpatient stay:

   1. The Member's MCO at the time of inpatient admission shall be responsible only for the inpatient per diem costs from the effective date of admission through the date of discharge.

   2. The new MCO shall assume, as of the effective date of enrollment for its new Member, financial responsibility for all non-inpatient costs. These costs include the charges related to the inpatient stay but which are performed and billed separately (e.g., the services of the attending physician or a consulting specialist).

   3. Upon discovery of the Member's disenrollment, the MCO shall notify the DEPARTMENT of the inpatient status and coordinate care and discharge planning with the new managed care plan. The DEPARMENT will in turn notify the new managed care plan. The MCO shall coordinate care and discharge planning with the new managed care plan.

f. The MCO shall retain responsibility for Members who are inpatients in long-term chronic disease hospitals or nursing facilities until the Members are discharged from the facility or disenroll from the MCO.

1. If disenrollment from the MCO is due to voluntary plan change, responsibility for the Member shall be pursuant to subsection (e) above.

2. The DEPARTMENT will disenroll a Member at the end of the month during which the Member has been inpatient in the facility for ninety (90) continuous days. However, the Department will disenroll such Members only in the month following the month in which the MCO notified the DEPARTMENT that the Member was an inpatient in a chronic disease hospital or a nursing facility and was admitted for reasons other than for behavioral health diagnoses.

g. Re-categerization

1. Members who disenroll due to a re-categerization to a to Medicaid fee-for-service category shall revert to fee-for-service on the effective date of the eligibility change.

2. For Members who move from HUSKY A to either HUSKY B or Charter Oak while inpatients, the MCO shall provide continued coverage for the ongoing inpatient hospital stays as part of the MCO's HUSKY A coverage.

3. For Members who move from either Charter Oak or HUSKY B to HUSKY A while inpatients, the MCO shall provide continued coverage for the ongoing inpatient hospital stays as part of the MCO's HUSKY A coverage

4. For Members who move from Charter Oak to HUSKY B while inpatients, the MCO shall provide continued coverage for the ongoing inpatient hospital stays as part of the MCO's HUSKY B coverage.

5. For Members who move from HUSKY B to Charter Oak while inpatients, the MCO shall provide continued coverage for the ongoing inpatient hospital stays as part of the MCO's HUSKY B coverage.

HUSKY A & B and Charter Oak
Inpatient/Eligibility Re-categerization Changes – Responsible Entity

Description	Admitting MCO	New Continued MCO	Responsible Entity
HUSKY A, different MCO	A1	A2	A1
HUSKY A to FFS	A1	FFS	FFS
HUSKY A to HUSKY B (same MCO, different coverage)	A1	B1	A1
HUSKY A to HUSKY B (different MCO, different coverage)	A1	B2	A1
HUSKY A to Charter Oak (same MCO, different coverage)	A1	Ch-1	A1

HUSKY A to Charter Oak (different MCO, different coverage)	A1	Ch-2	A1
HUSKY B, different MCO	B1	B2	B1
HUSKY B to A (FFS)	B1	FFS	FFS
HUSKY B to A (same MCO, different coverage)	B1	A1	A1
HUSKY B to A (different MCO, different coverage)	B1	A2	A2
HUSKY B to Charter Oak (same MCO, different coverage)	B1	Ch-1	B1
HUSKY B to Charter Oak (different MCO, different coverage)	B1	Ch-2	B1
Charter Oak, different MCO	Ch-1	Ch-2	Ch-1
Charter Oak to HUSKY A (FFS)	Ch-1	FFS	FFS
Charter Oak to HUSKY A (same MCO, different coverage)	Ch-1	A1	A1
Charter Oak to HUSKY A (different MCO, different coverage)	Ch-1	A2	A2
Charter Oak to HUSKY B (same MCO, different coverage)	Ch-1	B1	B1
Charter Oak to HUSKY B (different MCO, different coverage)	Ch-1	B2	B2
HUSKY A to disenrolled due to loss of eligibility	A1		A1
HUSKY B to disenrolled due to loss of eligibility	B1		B1
Charter Oak to disenrolled due to loss of eligibility	Ch-1		Ch-1

Code		
A1 = HUSKY A, MCO #1	A2 = HUSKY A, MCO #2	FFS = Fee-for-service
B1 = HUSKY B, MCO #1	B2 = HUSKY B, MCO #2	= Disenrolled b/c ineligible

The Bidder shall:

a. Propose a method for identifying inpatient status of HUSKY A individuals for whom a correction of enrollment effective date is needed due to their inpatient stay pursuant to subsection d.

b. Propose a method for tracking and reporting to the DEPARTMENT's agent disenrollment during an inpatient stay.

c. Propose a method to coordinate care when a member disenrolls from one MCO and enrolls with another.

3.24 Continuous Enrollment

a. The MCO shall not discriminate against individuals eligible to enroll with the MCO on the basis of race, creed, color, national origin, ancestry, sex, marital status, age, lawful source of income, mental retardation, mental or physical disability or sexual orientation and will not use any policy or practice that has the effect of discriminating on any such basis. The MCO shall not discriminate in enrollment activities on the basis of health status or the individual's need for health care services, or on any other basis, and shall not attempt to discourage or delay enrollment with the MCO of prospective Members or encourage disenrollment from the MCO of current Members.

b. The MCO shall conduct continuous open enrollment during which the MCO shall accept individuals eligible for coverage under this contract in the order in which they are enrolled without regard to the need for health services, health status of the individual or any other factor(s).

HUSKY A

c. The MCO shall accept as HUSKY A Members those newborns born to a HUSKY A Member. The effective date of enrollment shall be the child's date of birth. However, the MCO shall not enroll newborns who are placed for private adoption or when the mother has indicated in writing that she does not wish coverage for the child.

d. The MCO shall notify the DEPARTMENT of newborns born to their HUSKY A Members, for whom they have not received enrollment notification from the DEPARTMENT. The MCO shall use the DEPARTMENT's notification form for this purpose. Should the MCO fail to report the child's birth within six (6) months from a child's date of birth, the MCO shall reimburse the DEPARTMENT for any Medicaid fee-for-service claims paid for contract services that occurred for newborn Members prior to processing the newborn's enrollment into the MCO.

e. If the MCO discovers that a HUSKY A Member's new or continued enrollment was in error, the MCO shall notify the DEPARTMENT within sixty (60) days of the discovery or sixty (60) days from the date that the MCO had the data to determine that the enrollment was in error, whichever comes first. Other than the case of a newborn retroactively enrolled, failure to notify the DEPARTMENT within the parameters defined in this section and within established procedures will result in the retention of the Member by the MCO for the erroneous period of enrollment.

HUSKY B

f. If the parent or authorized representative submits an application on behalf of a newborn child within thirty (30) days from the child's date of birth in accordance with Section 17b-292(f) of the General Connecticut Statutes, then the MCO shall :

1. Accept as a HUSKY B Member the newborn child; and
2. Treat the child's date of birth as the effective date of enrollment.

g. For purposes of premium assignment for HUSKY B Members:
   1. The newborn HUSKY B Member shall not incur a premium for the first four (4) months of coverage.
   2. The DEPARTMENT will pay the premium for the newborn's first four (4) months.
   3. The MCO shall provide the newborn Member's legally responsible family member(s) with reasonable notice of their obligation to pay any premium for continuing coverage beginning with the fifth (5^{th}) month of coverage.

Charter Oak

h. The MCO shall immediately contact the DEPARTMENT regarding any Charter Oak Member who:
   1. Is under the age of 19; and/or
   2. May be pregnant.

   In addition, the MCO shall report to the DEPARTMENT information regarding Charter Oak Members with third party coverage in a manner that is consistent with the provisions of Section 3.35, Utilization Management and Prior Authorization Requirements. Consistent with Section 7.01, Eligibility Determinations, the MCO shall also report any other information that may affect Member eligibility.

The Bidder shall:

a. Describe its process for identifying newborns born to their HUSKY A Members, for whom they have not received enrollment notification from the DEPARTMENT.

b. Provide a sample notice and describe its process for providing families of HUSKY B newborns reasonable notice of their obligation to pay any premium for continuing coverage beginning with the fifth (5^{th}) month of coverage.

3.25 Special Disenrollment

a. The MCO may request in writing and the DEPARTMENT may approve disenrollment of specific Members upon evidence of "good cause". The request shall cite the specific event(s), date(s) and other pertinent information substantiating the MCO's request. Additionally, the MCO shall submit any other information concerning the MCO's request that the DEPARTMENT may require in order to make a determination of "good cause".

b. Good cause is defined as a case in which a Member:
   1. Exhibits uncooperative or disruptive behavior. If, however, such behavior results from the Member's special needs, good cause may only be found if the Member's continued enrollment seriously impairs the MCO's ability to furnish services to either the particular Member or others; or
   2. Permits others to use or loans his or her membership card to others to obtain care or services.

c. The following shall not constitute good cause:

1. Extensive or expensive health care needs;
2. A change in the member's health status;
3. The member's diminished mental capacity; or
4. Uncooperative or disruptive behavior related to a medical condition except as described in b.1, above.

d. The effective date for an approved disenrollment shall be no later than the first day of the second (2nd) month following the month in which the MCO files the disenrollment request. If the DEPARTMENT fails to make the determination within this timeframe, the disenrollment shall be deemed approved.

e. The DEPARTMENT will notify an MCO prior to enrollment if a Member was previously disenrolled for cause from another MCO pursuant to this section.

The Bidder shall:

Describe its process to reach out to a Member to avoid unnecessary special disenrollment.

3.26 Linguistic Access

a. The MCO shall take appropriate measures to ensure adequate access to services by Members with limited English proficiency. These measures shall include, but not be limited to:

1. Promulgation and implementation of linguistic accessibility policies with application for MCO staff, network providers and subcontractors;
2. Identification of a single individual at the MCO for ensuring compliance with linguistic accessibility policies;
3. An assertive effort to identify individuals with linguistic access needs and persons with limited English proficiency as soon as possible following enrollment;
4. Provision of both oral interpretation and materials translation services;
5. Provision of a Member Handbook, notices of action and grievance/administrative hearing information in languages other than English, and
6. Notification to its members that oral interpretation is available for any language.

b. The MCO shall provide Member educational materials in languages other than English and Spanish if more than five percent (5%) of the MCO's Members in the State of Connecticut speak the alternative language. However, this requirement shall not apply if the alternative language has no written form. Additionally, the materials shall take into consideration the special needs of those who, for example, have limited reading proficiency. The MCO may rely upon initial enrollment and monthly enrollment data from the DEPARTMENT to determine the percentage of Members who speak alternative languages. In all materials and correspondence, the MCO shall inform members that written materials are available in these alternative languages.

c. The MCO shall provide information in alternative formats and in an appropriate manner that considers the special needs of Members with disabilities to ensure access to services by persons with visual, hearing and other disabilities.

d. The DEPARTMENT will provide HUSKY Member information concerning primary language, visual impairments and hearing disabilities through the daily and monthly enrollment files.

The Bidder shall:

a. Describe its process to ensure adequate access to services by Members with limited English proficiency; and

b. Describe its assertive effort to identify individuals with linguistic access needs.

3.27 Services for Members

a. The MCO shall develop, implement and maintain an ongoing process of Member information and education that shall include, but is not limited to:

   1. A Member Handbook;
   2. A provider directory;
   3. Website;
   4. Newsletter; and
   5. Other Member materials.

b. The MCO's website and written materials for members shall be in an easily understood format and language. All written materials and correspondence with Members shall be culturally sensitive and written at no higher than a seventh (7^{th}) grade reading level.

c. Within one week from a Member's initial enrollment, the MCO shall provide the Member new enrollment materials including a handbook, Membership Card, and provider directory except that if a Member loses eligibility and re-enrolls in the MCO less than ninety (90) days after losing eligibility, the MCO is not required to send the Member new enrollment materials. If the lapse in enrollment is more than ninety (90) days, the MCO shall send new enrollment materials. At least once per year thereafter, the MCO shall notify Members of their right to request the Member Handbook.

d. The MCO's provider directory shall include, at a minimum, the names, location, telephone numbers and non-English languages spoken by current contracted providers in the Member's service area. Electronic lists shall also include up-to-date information as to whether providers are not accepting new patients. The provider directory shall include, at a minimum, information on PCPs, specialists and hospitals.

e. The MCO shall make a good faith effort to give written notice to members of termination of a network provider at least thirty (30) days prior to effective date or termination. The notice to members shall apply to those members whose designated PCP terminated from the MCO's network or for those members who had an established relationship with any other provider including but not limited to specialists or clinics.

f. The MCO shall submit and propose to the DEPARTMENT for its review and approval prior to distribution all informational and educational materials directed at Members or prospective Members, including, but not limited to the following:

   1. Member Handbook;
   2. Membership card;
   3. Introductory and other text from the provider directory; and
   4. All communications to Members regarding HUSKY A, HUSKY B, or Charter Oak information.

g. The DEPARTMENT will review such materials within thirty (30) days from the date the MCO proposes the materials to the DEPARTMENT unless the DEPARTMENT notifies the MCO that it requires additional time to review the materials. The DEPARTMENT will not arbitrarily withhold approval and the DEPARTMENT reserves the right to require revisions to reflect contractual provisions or applicable federal or state statutes or regulations.

h. The MCO shall provide each Member written notice of any significant change, as determined by the DEPARTMENT, at least thirty (30) days before the intended effective date of the change.

i. The MCO shall revise its Member Handbook periodically or as required by the DEPARTMENT to address significant changes or shall inform Members of such changes through some other means, as approved by the DEPARTMENT. The MCO shall distribute the revised Member Handbook within six (6) weeks from receiving the DEPARTMENT's written approval of changes.

j. The MCO shall identify to the DEPARTMENT the individual who is responsible for the performance of the Member Services DEPARTMENT.

k. The MCO shall maintain an adequately staffed Member Services office to receive telephone calls in order to answer Members' questions, respond to Members' complaints and resolve problems informally.

l. The MCO shall provide Members with a toll-free telephone number that the Members may use to contact the MCO's Member Services office.

   1. With respect to the toll-free Member Services telephone number, the MCO shall:

      (a) Ensure that, at a minimum, Member Services representatives are available during core business hours of 8:00 a.m. to 5:00 p.m. on Mondays through Fridays.

      (b) Provide an automated system available during non-business hours, including weekends and holidays, to serve callers to the Member Services telephone line. The automated system shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The MCO shall ensure that:

         (1) The automated system's voice mailbox has adequate capacity to receive all messages; and

         (2) Representatives from the MCO's Member Services department respond to all messages by the close of business on the next business day.

2. The MCO may at its discretion exceed the required minimum hours for the toll-free Member Services telephone line by offering extended service times in the mornings, evenings, and on weekends and State of Connecticut holidays.
3. The MCO may at its discretion provide to callers in a queue who have an expected hold time of more than thirty (30) seconds the opportunity to receive an automatic call back as soon as the next Member Services representative becomes available.
4. The MCO shall adhere to the following minimum performance standards for the MCO's Member Services telephone line:
   (a) MCO representatives answer ninety percent (90%) of calls to the Member Services number within sixty (60) seconds;
   (b) MCO representatives answer ninety-seven percent (97%) of calls to the Member Services number within one-hundred twenty (120) seconds; and
   (c) The call abandonment rate to the Member Services number does not exceed five percent (5%).

The DEPARTMENT will establish monitoring criteria, which may involve reporting of performance over various four-hour increments with disproportionate sampling on Mondays and on business days following public holidays.

m. The MCO shall submit call response and abandonment reports for the preceding six (6) month period to the DEPARTMENT upon request.

n. The MCO's Member Services department shall include bilingual staff (Spanish and English) and real-time oral interpretation services for speakers of non-English languages. The MCO shall have text-telephone device (TTD) or equivalent system to communicate by telephone with hearing-impaired Members. The MCO shall also make available real-time oral interpretation services for all non-English languages (including American Sign Language interpretation) at provider sites either directly or through a contractual obligation with the service provider.

o. The MCO shall require staff of the Member Services department to identify themselves to Members when responding to Members' questions or complaints. The DEPARTMENT reserves the right to request Member Services Training Material for review and request revisions or changes in the material at any time.

p. When Members contact the Member Services department to ask questions about, or complain about, the MCO's failure to respond promptly to a request for contract services, or the denial, reduction, suspension or termination of contract services, the MCO shall:
   1. Attempt to resolve such concerns informally;
   2. Inform Members of the appropriate appeal and administrative hearing processes applicable for HUSKY A, HUSKY B and Charter Oak Members; and
   3. Upon request, mail to HUSKY A Members, within one business day, forms and instructions for filing a grievance.

q. At the time of enrollment and at least annually thereafter, the MCO shall inform its Members of the applicable procedural steps for filing an appropriate appeal and requesting an administrative hearing for HUSKY A Members or the Department of

Insurance external review process applicable for HUSKY B and Charter Oak Members.

r. The MCO shall monitor and track PCP transfer requests and follow up on complaints made by Members as necessary.

s. The MCO may provide outreach to its current Members at the time of the Member's renewal of eligibility. The outreach may involve special mailings or phone calls as reminders that the Member must complete the HUSKY or Charter Oak renewal forms to ensure continued coverage.

t. The MCO shall make appropriate referrals of Members who express the need for or may require pharmacy, dental or behavioral health services. The MCO shall develop appropriate procedures for managing urgent or crisis calls and communicating Member specific crisis management information to the CT BHP ASO for effective coordination of care.

Sanction: If the MCO does not meet he incoming call response or call abandonment standards set forth in paragraph (l), then the DEPARTMENT may impose a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions,.

Sanction: For each documented and validated instance of failure to provide appropriate linguistic accessibility to Members, the DEPARTMENT may impose a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions,.

The Bidder shall:

a. Describe its Member services operation, listing the number of staff and staff person responsible for the member services office and their qualifications. The Bidder shall also identify the Connecticut location of its Member Services office.

b. Describe its after-hours call center operations.

c. Describe its complaint management processes. For HUSKY A, the Bidder shall include a description of the grievance management process.

3.28 Content of Member Handbook

The Member Handbook that shall address and explain, at a minimum, the following:

a. Scope of Coverage

1. The amount, duration and scope of contract services;
2. Restrictions on services (e.g., coverage limitations and service exclusions) and circumstances in which the Member could be held liable for payment for services;
3. Special access and other features of the MCO's managed care plan;
4. Family planning services and, for HUSKY A Members, the availability of family planning from out-of network providers;
5. Children's services, which for HUSKY A Members shall include EPSDT;
6. Case management services targeted to Members as medically necessary and appropriate; and
6. For HUSKY A Members, procedures to request non-emergency medical transportation and transportation options.

b. Access to Services

1. Access and availability standards;
2. Prior authorization process;
3. Definition of and distinction between emergency care and urgent care and the extent to which emergency coverage is available, including: the fact that prior authorization is not necessary for emergency care, the procedures for obtaining emergency services including the use of 911; the fact that the Member can obtain emergency care in any hospital or other setting;
4. Policies on the use of urgent care services;
5. How to access care twenty-four (24) hours a day;
6. Restrictions on the Member's freedom of choice among providers;
7. Limitations on reimbursement for services from out-of-network providers;
8. Information on how to access pharmacy, behavioral health and dental services; and
9. How to obtain any other benefits that are available to the Member but are not covered under this contract.

c. Member Services

1. Contact information (addresses, office hours, and toll-free telephone numbers for the Member Services office);
1. Enrollment/disenrollment/managed care plan changes;
2. Procedures for selecting and changing PCPs;
3. Policies on referrals for specialty care and other benefits not furnished by the PCP;
4. Assistance with locating appropriate providers and scheduling appointments; and
5. Availability of provider network directory and updates.

d. Member Rights and Responsibilities (including those described in Section 3.03, Member Rights);

e. Cost-Sharing

1. An overview of financial obligations of the Member (if any);
2. Exemption for American Indians and Alaskan Natives;
3. Cost-sharing (including premiums, deductibles, co-payments, and co-insurance, as applicable);
4. Annual aggregate cost-sharing maximums per Member or per family;
5. Consistent with subsection (a), service limitations (including both quantity and dollar caps) and lifetime benefit maximums; and
6. The Member's rights to request a review of determinations about cost-sharing and the fulfillment of annual aggregate cost-sharing maximums and lifetime benefit maximums.

f. Appeal Procedures

1. The requirement that requests for all levels of the internal appeals process shall be mailed or faxed to a single address.
2. For HUSKY A Members, information about the DEPARTMENT's administrative hearing process, including the circumstances under which an expedited appeal is available. The materials should include the following:
   (a) The right to file appeals and the right to file hearing requests;
   (b) The method for obtaining a hearing, including procedural steps and timeframes for filing an appeal and administrative hearing request;
   (c) The timeframe for maintaining benefits pending the conclusion of the appeal and administrative hearing processes;
   (d) The right to representation;
   (e) The availability of assistance with filing; the toll-free numbers for filing appeals; and
   (f) The circumstances in which services will be continued pending a hearing; and the need to notify the MCO and the DEPARTMENT of legal representation.
3. For HUSKY B and Charter Oak Members, the Connecticut Insurance Department (CID) external appeal process, including the circumstances under which an expedited appeal is available. The materials shall include the following:
   (a) If the HUSKY B or Charter Oak Member has exhausted the MCO's internal appeals process and has received a final written decision from the MCO upholding the MCO's original denial of the good or service, the HUSKY B or Charter Oak Member may file an external appeal with the CDI within sixty (60) days of receiving the final written appeal decision;
   (b) The HUSKY B or Charter Oak Member may be required to pay a filing fee for the CDI appeal. The DEPARTMENT will pay the filing fee on behalf of any HUSKY B Members in Income Bands 1 and 2. HUSKY B Members in Income Band 3 shall be responsible for the payment of the filing fee;
   (c) The non-refundable filing fee for an external appeal through the CDI is $25;
   (d) The HUSKY B or Charter Oak Member will be asked to submit certain information in support of his or her appeal request, including a photocopy of his or her HUSKY B or Charter Oak Member ID card. The HUSKY B or Charter Oak Member (or the Member's legal representative) will also be asked to sign a release of medical records;
   (e) The CID will assign the appeal to an outside, independent entity. The reviewers will conduct a preliminary review and determine whether the appeal meets eligibility for review. The HUSKY B or Charter Oak Member will be notified within five (5) business days of the CDI's receipt of the request whether the appeal has been accepted or denied for full review; and
   (f) HUSKY B and Charter Oak Members may obtain (i) information about the external review process; and (ii) and a copy of the CDI External Appeal Consumer Guide from the CID, P.O. Box 816, Hartford, CT 06142 or at (860) 297-3862.

g. Preventive Health Guidelines and Preventive Care;

h. Coordination of Benefits and Third-Party Liability;

i. Advance Directives; and

j. A brief overview of the structure and operation of the managed care plan and physician incentive plans (if applicable).

The Bidder shall:

Provide a sample Member Handbook topic layout and/or samples of member handbooks used by the MCO in similar programs.

3.29 Member Website

a. The MCO shall provide a transparent, easy-to-navigate website for HUSKY A, HUSKY B and Charter Oak.

b. The MCO shall collaborate with the DEPARTMENT to determine the content on the HUSKY Website or page. The final content and format of the MCO's website(s) for HUSKY A, HUSKY B and Charter Oak shall be subject to the DEPARTMENT's approval.

c. The MCO shall structure the website(s) for easy navigation and easy identification. If the MCO embeds the website(s) within a more complex corporate website, the MCO shall ensure that the HUSKY A, HUSKY B, and Charter Oak link(s) is clearly accessible from the corporate main site.

c. All Member materials on the website shall be in both English and Spanish. Additionally, the MCO shall ensure that the website provides, in a prominent place, an option for Spanish selection.

d. The MCO shall ensure that the website is compliant with § 508 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794d) so that persons with visual impairments and other disabilities can access the content on the website. Note: the federal government has provided compliance information online at http://www.section508.gov/.

e. At minimum, the MCO's website(s) shall include each of the following elements:

   1. HUSKY A, HUSKY B, and Charter Oak contact service information through links to the DEPARTMENT's primary websites (e.g., www.ctmedicalprogram.com, www.huskyhealth.com, www.ctbhp.com);

   2. Provider look-up functionality that permits searches using combinations of the following criteria, which the MCO shall update at least monthly:

      (a) Provider category;

      (b) Clinical specialty;

      (c) Provider name;
      (d) Languages spoken;

      (e) Zip code of service locations; and

      (f) Whether provider is accepting new patients.

   3. Functionality enabling for users to browse or search provider results by driving distance;

4. Link(s) to an internet-based map service;
5. Provider surveys and feedback options; and
6. All information contained in the Member Handbook(s).

The Bidder shall:

Describe its website capabilities and functionalities.

3.30 Marketing Guidelines

a. The MCO shall obtain prior approval from the DEPARTMENT for all MCO-specific marketing activities and materials targeting the HUSKY and Charter Oak populations including, but not limited to:

1. Annual marketing plans and revisions to such plans, including description of proposed marketing approaches and marketing procedures.
2. HUSKY or Charter Oak application materials or information that mentions Medicaid, Medical Assistance, Title XIX, Title XXI State Children's Health Insurance Program (SCHIP), HUSKY, or Charter Oak.
3. The use of the HUSKY or Charter Oak logo and name in their marketing materials, subject to the following:

a) The HUSKY logo shall be used in conjunction with and placed in the vicinity of the HUSKY name or the following language unless alternative language has been prior approved by the DEPARTMENT.

- *HUSKY gives families the freedom of choice to enroll in one of several participating health plans. Toll-free information: 1-877-CT-HUSKY;*
- *A HUSKY health plan, 1-877-CT-HUSKY*

b) The Charter Oak logo shall be used in conjunction with and placed in the vicinity of the Charter Oak name or the following text unless alternative text has been prior approved by the DEPARTMENT.

- *Charter Oak gives families the freedom of choice to enroll in one of several participating health plans. Toll-free information:* ***[Number TBD***
- *A Charter Oak health plan:* ***[number TBD]***

c) The font size for the HUSKY and/or Charter Oak phone number shall not be smaller than the MCO's phone number.

4. Corporate marketing that includes HUSKY A, HUSKY B, or Charter Oak. No prior approval is required for corporate marketing that exclusively promotes the corporate brand and does not mention HUSKY or Charter Oak.

c. The MCO shall not promote its managed care plan through misleading, inaccurate or deceptive electronic, printed or artistic materials characterized by the following:

1. Accuracy: The MCO shall present accurate material. The DEPARTMENT will disallow any information that it determines is inaccurate (including misleading or exaggerated). This includes, but is not limited to, inaccurate statements about the nature of the eligibility or enrollment process, the positive attributes of the managed care plan, about the disadvantages of competing managed care plans

or implying that a given managed care plan is the only HUSKY or Charter Oak managed care plan;

2. Misleading or exaggerated claims: The MCO shall not present misleading or exaggerated claims about the MCO's positive attributes. Misleading references include, but are not limited to, any MCO advertisement that its health care services are free to its Medicaid (HUSKY A) Members since potential members could conclude from the advertisement that only this managed care plan provides free services. The MCO may differentiate itself by promoting its legitimate positive attributes;
3. Endorsements: The MCO shall not present false or misleading statements or assertions that the MCO or any of its products is endorsed by the DEPARTMENT or CMS or any other governmental entity;
4. Threatening messages: The MCO shall not create, advertise, or present threatening implications about the DEPARTMENT's mandatory assignment process for HUSKY A or HUSKY B Members or other aspects of HUSKY A , HUSKY B, or Charter Oak or create, advertise, or present threatening scenarios that do not accurately depict the consequences of choosing a different managed care plan including, but not limited to those messages that suggest that a potential Member by not selecting a particular managed care plan or the failure to join a particular managed care plan would lose or not qualify for HUSKY or Charter Oak benefits or would endanger the Member's health status, personal dignity, or the opportunity to succeed in various aspects of their lives;
5. Deceptive practices: The MCO shall not engage in deceptive, fraudulent or abusive practices for any purpose including but not limited to enticing prospective members to change managed care plan membership or to retain managed care plan membership;
6. Discrimination: The MCO shall not discriminate against any eligible individual on the basis of health status or need for future health care services;
7. Parallel promotions: The MCO shall not promote enrollment in HUSKY A, HUSKY B, or Charter Oak or the MCO in conjunction with the sale or offering of private insurance (exclusive of dental and other riders approved in advance by the DEPARTMENT and offered by the MCO to Charter Oak clients for purchase); and
8. The MCO shall not influence enrollment in conjunction with the sale or offering of any private insurance (exclusive of dental and other riders approved in advance by the DEPARTMENT and offered by the MCO to Charter Oak clients for purchase).

d. The MCO shall distribute marketing materials to its entire service area.

e. The DEPARTMENT will review materials submitted for DEPARTMENT approval and respond to review requests from the MCO within thirty (30) days from the receipt of the material. If the DEPARTMENT does not respond to materials submitted for approval within thirty (30) days, the MCO may use the materials as presented to the DEPARTMENT. However, the DEPARTMENT reserves the right to request revisions or recall specific materials at any time.

f. MCO representatives shall not actively solicit new Members at provider sites.

g. MCO representatives shall not distribute materials at DSS offices including hospital located eligibility offices and shall not position their representatives at or near DSS eligibility offices or at the sites of DSS contractors for the purposes of marketing and solicitation; however, the MCO may provide its materials to the DEPARTMENT, who will display those materials.

h. The MCO shall not conduct personal, small group or face-to-face marketing activities except as provided in (k) below.

i. The MCO shall distribute this section of the contract to all its network providers and prohibit providers from marketing or promoting any managed care plan. Network providers may display DEPARTMENT approved materials and brochures. Providers may inform their patients of the managed care plans in which they participate and may explain that the patients must enroll in one of these managed care plans if they wish to preserve their existing relationship.

j. The MCO shall not market or promote its managed care plan through any means of telemarketing, mass mailings or any other means by which the MCO may establish unsolicited personal contact with potential Members; however, the MCO may respond with permitted information to unsolicited telephone calls from potential Members and may return calls to them when the potential Member requests a return call. The MCO may also provide DEPARTMENT-approved materials when requested by a potential Member. Notwithstanding this provision, MCO may send a limited amount of unsolicited mail to actual Charter Oak Members regarding the availability of dental and other riders approved in advance by the DEPARTMENT and offered by the MCO to Charter Oak clients for purchase. The MCO may also discuss these riders with potential Members during routine contacts initiated by the potential Members. However, the MCO may not make unsolicited calls or other contacts to potential or actual Charter Oak members about these riders.

k. The MCO shall not conduct promotional group meetings or individual solicitation with potential members at:

    1. The offices of the MCO;

    2. Private clubs;

    3. Private residences including, but not limited to, situations where the potential Member desires and/or requests a home visit. MCO staff may visit Member homes after enrollment becomes effective, as part of their orientation/education efforts; and

    4. Employer sites including, but not limited to, soliciting employees directly or soliciting employers to promote the MCO to their employees or customers.

l. The MCO may conduct outreach or market their managed care plan at events and meetings open to the general public including those events held at public facilities, churches, health fairs, or other community sites and those they organize or sponsor when the MCO:

    1. Notifies the DEPARTMENT in advance of such meetings by submitting to the DEPARTMENT on a monthly basis schedules or calendars of educational and marketing events for the following month. The schedules shall contain sufficient information to allow the DEPARTMENT to attend the events and to monitor them;

    2. Utilizes DEPARTMENT-approved materials in the presentations and complies with the DEPARTMENT's marketing guidelines; and

3. Restricts their information request from potential Members to their name, address, phone number and family size.

m. The MCO and its marketing staff or representatives shall not under any circumstance request or require personal contact information of potential members in return for a gift item nor access the following personal information from the MCO's data bank or from the potential Member or any other source: social security numbers, birth dates, or children's names or any other individual information related to family members or potential Members.

n. The MCO (and its providers) may disseminate promotional token gifts of nominal value (magnets, pens, bags, jar grippers, etc.) at approved events and with approved materials to potential Members when:

1. The DEPARTMENT has approved them in advance of their dissemination, and

2. Their unit cost value is less than two dollars ($2)and the aggregate cost per potential member shall not knowingly exceed four dollars ($4) per occasion.

o. The MCO may provide the following to Members when the DEPARTMENT has approved the items and the criteria for distributing the items before the MCO distributes them:

1. Token gifts to Members including magnets, phone labels, and other nominal items that promote the MCO's care coordination programs (e.g. through advertising the Member Services hotline and/or the PCP office phone number) or to reinforce medically "good" behavior (e.g. baby T-shirt showing immunization schedule once a woman completes targeted series of prenatal visits);

2. "Welcome" packets sent to new Members; and

3. Health education materials, which include but are not limited to videos, CDs, DVDs, cassettes and other media.

p. The MCO shall not provide or sponsor incentives unless explicitly approved by the DEPARTMENT. Such incentives include, but are not limited to:

1. Cash or gifts, including gift certificates, to Members or potential Members;

2. Gifts of any kind to agencies that host meetings with potential Members;

3. Beverages or light refreshments at marketing events or in conjunction with marketing activities; and

4. Raffles in association with marketing related activities or for the purpose of collecting information for marketing activities.

q. The MCO shall not coerce or intimidate Members from changing their managed care plan through enticements or performing the action on behalf of the Member.

r. The MCO may disseminate general health information materials to their members without prior approval from the DEPARTMENT, however, the MCO shall submit a copy of general health information materials to the DEPARTMENT upon initial distribution.

s. The MCO may conduct health education and prevention activities at FQHCs and other provider sites when the MCO notifies the DEPARTMENT of such events through its monthly schedule or calendar, the materials conform to the relevant

provisions of this section, and such activities are not associated with marketing or promotional activities.

t. The MCO shall follow DEPARTMENT approved procedures when approached by Members or potential Members including:

1. An MCO representative shall use an approved script when promoting the MCO's managed care plan.

2. MCO representatives may provide potential Members the use of their cell phones to call the enrollment broker when the potential Member initiates an interest in calling the enrollment broker and requests the use of a phone. However, before providing a phone, the MCO representative shall advise the potential Member that:

a) The potential Member has a choice of which managed care plan to select; and

b) The potential Member should request the enrollment broker to verify that his/her PCP is included in the managed care plan that he/she has selected.

3. An MCO representative may dial the telephone number to the enrollment broker, however, when the enrollment broker answers the telephone, the MCO representative shall identify him/herself by name and managed care plan to the enrollment broker and then hand the phone over to the potential Member. The MCO representative shall provide the potential Member privacy when he/she is on the phone with the enrollment broker. For purposes of this provision, privacy means that the MCO's representative shall remove himself/herself physically from the area so he/she cannot overhear the conversation between the Potential member and enrollment broker.

5. An MCO representative shall not call the enrollment broker or utilize a third party and change the managed care plan on behalf of a potential Member.

6. An MCO representative shall not coach or coerce potential Members during or after the use of the telephone for a call with the enrollment broker

7. An MCO representative may attempt to contact a potential Member not more than twice following an initial contact at an event to follow-up.

u. The MCO shall not compensate marketing staff, whether they are employees, independent contractors, independent insurance brokers or marketing representatives, through the use of a per member incentive for managed care plan changes or enrollment and shall hold the DEPARTMENT harmless for any and all claims, complaints or causes of actions that shall arise as a result of this contractually imposed salary, benefits and other compensation structure for marketing representatives through the use of a per member incentive or similar bonus type of reimbursement.

v. The MCO shall implement policies and procedures to manage the actions of marketing staff to ensure compliance with marketing guidelines.

w. The MCO shall obtain the DEPARTMENT's prior approval for marketing/outreach training curricula for marketing personnel. Such materials shall include, at a minimum, marketing and outreach expectations and limitations and these guidelines and shall require all its marketing personnel to participate in training sessions that the DEPARTMENT may develop or require.

x. Expenditures on marketing and marketing related activities shall not exceed one percent (1.0%) of the MCOs administrative expenditures during the first three years of the resultant contract. Marketing expenditures shall not exceed one half of one percent (0.5%) of administrative expenditures during the last two years of the resultant contract.

y. The following grid provides a summary of the marketing guidelines.

Permitted = 1; Not Permitted = 2; Permitted With Dept. Approval = 3

§	Marketing Guidelines Summary	1	2	3
	Type of Marketing Activity			
1	Marketing materials and approaches			
2	MCO marketing in provider care sites		X	
3	MCO advertising in DEPARTMENT- eligibility offices, including hospital-based			X
4	Face to face allowed marketing activities			X
5	Provider communications with Medicaid patients about MCO options			X
6	Potential Member-initiated telephone conversations with MCO and Provider staff	X		
7	Mailings by MCO in response to potential Member requests			X
8	Unsolicited MCO mailings		X	
9	Cold calling and telemarketing		X	
10	MCO group meetings held at MCO		X	
11	MCO marketing at public facilities such as churches, health fairs			X
13	MCO group meetings held in private clubs or private homes		X	
13	Individual solicitation at residences		X	
14	Marketing at employer sites and employer solicitation		X	
15	Gifts, cash, incentives, or rebates to potential Members			X
16	Raffles to prospective members		X	
17	Gifts to Members for specific health events			X
18	Phoning by potential Members from health care provider locations		X	
19	Beverages and light refreshments for potential Members at meetings		X	
20	Use HUSKY or Charter Oak name and logo (as specified)	X		
21	Generic Health Education materials	X		
22	HUSKY or Charter Oak specific Health Education materials			X
23	Health education and prevention activities at providers sites, as specified	X		
24	Soliciting contact information from members, prospective members, as specified			X
25	Communication with Members by marketing/outreach staff, telephone use, as specified only			X

The Bidder shall:

Submit an outline of its proposed marketing and outreach plan and samples of relevant materials used in its Medicaid or similar markets.

3.31 Health Education

The MCO shall routinely, but no less frequently than annually, remind and encourage Members to utilize benefits including physical examinations, which are available and designed to prevent illness. The MCO shall also offer periodic screening programs that, in the opinion of the medical staff, would effectively identify conditions indicative of a health problem. The MCO shall keep a record of all activities it has conducted to satisfy this requirement.

The Bidder shall:

Submit a plan of how it will meet this requirement.

3.32 Internal and External Quality Assurance

a. The MCO shall ensure that its staff, subcontractors and providers render consistently high-quality services. The MCO shall also ensure that all contract services are medically necessary and medically appropriate; this requirement shall apply to all contract services, regardless of whether in-network or out-of-network providers render the services. The MCO shall implement a quality assessment and performance improvement (QAPI) program in order to monitor and continuously improve the quality of care. In addition, the DEPARTMENT and its External Quality Review Organization (EQRO) will monitor the MCO's compliance with all requirements in this section.

b. The MCO shall comply with applicable federal and state regulations and DEPARTMENT policies and requirements concerning quality assessment and program improvement. The MCO will develop and implement an internal QAPI program consistent with the guidelines as provided in Appendix F Standards for Internal Quality Assurance Programs for Health Plans. The MCO's QAPI program shall include provisions that:

   1. Detail the review process by appropriate health professionals regarding the delivery of contract services;
   2. Detail the MCO's systems and processes to collect performance and Member outcomes;
   3. Describe the process for circulating and these data and related findings among the MCO's providers;
   4. Describe the process for amending the QAPI and making needed changes;
   5. Include at least two performance improvement projects of the MCO's own choosing;
   6. Include at least two performance improvement projects required by the DEPARTMENT; and
   7. Detail the MCO's systems and other mechanisms to detect both under utilization and over utilization of services.

c. The MCO shall provide descriptive information on the operation, performance and success of its QAPI program to the DEPARTMENT upon request.

d. The MCO shall maintain and operate a QAPI program that includes at least the following elements:

   1. A QAPI plan.
   2. A full-time Quality Assurance Director, who is responsible for the operation and success of the QAPI program. This person shall have adequate experience to ensure a successful QAPI program, and shall be accountable for the quality systems of all the MCO's providers, as well as the MCO's subcontractors.
   3. The Quality Assurance Director shall spend an adequate percentage of time on QAPI activities to ensure that a successful QAPI program will exist. Under the QAPI program, there shall be access on an as-needed basis to the full compliment of health professions (e.g., pharmacy, physical therapy, nursing, etc.) and

administrative staff. A Quality Assurance Committee that includes representatives from the following shall provide oversight of the program:

(a) A variety of medical disciplines (e.g., medicine, surgery, mental health, etc.);

(b) Administrative staff; and

(c) Board of Directors of the MCO.

e. The Quality Assurance Committee shall be organized operationally within the MCO such that it can be responsible for all aspects of the QAPI program.

f. QAPI activities shall be sufficiently separate from Utilization Review/Management activities, so that QAPI activities can be distinctly identified as such.

g. The QAPI activities of the MCO's network providers and subcontractors, if separate from the MCO's QAPI activities, shall be integrated into the overall MCO QAPI program, and the MCO shall provide feedback to its in-network providers and subcontractors regarding the operation of any such independent QAPI effort. The MCO shall remain, however, fully accountable for all quality assurance relative to its in-network providers and subcontractors.

h. The Quality Assurance Committee shall meet at least quarterly and produce written documentation of committee activities to be shared with the DEPARTMENT.

i. The results of the QAPI activities shall be reported in writing at each meeting of the Board of Directors.

j. The MCO shall have a written procedure for following up on the results of QAPI activities to determine success of implementation. The MCO shall document in writing its follow-up efforts.

k. Where the DEPARTMENT determines that a QAPI plan does not meet the above requirements, the DEPARTMENT may provide the MCO with a model plan. The MCO agrees to modify its QAPI plan based on negotiations with the DEPARTMENT.

l. The MCO shall monitor access to and quality of contract services for its Member population, and, at a minimum, use this mechanism to capture and report all of the DEPARTMENT's required utilization data.

m. To the extent permitted under state and federal law, the MCO certifies that all data and records requested shall, upon reasonable notice, be made available to the DEPARTMENT.

n. The MCO shall be an active participant, as appropriate in the EQRO's quality improvement focus studies and shall cooperate with the DEPARTMENT in other studies of mutual interest initiated by the DEPARTMENT.

o. The MCO shall comply with EQRO and other external review activities scheduled by an organization contracted by the DEPARTMENT. The MCO's participation with such a review may include, but not limited to, collecting and providing data including, but not limited to, policies, procedures, encounter and medical data, and/or making data available to the EQRO.

p. At least one of the MCO's performance improvement project shall focus on one of the following areas:

1. Prevention and care of acute and chronic conditions;

2. High volume services;

3. Continuity and coordination of care;
4. Appeals, grievances and complaints;
5. Access to and availability of services; or
6. Other project subject to DEPARTMENT approval.

q. All of the performance improvement projects shall:
   1. Include the measurement of performance and quality indicators that are:
      a) Objective;
      b) Clearly and unambiguously defined;
      c) Based on current clinical knowledge or health services research;
      d) Valid and reliable;
      e) Systematically collected; and
      f) Capable of measuring outcomes such as changes in health status or Member satisfaction or valid proxies of those outcomes.
   2. Implement system interventions to achieve quality improvement;
   3. Evaluate the effectiveness of the interventions;
   4. Plan and initiate activities for increasing or sustaining improvement; and
   5. Represent the entire population to which the quality indicator is relevant.

r. The MCO acknowledges that CMS, in consultation with states and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by the DEPARTMENT in this contract.

s. The MCO shall commission and pay for an annual NCQA Consumer Assessment of Health Plans Survey (CAHPS) of combined HUSKY A, HUSKY B, and Charter Oak Members using an independent NCQA certified vendor. The MCO's Child Medicaid CAHPS survey shall include questions for children with chronic conditions. The MCO shall provide a copy of the CAHPS survey and survey results to the DEPARTMENT.

t. The MCO shall participate in joint quality improvement initiatives as directed by the DEPARTMENT.

u. The MCO shall provide reports and communications in electronic format when requested by the DEPARTMENT.

The Bidder shall:

Propose a comprehensive quality assurance program addressing the requirements in this section.

3.33 Medical Records

a. The MCO shall establish a confidential, centralized record, for each Member, which includes information of all medical goods and services received. The medical record shall demonstrate coordination of Member care; for example, relevant medical information from referral sources and out-of-network providers shall be reviewed and

entered into Members' medical records. The medical record shall comply with the confidentiality provisions of Section 3.54, Confidentiality, as well as all state and federal law governing the privacy of individually identifiable health care information.

b. The MCO may delegate maintenance of the centralized medical record to the Member's PCP, provided however, that the record shall be made available upon request and reasonable notice, to the DEPARTMENT(s) at a centralized location. The medical record shall meet the DEPARTMENT's medical record requirements as defined by the DEPARTMENT in its regulations. The medical record shall comply with the requirements of NCQA or other national accrediting body with a recognized expertise in managed care.

c. The MCO shall also simultaneously maintain, in addition to the medical record, a record of all contacts with each Member in a computerized database and shall provide the DEPARTMENT such information at its request.

d. Entities governed under Conn. Gen. Stat. § 38a-975 et seq., known as the "Connecticut Insurance Information and Privacy Act," shall observe the provisions of such Act with respect to disclosure of personal and privileged information as such terms are defined under the Act.

c. The MCO shall provide its medical record and any other documents, files and records pertaining to a Member to another managed care plan for care coordination only when the Member has changed enrollment to the other managed care plan and the MCO has been so notified by the DEPARTMENT or when requested by the DEPARTMENT.

d. The MCO shall share information and provide copies of medical records pertaining to a Member to the CT BHP ASO or Dental ASO upon the request of the Member, DEPARTMENT, BHP ASO, or Dental ASO.

3.34 Clinical Data and Other Reporting

a. For each of the reports described in this section, the MCO shall provide separate reports for HUSKY A, HUSKY B, and Charter Oak at the DEPARTMENT's request.

b. **Utilization Data:**

1. The MCO shall submit at a minimum, semi-annually, to the DEPARTMENT utilization and other reports for the purpose of assisting the DEPARTMENT in its efforts to assess utilization and evaluate the performance of the MCO.

   a) Inpatient care;

   b) Preventive care;

   c) Prior authorization outcomes;

   d) Maternal, prenatal care, and child health;

   e) EPSDT/well-child services;

   f) Asthma appropriate medication usage;

   h) Grievance and appeals management; and

   i) Other services as agreed to between the DEPARTMENT and the MCO.

2. The DEPARTMENT will consult with the MCO, through a workgroup comprised of DEPARTMENT and managed care plan representatives that meets on a periodic basis, or a similar process, on the necessary data, methods of collecting the data and the format and media for new reports or changes to existing reports.
3. The DEPARTMENT will provide the MCO with final specifications for submitting all reports no less than ninety (90) days before the reports are due. The MCO shall submit reports on a schedule to be determined by the DEPARTMENT, but not more frequently than quarterly. Before the beginning of each calendar year, the DEPARTMENT will provide the MCO with a schedule of utilization reports that shall be due that calendar year. Due dates for the reports shall be at the discretion of the DEPARTMENT, but not earlier than ninety (90) days after the end of the period that they cover.
4. For each report the DEPARTMENT will consider using any HEDIS standards promulgated by the NCQA that cover the same or similar subject matter. The DEPARTMENT reserves the right to modify HEDIS standards, or not use them at all, if in the DEPARTMENT's judgment, the objectives of HUSKY A, HUSKY B or Charter Oak can be better served by using other methods.
5. The DEPARTMENT will choose a random sample of administrative and medical records each year in order to validate reported data. The MCO will provide required records to the DEPARTMENT, at a location upon reasonable notice. The DEPARTMENT will review the records and report on the extent to which the reporting measure results are validated through comparison with the records. Prior to finalizing its report, the DEPARTMENT will afford the MCO reasonable opportunity to suggest corrections to or comment upon the findings.

c. **Behavioral Health and Transportation Data:**

1. The MCO shall provide to the CT BHP ASO daily and monthly reports and/or data of services as mutually agreed upon. The MCO shall produce such reports in a format as mutually agreed upon. Examples of the service subjects for reporting may include but not be limited to the following:
   a) Behavioral health emergency department visits;
   b) Behavioral health emergency room recidivism;
   c) Substance abuse and neonatal withdrawal;
   d) Child and adolescent obesity and/or type II diabetes;
   e) Sickle cell;
   f) Eating disorders; and
   g) Medical detox.
2. The DEPARTMENT will provide specific behavioral health encounter data to the MCO upon request to support quality management activities and coordination. The format of the data extract will be consistent with the encounter data-reporting format, or other format mutually agreed upon by the DEPARTMENT and the MCO.
3. The MCO shall report medical and behavioral transportation data and transportation related complaints to the DEPARTMENT and shall distinguish

behavioral health non-emergency medical transportation from medical non-emergency medical transportation.

d. **Encounter Data:**

1. The MCO shall provide the DEPARTMENT with an electronic record of every encounter between a provider and a Member within fifteen (15) days of the close of the month in which the specific encounter occurred, was paid for, or was processed whichever is later but no later than one-hundred eighty (180) days from the encounter. The MCO shall code and format such encounters in accordance with the specifications outlined in the DEPARTMENT's Encounter Submission and Reporting Guide. The DEPARTMENT shall analyze each month's encounter submission file. The DEPARTMENT will reject those records that contain invalid or missing data and result in a critical edit failure as outlined in the Encounter Submission and Reporting Guide.

2. Encounter data and any other types of data submitted by the MCO that the DEPARTMENT designates as data relied upon by the DEPARTMENT to set rates shall be certified by one of the following: the MCO's Chief Executive Officer or Chief Financial Officer or an individual who has delegated authority to sign for and who reports directly to either the Chief Executive Officer or Chief Financial Officer. The certification shall attest, based on the best knowledge, information and belief, as follows: 1) to the accuracy, completeness and truthfulness of the data and 2) to the accuracy, completeness and truthfulness of the reports required pursuant to this section. The MCO shall submit the certification concurrently with the certified data.

   Performance Measure: The overall volume of rejected encounters shall not exceed five percent (5%) in any given month.

   a) The overall acceptance rate in any given month shall not be less than ninety-five percent (95%) for the initial submission of encounters.

   b) The overall acceptance rate (initial and corrected encounters) for any given month shall not be less than ninety-eight percent (98%) within ninety (90) days of the initial submission.

   c) The overall acceptance rate (initial and corrected encounters) for any given month shall not be less than ninety-nine point six percent (99.6%) within one-hundred twenty (120) days of the initial submission.

4. The DEPARTMENT shall also analyze the MCO's encounter submissions for completeness. On a quarterly basis, no less than six (6) months from the date of service on the encounter, the DEPARTMENT will compare encounter data utilization levels to the MCO self-reported utilization levels in the reports specified in Sections 3.38(a)-(f), Clinical Data and Other Reporting.

   Performance Measure: Encounter data shall not be over or under the MCO self-reported utilization levels for the same time period by ten percent (10%) or more.

e. **Grievance Data (HUSKY A):**

The MCO shall maintain a log and report of grievances from HUSKY A Members that the MCO resolved informally. The MCO shall make the log available to the DEPARTMENT upon request. The MCO shall include in the log a short dated summary of the problem, the response and the resolution.

f. **Complaints Data** (HUSKY B and Charter Oak)**:**

The MCO shall maintain a log and report of complaints that it receives from HUSKY B and Charter Oak Members. The MCO shall make the log available to the DEPARTMENT upon request. The MCO shall include in the log a short dated summary of the problem, the response and the resolution.

Sanction: Failure to comply with the above reporting requirements in a complete, accurate and timely manner may result in a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions,.

The Bidder shall:

Submit a plan of how it will meet the reporting requirements. The plan should include a description of its system capabilities (hardware and software systems and programs) that support the production of complete and accurate data files and reports for submission to the DEPARTMENT.

3.35 Utilization Management and Prior Authorization Requirements

a. The MCO shall make prior authorization determinations as to whether a requested contract service is consistent with a Member's care plans, is medically necessary, and is medically appropriate. However, the MCO shall not require prior authorization for the following contract services:

1. Preventive care, including:
   (a) Periodic and well-child visits and well-care visits;
   (b) Immunizations; and
   (c) Prenatal care.
2. Preventive family planning services including:
   (a) Reproductive health exams;
   (b) Member counseling;
   (c) Member education;
   (d) Lab tests to detect the presence of conditions affecting reproductive health;
   (e) Screening, testing and treatment of pre and post-test counseling for sexually transmitted diseases and HIV; and
   (f) Emergency ambulance services or emergency care.

b. The MCO shall develop and adhere to written policies and procedures for processing requests for initial and continuing authorizations of services. The MCO shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions. The MCO shall ensure that only a health care professional who has appropriate clinical expertise in treating the Member's condition or disease makes such authorization decisions

d. The MCO shall provide a notice of action for HUSKY A Members as described in Section 4.05, Notices of Action and Continuation of Benefits. The MCO shall provide a denial notice to HUSKY B and Charter Oak Members as described in Section 5.24,

Denial Notice., . For all Members, the MCO shall verbally notify the provider requesting authorization of the decision as soon as possible and also send a copy of the notice of action or denial notice (as applicable) to the requesting provider.

e. The MCO shall make authorization decisions and issue a written notice of action or denial notice (as applicable) to the Member and the provider as expeditiously as the Member's health condition requires, but not exceeding fourteen (14) days following receipt of the request for service.

   1. This standard fourteen (14) day authorization period may be extended one time only by an additional fourteen (14) days if:

      (a) The Member or requesting provider asks for an extension; or

      (b) The MCO documents that the extension is in the Member's interest because additional information is needed to authorize the service and the failure to extend the timeframe will result in the denial of the service. The DEPARTMENT may request such documentation from the MCO.

   2. In the situations described in (2) above, the MCO shall give the Member and provider the written notice of the reason for the decision to extend the timeframe. Consistent with Section 4.06, Appeals and Administrative Hearing Processes, and Section 4.07, Expedited Review and Administrative Hearings, the MCO shall also inform the HUSKY A Members of the right to file a grievance if he or she disagrees with the decision to extend the timeframe.

f. The MCO shall expedite its authorization decision if a provider indicates, or the MCO determines that following the timeframe in subsection (e) of this section could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.

   1. The MCO shall issue a decision no later than three (3) business days after receipt of the request for service. This three- (3-) day period may be extended for an additional fourteen (14) days if the case meets either of the criteria in subsection (e)(1) above. The MCO shall provide notice of its decision in a manner that is consistent with subsection (d) above.

   2. With regard to any fourteen- (14) day extensions, the MCO shall immediately give verbal notice to the Member and the provider. The MCO shall also give written notice to both the Member and the provider. Consistent with Section 4.06, Appeals and Administrative Hearing Processes and 4.07, Expedited Review and Administrative Hearings, the MCO shall also inform the HUSKY A Members of the right to file a grievance and/or receive an expedited hearing.

g. The MCO may subcontract with a licensed utilization review company to perform some or all of the MCO's utilization management functions. If the MCO subcontracts for any portion of the utilization management function, the MCO shall provide a copy of any such subcontract to the DEPARTMENT and any such subcontracts will be subject to the provisions of Section 3.58, Freedom of Information, of this contract. The DEPARTMENT will review and approve the subcontract, subject to the provisions of Section 3.38 to ensure the appropriateness of the subcontractor's policies and procedures. The MCO shall conduct regular and comprehensive monitoring of a utilization management subcontractor.

h. The MCO shall not compensate any subcontractor or other entity performing utilization management or utilization review functions to provide any incentive for the individual to deny, limit or discontinue medically necessary services to any Member.

i. If the MCO disagrees with a clinical management decision made by the CT BHP ASO, the MCO may raise the issue with the CT BHP ASO on behalf of the Member and seek to resolve the issue informally. If the issue remains unresolved, the DEPARTMENT will conduct an expedited review of the issue at the request of the MCO.

j. The MCO and its subcontractors shall comply with the utilization review provisions of Conn. Gen. Stat. § 38a–226c.

The Bidder shall:

a. Describe policies and procedures for processing requests for initial and continuing authorizations of services and mechanisms in place to ensure consistent application of review criteria for authorization decisions.

b. Identify services for which the MCO may require prior authorization and rationale as to why prior authorization review is appropriate for these services.

3.36 Provider Appeal Process

a. In addition to the appeals processes required in Sections 4.06, Appeals and Administrative Hearing Processes, the MCO shall have an internal appeal process through which a health care provider may appeal the MCO decision on behalf of a HUSKY A Member.

b. The health care provider appeal process shall not include any appeal rights to the DEPARTMENT or any rights to an administrative hearing.

The Bidder shall:

a. Fully describe its process for managing grievances.

b. Fully describe its process for managing appeals and preparation for administrative hearings.

3.37 Third Party Coverage

a, The DEPARTMENT is the payer of last resort when third party resources are available to cover the costs of medical services provided to Medicaid clients. Pursuant to this requirement, the MCO shall comply with federal and state statutes and regulations regarding third party liability. The MCO shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to HUSKY A, HUSKY B, and Charter Oak Members under this contract. The MCO shall be responsible for identifying appropriate third party resources, and if questions arise they shall consult with the DEPARTMENT. The MCO shall pursue, collect, and retain any monies from third party payers for contract services to Members under this contract, subject to the provisions below.

b. For purposes of this section, “health insurance” shall be any arrangement under which an entity is, by statute, contract or agreement, legally responsible for payment

of a claim for a health care item or service, regardless of whether the entity is financially at risk for the cost of a health care item or service; such entities shall include but not be limited to self-insured plans, self-funded plans, self-administered plans, and group health plans (as defined in § 607(1) of the Employee Retirement Income Security Act of 1974); service benefit plans; managed care organizations; health care centers; pharmacy benefit managers; behavioral health organizations; and dental benefit managers. This definition of "health insurance" shall not include Medicare, health casualty insurance, workers' compensation, or tortfeasors who may be responsible for payment for contract services for the MCO's Members.

c. The DEPARTMENT hereby assigns to the MCO all rights to third party recoveries from Medicare, health insurance, casualty insurance, workers' compensation, tortfeasors, or any other third parties who may be responsible for payment for contract services for the MCO's Members.

d. The MCO may assign the right of recovery to their subcontractors and/or network providers. Notwithstanding any such assignment of the right of recovery, the MCO remains responsible for the effective and diligent performance of third party recovery.

1. Other Insurance, Cost Avoidance and Third Party Resources

(a) For purposes of this section, "cost avoidance" shall be the rejection and return of a claim for contract services to the submitting provider in order for the provider to pursue payment up to the legal limit of liability from Medicare or the Member's health insurance. Following the determination of liability by Medicare or the Member's health insurance, the MCO shall reimburse the network provider for balances not paid by Medicare or the Member's health insurance.

(b) The MCO shall have primary responsibility for cost avoidance through the coordination of benefits relative to Medicare and health insurance. The MCO shall avoid initial payments of claims, as permitted by federal law, for Members with Medicare or health insurance.

(1) The MCO shall allow exceptions to its general cost avoidance policy for prenatal care for pregnant woman and preventive pediatric services (including early and periodic screening and diagnosis and treatment as defined in 42 CFR Part 441) if the Member's health insurance is derived from an absent parent whose obligation to pay support is being enforced by the DEPARTMENT.

(2) The MCO may allow exceptions to its general cost avoidance policy for non-inpatient hospital care associated with labor and delivery, and post-partum care.

(3) The MCO shall ensure that the requirements in this section related to the coordination of benefits (including any verification processes) do not obstruct Members' access to contract services nor obstruct providers in verifying coordination of benefits (COB) coverage with the MCO.

(c) When cost avoidance is not possible (or when a permitted exception applies), the MCO may utilize post-payment recovery. In such situations, the MCO shall seek recovery from the Member's health insurance for the cost of services within thirty (30) days after the end of the month in which it paid the network provider's claim.

(d) If a third party insurer requires the Member to pay any cost-sharing, the MCO is responsible for making any such payments to the extent that the third party insurer's co-payment exceeds the cost-sharing applicable under this contract.

(e) If a third party insurer pays for only some services covered under this contract or for only part of a particular contract service, the MCO shall be liable up to the allowed amount in accordance with the MCO's fee schedule, for the full extent of services covered under this contract, even if the services are provided outside of the MCO's provider network.

(f) If a third party insurer covers a Member, the MCO is bound by any prior authorization decisions made by the third party insurer.

(g) If the MCO learns of retroactive health insurance after it has paid for contract services for a Member, then the MCO or its assignee has first right to recovery from a Member's health insurance within sixty (60) days of date of service or date of submission of its network provider's claim, whichever is later.

(h) If the MCO has not initiated recovery after sixty (60) days from the date of service or submission of its network provider's claim, whichever is later, then the right to initiate and pursue recovery is shared by the MCO and the DEPARTMENT and will go to the first party to document initiation of recovery, which can be documented as described below.

(i) In pursing third-party recovery, the MCO, network providers, and subcontractors shall seek recovery of the cost of contract services actually rendered to the Member, notwithstanding the fact that the MCO may pay the subcontractor on a capitated basis.

(j) The MCO shall maintain records of recoveries of all third party collections, including cost avoidance and recovery actions.

(1) The MCO or its assignees shall maintain dated documentation of the initiation of its claim to recovery against a health insurer or other third party payer. The MCO shall document initiation of recovery by formal communication in written or electronic form to the liable third party, specifically requesting reimbursement up to the legal limit of liability for any services provided to the MCO's Member covered under the State Medicaid Plan.

(2) The MCO shall provide to a designated contact person at the DEPARTMENT with an electronic list of the MCO's members for which health insurance reimbursement is being sought. This electronic information shall be in an Microsoft Excel, text or other similar type of file and shall identify the name of the client, client identification number, name of the health insurance company billed, date the health insurance company was billed, the type of claim/service billed, the date(s) of service billed, the dollar amount billed, the provider name, the provider Medicaid number, and the provider tax identification number. Conversely, at the MCO's request, the DEPARTMENT will provide this same described information on member services for which the state agency has initiated recovery after the MCO's exclusive sixty (60) day recovery right has expired.

(3) The DEPARTMENT may use the MCO's electronic recovery information (described above), the MCO's encounter claim experience, or other methods to determine and validate that it has the right to initiate recovery after the MCO's exclusive sixty (60) day recovery right has expired.

(4) Any disputes between the State and the MCO as to which party first initiated recovery shall be determined by the Contract Administrator, after the MCO is given an opportunity to present evidence and meet with the DEPARTMENT in support of its claim.

(5) The amounts avoided or recovered by the MCO will be considered in establishing future capitated rates paid to the MCO.

(k) The DEPARTMENT will supply the MCO with a monthly file of Members for whom third party coverage has been identified. The information will also be available to the MCO and its assignees from the DEPARTMENT's Automated Electronic Voice Response System.

(l) The MCO shall report to the DEPARTMENT within five (5) business days any HUSKY B or Charter Oak Member who appears to have third party insurance coverage. The MCO shall notify the DEPARTMENT in a format specified by the DEPARTMENT.

(m) In order to identify member health insurance, the MCO or its assignee may conduct data matches with health insurance.

(n) The MCO shall notify the DEPARTMENT within thirty (30) days if the MCO (or its network provider or subcontractor) discovers through data matches or other means of identification that a Member has become eligible for coverage by a liable third party.

(1) In notifying the DEPARTMENT of member health insurance information, the MCO shall provide high quality, verified member health insurance information suitable for use on the DEPARTMENT's Eligibility Management System (EMS) for the coordination of benefits between the MCO, its network providers, and the legally liable third party.

(2) The MCO shall provide health insurance information in the technical formats and requirements specified by the DEPARTMENT.

(o) The MCO or its assignee may seek recovery for a member's cost of care resulting from a work-related accident from the State Workers Compensation Commission.

(p) The MCO shall fully cooperate with the DEPARTMENT in all third party recovery efforts.

(q) The MCO shall educate its Members on how to access services when a third party insurer covers a Member.

2. Tort Recoveries

(a) The Department or the Department of Administrative Services and the MCO share the right to seek reimbursement of costs of services provided to the MCO's member from recoveries made by the member against a tortfeasor. The right to seek reimbursement of such costs goes to the party which first initiated a valid and legal claim for reimbursement. The party making the claim for reimbursement must request reimbursement up to the legal limit of

liability for all services provided to the MCO's member covered under the State Medicaid Plan.

(b) Disputes between the State of Connecticut and the MCO as to which party first initiated reimbursement will be determined by the Contract Administrator on the written submissions of the Department/ Department of Administrative Services and the MCO as directed by the Contract Administrator. The Department/Department of Administrative Services and the MCO shall make a good faith effort to resolve any such dispute prior to submitting the issue to the Contract Administrator.

(c) In general, recovery activity will be deemed to have been "initiated" when actual notice of the claim is received by the attorney who represents the MCO's member in a tort claim against a tortfeasor.

3.38 Subcontracting

a. The MCO may subcontract for any function, excluding Member Services, covered by this contract, subject to the requirements of this contract. No subcontract shall operate to terminate the legal responsibility of the MCO to assure that all activities carried out by the subcontractor conform to the provisions of the contract. Subcontracts shall not terminate the legal liability of the MCO under this contract.

b. If the MCO delegates any function to a subcontractor, the MCO shall ensure that the subcontract complies with federal requirements, including applicable provisions of 42 CFR § 438.230(b) and 42 CFR § 434.6.

c. Before delegating any of the requirements of this contract, the MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. All subcontracts shall be in writing, shall include any general requirements of this contract that are appropriate to the services being provided, and shall assure that all delegated duties of the MCO under this contract are performed, including any reporting requirements. The subcontract shall also provide for revocation or other sanctions if the subcontractor's performance is inadequate. All subcontracts shall also provide for the right of the DEPARTMENT or other governmental entity to enter the subcontractor's premises to inspect, monitor or otherwise evaluate the work being performed as a delegated duty of this contract, as specified in Section 3.51.

c. With the exception of subcontracts specifically excluded by the DEPARTMENT, all subcontracts shall include verbatim the definitions of Medical Appropriateness / Medically Appropriate and Medically Necessary/Medical Necessity as set forth in Section 1, Definitions. All subcontracts shall require the use of these definitions by subcontractors in all requests for approval of contract services made on behalf of Members. All subcontracts shall also provide that the subcontractor shall make decisions regarding both acute and chronic care according to these definitions.

d. Within fifteen (15) days of the effective date of this contract, the MCO shall provide the DEPARTMENT with a report of those functions under this contract that the MCO anticipates providing through a subcontract. The report shall identify the names of the subcontractors, their addresses and a summary of the services they will be providing. The MCO shall provide, for the DEPARTMENT's review and prior approval, all subcontracts related to the provision of contract services, utilization management/review, quality assessment and program improvement, claims

processing, and marketing. In addition, the DEPARTMENT reserves the right to review and prior approve other subcontracts. If the MCO intends to enter into any additional subcontracts after the MCO's initial compliance with this section, the MCO shall obtain the advance written approval of the DEPARTMENT. The MCO shall provide the DEPARTMENT with a draft of the proposed subcontract thirty (30) days in advance of the completion of the MCO's negotiation of such subcontract. In addition, amendments to any subcontract, excluding those of a technical nature, shall require the pre-review and approval of the DEPARTMENT.

e. All subcontracts shall include provisions for a well-organized transition in the event of termination of the subcontract for any reason. Such provisions shall ensure that an adequate provider network will be maintained at all times during any such transition period and that continuity of care is maintained for all Members.

f. The MCO shall monitor all subcontractors' performance on an ongoing basis and shall conduct a formal review of subcontractors identified in subsection (d) above once a year. All subcontracts identified in subsection (d) above shall include a provision that will require the subcontractor and the MCO to take corrective action when an MCO identifies deficiencies or areas for improvement,.

g. In the event that a subcontract identified in subsection (d) above is terminated, the MCO shall submit a written transition plan to the DEPARTMENT sixty (60) days in advance of the scheduled termination. The transition plan shall include provisions concerning financial responsibility for the final settlement of provider claims and data reporting, which at a minimum shall include a claims aging report prepared in accordance with Section 3.53 (b)(4), Financial Records and Reports of this contract, with steps to ensure the resolution of the outstanding amounts. The MCO shall submit this plan prior to the DEPARTMENT's approval of the replacement subcontractor.

h. All subcontracts identified in subsection (d) above shall include a provision that the MCO will withhold a portion of the final payment to the subcontractor, as a surety bond to ensure compliance under the terminated subcontract.

i. The MCO shall have no right to and shall not assign, transfer or delegate this contract in its entirety, or any right or duty arising under this contract without the prior written approval of the DEPARTMENT. The DEPARTMENT in its discretion may grant such written approval of an assignment, transfer or delegation provided, however, that this paragraph shall not be construed to grant the MCO any right to such approval.

j. This section shall not be construed as restricting the MCO from entering into contracts with providers in order to deliver contract services to Members.

k. Any subcontract shall contain terms that shall require the subcontractor to maintain books, records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices which sufficiently and properly reflect all direct and indirect costs; and that these records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the state, or, where applicable, federal agencies; and that the subcontractor shall retain all such records concerning this contract for a period of three (3) years after the completion and submission of the MCO's annual financial audit to the State.

The Bidder shall:

a. Identify all functions for which the bidder intends to subcontract and the respective subcontractors for those functions.

b. Provide a sample subcontract for proposed subcontractors for those functions identified in subsection (d) above.

3.39 Timely Payment of Claims

The MCO (or any other subcontractor who adjudicates claims) shall pay its providers the amount of any clean claim(s) plus interest at the rate of fifteen percent (15%) per annum (or other amount as stipulated by a provider contract) for any clean claim(s) that the MCO (or subcontractor) pays after forty-five (45) days of receipt of such claim(s). In accordance with Section 3.53 (b)(5), Financial Records and Reports, the MCO shall provide to the DEPARTMENT information related to interest paid beyond the forty-five (45) day timely filing limit or as otherwise stipulated by provider contracts.

The Bidder shall:

a. Describe its procedures to process claims in a timely manner, identify late payments and payments of interest to providers. Include a description of your claims processing system and interplay between manual and systematic claims processing functions.

b. Provide a copy of the section of the provider agreement of provider manual which addresses timely payment requirements, clean claims and other claims processing provisions between the MCO and its network providers.

3.40 Fraud and Abuse

a. The MCO shall not knowingly take any action or fail to take action that could result in an unauthorized benefit to the MCO, its employees, or its subcontractors or to a Member.

b. The MCO commits to preventing, detecting, investigating, and reporting potential fraud and abuse occurrences, and shall assist the DEPARTMENT and the Department of Health and Human Services (HHS) in preventing and prosecuting fraud and abuse in HUSKY A, HUSKY B, and Charter Oak.

c. The MCO acknowledges that the HHS, Office of the Inspector General has the authority to impose civil monetary penalties on individuals and entities that submit false and fraudulent claims to DSS.

d. The MCO shall immediately notify the DEPARTMENT when it detects a situation of potential fraud or abuse, including, but not limited to, the following:

    1. False statements, misrepresentation, concealment, failure to disclose, and conversion of benefits;

    2. Any giving or seeking of kickbacks, rebates, or similar remuneration;

    3. Charging or receiving reimbursement in excess of that provided by the DEPARTMENT; and

4. False statements or misrepresentation made by a provider, subcontractor, or Member in order to qualify for HUSKY A, HUSKY B, or Charter Oak.

e. Upon receipt of written notification from the DEPARTMENT, the MCO shall cease any conduct that the DEPARTMENT deems to be abusive of HUSKY A, HUSKY B, or Charter Oak, and to take any corrective actions requested by the DEPARTMENT.

f. The MCO attests to the truthfulness, accuracy, and completeness of all data submitted to the DEPARTMENT, based on the MCO's best knowledge, information, and belief. This data certification requirement includes encounter data and applies to the MCO's subcontractors.

g. The MCO shall have administrative and management procedures and a mandatory compliance plan to guard against fraud and abuse. The MCO's compliance plan shall include but not necessarily be limited to, the following efforts:

1. Designating a compliance officer and a compliance committee, responsible to senior management;

2. Establishing written policies, procedures and standards that demonstrate compliance with all applicable federal and state fraud and abuse requirements. These include but are not limited to the following:

(a) Regs., Conn. State Agencies § 17b-262-770 through 773, which relate to federal and state requirements regarding false claims and whistleblower protections; and

(b) Sections 1128, 1156, and 1902(a)(68) of the federal Social Security Act.

3. Establishing effective lines of communication between the compliance officer and MCO employees, subcontractors, and providers;

4. Conducting regular reviews and audits of operations to guard against fraud and abuse;

5. Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly;

6. Effectively training and educating employees, providers, and subcontractors about fraud and abuse and how to report it;

7. Effectively organizing resources to respond to complaints of fraud and abuse;

8 Establishing procedures to process fraud and abuse complaints; and

9. Establishing procedures for prompt responses to potential offenses and reporting information to the DEPARTMENT.

h. The MCO shall examine publicly available data, including but not limited to the OIG's List of Excluded Individuals/Entities (LEIE) database to determine whether any potential or current employees, providers, or subcontractors have been suspended or excluded or terminated from the Medicare, Medicaid, or other federal health care program. For reference, the LEIE database is available online at http://www.oig.hhs.gov. The MCO shall comply with, and give effect to, any such suspension, exclusion, or termination in accordance with the requirements of state and federal law.

i. The MCO shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest, five percent (5%) or more, in

the managed care plan, or any subcontractor in which the MCO has a five percent (5%) or more ownership interest.

j. The MCO shall immediately provide full and complete information when it becomes aware of any employee or subcontractor who has been convicted of a civil or criminal offense related to that person's involvement under Medicare, Medicaid, or any other federal or state assistance program prior to entering into or renewing this contract.

k. The MCO shall not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations or from participating in non-procurement activities under regulations or guidelines implementing Executive Order 12549.

Sanction: The DEPARTMENT may impose a sanction, up to and including a Class C sanction for the failure to comply with any provision of this section, or take any other action set forth in Section 6, Corrective Action and Contract Termination of this contract, including terminating or refusing to renew this contract or any other Sanction or remedy allowed by federal or state law.

The Bidder shall:

Describe its fraud and abuse administrative and management policies and procedures and mandatory compliance plan to guard against fraud and abuse.

3.41 Member Charges for Non-Contract Services

a. The MCO shall permit a provider to charge a Member for services, goods or items that are not covered under this contract only if the Member:

   1. Knowingly elects to receive the services, goods or items; and

   2. Enters into an agreement in writing to pay for such services, goods or items prior to receiving them.

b. For purposes of this section, services not covered under this contract include the following:

   1. Services not covered under the Medicaid or SCHIP State Plan or Charter Oak;

   2. Services that are provided in the absence of appropriate authorization; and

   3. Services that are provided out-of-network unless otherwise specified in the contract, policy or regulation (e.g., family planning for HUSKY A Members or emergency services for all Members).

3.42 Limited Coverage of Some Benefits

a. Some contract services are covered only up to a specified dollar or quantity limit, as set forth in Section 5.21, Service Limits and Exclusions, Appendix A (HUSKY A), Appendix B (HUSKY B), Appendix C (Charter Oak), and Appendix L Charter Oak Plan Design Worksheet. This dollar or quantity limit is the allowance for which the MCO shall be responsible. If the Member decides to access these contract services, the MCO shall cover them up to the specified allowance.

b. The MCO shall ensure that the Member is not charged the amount of the covered allowance for the limited contract services described in Appendix A (HUSKY A), Appendix B (HUSKY B), and Appendix C (Charter Oak). However, the MCO shall require Members to comply with the applicable cost-sharing described in Section 5.02, Maximum Annual Out-of-Pocket Limits for Certain Types of Cost-Sharing, 5.11, Deductibles, 5.13, Co-payments, and 5.15, Coinsurance.

c. The Member is responsible for paying any remaining balance beyond the covered allowance consistent with this section.

3.43 Changes Due to a Section 1115 or 1915(b) Freedom of Choice Waiver

The conditions of enrollment described in the contract, including but not limited to enrollment and the right to disenrollment, are subject to change as provided in any waiver under Section 1115 or 1915(b) of the Social Security Act (as amended) obtained by the DEPARTMENT.

3.44 Passive Billing

Capitation payments to the MCO will be based on a passive billing system. The MCO is not required to submit claims for the capitation payment for HUSKY A, HUSKY B, or Charter Oak Members. Capitation payments will be based on MCO membership data as reflected in the enrollment files provided by the DEPARTMENT and enrollment broker to the MCO. On a monthly basis the enrollment broker will provide the MCO with a detailed capitation remittance file.

3.45 Solvency Requirements

a. If the MCO is licensed by the Connecticut Insurance Department, the MCO shall, at all times, maintain capitalization and financial reserves in accordance with Conn. Gen. Stat. § 38a-41 et seq. and Conn. Gen. Stat. § 38a-175 et seq., and as required by the Connecticut Insurance Department.

b. If the MCO is licensed as a health care center by the Connecticut Insurance Department, the MCO shall, at all times, maintain capitalization and financial reserves in accordance with the Connecticut Health Care Centers Act under Conn. Gen. Stat. § 38a-175 et seq. and as required by the Connecticut Insurance Department.

c. If the MCO is not licensed by the Connecticut Insurance Department and the Commissioner of the Department of Social Services exercises his authority in accordance with Conn. Gen. Stat. § 38a-559 and section 23(e)(2),(3) of Public Act 07-02 (June Special Session) (Charter Oak Health Plan) to contract with the MCO, the MCO shall establish and maintain a sequestered capital minimum reserve fund of $500,000 plus two percent (2%) of ongoing annual capitation premiums.

    1. The MCO shall place these funds in a restricted account for the duration of the MCO's existence, to be accessed only in the event such funds are needed to meet unpaid claims liabilities.

2. The MCO shall restrict this account such that any withdrawals or transfers of funds will require signatures of authorized representatives of the MCO and the DEPARTMENT.
3. The MCO shall deposit the initial $500,000 into the account by the beginning of the MCO's first enrollment period.
4. The MCO shall make quarterly deposits into this account so that the account balance is equal to $500,000 plus two percent (2%) of the premiums received during the preceding twelve (12) months.

3.46 Pay-for-Performance

The MCO shall cooperate and participate in a provider Pay-for-Performance (P4P) incentive program. The goal of P4P is to enhance access to health care services by HUSKY and Charter Oak Members and improve program quality and efficiency of the service delivery system through provider practice improvements.

The DEPARTMENT will calculate the P4P performance measures and the MCO's pro-rated share incentive payment to be sent to providers. The MCO's share of the provider incentive payments will be proportional to the MCOs membership.

The MCO shall:

a. Designate a representative to the DEPARTMENT's Pay-for-Performance Core Advisory Team;
b. Participate in the establishment of incentive structures, performance indicators, goals and measures;
c. Encourage participation in P4P by its network providers; and
d. Set aside one percent (1%) of the capitation payments received by the MCO under this contract and use the set aside funds towards its share of the provider incentive payments.

The Bidder shall:

Indicate its intent to meet the requirements listed above.

3.47 Provider Compensation

a. The MCO shall comply with CMS's Physician Incentive Plan (PIP) requirements in 42 CFR § 422.208 and 42 CFR § 422.210. The MCO may operate a PIP only if:
    1. No specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual Member; and
    2. The stop-loss protection and disclosure requirements of 42 CFR § 422.208 and 42 CFR § 422.210 are met.
    b. The MCO shall provide assurance to the DEPARTMENT that the requirements of 42 CFR § 422.208 are met.
c. The MCO shall provide assurance to the DEPARTMENT (1) prior to the effective date of this contract and (2) upon the anniversary or renewal effective date of this contract. The MCO shall provide to a Member upon request information regarding

whether the MCO uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, and whether stop-loss protection is provided.

d. The DEPARTMENT reserves the right to inspect any physician incentive plans.

e. The DEPARTMENT may impose Class C sanctions pursuant to Section 6.05, Monetary Sanctions, for failure to comply with 42 CFR §§ 422.208 and 422.210.

f. Reimbursement by the MCO to federally qualified health centers (FQHCs) shall be at the rate set by the DEPARTMENT.

g. Reimbursement by the MCO to physicians and hospitals shall be at no less than the DEPARTMENT's Medicaid fee schedule.

3.48 Members Held Harmless

a. The MCO shall not hold any HUSKY A, HUSKY B or Charter Oak Member liable for:

   1. The debts of the MCO in the event of the MCO's insolvency;

   2. The cost of contract services to the Member if the DEPARTMENT does not pay the MCO or the DEPARTMENT or the MCO does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement; and/or

   3. Payments for contract services furnished under a contract, referral, or other arrangement, to the extent those payments are in excess of the amount that the Member would owe if the MCO directly provided the service.

3.49 Audit Liabilities

In addition to and not in any way in limitation of the MCO's obligations pursuant to this contract, it is understood and agreed by the MCO that the MCO shall be liable for any finally determined State or Federal audit exceptions and shall return to the DEPARTMENT all payments made under the contract to which exception has been taken or which have been disallowed because of such an exception.

3.50 Insurance

a. The MCO shall procure and maintain such insurance as is required by currently applicable federal and state law and regulation. Such insurance should include, but not be limited to, the following:

   1. Liability insurance (general, errors and omissions, and directors and officers coverage);

   2. Fidelity bonding or coverage of persons entrusted with handling of funds;

   3. Workers compensation; and

   4. Unemployment insurance.

b. The MCO shall name the State of Connecticut as an additional insured party under any insurance, except for professional liability, workers compensation, unemployment insurance, and fidelity bonding maintained for the purposes of this

contract. However, the MCO shall name the State of Connecticut as either a loss payee or additional insured for fidelity bonding or coverage.

c. The MCO shall provide prior notification to the DEPARTMENT of its intent to purchase or modify reinsurance protection for their HUSKY or Charter Oak membership. The MCO shall provide to the DEPARTMENT, the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements for prior approval.

3.51 Inspection of Facilities

a. The MCO shall provide the State of Connecticut and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the MCO's premises or other places, including the premises of any subcontractor, where work under this contract is performed, to inspect, monitor or otherwise evaluate work performed pursuant to this contract. The MCO shall provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties. The DEPARTMENT will request access in advance in writing except in case of suspected fraud and abuse.

b. In the event right of access is requested under this section, the MCO or subcontractor shall upon request provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort.

c. The DEPARMENT will give the MCO ten (10) business days to respond to any findings of an audit before the DEPARTMENT finalizes its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

3.52 Examination of Records

a. The MCO and its subcontractors shall develop and keep such records as are required by federal or state law or other authority or as the DEPARTMENT determines necessary or useful for assuring quality performance of this contract. The DEPARTMENT shall have an unqualified right of access to such records.

b. The MCO and its subcontractors shall permit audits or reviews by the DEPARTMENT and HHS or their agent(s) of the MCO's records related to the performance of this contract.

c. The MCO shall provide the DEPARTMENT with reasonable access to records the MCO maintains for the purposes of this contract. The DEPARTMENT will request access in writing except in cases of suspected fraud and abuse. The MCO shall make all requested medical records available within thirty (30) days of the DEPARTMENT’s request. Any contract with a subcontractor shall include a provision specifically authorizing access in accordance with the terms set forth in Section 3.51, Inspection of Facilities.

d. The MCO shall grant the DEPARTMENT access to and use of any data files retained or created by the MCO for systems operation under this contract.

e. The MCO, for purposes of audit or investigation, shall provide the State of Connecticut, the Secretary of HHS and his or her designated agent, and any other

legally authorized governmental entity or their authorized agents access to all the MCO's materials and information pertinent to the services provided under this contract, at any time, until the expiration of three (3) years from the completion date of this contract as extended.

f. The State may record any information and make copies of any materials necessary for the audit.

g. The MCO and its subcontractors shall retain financial records, supporting documents, statistical records and all other records supporting the services provided under this contract for a period of five (5) years from the completion date of this contract. If any litigation, claim or audit commences before the expiration of the five (5) year period, the MCO shall retain all records until all litigation, claims or audit findings involving the records have been resolved.

3.53 Financial Records and Reports

a. The MCO shall maintain for the purpose of this contract, an accounting system that conforms to generally accepted accounting principles (GAAP).

b. The MCO shall provider all reports in formats developed by the DEPARTMENT with separate sections for HUSKY A, HUSKY B, and Charter Oak. The MCO should anticipate the DEPARTMENT's modification of these requirements so as to enable the DEPARTMENT to respond to inquiries that the DEPARTMENT receives regarding the financial status of HUSKY or Charter Oak, to determine the relationship of capitation payments to actual appropriations for HUSKY and Charter Oak, and to allow for proper oversight of fiscal issues related to HUSKY and Charter Oak. The MCO shall cooperate with the DEPARTMENT(s) to meet these objectives. The following is a partial list of required reports:

   1. Audited financial reports with an income statement by MCO HUSKY/Charter Oak line of business. If the MCO is licensed as a health care center or insurance company, then the MCO shall conduct and report the annual audited financial reports for the MCO and the audited financial reports per MCO HUSKY/Charter Oak line of business in accordance with Conn. Gen. Stat. § 38a-54. If the MCO is not licensed as a health care center or insurance company, then the MCO shall complete the annual audited financial reports for the MCO and the audited financial reports per MCO line of business in accordance with generally accepted auditing standards.

      The MCO may elect to combine HUSKY A, HUSKY B, and Charter Oak in the audited financial statement. If this election is made, the MCO shall also submit the following: a separate unaudited income statement for HUSKY A, HUSKY B, and Charter Oak which will be compared to the audited financial statement.

   2. Unaudited financial reports, HUSKY/Charter Oak line of business (formats shown in Appendix H, Unaudited Quarterly Financial Reports). The MCOS shall submit reports quarterly, forty-five (45) days subsequent to the end of each quarter. Every line of the requested report shall contain a dollar figure or an indication that said line is not applicable.

   3. Annual and Quarterly Statements. If the MCO is licensed as a health care center or insurance company, the MCO shall submit Annual and Quarterly Statements to the Connecticut Insurance Department in accordance with Conn. Gen. Stat. §

38a-53. The MCO shall submit one copy of each statement to the DEPARTMENT in accordance with the Connecticut Insurance Department submittal schedule.

4. Claims Aging Inventory Report (format shown in Appendix G, Claims Inventory, Aging Reports), or any other format approved by the DEPARTMENT). The Claims Aging Inventory Report will include all HUSKY/Charter Oak claims outstanding as of the end of each quarter by type of claim, claim status and aging categories. If a subcontractor is used to provide services and/or adjudicate claims, the MCO shall provide a Claims Aging Inventory Report in the required format for each subcontractor that has claims outstanding. The Claims Aging Inventory Reports shall be submitted to the DEPARTMENT forty-five (45) days subsequent to the end of each quarter.
5. Denied Claims Report. The MCO shall also submit a Denied Claims report, to include all HUSKY/Charter Oak provider claims denied, by reason as of the end of each quarter.
6. Claims Turn Around Time Report (format shown in Appendix F, Claims Inventory, Aging Reports) or any other format approved by the DEPARTMENT). For those claims processed in forty-six (46) days or more, the report shall indicate if interest was paid in accordance with Section 3.39, Timely Payment of Claims, of this contract. If a subcontractor is used to provide services and/or adjudicate claims, the MCO shall provide a Claims Turn Around Time Report in the required format for each subcontractor that has claims outstanding. The Claims Turn Around Time Report shall be submitted to the DEPARTMENT forty-five (45) days subsequent to the end of each quarter.

c. Consistent with Section 3.52, Examination of Records, the MCO shall maintain accounting records in a manner that enables the DEPARTMENT to easily audit and examine any books, documents, papers and records maintained in support of the contract. The MCO shall make all such documents available to the DEPARTMENT at its request, and the MCO shall ensure that these documents are clearly identifiable as pertaining to the contract.

d. The MCO shall make available on request all financial reports required by the terms of any current contract with any other state agency(s) provided said agency agrees that such information may be shared with the DEPARTMENT.

3.54 Confidentiality

a. The MCO shall maintain the confidentiality of applicant and Members records (including but not limited to medical records) in conformance with this contract and federal and state law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320 d-2 et seq. and the implementing privacy regulations at 45 CFR Parts 160 and 164; 42 CFR § 434.6(a)(8); the Connecticut Insurance Information and Privacy Act; Conn. Gen. Stat. § 17b-90; Conn. Gen. Stat. § 38a-975 et seq.; and, as applicable, the Gramm-Leach-Bliley Act, 15 U.S.C. § 6801 et seq.

b. The MCO shall regard as strictly confidential all material and information relative to individual applicants or Members. This shall include any information that the

DEPARTMENT provided to the MCO in performance of the contract, whether in verbal, written, recorded magnetic media, or other form.

c. The MCO shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with federal and state law. This includes procedures regarding access to patient information, records, and data. All requests for data or patient records for participation in studies, whether conducted by the MCO or outside parties, shall be subject to approval by the DEPARTMENT.

d. The MCO shall not release any information provided by the DEPARTMENT or providers or any information generated by the MCO without the express consent of the Contract Administrator, except as specified in this contract and as permitted by applicable federal and state law.

3.55 Compliance with Applicable Laws, Rules, Policies, and Bulletins

The MCO in performing this contract shall comply with all applicable federal and state laws, regulations, provider bulletins and written policies, as set forth in the DEPARTMENT's provider manuals or issued as policy transmittals to the MCO. This shall include but not be limited to compliance with licensing requirements. In the provision of services under this contract, the MCO and its subcontractors shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the contract. This includes, but is not limited to Titles XIX and XXI of the Social Security Act and Title 42 of the Code of Federal Regulations.

3.56 MCO Licensure Requirements

If the MCO is licensed by the Connecticut Insurance Department, it shall maintain such licensure at all times during the period of this contract.

3.57 Advance Directives

a. The MCO shall comply with the provisions of 42 CFR § 422.128 relating to written policies and procedures for advance directives. The MCO shall:

   1. Maintain written policies and procedures that meet the requirements for advance directives in Subpart I of 42 CFR Part 489;

   2. Maintain policies and procedures for all adults receiving medical care through the MCO;

   3. Provide each adult Member with written information on advance directives policies with respect to the following:

      a) Rights under State of Connecticut law, including a description of Conn. Gen. Stat. §§19a-570-580d;

      b) The MCO's policies regarding the implementation of those rights, including any limitations regarding the implementation of advance directives as a matter of conscience; and

      c) That complaints concerning noncompliance with advance directive requirements may be filed with the Connecticut Department of Public Health.

4. Provide each adult Member with information on changes in Connecticut law regarding advance directives as soon as possible, but no later than ninety (90) days after the effective date of the change.

3.58 Freedom of Information

a. Due regard will be given for the protection of proprietary information contained in all documents received by the DEPARTMENT; however, the MCO is aware that all materials associated with the contract are subject to the terms of the state Freedom of Information Act, Conn. Gen. Stat. § 1-200 et seq., and all rules, regulations and interpretations resulting therefrom. When materials are submitted by the MCO or a subcontractor to the DEPARTMENT and the MCO or subcontractor believes that the materials are proprietary or confidential in some way and that they should not be subject to disclosure pursuant to the Freedom of Information Act, it is not sufficient to protect the materials from disclosure for the MCO to state generally that the material is proprietary in nature and therefore, not subject to release to third parties. If the MCO or the MCO's subcontractor believes that any portions of the materials submitted to the DEPARTMENT are proprietary or confidential or constitute commercial or financial information, given in confidence, those portions or pages or sections the MCO believes to be proprietary must be specifically identified as such. Convincing explanation and rationale sufficient to justify each claimed exemption from release consistent with Conn. Gen. Stat. § 1-210 must accompany the documents when they are submitted to the DEPARTMENT. The rationale and explanation must be stated in terms of the prospective harm to the MCO's or subcontractor's competitive position that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above cited statue. The final administrative authority to release or exempt any or all material so identified by the MCO or the subcontractor rests with the DEPARTMENT. The DEPARTMENT is not obligated to protect the confidentiality of materials or documents submitted to it by the MCO or the subcontractor if said materials or documents are not identified in accordance with the above-described procedure.

b. The MCO understands the DEPARTMENT's need for access to eligibility and paid claims information and is willing to provide such data relating to the MCO to accommodate that need. The MCO is committed to providing the DEPARTMENT access to all information necessary to analyze cost and utilization trends; to evaluate the effectiveness of provider networks, benefit design, and medical appropriateness; and to show how the HUSKY/Charter Oak population compares to the MCO's enrolled population as a whole. The MCO and the DEPARTMENT each understand and agree that the systems, procedures and methodologies and practices used by the MCO, its affiliates and agents in connection with the underwriting, claims processing, claims payment and utilization management functions of the MCO, together with the underwriting, provider network, claims processing, claims history and utilization data and information related to the MCO, may constitute information which is proprietary to the MCO and/or its affiliates (collectively, the "Proprietary Information"). Accordingly, the DEPARTMENT acknowledges that the MCO shall not be required to divulge Proprietary Information if such disclosure would jeopardize or impair its relationships with providers or suppliers or would materially adversely affect the MCO's or any of its Affiliates' ability to service the needs of its customers or the DEPARTMENT as provided under this contract unless the DEPARTMENT

determines that such information is necessary in order to monitor contract compliance or to fulfill, Sections 3.32, Internal and External Quality Assurance and 3.51, Inspection of Facilities, of this contract. The DEPARTMENT agrees not to disclose publicly and to protect from public disclosure any proprietary or trade secret information provided to the DEPARTMENT by the MCO and/or its Affiliates' under this contract to the extent that such information is exempted from public disclosure under the Connecticut Freedom of Information Act.

3.59 Nonsegregated Facilities

a. As used in this certification, the term "segregated facilities" includes any waiting rooms, restaurants and other eating areas, parking lots, drinking fountain, recreation or entertainment areas, transportation, and housing facilities provided for employees which are segregated on the basis of race, creed, color, national origin, ancestry, sex, marital status, age, lawful source of income, mental retardation, mental or physical disability or sexual orientation.

b. The MCO shall not maintain or provide for its employees any segregated facilities at any of its establishments. Further, the MCO shall not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained.

c. The MCO agrees that a breach of this certification is a violation of Equal Opportunity in Federal employment. In addition, the MCO shall comply with the Federal Executive Order 11246 entitled "Equal Employment Opportunity" as amended by Executive Order 11375 and as supplemented in the United States Department of Labor Regulations (41 CFR § Part 30).

d. Except in cases in which the MCO has obtained identical certifications from proposed subcontractors for specific time periods, the MCO shall obtain identical certifications from proposed subcontractors which are not exempt from the provisions for Equal Employment Opportunity; retain such certifications in its files; and forward a copy of this clause to such proposed subcontractors (except where the proposed subcontractors have submitted identical certifications for specific time periods).

3.60 Civil Rights

a. The MCO shall comply with all federal and state laws relating to non-discrimination and equal employment opportunity, including but not limited to the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; 47 U.S.C. § 225; 47 U.S.C. § 611; Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e; Title IX of the Education Amendments of 1972; Title VI of the Civil Rights Act, 42 U.S.C. § 2000d et seq.; the Civil Rights Act of 1991; § 504 of the Rehabilitation Act, 29 U.S.C. §794 et seq.; the Age Discrimination in Employment Act of 1975, 29 U.S.C. §§621-634; regulations issued pursuant to those Acts; and the provisions of Executive Order 11246 dated September 26, 1965 entitled "Equal Employment Opportunity" as amended by Federal Executive Order 11375, as supplemented in the United States Department of Labor Regulations (41 CFR Part 60-1 et seq., Obligations of Contractors and Subcontractors). The MCO shall also comply with Conn. Gen. Stat. §§4a-60, 4a-61, 31-51d, 46a-64, 46a-71, 46a-75 and 46a-81.

b. The MCO shall not deny persons employment, deny them the right of participation, deny them benefits or otherwise subject them to discrimination on the basis of race, creed, color, national origin, ancestry, sex, marital status, age, lawful source of income, mental retardation, mental or physical disability or sexual orientation under any program or activity connected with the implementation of this contract. Further, the MCO and its providers shall not discriminate between Members under this contract and other members of the MCO.

c. The MCO shall conduct all hiring in connection with this contract on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The MCO shall provide for equal employment opportunities in its employment practices. in accordance with Federal Executive Order 11246, dated September 24, 1965 entitled "Equal Employment Opportunity", as amended by Federal Executive Order 11375 and as supplemented in the United States Department of Labor Regulations, 41 CFR Part 60-1, et seq.

d. The MCO shall comply with the Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Policy, which mandates that all Members have equal access to the best health care, regardless of race, color, national origin, age, sex, or disability. Specifically, the MCO shall:

    1. Ensure that its subcontractors and providers render services to Members in a non-discriminatory manner.

    2. Ensure that Members are not excluded from participation in or denied the benefits of HUSKY A, HUSKY B, or Charter Oak because of prohibited discrimination.

    3. Within the resources available through the capitation rate, allocate financial resources to ensure equal access and prevent discrimination on the basis of race, color, national origin, age, sex, or disability.

    4. Provide to the DEPARTMENT or to CMS, upon request, any available data or information regarding these civil rights concerns.

    5. Unless otherwise specified by the contract, provide contract services to Members under this contract in the same manner as those services are provided to other members of the MCO, although delivery sites, services and provider payment levels may vary.

    6. Ensure that the locations of facilities and practitioners providing health care services to Members are sufficient in terms of geographic convenience to low-income areas, handicapped accessibility and proximity to public transportation routes, where available.

    7. Ensure that its network providers offer hours of operation that are no less than those offered to the MCO's commercial members (if any) or to the provider's other patients.

    8. Use hiring processes that foster the employment and advancement of qualified persons with disabilities.

e. The MCO acknowledges that in order to achieve the civil rights goals set forth in the CMS Civil Rights Compliance Policy, CMS has committed itself to incorporating civil rights concerns into the culture of its agency and its programs and has asked all of its partners, including the DEPARTMENT and the MCO, to do the same. The MCO further acknowledges that CMS will be including the following civil rights concerns

into its regular program review and audit activities: collecting data on access to and participation of minority and disabled Members; furnishing information to Members, subcontractors, and providers about civil rights compliance; reviewing CMS publications, program regulations, and instructions to assure support for civil rights; and initiating orientation and training programs on civil rights.

f. Nothing in this section shall preclude the implementation of a provider lock-in feature by the MCO, subject to the DEPARTMENT's prior, written approval.

4. PROVISIONS APPLICABLE TO HUSKY A ONLY

4.01 Specialized Outpatient Services for Children under DCF Care and Out-of-State Residential Treatment – (HUSKY A)

a. The MCO shall pay for a comprehensive multi-disciplinary examination for initial placement only, for each HUSKY A Member under the age of twenty-one (21) entering the care of the Department of Children and Families (DCF), within thirty (30) days of placement into out-of-home care.

   1. The multi-disciplinary examination shall consist of a thorough assessment of the Member's functional, medical, developmental, educational, and mental health status.
   2. The evaluation shall identify any additional specialized diagnostic and therapeutic needs within each area of the assessment.
   3. Physicians and other medical and mental health providers specializing in the assessment areas shall conduct the multi-disciplinary examination.
   4. Each multi-disciplinary examination shall occur at a single location.
   5. All components of the examination shall be performed on the same day, excluding additional needed examinations, unless otherwise indicated.
   6. The multi-disciplinary examination provider shall report the findings and conclusions of the examination in a form acceptable to DCF. The report must be received by DCF within fifteen (15) days of the examination. The provider shall also provide updates to DCF on any additional examinations.

b. The MCO's providers shall provide foster parent training on the use of special equipment or medications as needed.

c. The MCO shall require regular collaboration between providers and DCF Regional Offices and Central Office medical, mental health and social work staff and consultants. The MCO shall assign staff to act as liaisons to identify, address and resolve health care delivery issues, barriers to comprehensive care and other problem areas. DCF shall specify the contact persons by name, title and phone number who will be available for periodic meetings between DCF and the MCO and shall facilitate the initiation of these meetings with the MCO.

d. When DCF places a child in an out-of-state residential treatment facility or foster care, either at initial enrollment or during an enrollment period with the MCO, the MCO shall be financially responsible for services not covered in the per diem rate of the facility.

The Bidder shall:

Describe its process and organization structure to support the collaboration between its providers and DCF to identify, address and resolve health care delivery issues, barriers and other problem areas.

4.02 Persons with Special Health Care Needs

a. The DEPARTMENT will provide to the MCO information that identifies HUSKY A Members who are:

   1. Eligible for Supplemental Security Income;
   2. Over sixty-five (65) years of age;
   3. Children receiving foster care or otherwise in an out-of-home placement or receiving Title IV E foster care or adoption services; and
   4. Children enrolled in Title V's Children with Special Health Care Needs program.

b. The MCO shall conduct an assessment of these individuals and HUSKY A Members with special health care needs and make a referral to the Member's PCP to develop a treatment plan, as appropriate.

c. The MCO shall have a mechanism in place to allow HUSKY A Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

4.03 Grievances

a. The MCO shall implement and maintain procedures to manage grievances for HUSKY A Members. Grievances are expressions of dissatisfaction about any matter, other than those matters that qualify as an action as defined in Section 4.04, Notices of Action and Continuation of Benefits.. The subject matters of grievances may include, but are not limited to, quality of care, rudeness by a provider or MCO staff person or failure to respect a HUSKY A Member's rights.

b. The MCO shall maintain adequate records to document the filing of a grievance, the actions taken, the MCO personnel involved and the resolution. The MCO shall report grievances in a mutually agreed upon format as requested by the DEPARTMENT.

c. A HUSKY A Member, or a provider acting on a HUSKY A Member's behalf, may file a grievance either orally or in writing. The MCO shall acknowledge the receipt of each grievance and provide reasonable assistance with the process, including but not limited to providing oral interpreter services and toll free numbers with TTY/TTD and interpreter capability.

d. If the grievance involves a denial of expedited review of an appeal or some other clinical issue, the grievance shall be reviewed within one business day by a health care professional with appropriate clinical expertise.

e. The MCO shall resolve each grievance as expeditiously as the Member's health requires. If the HUSKY A Member filed the grievance orally, the MCO may resolve the grievance orally, but shall maintain documentation of the grievance and its resolution. If the Member filed a written grievance, the resolution shall be in writing. If applicable, each grievance shall be handled by an individual who was not involved in any previous level of decision-making. The MCO shall resolve each grievance in ninety (90) or fewer days.

4.04 Notices of Action and Continuation of Benefits

a. The MCO or its subcontractor (as duly authorized by the MCO) shall mail a written notice of action (NOA) to a HUSKY A Member whenever the MCO takes action upon a request for medical services from the Member's treating PCP, or other treating provider, functioning within his or her scope of practice as defined under state law. For purposes of this requirement, an "action" includes:

   1. The denial or limited authorization of a requested service, including the type or level of service;
   2. The reduction, suspension or termination of a previously authorized service;
   3. The denial, in whole or in part, of payment for a service;
   4. The failure to act within the timeframes for utilization review decisions, as described in Section 3.35, Utilization Management and Prior Authorization Requirements, and
   5. The failure to provide access to services in a timely manner as required by Section 3.14, PCP and Specialist Selection, Scheduling, and Capacity, or the failure to provide access to consultations and specialist referrals within three (3) months.

b. The NOA requirements shall apply to all categories of health care services including transportation to medically necessary appointments. The NOA requirements apply equally to requests for contract services and non-contract services.

c. When a Member has both medical and behavioral health conditions or both medical and dental conditions and an MCO action affects both conditions, the MCO shall, as necessary, consult with the Dental or BHP ASO in preparation for the hearing.

d. The MCO shall issue an NOA described in (a)(3) above if the denial of payment for services already rendered may or will result in the Member being held financially responsible including, but are not limited to:

   1. The provision of emergency services that do not appear to meet the prudent layperson standard;
   2. The provision of services outside of the United States; and
   3. The provision of non-contract services with the Member's written consent as described in Section 3.41, Member Charges for Non-Contract Services.

e. The MCO shall not issue an NOA for the denial of payment for contract services that have already been provided to the Member if the denial is based on a procedural or technical issue, and the Member may not be held financially liable for the services including, but not limited to:

   1. A provider's failure to comply with prior authorization rules for services that the Member has already received; and
   2. Incorrect coding or late filing by a provider for services that the Member has already received.

   Nothing herein shall relieve the MCO from its responsibility to hold a Member harmless for the cost of contract services and its responsibility to ensure that the MCO's network providers hold a Member harmless for the cost of contract services.

f. The MCO shall issue an NOA for actions described in (a)(5) above only if the Member notifies the MCO of his or her inability to obtain timely access to services.

1. The MCO shall provide the Member with immediate assistance in accessing the services.
2. If the Member has been unable to access emergency services, the MCO shall issue an NOA immediately.
3. The MCO shall issue an NOA for non-emergent services, if a Member contacts the MCO concerning the inability to access a contract service within the timeframes referenced in (a)(5) above, and three (3) business days later the Member has not accessed or made arrangements for receiving the service that are satisfactory to the Member,

g. The MCO shall issue an NOA if the MCO approves a good or service that is not the same type, amount, duration, frequency or intensity as that requested by the provider, consistent with current DEPARTMENT policy.

h. The MCO shall determine the written language understood by the Member if a Member reads only a language other than English. For Members who are unable to read English, the MCO shall provide an NOA in accordance with Section 3.26, Linguistic Access, and Section 3.27, Services for Members.

i. The MCO shall mail an advance NOA for a termination, suspension or reduction of a previously authorized service to a Member at least ten (10) days before the date of any action described in (a) above, consistent with current DEPARTMENT policy. The MCO may shorten the period of advance notice to five (5) days before the date of action if:

1. The MCO has facts indicating that the action should be taken because of probable fraud by the Member; and
2. The facts have been verified, if possible, through reliable secondary sources.

j. For any Member who is under the care of the Department of Children and Families (DCF), the MCO shall send the NOA to the Member's foster parents and the DCF contact person specified by the DEPARTMENT**.**

k. All notices related to actions described in (a) above shall clearly state or explain:

1. The action the MCO intends to take or has taken;
2. The reasons for the action;
3. The statute, regulation, the DEPARTMENT's Medical Services Policy section, or when there is no appropriate regulation, policy or statute, the contract provision that supports the action;
4. The address and toll-free number of the MCO's Member Services Department;
5. The Member's right to challenge the action by filing an appeal and requesting an administrative hearing;
6. The procedure for filing an appeal and for requesting an administrative hearing;
7. How the Member may obtain an appeal form and, if desired, assistance in completing and submitting the appeal form;
8. That the Member will lose his or her right to an appeal and administrative hearing if he or she does not complete and file a written appeal form with the DEPARTMENT within sixty (60) days from the date the MCO mailed the initial NOA;

9. That the MCO shall issue a decision regarding an appeal by the date that the administrative hearing is scheduled, but no more than thirty (30) days following the date the DEPARTMENT receives it;
10. That, if the Member files an appeal he or she is entitled to meet with or speak by telephone with a DEPARTMENT representative and the MCO representative who will decide the appeal. The Member is entitled to submit additional documentation or written material for the MCO's consideration;
11. That the Member may proceed automatically to an administrative hearing if he or she is dissatisfied with the MCO's appeal decision concerning the denial of contract services or a reduction, suspension, or termination of ongoing contract services, or if the MCO fails to render an appeal decision by the date the administrative hearing is scheduled;
12. That at an administrative hearing, the Member may represent himself or herself or use legal counsel, a relative, a friend, or other spokesperson;
13. That if the Member obtains legal counsel who will represent the Member during the appeal or administrative hearing process, the Member must direct his or her legal counsel to send written notification of the representation to the MCO and the DEPARTMENT;
14. That if the circumstances require advance notice, the Member's right to continuation of previously authorized contract services, provided that the Member files an appeal/request for administrative hearing form with the DEPARTMENT on or before the intended effective date of the MCO's action or within ten (10) calendar days of the date the NOA is mailed to the Member, whichever is later;
15. The circumstances under which expedited resolution is available and how to request expedited resolution; and
16. Any other information specified by the DEPARTMENT.

l. The MCO shall mail the NOA within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid contract services, ten (10) days in advance of the effective date;
2. For standard authorization decisions to deny or limit services, as expeditiously as the Member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for services;
3. If the MCO extends the fourteen (14) day time frame for denial or limitation of a service as permitted in this Section as expeditiously as the Member's condition requires and no later than the date the extension expires;
4. For service authorization decisions not reached within the timeframes in this section (which constitutes a denial and thus is an adverse action), on the date the timeframe expires;
5. For expedited service authorization decisions as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for services;
6. For denial of payment where the Member may be held liable, at the time of any action affecting the claim; and

7. For failure to provide timely access to services as expeditiously as the Member's health requires, but no later than three (3) business days after the Member contacts the MCO.

m. The ten (10) day advance notice requirements do not apply to the circumstances described in 42 CFR § 431.213. An NOA need not be sent to the Member ten (10) days in advance of the action, but may be sent no later than the date of action and will be considered an exception to the advance notice requirement, if the action is based on any of the following circumstances:

1. A denial of services;
2. The MCO has received a clear, written statement signed by the Member that:
   a) The Member no longer wishes to receive the goods or services; or
   b) The Member gives information which requires the reduction, suspension, or termination of the goods or services, and the Member indicates that he or she understands that this must be the result of supplying that information; and
3. The Member has been admitted to an institution where he or she is ineligible for the goods or services. In this instance, the Member must be notified on the notice of admission that any goods or services being reduced, suspended, or terminated will be reevaluated for medical necessity upon discharge, and the Member will have the right to appeal any post-discharge decisions.

If the circumstances are an exception to the advance notice requirement as set forth above the Member does not have the automatic right to continuation of ongoing goods or services. In these circumstances, however, and in any instance in which the MCO fails to issue an advance notice when required, the reduced, suspended, or terminated goods and services shall be reinstated if the Member files a written appeal form with the DEPARTMENT within ten (10) days of the date the notice is mailed to the Member.

n. The MCO shall follow the requirements for continuation of services set forth in 42 CFR § 438.420. The right to continuation of ongoing contract services applies to the scope of services previously authorized. The right to continuation of services does not apply to subsequent requests for approval that result in denial of the additional request or re-authorization of the request at a different level than requested. For example, the right to continuation of services does not apply to a request for additional home health care services following the expiration of the approved number of home health visit. The MCO shall treat such requests as a new service authorization request and provide a denial notice.

o. The MCO is not required to issue an NOA when decisions regarding the treatment of a Member do not constitute an action by the MCO. This would include situations in which the Member's PCP or treating physician:

1. Refuses to prescribe (or prescribes an alternative to) a particular service sought by a member; and/or
2. Orders the reduction, suspension, or termination of goods or services.

p. The MCO shall conduct an expedited review of a HUSKY A Member's request, according to the timeframe in Section 4.06(e), Expedited Review and Administrative Hearings, if the Member disagrees with the action of the provider described in (o) above and contacts the MCO to request authorization for the service.

1. The MCO shall issue an NOA if the MCO affirms the provider's action to deny, terminate, reduce or suspend the service.
2. If the HUSKY A Member requests an appeal and hearing, the MCO shall continue authorization for the services, to the extent services were previously authorized, unless the MCO determines that continued provision of the services could be harmful to the Member.
3. The MCO shall also advise the HUSKY A Member of his or her right to a second opinion from another provider. Because only a licensed health care provider, and not the MCO, may prescribe or provide medical services, the HUSKY A Member may not be able to receive some or all of the requested contract services while the appeal is pending.
4. If the MCO approves the HUSKY A Member's request for the good or service, the MCO shall inform the Member of the approval and shall inform the Member of the right to a second opinion.

q. The DEPARTMENT will provide standardized NOA forms to be used by the MCO and its subcontractors. The DEPARTMENT will also provide standardized appeal/hearing request forms to be used by the MCO and its subcontractors. The MCO and its subcontractors shall not alter the standard format of either form without prior, written approval of the DEPARTMENT.

r. The DEPARTMENT will conduct random reviews and audits of the MCO and its subcontractors, as appropriate, to ensure that the MCO sends accurate, complete and timely NOAs to Members.

Sanction: If the DEPARTMENT determines during any audit or random monitoring visit to the MCO or one of its subcontractors that an NOA fails to meet any of the criteria set forth herein, the DEPARTMENT may impose a strike towards a Class A sanction sin accordance with Section 605, monetary Sanctions. If the deficiencies which give rise to a Class A sanction continue for a period in excess of ninety (90) days, the DEPARTMENT may impose a Class B sanction.

4.05 Appeals and Administrative Hearing Processes

a. The MCO shall have a timely and organized appeals process. The appeals process shall be available for resolution of disputes between the MCO and its HUSKY A Members concerning the MCO's actions.

b. The MCO shall develop written policies and procedures for its appeals process. Those policies and procedures must be prior approved by the DEPARTMENT in writing and shall include the elements specified in this contract. The MCO shall not be excused from providing the elements specified in this contract pending the DEPARTMENT's written approval of the MCO's policies and procedures.

c. The MCO shall maintain a record keeping system for appeals that shall include a copy of the appeal, the response, the resolution, and supporting documentation.

d. The MCO shall ensure that network providers and subcontractors are familiar with the appeal process and shall provide information on the process to providers and subcontractors. The MCO shall provide information on the appeal process to its providers and subcontractors at the time it enters into contracts or subcontracts. The MCO shall ensure that appeal forms are available at each primary care site. At a

minimum, appeals assistance shall include providing forms on request, assisting the HUSKY A Member in filling out the forms upon request, and sending the completed form to the DEPARTMENT upon request.

e. Consistent with Section 3.26, Linguistic Access, and section 3.27, Services for Members, the MCO shall develop and make available to HUSKY A Members and potential HUSKY A Members appropriate alternative language versions of all appeals materials. These materials include but are not limited to, the standard information contained in NOA and appeals forms. The DEPARTMENT must approve such materials in writing.

f. A HUSKY A Member may request an appeal either orally or in writing. When requesting an appeal orally, unless the HUSKY A Member is seeking an expedited appeal review, the Member must follow up an oral request in writing. The MCO shall advise any HUSKY A Member who requests an appeal orally, that the Member must file a written appeal within sixty (60) days of the NOA in order to receive an administrative hearing and the Member must file an appeal within ten (10) days of the mailing of the NOA or the effective date of the intended action in order to continue previously authorized services pending the appeal and hearing. In all other respects, the MCO shall use a unified process for pursuing an appeal and for requesting an administrative hearing. The MCO and the DEPARTMENT shall treat the filing of a written appeal as a simultaneous request for an administrative hearing. The MCO shall attempt to resolve appeals at the earliest point possible. If the MCO is not able to render a decision by the time the administrative hearing is scheduled, the HUSKY A Member will automatically proceed to the administrative hearing.

g. The HUSKY A Member, the HUSKY A Member's authorized representative, or the HUSKY A Member's conservator may file an appeal on a form approved by the DEPARTMENT. A provider, acting on behalf of the HUSKY A Member and with the Member’s written consent, may file an appeal. A provider may not file an administrative hearing request on behalf of a HUSKY A Member unless the authorized representative requirements in DSS Uniform Policy Manual Section 1525.05 are met. The MCO shall request a copy of the written consent from the HUSKY A Member. Appeals shall be mailed or faxed to a single address within the DEPARTMENT. The appeal form shall state both the mailing address and fax number at the DEPARTMENT where the form must be sent. If the MCO or it’s subcontractor receive an appeal directly from a HUSKY A Member or the HUSKY A Member's authorized representative or conservator, the MCO shall date stamp and fax the appeal to the appropriate fax number at the DEPARTMENT within two (2) business days.

h. Within thirty (30) days of receipt of a written appeal, the DEPARTMENT will schedule an administrative hearing and notify the HUSKY A Member and MCO of the hearing date and location. If a HUSKY A Member is disabled, the hearing may be scheduled for the HUSKY A Member’s home, if requested by the HUSKY A Member.

i. The DEPARTMENT will date stamp and forward the appeal by fax to the MCO within two (2) business days of receipt. The fax to the MCO will include the date the HUSKY A Member mailed the appeal to the DEPARTMENT. The postmark on the envelope will be used to determine the date the appeal was mailed.

j. An individual or individuals having final decision-making authority shall conduct the MCO's review of the appeal. Any appeal stemming from an action based on a determination of medical necessity or involving any other clinical issues shall be

decided by one or more physicians who were not involved in making that medical determination. All the documentation of the review conducted by the physicians shall be signed and entered into the hearing summary.

k. The MCO shall decide an appeal on the basis of the written documentation available unless the HUSKY A Member requests an opportunity to meet with the individual or individuals making that determination on behalf of the MCO and/or requests the opportunity to submit additional documentation or other written material. The HUSKY A Member shall have a right to review his or her MCO record, including medical records and any other documents or records considered during the appeal process. The HUSKY A Member's right to access medical records shall be consistent with HIPAA privacy regulations and any applicable state or federal law.

l. If the HUSKY A Member wishes to meet with the decision maker, the meeting can be held via the telephone or at a location accessible to the HUSKY A Member, including the HUSKY A Member's home if requested by a disabled HUSKY A Member or any of the DEPARTMENT's office locations through video conferencing, subject to approval of the DEPARTMENT's Regional Offices. The MCO shall invite a representative of the DEPARTMENT to attend any such meeting.

m. The MCO shall mail to the HUSKY A Member a written appeal decision, described below, with a copy to the DEPARTMENT, by the date of the DEPARTMENT's administrative hearing as expeditiously as the Member's health condition requires, but no later than thirty (30) days from the date on which the appeal was received by the DEPARTMENT. If the Member is dissatisfied with the MCO's decision regarding the denial, reduction, suspension, or termination of contract services, or if the MCO does not render a decision by the time of the administrative hearing, the Member may automatically proceed to the administrative hearing.

n. The MCO's written appeal decision shall include the HUSKY A Member's name and address; the provider's name and address; the MCO name and address; a complete description of the information or documents reviewed by the MCO; a complete statement of the MCO's findings and conclusions, including the section number and text of any contractual provision or DEPARTMENTAL policy provision that is relevant to the appeal decision; and a clear statement of the MCO disposition of the appeal.

o. As part of its written appeal decision, the MCO shall remind the HUSKY A Member that:

    1. If the HUSKY A Member is dissatisfied with the MCO's appeal decision, the DEPARTMENT has already reserved a time to hold an administrative hearing concerning that decision;

    2. The HUSKY A Member has the right to automatically proceed to the administrative hearing, and that the MCO shall continue previously authorized contract services pending the administrative hearing decision, provided the HUSKY A Member filed their appeal within ten (10) days of the date of the NOA;

    3. If the appeal pertains to the suspension, reduction, or termination of contract which have been maintained during the appeals process, and the MCO's appeals decision affirms the suspension, reduction, or termination of contract services, those contract services will be suspended, reduced, or terminated in accordance with the MCO's appeals decision unless the HUSKY A Member proceeds to an administrative hearing;

4. If the HUSKY A Member wishes to withdraw the request for an administrative hearing, he or she may contact the DEPARTMENT's Office of Legal Counsel, Regulations, and Administrative Hearings; and
5. If the HUSKY A Member fails to appear at the administrative hearing and does not have a valid reason for his or her absence, the HUSKY A Member's reserved hearing time will be cancelled and any disputed contract services that were maintained will be suspended, reduced, or terminated in accordance with the MCO's appeals decision.

p. If the HUSKY A Member proceeds to an administrative hearing, the MCO shall make its entire file concerning the HUSKY A Member and the appeal, including any materials considered in making its decision, available to the DEPARTMENT. The parties to an administrative hearing shall include the MCO and the Member or representatives of a deceased Members estate.

q. If the MCO fails to issue an appeal decision by the date that an administrative hearing is scheduled, but no later than thirty (30) days following the date the appeal was received by the DEPARTMENT, an administrative hearing will be held as originally scheduled. At the hearing, the MCO shall prove good cause for having failed to issue a timely decision regarding the appeal. Good cause for the MCO's failure to issue a timely decision shall include, but not be limited to, documented efforts to obtain additional medical records necessary for the MCO's decision on the appeal and the HUSKY A Member's refusal to sign a release for medical records necessary for the decision on the appeal.
    1. The MCO's inability to prove good cause shall constitute a sufficient basis for upholding the appeal, and the hearing officer, in his or her discretion, may uphold the appeal solely on that basis.
    2. If the MCO proves good cause for having failed to issue a timely appeal decision, the hearing officer may order a continuance of the hearing pending the issuance of the appeal decision by a certain date, or the hearing officer may proceed with the hearing.

r. The individual who issued the MCO's original or final decision shall prepare and/or approve the summary for the administrative hearing, subject to approval by the DEPARTMENT prior to the hearing, and the MCO shall present proof of all facts supporting its initial action if the administrative hearing proceeds in the absence of an appeal decision. The MCO shall submit a draft hearing summary seven (7) business days prior to the scheduled hearing date and a final, signed hearing summary to the DEPARTMENT and the HUSKY A Member no later than five (5) business days prior to the scheduled hearing date. The hearing summary shall include reference to any relevant provisions of this contract or any DEPARTMENT policies that support its decision.

s. If the HUSKY A Member is represented by legal counsel at the hearing and has not notified either the DEPARTMENT or the MCO of the representation, the MCO may request a continuance of the hearing or may ask the hearing officer to hold the hearing record open for additional evidence or submissions. The hearing officer at his or her discretion will grant a continuance or hold the record open.

t. If a representative of the MCO fails to attend a scheduled session of an administrative hearing, the MCO's failure to attend shall constitute a sufficient basis for upholding the appeal, and the hearing officer, in his or her discretion may close

the hearing and uphold the appeal solely on that basis. This provision shall not apply unless the MCO receives notice of the hearing at least five (5) business days prior to the administrative hearing.

u. If the DEPARTMENT's Office of Legal Counsel, Regulations, and Administrative Hearings is advised in writing that the HUSKY A Member does not intend to proceed to an administrative hearing, the DEPARTMENT will fax such notice to the MCO and the DEPARTMENT liaison.

v. The MCO representative attending the administrative hearings should either be the individual who issued the MCO's final decision or another individual with appropriate medical training.

w. The MCO shall designate one primary and one back-up contact person for its appeal/administrative hearing process.

x. If the DEPARTMENT's hearing officer reverses the MCO's decision to deny, limit or delay services that were not furnished while the appeal was pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires.

4.06 Expedited Review and Administrative Hearings

a. The appeal process shall allow for expedited review. If the appeal contains a request for expedited review, it will be forwarded by fax to the MCO within one business day of receipt by the DEPARTMENT. The fax will include the date the HUSKY A Member mailed the appeal. The postmark on the envelope will be used to determine the date the appeal was mailed. If the MCO receives an oral request for expedited appeal, the MCO shall notify the DSS liaison by fax or telephone within one business day of the oral request.

b. The MCO shall determine, within one business day of receiving the appeal which contains a request for an expedited review from the DEPARTMENT, or within one business day of receiving an oral request for an expedited appeal, whether to expedite the appeal or whether to perform it according to the standard timeframes. If the HUSKY A Member's provider indicates or the MCO determines that the appeal meets the criteria for expedited review, the MCO shall notify the DEPARTMENT immediately that the MCO will be conducting the appeal on an expedited basis.

c. The MCO shall perform an expedited appeal when the standard timeframes for determining an appeal could seriously jeopardize the life or health of the Member or the Member's ability to attain, maintain or regain maximum function. The MCO shall expedite its review in all cases in which the HUSKY A Member's provider indicates, in making the request for expedited review on behalf of the Member or supporting the Member's request, that taking the time for a standard appeal review could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function and if the DEPARTMENT requests the MCO to conduct an expedited review because the DEPARTMENT believes a specific case meets the criteria for expedited review.

d. If the MCO denies a request for expedited review, the MCO shall perform the review within the standard timeframe and make reasonable efforts to give the HUSKY A Member prompt oral notice of the denial and follow up within two (2) calendar days with a written notice.

e. The MCO shall perform an expedited review and issue an appeal decision within a timeframe appropriate to the condition or situation of the Member, but no more than three (3) business days from the DEPARTMENT's receipt of the written appeal or three (3) business days from an oral request received by the MCO.

f. The MCO may extend the timeframe for decisions in paragraph e by up to fourteen (14) days if:

   1) The HUSKY A Member requests the extension; or

   2) The MCO can demonstrate that the extension is in the Member's interest because additional information is needed to decide the appeal and if the timeframe is not extended, the appeal will be denied. The DEPARTMENT may request this documentation from the MCO.

g. The MCO shall ensure that no punitive action is taken against a provider who requests an expedited appeal or supports a Member's appeal.

h. The MCO shall issue a written appeal decision for expedited appeals. The written notice of the resolution shall meet the requirements of Section 4.05(o) and (p), Appeals and Administrative Hearing Processes, . The MCO shall also make reasonable efforts to provide the HUSKY A Member oral notice of an expedited appeal decision.

i. The DEPARTMENT also provides expedited administrative hearings for HUSKY A Members, where required. The DEPARTMENT will issue a hearing decision as expeditiously as the Member's health condition requires, but no later than three (3) business days after the DEPARTMENT receives from the MCO, the administrative case file and information for any appeal that meets the requirements for an expedited hearing. A HUSKY A Member is entitled to an expedited hearing for the denial of a service if the denial met the criteria for expedited appeal but was not resolved within the expedited appeals timeframe or was resolved within the expedited appeals timeframe, but the appeals decision was wholly or partially adverse to the HUSKY A Member.

Sanction: If the MCO fails to provide expedited appeals in appropriate circumstances, the DEPARTMENT may impose a Class B sanction pursuant to Section 6.05, Monetary Sanctions,.

5. PROVISIONS APPLICABLE TO BOTH HUSKY B AND CHARTER OAK (unless otherwise specified)

5.01 Cost-Sharing Exemption for American Indians/Alaskan Natives

a. Persons of American Indian/Alaskan Native (AI/AN) descent who are members of a Federally recognized tribe are exempted from paying any cost-sharing if:

   1. They are enrolled in HUSKY B in Income Bands 1 or 2; or

   2. They are enrolled in Charter Oak in Income Bands C1, C2, C3 or C4.

b. The DEPARTMENT will determine each AI/AN person's eligibility for HUSKY B and Charter Oak and the appropriate Income Band. The DEPARTMENT will also determine whether or not the person qualifies for the AI/AN cost-sharing exemption. The DEPARTMENT will notify the MCO which HUSKY B or Charter Oak Members qualify for the exemption. The MCO shall ensure that its providers and subcontractors neither charge nor collect any cost-sharing from such Members as of the date the DEPARTMENT notifies the MCO.

c. The MCO shall notify its providers and subcontractors of the AI/AN exemption from cost-sharing. The MCO's Member Handbooks and information handouts shall include information about the AI/AN exemption from cost-sharing. The MCO shall refer any HUSKY B or Charter Oak Members who believe they qualify for the AI/AN exemption to the DEPARTMENT for a determination of their qualification.

d. The MCO shall provide all qualified AI/AN Members (i.e., those in HUSKY B Income Bands 1 and 2 and Charter Oak Income Bands C1, C2, C3, and C4 eligible for the cost-sharing exemption) with Membership identification cards stating "no cost-sharing." The MCO shall inform its providers and subcontractors that they may neither charge not collect any cost-sharing from qualified AI/AN Members with Membership cards so noted.

e. If a qualified AI/AN Member has incurred any cost-sharing, then the MCO shall reimburse all such payments within thirty (30) days of discovering the error. The MCO shall review Member accounts quarterly to determine whether any qualified AI/AN Members have incurred any cost-sharing. The MCO shall complete the quarterly review no later than fifteen (15) days after the end of each quarter. The MCO shall make the review (including the methodology and the results) available to the DEPARTMENT upon request.

Sanction:

The DEPARTMENT may impose a sanction up to and including a Class B sanction pursuant to Section 6.05, Monetary Sanctions. if the MCO fails to exempt a qualified AI/AN Member from cost-sharing.

5.02 Maximum Annual Out-of-Pocket Limits for Certain Types of Cost-Sharing

a. The MCO shall ensure that a HUSKY B Member does not incur a combined amount of premiums and co-payments during the twelve-month eligibility period that exceeds the following maximum annual out-of-pocket limits:

1. The HUSKY B Income Band 1 limit shall be $650.
2. The HUSKY B Income Band 2 limit shall be $1,250; and
3. The HUSKY B Income Band 3 shall have no limit.

A HUSKY B Member shall count the cost-sharing incurred by other HUSKY B Members in his or her family towards his or her own maximum annual out-of-pocket limit. Section 5.16, Tracking Co-Payments and Co-Insurance**,** describes the method for aggregating HUSKY B cost-sharing among multiple HUSKY B Members in the same family. However, a HUSKY B Member shall not count the value of the any contract services above the limits described in Appendices C and L (Charter Oak Plan Design Worksheet) for which the Member pays the MCO.

b. Once a HUSKY B Member reaches the maximum annual out-of-pocket limit, then the MCO shall neither charge nor collect from the Member any additional premiums for the remainder of the twelve-month eligibility period. The MCO shall also ensure that its providers and subcontractors neither charge nor collect any additional co-payments from the Member during the remainder of the twelve-month eligibility period.

c. The MCO shall ensure that a Charter Oak Member does not incur a combined amount of co-payments and co-insurance during the twelve-month eligibility period that exceeds the following maximum annual out-of-pocket limits:

   1. Charter Oak Income Band C1 limits shall be in the amount of $150 for families with one Charter Oak Member and $300 for families with two or more Charter Oak Members;
   2. Charter Oak Income Band C2 limits shall be in the amount of $200 for families with one Charter Oak Member and $350 for families with two or more Charter Oak Members;
   3. Charter Oak Income Band C3 limits shall be in the amount of $400 for families with one Charter Oak Member and $600 for families with two ore more Charter Oak Members;
   4. Charter Oak Income Band C4 limits shall be in the amount of $750 for families with one Charter Oak Member and $1,400 for families with two or more Charter Oak Members; and
   5. Charter Oak Income Band C5 limits shall be in the amount of $900 for families with one Charter Oak Member and $1,750 for families with two ore more Charter Oak Members.

   In calculating the maximum annual out-of-pocket limits, a Charter Oak Member shall not count the value of the any contract services above the limits described in Appendices C and L (Charter Oak Plan Design Worksheet) for which the Member pays the MCO.

d. Once a Charter Oak Member reaches the maximum annual out-of-pocket limit, then the MCO shall ensure that its providers and subcontractors neither charge nor collect any additional co-payments or co-insurance from the Member during the remainder of the twelve-month eligibility period.

e. The maximum annual out-of-pocket limits for both HUSKY B and Charter Oak apply to the Member's twelve-month eligibility period (rather than, for example, the calendar year).

   1. The twelve-month eligibility period begins on the Member's initial eligibility date or, for subsequent years, on the anniversary of the initial eligibility date.

   2. If a HUSKY B or Charter Oak Member switches managed care plans, then the MCO shall credit the cost-sharing that a Member incurred during the current eligibility period in another managed care plan towards the Member's maximum annual out-of-pocket limit.

f. The MCO shall review HUSKY B and Charter Oak Member accounts at least quarterly to determine which Members have reached their applicable maximum annual out-of-pocket limit. The MCO shall complete the review no later than fifteen (15) days after the end of each review period. The MCO shall make the review (including the methodology and the results) available to the DEPARTMENT upon request.

g. The MCO shall not consider any Member payments for non-contract services when determining whether a Member has met his or her maximum annual out-of-pocket limit.

h. The MCO shall consider certain payments from external entities or individuals made on behalf of the Member when determining whether a Member has met his or her maximum annual out-of-pocket limit.

   1. For a HUSKY B Member, the MCO shall consider payments from external entities or individuals for the Member's premiums or co-payments; and

   2. For a Charter Oak Member, the MCO shall consider payments from external entities or individuals for the Member's for co-payments and co-insurance.

i. In the event that a HUSKY B or Charter Oak Member reports to the DEPARTMENT any interim changes that affect eligibility, the DEPARTMENT will adjust the eligibility category and Income Band for the Member as necessary. The MCO shall carry over the tracking of co-payments and co-insurance from one Income Band to the other within the twelve-month eligibility period for Members who move between Income Bands. In addition:

   1. For a HUSKY B Member in Income Band 1 or 2 who is changing to Income Band 2 or 1 (respectively), the MCO shall credit any co-payments for contract services that the Member incurred during the twelve-month eligibility period towards the Member's maximum annual out-of-pocket limit. However, the MCO shall not issue any refunds for such credits (i.e., the MCO shall not issue a refund to the Member if the credit exceeds the Member's new maximum annual out-of-pocket limit).

   2. For a HUSKY B Member in Income Bands 1 or 2 who is moving to Charter Oak, the MCO shall credit any co-payments for contract services that the Member incurred during the twelve-month eligibility period towards the Member's (a) Charter Oak deductible and (b) maximum annual out-of-pocket limit in Charter Oak. However, the MCO shall not issue any refunds for such credits.

   3. For a Charter Oak Member who is changing Income Bands, the MCO shall credit any co-payments, co-insurance and deductibles for contract services that the Member incurred during the twelve-month eligibility period towards the Member's

(a) Charter Oak deductible and (b) maximum annual out-of-pocket limit for Charter Oak. However, the MCO shall not issue any refunds for such credits.

4. For a HUSKY B Member who is moving into Income Bands 1 or 2 from Income Band 3, the MCO shall begin tracking co-payments with the Member's effective date of enrollment in Income Band 1 or 2.

5. The limitations to refunds in subsections 1 through 3 above shall apply only to situations in which a Member changed Income Bands or eligibility categories. Nothing in this section shall preclude the MCO from issuing refunds to Members in other situations as appropriate.

j. If a Member believes he or she has reached the maximum annual out-of-pocket limit, then the Member may request, in writing, that the MCO review the cost-sharing that the Member has incurred. The MCO shall then conduct this review and respond to the Member, in writing, within three (3) weeks of the date of the Member's written request. If the Member disagrees with the MCO's determination, the Member may request, in writing, a review by the DEPARTMENT. The MCO and the Member shall abide by the decision of the DEPARTMENT. The MCO shall include a summary of this right and the appropriate procedures to request the review in its Member Handbook.

5.03 Premium Billing and Collection

a. The MCO shall bill the HUSKY B or Charter Oak Member or applicant for the premium payments and shall collect the premium payments. The HUSKY B or Charter Oak applicant may be billed up to thirty (30) days in advance of the coverage period. The coverage period shall be no less than one month and no more than one year. The MCO shall offer all HUSKY B or Charter Oak applicants or Members the option of a schedule of monthly premium payments. The initial bill to new Members may include billing for multiple months of membership to allow HUSKY B or Charter Oak Members the opportunity to make payments current to the first prospective coverage month.

b. Premium payments for HUSKY B and Charter Oak Members shall vary according to income as follows:

1. The MCO shall neither charge nor collect any premiums from HUSKY B Members in Income Band 1.

2. The MCO shall charge and collect premiums for HUSKY B Members in Income Bands 2 and 3 as follows:

(a) HUSKY B Income Band 2 premiums shall be in the amount of $30 per month for families having one Member in HUSKY B and $50 per month for families having more than one Member in HUSKY B.

(b) HUSKY B Income Band 3 premiums shall be the average capitation rates that the DEPARTMENT pays on behalf of HUSKY B Members in Income Band 1.

3. The MCO shall charge and collect premiums for Charter Oak Members in Income Bands C1, C2, C3, C4, and C5 as follows:

(a) Charter Oak Income Band C1 premiums shall be in the amount of $75 per month for each Charter Oak Member in that Income Band;

(b) Charter Oak Income Band C2 premiums shall be in the amount of $100 per month for each Charter Oak Member in that Income Band;

(c) Charter Oak Income Band C3 premiums shall be in the amount of $175 per month for each Charter Oak Member in that Income Band;

(d) Charter Oak Income Band C4 premiums shall be in the amount of $200 per month for each Charter Oak Member in that Income Band; and

(e) Charter Oak Income Band C5 premiums shall be the capitation rate for Income Band C1 plus the Member premium for Income Band C1, with a target of $250 per month for the first year of the program.

c. The premium provisions and amount are subject to change. The DEPARTMENT will provide the MCO sixty (60) days advance notice of any premium changes unless a statutory change precludes such advance notice.

5.04 Notification of Premium Payments Due

a. The MCO shall provide the HUSKY B or Charter Oak Member or applicant with reasonable prior notice of any premiums to be paid.

b. The notice shall contain:

1. The amount of the premium due;

2. The date the premium is due;

3. The effective date of disenrollment in case of failure to remit the premium by the due date;

4. Information concerning lock-out if the Member is disenrolled due to non-payments of the premium;

5. An instruction to immediately contact the DEPARTMENT if the HUSKY B or Charter Oak Member or applicant cannot remit the premium by the due date because of a decrease in income or other changes in circumstances; and

6. Any additional information that the DEPARTMENT requires for the notice.

Sanction: If the MCO fails to provide prior notice as required in this Section, the DEPARTMENT may impose a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions..

5.05 Non-payment of the Premium Payments

a. Non-payment of premium may result in the HUSKY B or Charter Oak Member's disenrollment from the MCO.

1. The effective date of disenrollment for HUSKY B Members in Income Band 2 and Charter Oak Members in Income Bands C1, C2, C3 and C4 shall be the first of the month following the month for which premium payment was not received.

2. The effective date of disenrollment for HUSKY B Members in Income Band 3 and Charter Oak Members in Income Band C5 shall be the first of the month for which premium payment was not received.

3. Once disenrolled from the MCO due to non-payment of premiums, a Member will be locked-out (unable to re-enroll) for three (3) months, unless the Member establishes good cause for non-payment of his or her premium(s).

b. The MCO shall notify, in writing, the HUSKY B or Charter Oak Member or applicant if a premium is not received by the due date.

c. The notice shall contain:

1. The amount of the premium(s) that is due (see subsection (a) above);
2. The date the premium(s) was due and any applicable grace period (see subsection (a) above);
3. The effective date of disenrollment for failure to remit the premium(s) (see subsection (a) above);
4. Information concerning the three-month lock-out for failure to remit the premium(s);
5. An instruction to immediately contact the DEPARTMENT if the HUSKY B or Charter Oak Member or applicant cannot remit the premium(s) by the due date because of a decrease in income or other change in family circumstances; and
6. Any additional information required to be included in the notice by the DEPARTMENT.

c. The MCO shall collaborate with the DEPARTMENT to establish billing and collection procedures. The MCO shall notify the DEPARTMENT (using established procedures) when it does not receive premiums by the due date.

d. Subject to the DEPARTMENT's approval, the MCO shall define "good cause" for non-payment of premiums for purposes of this Section. The MCO shall have the discretion to determine whether a HUSKY B or Charter Oak Member satisfies its definition of "good cause."

Sanction: If the MCO fails to provide notice for non-payment (as described above) or if the MCO fails to notify the DEPARTMENT of a Member's failure to pay a premium by the due date, the DEPARTMENT may impose a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions..

5.06 Premium Payments Received after Member Disenrollment

The MCO shall apply any premium payment received after a HUSKY B or Charter Oak Member has disenrolled to the Member's past due balance. Following the application of the payment to the past due balance, the MCO shall apply the any excess funds to future months coverage or reimburse the HUSKY B or Charter Oak Member, whichever the Member prefers. The MCO shall issue such refunds within sixty (60) days of receiving the premium payment.

5.07 Re-enrollment

A HUSKY B or Charter Oak Member may re-enroll at the end of the three-month lock-out period or earlier (but no earlier than the first prospective enrollment month) if the Member provides good cause and remits past due

premiums. Upon the effective date of re-enrollment, the MCO shall resume providing contract services to the re-enrolled HUSKY B or Charter Oak Member.

5.08 Member Premium Paid by Another Entity or Individual

a. The MCO shall accept funds from other entities (including tribal organizations) and private individuals for the purpose of subsidizing the payment of premiums. However, if a tribal organization is making a payment, then the MCO shall confirm that its acceptance of such payment does not violate Section 5.01 (Cost-Sharing Exemption for American Indians/Alaskan Natives).

b. The MCO shall accept payments from parents on behalf of their adult children who are HUSKY B or Charter Oak Members or applicants. Similarly, the MCO shall accept payments from the relatives of HUSKY B and Charter Oak Members and applicants.

c. To ensure that an employer does attempt to shift coverage from the employer to HUSKY B or Charter Oak by paying the HUSKY B or Charter Oak premiums, the MCO shall conduct periodic audits of received payments. The MCO shall conduct these audits in accordance with DSS and MCO agreed upon criteria and schedule.

Sanction: If the MCO fails to conduct audits in accordance with the agreed upon criteria and schedule, the DEPARTMENT may impose sanctions up to and including a Class B sanction.

5.09 Partial Premium Payments

Unless the DEPARTMENT provides superseding policy guidance, the MCO shall process premium payments in the following manner:

a. Absent specific, written instructions from the premium payer, the MCO shall allocate partial premium payments for Members in the same family in the following order:

    1. Pregnant Members; then

    2. Youngest Member under age 21 to oldest Member under age 21; then

    3. Oldest Member who is age 21 or older in the family to the youngest Member who is age 21 or older in the family.

b. If the premium payer indicates on the “premium due” notice that he or she is sending only a partial payment, then he or she may provide written instructions (e.g., using a check box and signature) as to how the payment should be allocated. The MCO’s notice shall state (or some other supplementary material or notice shall clarify) that if the MCO receives no such instructions, then it will use the default rules for allocating the payment as described in (a) above.

c. If the MCO receives instructions from multiple premium payers regarding the same Member(s), then it will use the payment in accordance with the written instructions and return any balance. If the premium payer(s) provide no written instructions, then the MCO will use the default rules for allocating the payment as described in (a) above.

5.10 Tracking Premium Payments

a. The MCO shall establish and maintain a system to track the premium payments received for HUSKY B and Charter Oak Members and applicants.

    1. The MCO shall cease tracking premium payments for HUSKY B Members in Income Band 2 who move into Income Band 3; the MCO shall cease such tracking on the effective date of the change. For HUSKY B Members moving into Income Band 1 or 2 from Income Band 3, the MCO shall begin tracking on the effective date of the change.

    2. The MCO shall cease tracking premium payments for Charter Oak Members in Income Band C1, C2, C3 or C4 who move into Income Band C5; the MCO shall cease such tracking on the effective date of the change. For Charter Oak Members moving into Income Band C1, C2, C3 or C4 from Income Band C5, the MCO shall begin tracking on the effective date of the change.

b. The MCO shall send a monthly file to the DEPARTMENT showing the premiums received for HUSKY B or Charter Oak Members and applicants. If the HUSKY B or Charter Oak Member disenrolls and then enrolls in another managed care plan within the twelve-month eligibility period, then the DEPARTMENT will forward the HUSKY B or Charter Oak Member premium totals for the twelve-month eligibility period to the new managed care plan.

c. If a HUSKY B or Charter Oak Member is disenrolled due to non-payment of premiums, the MCO may cease tracking the premium payments. However, the MCO shall keep the tracked information on file in case the Member re-enrolls after payment of the past due premium within the twelve-month eligibility period. If the HUSKY B or Charter Oak Member re-enrolls, then the MCO shall resume tracking the premium payments paid for the remainder of the twelve-month eligibility period.

Sanction: If the MCO fails to comply with any of the provisions of this section, the DEPARTMENT may impose sanctions up to and including a Class B sanction pursuant to Section 6.05, Monetary Sanctions..

The Bidder shall:

Describe its method and processes to comply with the requirements of this section, including:

a. Tracking premium payments;

b. Tracking overdue or late premiums; and

c. Premium billing and collections process.

5.11 Deductibles

a. For HUSKY B Members, the MCO shall not apply (nor shall it allow providers to collect) deductibles.

b. For Charter Oak Members, the MCO shall impose (and allow providers to collect) annual deductible amounts, after which the MCO shall be responsible for the costs of services that are subject to co-payments and coinsurance. The deductibles shall vary by the number of Members per family and Income Band as follows:

1. Charter Oak Income Band C1 deductibles shall be in the amount of $150 for families with one Charter Oak Member and $300 for families with two Charter Oak Members;
2. Charter Oak Income Band C2 deductibles shall be in the amount of $200 for families with one Charter Oak Member and $350 for families with two Charter Oak Members;
3. Charter Oak Income Band C3 deductibles shall be in the amount of $400 for families with one Charter Oak Member and $600 for families with two Charter Oak Members;
4. Charter Oak Income Band C4 deductibles shall be in the amount of $750 for families with one Charter Oak Member and $1,400 for families with two Charter Oak Members; and
5. Charter Oak Income Band C5 deductibles shall be in the amount of $900 for families with one Charter Oak Member and $1,750 for families with two Charter Oak Members.

5.12 Tracking Deductibles (Charter Oak only)

a. The MCO shall establish a system to track each Charter Oak Member's payments toward his or her deductible. The MCO shall maintain accurate, up-to-date information in its system in order to ensure that the Member does not exceed the deductibles in Section 5.11, Deductibles.

b. The MCO shall require its providers and subcontractors to verify with the MCO whether a Charter Oak Member has reached the annual deductible limit before charging the Member any deductibles.

c. If a Charter Oak Member disenrolls, the MCO shall maintain the deductible information on file for costs incurred through the date of disenrollment. If the Member re-enrolls within the twelve-month eligibility period, the MCO shall resume tracking the deductible for the remainder of the twelve-month eligibility period.

d. Charter Oak Members shall not be required to make additional payments towards the deductible after they meet the annual deductible amount. When a Member reaches the deductible limit, the MCO shall inform its providers and subcontractors that the deductible limit has been met. The MCO shall also inform its providers as subcontractors that they shall neither charge nor collect further deductibles during the remainder of the twelve-month eligibility period. However, the MCO shall clarify that Charter Oak Members may still be liable for co-payments and co-insurance; the MCO shall explain how its providers shall verify this at each encounter. The MCO shall also report the date on which the Member's twelve-month eligibility period ends. The MCO shall provide this same information to the Member.

e. The MCO shall send a monthly file to the DEPARTMENT showing the amounts that Charter Oak Members incurred towards their deductibles. If the Member disenrolls and enrolls in another managed care plan within the twelve-month eligibility period, the DEPARTMENT will forward the Member's deductible totals for the twelve-month eligibility period to the new managed care plan.

Sanctions:

a. If the MCO fails to have an effective tracking system for deductibles for Charter Oak Members, the DEPARTMENT may impose a Class B sanction pursuant to Section 6.05, Monetary Sanctions..

b. Any one of the following may give rise to a strike toward a Class A Sanction pursuant to Section 6.05, Monetary Sanctions.:

   1. The MCO fails to inform its subcontractors, providers, and the Member when the Member has met his or her annual deductible limit;

   2. The MCO fails to submit a monthly file to the DEPARTMENT reporting on deductible payments of its Members; or

   3. The MCO fails to monitor the tracking system to determine if any Member has reached the annual deductible limits.

The Bidder shall:

Describe its method to:

a. Track deductibles; and

b. Notify providers, subcontractors, and Members when the Member has met his or her deductible.

5.13 Co-payments

a. For HUSKY B Members, the MCO shall allow providers to collect co-payments for all contract services. However, the MCO shall prohibit providers from charging or collecting co-payments for services exempted in Section 5.14(a), Co-payments Prohibited, below.

b. For Charter Oak Members, the MCO shall allow providers to collect co-payments for all contract services after a Member incurs his or her deductible. However, the MCO shall prohibit providers from charging or collecting co-payments for services exempted in Section 5.14(b), Co-payments prohibited, below.

c. The MCO shall allow providers to collect co-payments from HUSKY B and Charter Oak Members for non-emergency services provided in a hospital emergency department.

5.14 Co-payments Prohibited

a. For HUSKY B Members, the MCO shall neither impose nor allow its providers to collect co-payments for:

   1. Ambulance for emergency medical conditions;

   2. Durable medical equipment other than powered wheelchairs;

   3. Emergency services;

   4. Family planning services;

   5. Home health services;

   6. Hospice and short-term rehabilitation;

   7. Inpatient hospital services;

8. Inpatient physician services;
9. Laboratory and x-ray services, including diagnostic and treatment radiology and ultrasound treatment;
10. Occupational therapy;
11. Outpatient surgical visits;
12. Physical therapy;
13. Preadmission testing;
14. Preventive care and services, including all well-baby and well-child services as described in 42 CFR § 457.520;
15. Prosthetic devices;
16. Skilled nursing; and
17. Speech therapy.

b. For Charter Oak Members, the MCO shall neither impose nor allow its providers to collect co-payments for:
   1. Primary care physician visits for preventive care;
   2. Specialist physician visits for second opinions;
   3. Emergency services; and
   4. Ambulance services for emergency medical conditions.

5.15 Coinsurance

a. For HUSKY B Members, the MCO shall not apply (nor shall it allow providers to collect) coinsurance.

b. For Charter Oak Members, the MCO shall impose (and allow providers to collect) coinsurance after a Member has incurred his or her deductible. The MCO shall administer co-insurance requirements as follows:
   1. The MCO shall impose a coinsurance obligation only for the following contract services:
      (a) Ambulatory surgery;
      (b) Inpatient acute admissions;
      (c) Inpatient rehabilitation/skilled nursing facility admissions; and
      (d) Outpatient laboratory and x-rays.
   2. The MCO shall impose the specific co-insurance requirements described in Appendix L Charter Oak Plan Design Worksheet

5.16 Tracking Co-Payments and Co-Insurance

a. The MCO shall establish and maintain a system to track the co-payments and co-insurance that HUSKY B and Charter Oak Members incur. The MCO shall maintain

accurate, up-to-date information in its system in order to properly monitor maximum annual out-of-pocket limits described in Section 5.02, Maximum Annual Out-of-Pocket Limits for Certain Types of Cost-Sharing.

1. The MCO shall track the HUSKY B co-payments incurred by HUSKY B Members in Income Bands 1 and/or 2, including co-payments that Members incur for services provided by the CT BHP ASO and the dental ASO and for pharmacy services managed by the DEPARTMENT.
2. The MCO's system shall track the Charter Oak (i) co-payments and (ii) co-insurance incurred by Charter Oak Members, including co-payments and co-insurance that Members incur for services provided by the CT BHP ASO and the dental ASO and for pharmacy services managed by the DEPARTMENT.
3. The MCO shall track cost-sharing relative to each Member's respective twelve-month eligibility period.

b. With respect to families with one or more HUSKY B and/or Charter Oak Members:
   1. Consistent with Section 5.02(a) , Maximum Annual Out-of-Pocket Limits for Certain Types of Cost-Sharing, the MCO shall count the premiums and co-payments that a HUSKY B Member incurs towards the maximum annual out-of-pocket limit for all the other HUSKY B Members in that same family.
   2. Consistent with Section 5.02(c) , Maximum Annual Out-of-Pocket Limits for Certain Types of Cost-Sharing, the MCO shall count the co-payments and co-insurance that a Charter Oak Member incurs towards the maximum annual out-of-pocket limit for all the other Charter Oak Members in that same family.
   3. The MCO shall not count the cost-sharing amounts that a Charter Oak Member incurs towards the maximum annual out-of-pocket limit for HUSKY B Members in the same family. Likewise, the MCO shall not count the cost-sharing amounts that a HUSKY B Member incurs towards the maximum annual out-of-pocket limit for Charter Oak Members in the same family.

c. The MCO shall require its providers and subcontractors to verify with the MCO whether a HUSKY B or Charter Oak Member is subject to co-payments and/or co-insurance before charging co-payments or co-insurance for contract services.
   1. Providers shall neither charge nor collect any co-payments and/or co-insurance from a Member once the Member incurs his or her maximum annual out-of-pocket limit.
   2. When a Member incurs his or her maximum annual out-of-pocket limits, the MCO shall inform the providers, subcontractors, and Members that:
      (a) The Member has met the limit;
      (b) The providers and subcontractors shall neither charge nor collect any additional co-payments and/or co-insurance within the twelve-month eligibility period; and
      (c) The date when the twelve-month period ends.

d. If a HUSKY B or Charter Oak Member disenrolls, the MCO shall maintain on file the amounts of co-payments and co-insurance that the Member incurred for the twelve-month eligibility period through the date of disenrollment. If the HUSKY B or Charter Oak Member re-enrolls within the twelve-month eligibility period, the MCO shall

resume tracking the co-payments and co-insurance that the Member incurs during the remainder of the twelve-month eligibility period.

e. The MCO shall send a monthly file to the DEPARTMENT showing the co-payments and co-insurance that each Member has incurred. If the Member disenrolls and enrolls in another managed care plan within the twelve-month eligibility period, the DEPARTMENT will forward the Member's co-payments and/or co-insurance totals for the twelve-month eligibility period to the new managed care plan.

Sanctions:

a. If the MCO fails to have an effective system for tracking co-payments and co-insurance, then the DEPARTMENT may impose a Class B sanction pursuant to Section 6.05, Monetary Sanctions..

b. Any one of the following may give rise to a strike toward a Class A Sanction pursuant to Section 6.05, Monetary Sanctions.:

   1. The MCO fails to inform its subcontractors, providers, and the Member when the Member has met his or her maximum annual limit for co-payments and co-insurance;

   2. The MCO fails to submit a monthly file to the DEPARTMENT reporting on the co-payments and/or co-insurance amounts that HUSKY B and Charter Oak Members have incurred; or

   3. The MCO fails to monitor the tracking system to determine if Members have reached the maximum annual out-of-pocket limits.

The Bidder shall:

Describe its method to:

a. Track co-payments and co-insurance; and

b. Verify for its providers, subcontractors, and HUSKY B and Charter Oak Members when Members have met their maximum annual out-of-pocket limits (i.e., are subject to co-payments and/or co-insurance).

5.17 Enforceability of Cost-Sharing

a. The MCO shall allow its providers and subcontractors to require Members to pay the applicable deductible, co-payment and co-insurance amounts as a condition for the provision of contract services.

b. The MCO shall allow its providers and subcontractors to reduce or waive applicable deductible, co-payment and co-insurance amounts on a case-by-case basis.

5.18 Overpayments of Cost-Sharing

a. The MCO shall monitor data in its tracking systems for Member payments for premiums, co-payments and co-insurance to ensure that the Member does not exceed the maximum annual out-of-pocket limit. Further, the MCO shall monitor the data to ensure that the Member is not paying any deductibles, co-payments or co-

insurance in excess of the amounts required in Sections 5.11, Deductibles, 5.13, Co-payments, and 5.15, Coinsurance, respectively.

b. If the MCO receives more than the allowed premium amount for a Member, then the MCO shall repay the overpayment to the Member within thirty (30) days of receiving the payment, or apply the excess to future coverage months, whichever the HUSKY B or Charter Oak Member or applicant prefers.

c. If the MCO discovers that one of its providers or subcontractors has collected a co-payment amount from a HUSKY B Member that is higher than the applicable amount in 5.13, Co-payments, then the MCO shall refund the excess payment directly to the Member within thirty (30) days of the discovery. Additionally, if the MCO discovers that one of its providers or subcontractors has collected a deductible or co-insurance amount from a HUSKY B Member, then the MCO shall refund the payment directly to the Member within thirty (30) days of the discovery.

d. If the MCO discovers that one of its providers or subcontractors has collected a deductible, co-payment, or co-insurance amount from a Charter Oak Member that is higher than the applicable amounts in Sections 5.11, Deductibles, 5.13, Co-payments, and 5.15, Coinsurance, respectively, then the MCO shall refund the excess payment directly to the Member within thirty (30) days of the discovery.

e. Subject to subsection 5.02(i), the MCO shall repay any overpayments to HUSKY B Members within thirty (30) days of its determination that the Member has incurred premiums or co-payments in excess of the maximum annual out-of-pocket limit.

f. Subject to subsection 5.02(i), the MCO shall repay any overpayments to Charter Oak Members within thirty (30) days of its determination that the Member has incurred co-payments or co-insurance in excess of the maximum annual out-of-pocket limit.

g. The MCO shall tender all repayments to the Member even in cases in which another entity or individual paid all or part of the Member's cost-sharing.

h. Consistent with Section 5.02(j), Maximum Annual Out-of-Pocket Limits for Certain Types of Cost-Sharing, Members may request the MCO to review the cost-sharing that the Member incurred to determine whether the Member may have made an overpayment.

    1. If a HUSKY B or Charter Oak Member believes he or she has overpaid premiums, then the Member may request, in writing, that the MCO review the premiums that the Member remitted or were paid on behalf of the Member.

    2. If a HUSKY B or Charter Oak Member believes that a provider or subcontractor overcharged him or her for deductibles, co-payments, and/or co-insurance, then the Member may request, in writing, that the MCO review the cost-sharing charges and collections in question.

    3. Upon receiving a request for review of cost-sharing payments from a Member, the MCO shall then conduct a review. The MCO shall respond to the Member, in writing, within three (3) weeks of the date of the Member's written request.

    4. If the Member disagrees with the MCO's determination, the Member may request, in writing, a review by the DEPARTMENT. The MCO and Member shall abide by the decision of the DEPARTMENT.

The Bidder shall:

Describe its method to:

a. Use tracking systems to monitor for overpayments; and
b. Ensure that it tenders repayment of overpayment to the Member within thirty (30) days of discovery of the overpayment.

Sanction:

If the MCO fails to repay overpayments for premiums, deductibles, co-payments or co-insurance to the Member within thirty (30) days of the determination that the Member (or other entity or individual paying on behalf of the Member) has remitted excess payment, then the DEPARTMENT may impose a strike towards a Class A sanction pursuant to Section 6.05, Monetary Sanctions..

5.19 Annual Benefit Maximums and Lifetime Benefit Maximums

a. For HUSKY B Members, the MCO shall not apply either annual or lifetime benefit maximums for any contract services.
b. For Charter Oak Members, the MCO shall not impose an annual benefit maximum for contract services.
c. For Charter Oak Members, the MCO shall impose a $1,000,000 lifetime benefit maximum for contract service, which the MCO shall calculate as follows:
    1. The MCO shall count all claims payments that it, any other managed care plan, the CT BHP ASO, the dental ASO, or the DEPARTMENT made on behalf of the Member during the Member's enrollment in Charter Oak;
    2. The MCO shall not consider any Charter Oak Member cost-sharing or Member payments for non-contract services when calculating the Member's lifetime benefit maximum; and
    3. The MCO shall not consider any cost-sharing or costs for contract services while the Member was enrolled in HUSKY A or HUSKY B.

5.20 Tracking the Lifetime Benefit Maximum (Charter Oak only)

a. The MCO shall establish and maintain a system to track total claims payments for Charter Oak Members in order to adhere to the requirements of the lifetime benefit maximum.
    1. To calculate the total claims payments to date, the MCO shall aggregate all paid claims (including those claims that the CT BHP ASO, the dental ASO, and the DEPARTMENT paid) during each Member's respective twelve-month eligibility period.
    2. The MCO shall maintain accurate, up-to-date information in its system in order to adhere to the requirements of the lifetime benefits maximums described in Section 5.19, Annual Benefit Maximums and Lifetime Benefit Maximums.

b. Charter Oak Members shall not be eligible for Charter Oak contract services once their total claims payments to date for Charter Oak services meets their lifetime benefit maximum.

c. When a Charter Oak Member's total claims payments to date meets the lifetime benefit maximum, the MCO shall inform its providers, subcontractors, and the Member that:

   1. The Charter Oak Member has met his or her lifetime benefit maximum;

   2. The Member is no longer eligible for Charter Oak contract services; and

   3. The MCO will not reimburse providers and subcontractors for additional services provided to the Member while in Charter Oak.

d. The MCO shall send a monthly file to the DEPARTMENT showing the total claims payments to date for each Charter Oak Member. If the Member re-enrolls in the MCO or in a different managed care plan, then the DEPARTMENT will forward the disenrolling Member's total claims payments to date for all eligibility periods to the MCO or managed care plan.

e. If a Charter Oak Member disenrolls, then the MCO shall maintain the total claims payments to date information on file for claims payments made through the date of disenrollment. If the Member re-enrolls, the MCO shall resume tracking the benefits that it pays on behalf of the Member.

f. If a Charter Oak Member receives notification that he or she has reached his or her lifetime benefit maximum, he or she may request, in writing, that the MCO review the total claims payments to date for the Member. The MCO shall then conduct this review and respond to the Member, in writing, within three (3) weeks of the date of the Member's written request. If the Member disagrees with the MCO's determination, the Member may request, in writing, a review by the DEPARTMENT. The MCO and the Member shall abide by the decision of the DEPARTMENT. The MCO shall include a summary of this right and the appropriate procedures to request the review in its Member Handbook.

Sanctions:

a. If the MCO fails to have an effective system for tracking total claims payments to date, then the DEPARTMENT may impose a Class B sanction pursuant to Section 6.05, Monetary Sanctions..

b. Any one of the following may give rise to a strike toward a Class A Sanction pursuant to Section 6.05, Monetary Sanctions.:

   1. The MCO fails to inform its subcontractors, providers, Charter Oak Members and the DEPARTMENT when a Member has met his or her lifetime benefit maximum;

   2. The MCO fails to submit a monthly file to the DEPARTMENT reporting total claims payments to date for each Charter Oak Member; or

   3. The MCO fails to monitor the tracking system to determine whether Charter Oak Members' total claims payments to date meets or exceeds their lifetime benefit maximums.

The Bidder shall:

a. Describe its method to track total claims payments to date, including how it will aggregate claims that the CT BHP ASO, the dental ASO, and the DEPARTMENT paid on behalf of Charter Oak members while enrolled in Charter Oak;

b. Describe its method for notifying providers, subcontractors and Members when a Charter Oak Member meets his or her lifetime benefit maximum;

c. Describe its method for storing total claims payment data and transmitting updated information to the DEPARTMENT as required; and

d. Describe its method for investigating and adjudicating Charter Oak Member assertion that the total claims payments to date that the MCO has on file does not match the Member's actual claims history.

5.21 Service Limits and Exclusions

a. Consistent with Section 3.42, Limited Coverage of Some Benefits , the MCO shall impose the service limitations and exclusions for HUSKY B and Charter Oak as described in Appendices A, B, and C and Appendix L Charter Oak Plan Design Worksheet

b. For Charter Oak Members, the MCO shall impose the following coverage limitations:

    1. Outpatient Rehabilitation (speech therapy, physical therapy, and occupational therapy) shall be limited to 30 visits per year for all therapy combined;

    2. Primary Care Behavioral Health visits shall be limited to 30 visits per year and shall be subject to prior authorization;

    3. Durable Medical Equipment (DME) coverage shall be limited to $2,000 per year;

    4. Prescription drug and pharmacy services coverage shall be limited to $2,500 per year; and

    5. Inpatient Rehabilitation/Skilled Nursing Facility coverage shall be limited to fourteen (14) days per year unless it is documented to be a cost-effective alternative in lieu of hospitalization. The MCO shall submit documentation of cost-effectiveness to the DEPARTMENT, which shall have sole discretion to make this determination for each case. The MCO and Member shall abide by the DEPARTMENT's decision.

c. If a HUSKY B or Charter Oak Member receives notification from the MCO that he or she has reached the annual limit for any service, then the Member may request, in writing, that the MCO review the claims payments for the Member during the current twelve-month eligibility period. The MCO shall then conduct this review and respond to the Member, in writing, within three (3) weeks of the date of the Member's written request. If the Member disagrees with the MCO's determination, the Member may request, in writing, a review by the DEPARTMENT. The MCO and the Member shall abide by the decision of the DEPARTMENT. The MCO shall include a summary of this right and the appropriate procedures to request the review in its Member Handbook.

d. The MCO shall not impose the Charter Oak service limitations on former Charter Oak Members who are re-categorized as HUSKY A or HUSKY B Members during

the current twelve-month eligibility period. Rather, the MCO shall prospectively apply the HUSKY A and HUSKY B requirements to the Member beginning on the effective date of the eligibility change.

5.22 Tracking DME Utilization (Charter Oak only)

a. The MCO shall establish and maintain a system to track total claims payments for durable medical equipment (DME) for Charter Oak Members.
    1. To calculate the total claims payments to date, the MCO shall aggregate all paid claims for DME services during each Member's respective twelve-month eligibility period.
    2. The MCO shall maintain accurate, up-to-date information in its system in order to adhere to the requirements regarding the DME service limitation described in Section 5.21, Service Limits and Exclusions.
b. The MCO shall not make additional payments towards DME claims during the current twelve-month eligibility period once a Charter Oak Member has met the annual DME limit.
c. When a Charter Oak Member reaches the annual DME limit, the MCO shall inform providers, subcontractors, and the Member that:
    1. The Charter Oak Member has reached his or her annual DME limit;
    2. The MCO shall cover no more DME services for the Member during the current twelve-month eligibility period; and
    3. The date when the twelve-month eligibility period ends.
e. The MCO shall send a monthly file to the DEPARTMENT showing DME claims payments to date for each Charter Oak Member. The report shall include DME claims payments for each Member during the Member's respective, current twelve-month eligibility period.
f. If a Charter Oak Member disenrolls from the MCO, the MCO shall maintain on file the total claims payments for DME services associated with the Charter Oak Member during the current twelve-month eligibility period. If the Charter Oak Member re-enrolls in the MCO within the same twelve-month eligibility period, the MCO shall resume tracking the DME claims payments for the Member for the remainder of the period.
g. If the Charter Oak Member re-enrolls in a different managed care plan during the current twelve-month eligibility period, then the DEPARTMENT will forward the DME claims payment data to the new managed care plan.

Sanctions:

a. If the MCO fails to have an effective system for tracking total claims payments for DME services, then the DEPARTMENT may impose a Class B sanction pursuant to Section 6.05, Monetary Sanctions..
b. Any one of the following may give rise to a strike toward a Class A Sanction pursuant to Section 6.05, Monetary Sanctions.:
    1. The MCO fails to inform its providers, subcontractors, and the Charter Oak Member when the Member has met its annual DME limit;

2. The MCO fails to submit a monthly file to the DEPARTMENT reporting on DME claims of its Charter Oak Members; or
3. The MCO fails to monitor the tracking system to determine if any Charter Oak Member has reached the annual DME limit.

The Bidder shall:

a. Describe its method to track and monitor annual DME limits; and

b. Describe its method for notifying providers, subcontractors and Members when Charter Oak Members reach their DME limits.

5.23 Tracking Prescription Drug Utilization (Charter Oak only)

a. The MCO shall establish a system that accepts from the DEPARTMENT prescription drug claims payment data for Charter Oak Members.
   1. To calculate the total prescription drug claims payments to date, the MCO shall aggregate all paid claims for prescription drugs and pharmacy services during each Member's respective twelve-month eligibility period.
   2. The DEPARTMENT will transmit pharmacy claims data to the MCO on a routine (e.g., monthly) basis.
   3. The MCO shall maintain accurate, up-to-date information in its system in order to track and monitor the annual prescription drug limit for Charter Oak Members described in Section 5.19, Annual Benefit Maximums and Lifetime Benefit Maximums.

b. When a Charter Oak Member reaches the annual prescription drug limit, the MCO shall inform the DEPARTMENT. The MCO shall also notify providers, subcontractors and Members that:
   1. The Charter Oak Member has reached his or her annual prescription drug limit;
   2. The DEPARTMENT shall cover no more prescription drug services for the Member during the current twelve-month eligibility period; and
   3. The date when the annual period ends.

c. If a Charter Oak Member disenrolls from the MCO, the MCO shall maintain on file the total claims payments for prescription drugs associated with the Charter Oak Member during the current twelve-month eligibility period. If the Charter Oak Member re-enrolls in the MCO within the same twelve-month eligibility period, the MCO shall resume tracking the prescription drug claims payments for the Member for the remainder of the period.

d. If the Charter Oak Member re-enrolls in a different managed care plan during the current twelve-month eligibility period, then the DEPARTMENT will forward the claims payment data to the new managed care plan.

Sanctions:

a. If the MCO fails to have an effective system for tracking total claims payments for prescription drugs, then the DEPARTMENT may impose a Class B sanction pursuant to Section 6.05, Monetary Sanctions..

b. If the MCO fails to monitor the tracking system to determine if any Charter Oak Member has reached the annual prescription drug limit, then the DEPARTMENT may impose a Class A sanction pursuant to Section 6.05, Monetary Sanctions..

The Bidder shall:

Describe its method to monitor annual prescription drug limits.

5.24 Denial Notice

a. The MCO shall provide a written denial notice to the HUSKY B or Charter Oak Members in a manner consistent with Conn. Agencies Regs. § 17b-304-17. The MCO shall construe § 17b-304-17 to require notices for denials of payment.

b. The MCO shall send the denial notice to HUSKY B or Charter Oak Member's last known address.

c. All denial notices shall clearly state or explain:

1. Which specific contract services are denied;
2. The reasons for the denial;
3. The contract section and the section of the Regulations of the Connecticut State Agencies that supports the denial;
4. The Member's right to challenge the denial by filing an internal appeal with the MCO;
5. The address and toll-free number of the MCO's Member Services Department;
6. The procedure and timeframe for commencing each level of the MCO's internal appeals process, including the address to which any written request for appeal may be mailed;
7. The availability of an expedited internal appeal;
8. The external appeal process available through the Connecticut Department of Insurance (CDI);
9. That the HUSKY B or Charter Oak Member may submit additional documentation or written material for the MCO's consideration;
10. That the MCO's review may be based solely on information available to the MCO and its providers, unless the HUSKY B or Charter Oak Member requests a meeting or the opportunity to submit additional information;
11. That the MCO shall be responsive to questions that the HUSKY B or Charter Oak Member may have about the denial;
12. The specifications as to the format in which the HUSKY B or Charter Oak Member may file a request for an internal appeal;
13. An explanation as to how the HUSKY B and Charter Oak Member can get help with his or her appeal;
14. That the HUSKY B or Charter Oak Member will lose his or her right to challenge the denial within sixty (60) days from the date the MCO mailed the denial notice; and

15. That for each level of its appeals process, the MCO shall issue a decision regarding an appeal no more than thirty (30) days following the date that the MCO receives the request for review.

5.25 Internal Appeal Process

a. HUSKY B or Charter Oak Members shall have the opportunity to request an internal appeal of a decision made by the MCO regarding any denials. The internal appeal process shall be available for resolution of disputes between the MCO or MCO subcontractors and HUSKY B or Charter Oak Members concerning any denials. The MCO shall be responsible for ensuring compliance with the internal appeal process requirements set forth herein, independent of whether the MCO or one of its subcontractors is responsible for the denial(s) in question.

b. The MCO shall permit the HUSKY B or Charter Oak Member, the Member's authorized representative, or the Member's conservator to file appeals through the MCO's internal appeals process within sixty (60) days of the date that the MCO mailed the denial notice.

c. The MCO shall date stamp the appeal request in order to indicate the date on which the MCO received the request. The MCO shall use the postmark date on the original denial notice envelope determine whether the HUSKY B or Charter Oak Member, the Member's authorized representative or the Member's conservator filed a timely appeal.

d. The MCO shall have a timely and organized internal appeal process for receiving and acting upon request for review. The MCO shall develop written policies and procedures for each component of its internal appeals process. The MCO's policies and procedures shall include the elements specified in this contract and must be prior approved by the DEPARTMENT in writing. The MCO shall obtain written approval of the policies and procedures from the DEPARTMENT; documents under review by/pending approval from the DEPARTMENT shall not satisfy the requirements herein.

e. If the standard timeframe for an appeal could jeopardize the life or health of the Member of the Member's ability to regain maximum functioning, then the MCO shall follow the procedure described in Section 5.27, Expedited Review. Additionally, if the internal appeal contains a request for expedited review, then the MCO shall follow the procedure described in Section 5.27, Expedited Review.

f. The MCO's internal appeals process may consist of more than one level of review. An individual or individuals having final decision-making authority shall conduct the final level of the MCO's review. One or more physicians who were not involved in the denial determination shall decide any appeal arising from a denial based on a determination of medical necessity.

g. The HUSKY B or Charter Oak Member may requests an opportunity to meet with the individual or individuals conducting the internal appeal on behalf of the MCO and/or requests the opportunity to submit additional written documentation or other written material. If the HUSKY B or Charter Oak Member wishes to meet with the decision maker, the MCO shall hold the meeting via telephone or at a location accessible to the Member, whichever the Member prefers.

h. In the absence of a request from the Member to meet, the MCO shall decide an appeal on the basis of written documentation available to the MCO at the time of the request.

i. The MCO shall maintain a record-keeping system for each level of its appeal process, which shall include a copy of the HUSKY B or Charter Oak Member's request for review and the response and the resolution. The MCO shall make these materials available to the DEPARTMENT upon request.

j. The MCO shall provide information to HUSKY B and Charter Oak Members concerning its internal appeals process as well as the external appeal process available through the State of CDI. In its Member Handbook/packet and in written decision notices required in Section 5.26, Written Decision for Appeals, the MCO shall clearly specify the procedural steps and timeframes for each level of its internal appeals process and for filing an external appeal through the CDI. The MCO shall provide information on its internal appeals process and on the external CDI appeal process to providers and subcontractors, as it relates to HUSKY B and Charter Oak Members.

k. Consistent with Sections 3.26, Linguistic Access, and 3.27, Services for Members, the MCO shall develop and make available to HUSKY B and Charter Oak Members and potential Members appropriate alternative language versions of appeals materials. These materials include but are not limited to, the standard information contained in the denial notices. The DEPARTMENT must prior-approve such materials in writing.

l. The MCO shall designate one primary and one back-up contact person for its internal appeal process.

5.26 Written Decision for Appeals

a. The MCO shall issue a written decision for each level of its internal appeals process. The MCO shall mail each decision to the HUSKY B or Charter Oak Member. The MCO shall send a copy of each decision to the DEPARTMENT. The MCO shall send the appeal decision from decision-makers at the final level of review no later than thirty (30) days from the date on which the MCO received the appeal.

b. The MCO's written decision shall include:

   1. The HUSKY B or Charter Oak Member's name and address;
   2. The provider's name and address;
   3. The MCO name and address;
   4. A complete statement of the MCO's findings and conclusions, including the section number and text of any statute or regulation that supports the decision;
   5. A clear statement of the MCO's disposition of the appeal;
   6. A statement as to whether the HUSKY B or Charter Oak Member has exhausted the MCO's internal appeal procedure concerning the denial at issue; and
   7. Relevant information concerning the external appeals process available through the CDI, as described in Section 5.28, External Appeal Process through the CDI.

c. For each level of its internal appeals process, the MCO shall issue a decision within thirty (30) days of receiving the appeal. If the MCO fails to issue a decision within thirty (30) days, the DEPARTMENT will deem the decision to be a denial and the HUSKY B or Charter Oak Member may file an external appeal with the CDI, as more fully discussed in Section 5.28, External Appeal Process through the CDI.

d. The MCO shall include a copy of the CDI appeal form when issuing written decision that advises a HUSKY B or Charter Member that the MCO determined that an admission, service, procedure, or extension of stay was not medically necessary.

e The MCO shall include a copy of the HUSKY B – State of Connecticut – Insurance Department Request for External Appeal form approved by the DEPARTMENT with each written decision.

5.27 Expedited Review

a. The MCO's internal appeals process shall allow for expedited review. If a HUSKY B or Charter Oak Member requests an expedited review, the MCO shall determine within one business day of receipt of the request whether to expedite the review or whether to perform the review according to the standard timeframes.

b. The MCO shall perform an expedited review when the standard timeframes for determining an appeal could jeopardize the life or health of the HUSKY B or Charter Oak Member or the Member's ability to regaining maximum functioning. The MCO shall expedite its review in all cases in which such a review is requested by the Member's treating physician or primary care provider, functioning within his or her scope of practice as defined under state law, or by the DEPARTMENT.

5.28 External Appeal Process through the CDI

a. HUSKY B and Charter Oak Members who have exhausted the internal appeal mechanisms of the MCO and are not satisfied with the outcome of the MCO's final decision may file an appeal with the CDI pursuant to Conn. Gen. Stat. § 38a-478.

b. The MCO shall be bound by the CDI's external appeal decision.

The Bidder shall:

Fully describe its internal appeals process.

6. CORRECTIVE ACTION AND CONTRACT TERMINATION

6.01 Performance Review

a. A designated representative of the MCO and a designated representative of the DEPARTMENT shall meet on an annual basis, and as requested by either party, to review the performance of the MCO under this contract. The DEPARTMENT will keep written minutes of such meetings. In the event of any disagreement regarding the performance of services under this contract by the MCO, the designated representatives shall discuss the problem and shall negotiate in good faith in an effort to resolve the disagreement.

b. In the event that no such resolution is achieved within a reasonable time, the matter shall be referred to the Contract Administrator as provided under Section 6.02, the Settlement of Disputes clause of this contract. If the Contract Administrator determines that the MCO has failed to perform as measured against applicable contract provisions, the Contract Administrator may impose sanctions or any other penalty, set forth in this Section including the termination of this contract in whole or in part, as provided under this Section.

6.02 Settlement of Disputes

Any dispute arising under the contract that is not disposed of by agreement shall be decided by the Contract Administrator, whose decision shall be final and conclusive subject to any rights the MCO may have in a court of law. The foregoing shall not limit any right the MCO may have to present claims under Conn. Gen. Stat. § 4-141 et seq. or successor provisions regarding the claims commissioner, including without limitation Conn. Gen. Stat. § 4-160 regarding authorization of actions. In connection with any appeal to the Contract Administrator under this paragraph, the MCO shall have the opportunity to be heard and to offer evidence in support of its appeal. Pending final decision of a dispute, the MCO shall proceed diligently with the performance of services under this contract in accordance with the Contract Administrator's decision.

6.03 Administrative Errors

The MCO shall be liable for the actual amount of any costs in excess of $5,000 incurred by the DEPARTMENT as the result of any administrative error (e.g. submission of erroneous encounter data requiring re-processing of files by the DEPARTMENT or non-compliance with a Federal requirement causing loss of Federal reimbursement or recoupment of Federal dollars) by the MCO or its subcontractors. The DEPARTMENT may request a refund of, or recoup from subsequent capitation payments, the actual amount of such costs.

6.04 Suspension of New Enrollment

Whenever the DEPARTMENT determines that the MCO is out of compliance with this contract, unless corrective action is taken to the satisfaction of the DEPARTMENT, the DEPARTMENT may suspend the enrollment of new Members under this contract. The

DEPARTMENT, when exercising this option, will notify the MCO in writing of its intent to suspend new enrollment at least thirty (30) days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the DEPARTMENT, or may be indefinite. The suspension period may extend up to the contract expiration date as provided under PART I. The DEPARTMENT may also notify existing Members of MCO non-compliance and provide an opportunity to disenroll from the MCO and to re-enroll in another MCO.

6.05 Monetary Sanctions

The DEPARTMENT and the MCO agree that if by any means, including any report, filing, examination, audit, survey, inspection or investigation, the MCO is determined to be out of compliance with this contract, damage to the DEPARTMENT may or could result. Consequently, the MCO agrees that the DEPARTMENT may impose any of the following sanctions for noncompliance under this contract. Unless otherwise provided in this contract, the DEPARTMENT will deduct sanctions imposed under this section from capitation payment or, at the discretion of the DEPARTMENT, paid directly to the DEPARTMENT.

a. Sanctions for Noncompliance

1. Class A sanctions. Three (3) Strikes. Sanctions Warranted After Three (3) Occurrences

For noncompliance of the contract that does not rise to the level warranting Class B sanctions as defined in subsection (a)(2) of this section or Class C sanctions as defined in subsection (b) of this section, including, but not limited to, those violations defined as Class A sanctions in any provision of this contract, the following course of action will be taken by the DEPARTMENT:

a) The MCO shall receive a strike for each time the MCO fails to comply with the contract on an issue warranting a Class A sanction.

b) The DEPARTMENT will notify the MCO each time that it imposes a strike. After the third strike for the same contract provision, the DEPARTMENT may impose a sanction. If no specific time frame is set forth in any such contractual provision, the time frame is deemed to be the full length of the contract.

c) The MCO will be notified in writing at least thirty (30) days in advance of any sanction being imposed and will be given an opportunity to meet with the DEPARTMENT to present its position as to the DEPARTMENT's determination of a violation warranting a Class A sanction. At the DEPARTMENT's discretion, a sanction will thereafter be imposed. Said sanction will be no more than $2,500 after the first three (3) strikes. The next strike for noncompliance of the same contractual provision will result in a sanction of no more than $5,000 and any subsequent strike for noncompliance of the same contractual provision will result in a Class A sanction of no more than $10,000.

2. Class B Sanctions. Sanctions Warranted Upon Single Occurrence

For noncompliance with the contract which does not warrant the imposition of Class C sanctions as defined in subsection (b) of this section, including, but not

limited to, those violations defined as Class B sanctions in any provision of this contract, the following course of action will be taken by the DEPARTMENT:

The DEPARTMENT may impose a sanction at the DEPARTMENT's discretion if, after at least thirty (30) days notice to the MCO and an opportunity to meet with the DEPARTMENT to present the MCO's position as to the DEPARTMENT's determination of a violation warranting a Class B sanction, the DEPARTMENT determines that the MCO has failed to meet a performance measure which merits the imposition of a Class B sanction not to exceed $10,000.

b. Class C Sanctions. Sanctions Related to Noncompliance Potentially Resulting in Harm to an Individual Member

1. The DEPARTMENT may impose a Class C sanction on the MCO for noncompliance potentially resulting in harm to an individual Member, including, but not limited to, the following:

   a) Failing to substantially authorize medically necessary contract services that are required (under law or under this contract) to be provided to a Member;

   b) Imposing any cost-sharing or charge on Members except as specifically permitted under provisions of the approved Medicaid State Plan, the SCHIP State Plan, and the provisions of this contract;

   c) Discriminating among Members on the basis of their health status or requirements for contract services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX or Title XXI, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the MCO by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

   d) Misrepresenting or falsifying information that is furnished to the Secretary, the DEPARTMENT; Member, potential Member, or a health care provider;

   e) Failing to comply with the physician incentive requirements under Section 1903(m)(2)(A)(x) of the Social Security Act and 42 CFR § 422.208 and 422.210;

   f) Distributing directly or through any agent, subcontractor, or independent contractor marketing materials that have not been approved by the DEPARTMENT or containing false or misleading information; and

   g) Failing to comply with any other requirements of 42 U.S.C. §§ 1396b(m) or 1396u-2.

2. Class C sanctions for noncompliance with the contract under this subsection include the following:

   a) Withholding the next month's capitation payment to the MCO in full or in part;

   b) Assessment of liquidated damages:

      1) For each determination that the MCO fails to substantially provide medically necessary services, makes misrepresentations or false statements to Members, potential Members or health care providers, engages in marketing violations or fails to comply with the physician incentive plan requirements, not more than $25,000;

2) For each determination that the MCO discriminates among Members on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the MCO by eligible individuals based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary or DEPARTMENT, not more than $100,000;

3) For each determination that the MCO has discriminated among Members or engaged in any practice that has denied or discouraged enrollment, $15,000 for each individual not enrolled as a result of the practice up to a total of $100,000;

4) For a determination that the MCO has imposed cost-sharing or charges on Members in excess of the cost-sharing permitted, double the excess amount but not more than $25,000. The excess amount charged in such a circumstance shall be deducted from the penalty and returned to the Member concerned;

c) Freeze on new enrollment and/or alter the current enrollment; and/or

d) Appointment of temporary management as described in 7.06.

3. Prior to imposition of any Class C sanction, the MCO will be notified at least thirty (30) days in advance and provided, at a minimum, an opportunity to meet with the DEPARTMENT to present its position as to the DEPARTMENT's determination of a violation warranting a Class C Sanction. For any contract violation under this subsection, at the DEPARTMENT's discretion, the MCO may be permitted to submit a corrective action plan within twenty (20) days of the notice to the MCO of the violation. Immediate compliance (within thirty (30) days) under any such corrective action plan may result in the imposition of a lesser sanction on the MCO. If any sanction issued under this subsection is the functional equivalent of the termination of this contract, the MCO shall be offered a hearing to contest the imposition of such a sanction**.**

c. Other Remedies

1. Notwithstanding the provisions of this section, failure to provide required services will place the MCO in default of this contract, and the remedies in this section are not a substitute for other remedies for default that the DEPARTMENT may impose as set forth in this contract.

2. The imposition of any sanction under this section does not preclude the DEPARTMENT from obtaining any other legal relief to which it may be entitled pursuant to state or federal law.

d. CMS Sanctions

Pursuant to 42 CFR § 438.730, the DEPARTMENT may recommend the imposition of sanctions to CMS and CMS may sanction the MCO as described in that section. In the alternative, CMS may independently initiate the sanction process described in 42 CFR § 438.730(a) through (d). The MCO shall comply with all applicable sanction provisions set forth in 42 CFR § 438.730. CMS may deny payment to the DEPARTMENT for new Members under the circumstances described in 42 CFR §

438.730(e) and capitation payments to the MCO will be denied so long as payment for those Members is denied by CMS.

6.06 Temporary Management

The DEPARTMENT may impose temporary management upon a finding by the DEPARTMENT that: (1) there is continued egregious behavior by the MCO; (2) there is a substantial risk to the health of the Members; or (3) temporary management is necessary to ensure the health of the MCO's members while improvements are made to remedy the violations or until there is an orderly termination or reorganization of the MCO. For purposes of this section, "egregious behavior" shall include but not be limited to any of the violations described in Section 6.05b, Monetary Sanctions, or any other MCO behavior that is contrary to §§1903(m) and 1932 of the Social Security Act. After a finding pursuant to this subsection, Members shall be permitted to terminate enrollment without cause and the MCO shall be responsible for notification of such right to terminate enrollment. Nothing in this subsection shall preclude the DEPARTMENT from proceeding under the termination provisions of the contract rather than imposing temporary management. If however, the DEPARTMENT chooses not to first terminate the contract and repeated violations of substantive requirements in §§1903(m) or 1932 of the Social Security Act occur, the DEPARTMENT must than impose temporary management and allow Members to disenroll without cause. The DEPARTMENT may impose temporary management without a hearing.

6.07 Payment Withhold, Class C Sanctions or Termination for Cause

a. The DEPARTMENT may withhold capitation payments; impose sanctions including Class C Sanctions set forth in Section 6.05, Monetary Sanctions,; retain monies collected in pursuit of fraud or abuse, whether by the MCO, its providers, subcontractors or any other entity; or terminate the contract for cause. Cause shall include, but not be limited to: 1) use of funds and/or personnel for purposes other than those described in HUSKY A, HUSKY B, or Charter Oak and this contract; (2) failure to detect fraud or abuse and to notify the DEPARTMENT of fraud or abuse, as required by Section 3.51; and (3) if a civil action or suit in federal or state court involving allegations of health fraud or violation of 18 U.S. C. Section 1961 et seq. is brought on behalf of the DEPARTMENT.

b. Whenever the DEPARTMENT determines that the MCO has failed to provide one or more of the medically necessary contract services required, the DEPARTMENT may withhold an estimated portion of the MCO's capitation payment in subsequent months, such withhold to be equal to the amount of money the DEPARTMENT expects to pay for such services, plus any administrative costs involved. The MCO may not elect to withhold any required services in order to receive adjusted payment levels. Failure to provide required services will place the MCO in default of this contract, and the remedies in this section are not a substitute for other remedies for default which the DEPARTMENT may impose as set forth in this contract. The MCO shall be given at least seven (7) days written notice prior to the withholding of any capitation payment.

c. When it withholds payments under this section, the DEPARTMENT must submit to the MCO a list of the Members for whom payment is being withheld, the nature of

service(s) denied, and payments the DEPARTMENT must make to provide medically necessary services. When all payments have been made by the DEPARTMENT for contract services, the DEPARTMENT will reconcile the estimated withhold against actual payments.

d. The DEPARTMENT may also adjust payment levels accordingly if the MCO has failed to maintain or make available any records or reports required under this contract which the DEPARTMENT needs to determine whether the MCO is providing required contract services. The MCO will be given at least thirty (30) days notice prior to taking any action set forth in this paragraph.

6.08 Emergency Services Denials

If the MCO has a pattern of inappropriately denying payments for emergency services as defined in Section I, Definitions, the MCO may be subject to suspension of new enrollments, withholding of capitation payments, contract termination, or refusal to contract in a future time period. This applies not only to cases where the DEPARTMENT has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the DEPARTMENT is knowledgeable about documented abuse from other sources.)

6.09 Termination For Default

a. The DEPARTMENT may terminate performance of work under this contract in whole, or in part, whenever the MCO materially defaults in performance of this contract and fails to cure such default or make progress satisfactory to the DEPARTMENT toward contract performance within a period of thirty (30) days (or such longer period as the DEPARTMENT may allow). Such termination shall be referred to herein as "Termination for Default."

b. If after notice of termination of the contract for default, it is determined by the DEPARTMENT or a court that the MCO was not in default, the notice of termination shall be deemed to have been rescinded and the contract reinstated for the balance of the term.

c. If after notice of termination of the contract for default, it is determined by the DEPARTMENT or a court that the MCO was not in default or that the MCO's failure to perform or make progress in performance was due to causes beyond the control and without the error or negligence of the MCO, or any subcontractor, the notice of termination shall be deemed to have been issued as a termination for convenience pursuant to Section 7.09 and the rights and obligations of the parties shall be governed accordingly.

d. In the event the DEPARTMENT terminates the contract in full or in part as provided in this clause, the DEPARTMENT may procure contract services similar to those terminated, and the MCO shall be liable to the DEPARTMENT for any excess costs for such similar services for any calendar month for which the MCO has been paid to provide services to Members. In addition, the MCO shall be liable to the DEPARTMENT for administrative costs incurred by the DEPARTMENT in procuring such similar services. Provided, however, that the MCO shall not be liable for any excess costs or administrative costs if the failure to perform the contract arises out of

causes beyond the control and without error or negligence of the MCO or any of its subcontractors.

e. In the event of a termination for default, the MCO shall be financially responsible for Members in the current month at the applicable capitation rate.

f. The rights and remedies of the DEPARTMENT provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

g. In addition to the termination rights under Part I, the MCO may terminate this contract on ninety (90) days written notice in the event that the DEPARTMENT fails to (i) pay capitation claims in accordance with Part II Section 4.06 and Part II, Section 3.01 of this contract; or (ii) provide eligibility or enrollment/disenrollment information and fails to cure such default or make progress within a period of sixty (60) days of such default.

6.10 Termination for Mutual Convenience

The DEPARTMENT and the MCO may terminate this contract at any time if both parties mutually agree in writing to termination. At least sixty (60) days shall be allowed. The effective date shall be the first day of a month. The MCO shall, upon such mutual agreement being reached, be paid at the capitation rate for Members through the termination of the contract.

6.11 Termination for Financial Instability of the MCO

In the event of financial instability of the MCO, the DEPARTMENT shall have the right to terminate the contract upon the same terms and conditions as a Termination for Default.

6.12 Termination for Unavailability of Funds

a. The DEPARTMENT at its discretion may terminate this contract at any time in whole or in part. The DEPARTMENT at its discretion may also modify the terms of the contract if federal or state funding for the contract or for the Medicaid program as a whole is reduced or terminated for any reason. Modification of the contract includes, but is not limited to, reduction of the rates or amounts of consideration, reducing contract services, or the alteration of the manner of the performance in order to reduce expenditures under the contract. Whenever possible, the MCO will be given thirty (30) days notification of termination.

b. In the event of a reduction in the appropriation from the state or federal budget for the Division of Health Care Financing of the Department of Social Services or an across-the-board budget reduction affecting the Department of Social Services, the DEPARTMENT may either re-negotiate this contract or terminate with thirty (30) days written notice. Any reduction in the capitation rates that is agreed upon by the parties or any subsequent termination of this contract by the DEPARTMENT in accordance with this provision shall only affect capitation payments or portions thereof for contract services purchased on or after the effective date of any such reduction or termination. Should the DEPARTMENT elect to renegotiate the

contract, the DEPARTMENT will provide the MCO with those contract modifications, including capitation rate revisions, it would deem acceptable.

c. The MCO shall have the right not to extend the contract if the new contract terms are deemed insufficient notwithstanding any other provision of this contract. The MCO shall have a minimum of sixty (60) days to notify the DEPARTMENT regarding its desire to accept new terms. If the new capitation rates and any other contract modifications are not established at least sixty (60) days prior to the expiration of the initial or extension agreement, the DEPARTMENT will reimburse the MCO at the higher of the new or current capitation rates for that period during which the new contract period had commenced and the MCO's sixty (60) day determination and notification period had not been completed, and the MCO will be held to the terms of the executed contract.

6.13 Termination for Collusion in Price Determination

a. The MCO has previously certified that the prices presented in its proposal were arrived at independently, without consultation, communication, or agreement with any other bidder for the purpose of restricting competition; that, unless otherwise required by law, the prices quoted have not been knowingly disclosed by the MCO, prior to bid opening, directly or indirectly to any other bidder or to any competitor; and that no attempt has been made by the MCO to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

b. In the event that such action is proven, the DEPARTMENT shall have the right to terminate this contract upon the same terms and conditions as a Termination for Default.

6.14 Termination Obligations of Contracting Parties

a. The MCO shall be provided the opportunity for a hearing prior to any termination of this contract pursuant to any provision of this contract. The DEPARTMENT will give the MCO written notice of its intent to terminate, the reason for the termination and the date and time of the hearing. After the hearing, the DEPARTMENT will give the MCO written notice of its decision affirming or reversing the proposed termination. In the event of a decision to affirm the termination, the DEPARTMENT's written notice shall include the effective date of termination. The DEPARTMENT may notify Members of the MCO and permit such Members to disenroll immediately without cause during the hearing process.

b. Upon non-renewal or termination of this contract, the MCO shall immediately turn over or provide copies to the DEPARTMENT or to a designee of the DEPARTMENT all documents, files and records relating to persons receiving services and to the administration of this contract that the DEPARTMENT may request.

c. Upon contract termination, the MCO shall allow the DEPARTMENT full access to the MCO's facilities and all records to arrange the orderly transfer of the contracted activities. These records include the information necessary for the reimbursement of any outstanding Medicaid claims.

d. Where this contract is terminated due to cause or default by the MCO:

1. The DEPARTMENT will be responsible for notifying all Members of the date of termination and process by which the Members will continue to receive services; and
2. The MCO shall notify all providers and be responsible for all expenses related to notification to providers, subcontractors and Members.

e. If this contract is terminated for any reason other than default by the MCO, then:

1. The MCO shall ensure that an adequate provider network will be maintained at all times during the transition period and that continuity of care is maintained for all Members;
2. The MCO shall submit a written transition plan to the DEPARTMENT sixty (60) days in advance of the scheduled termination;
3. The DEPARTMENT will be responsible for notifying all Members of the date of termination and process by which the Members will continue to receive services;
4. The DEPARTMENT will be responsible for all expenses relating to said notification to members;
5. The MCO shall notify all providers and be responsible for all expenses related to such notification; and
6. The DEPARTMENT will withhold a portion, not to exceed $100,000, of the last month's capitation payment as a surety bond for a six (6) month period to ensure compliance under the contract.

6.15 Waiver of Default

Waiver of any default shall not be deemed a waiver of any subsequent default. Waiver of breach of any provision of the contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the contract unless stated to be such in writing, signed by an authorized representative of the DEPARTMENT, and attached to the original contract.

7. FUNCTIONS AND DUTIES OF THE DEPARTMENT

7.01 Eligibility Determinations

The DEPARTMENT will determine the initial and ongoing eligibility of each Member enrolled under this contract in accordance with the DEPARTMENT's eligibility policies. The MCO shall notify the DEPARTMENT of any changes that may affect Member eligibility, including age, pregnancy, residency, insurance status, or death, within thirty (30) days of learning of such changes

7.02 Populations Eligible to Enroll

Appendix J (HUSKY A Medicaid Coverage Groups) contains a list of the Medicaid groups eligible for managed care enrollment. The DEPARTMENT may add additional eligibility groups to the managed care population. The DEPARTMENT will notify the MCO of any changes in the eligibility categories. The MCO may at its own option serve additional groups.

7.03 Default Enrollment

a. The DEPARTMENT will assign to the MCO those Members who do not select a managed care plan within the period available for them to select a managed care plan. The DEPARTMENT will assign the Members on a rotating basis among all of the participating managed care plans and as each managed care plan's enrollment capacity allows.

b. The default assignment methodology is structured to evenly distribute families among all the participating managed care plans. However, due to variability in a managed care plan's enrollment capacity, family size and loss of eligibility, the outcome of the default assignment may not result in an even net default distribution among all the managed care plans.

7.04 Enrollment/Disenrollment

a. The DEPARTMENT's enrollment broker will manage enrollment, disenrollment and initial selection of PCPs.

   1. Coverage for new Members will be effective the first of the month
   2. Coverage for disenrolled Members will terminate on the last day of the month.

b. Members will remain continuously enrolled throughout the term of this contract, except where Members:

   1. Change managed care plans;
   2. Lose eligibility for HUSKY A, HUSKY B, or Charter Oak;
   3. Receive Medicare;
   4. Are re-categorized into a Medicaid category not enrolled in a managed care plan; or

5. HUSKY B or Charter Oak Members become delinquent on their premium payments.

c. Disenrollments due to loss of eligibility become effective upon on the last day of the month in which the Member loses eligibility or, if the Member never met eligibility requirements, as of the date of initial enrollment.

d. Disenrollments due to a Member's change in managed care plans will occur on the last day of the month in which the Member makes a managed care plan change and the Member's enrollment in a new managed care plan will occur on the first day of the following month. The MCO shall coordinate care to assure continuity in accordance with applicable DEPARTMENT policies.

e. Disenrollments due to receipt of Medicare become effective the month following the month in which the DEPARTMENT receives information of the existence of the Medicare coverage.

f. The DEPARTMENT will automatically enroll a HUSKY A Member into the managed care plan in which he or she was most recently enrolled if the Member was disenrolled solely because he or she lost Medicaid eligibility for a period of two months or less.

f. The DEPARTMENT determines Medicaid eligibility, and periodically the DEPARTMENT may reclassify a Member's Medicaid status from mandatory managed care coverage to non-managed care coverage. When the DEPARTMENT reclassifies a Member's coverage to non-managed care coverage, the Member's enrollment in managed care will end on the last day of the month.

g. The DEPARTMENT will exempt adults who receive SSI from managed care. The Member's enrollment in managed care will end on the last day of the month, and the exemption from managed care will occur the first day of the following month.

h. The DEPARTMENT will notify the MCO of enrollments and disenrollments specific to the MCO via a daily data file.

i. The enrollments and disenrollments processed on any given day will be made available to the MCO via the data file the following day (i.e. after the daily overnight batching has been processed).

j. In addition to the daily data file, a full file of all Members will be made available on a monthly basis. Both the daily data file and the monthly full file can be accessed by the MCO electronically via dial-up.

7.05 Lock-In/Open Enrollment

a. Upon enrollment into an MCO, Members will be locked-in to that MCO for a period of up to twelve (12) months. Members will not be allowed to change managed care plans during the lock-in period except for good cause, as defined below. The lock-in period is subject to the following provisions:

1. The first ninety (90) days of enrollment into a new managed care plan will be designated as the free-look period during which time the Member may change managed care plans.

2. The last sixty (60) days of the lock-in period will be an open enrollment period, during which time Members may change managed care plans.

3. Managed care plan changes made during the open enrollment period will go into effect on the first day of the month following the end of the lock-in period.

4. Members who do not change managed care plans during the open enrollment period will continue the enrollment in the same managed care plan and be assigned to a new twelve (12) month lock-in period.

b. The following shall constitute good cause for a Member to disenroll from the MCO during the lock-in period.

1. Unfavorable resolution of a Member complaint adjudicated through the MCO's internal complaint process and continued dissatisfaction due to repeated incidents of any of the following:

a) Documented long waiting times for appointments;

b) More than a forty-five (45) day wait for scheduling a well-care visit;

c) More than a two (2) business day wait for non-urgent, symptomatic office visit;

d) Unavailability of same day office visit or same day referral to an emergency provider for emergency care services;

e) Documented inaccessibility of MCO by phone or mail;

f) Phone calls not answered promptly;

g) Caller placed on hold for extended periods of time;

h) Phone messages and letters not responded to promptly; and

i) Rude and demeaning treatment by MCO staff.

2. Prior to pursuing the MCO's internal complaint process and without filing an appeal through the MCO, dissatisfaction due to any of the following:

a) Discriminatory treatment as documented in a complaint filed with the State of Connecticut, Commission on Human Rights and Opportunities (CHRO) or the DEPARTMENT's Affirmative Action Division;

b) PCP able to serve Member's specific individual needs (i.e. language or physical accessibility) is no longer participating with the MCO and there is no other suitable PCP within reasonable distance to the Member; or

c) Member has a pending lawsuit against the MCO; verification of pending lawsuit shall be provided.

7.06 Capitation Payments to the MCO

a. In full consideration of contract services rendered by the MCO, the DEPARTMENT agrees to pay the MCO monthly payments based on the capitation rates specified in Appendix M, Capitation Payment Amount – Tables, and as periodically amended.

The DEPARTMENT will make the payments in the month following the month to which the capitation applies.

b. The actuarial basis for the HUSKY capitation rates, as approved by CMS, is attached at Appendix M, Capitation Payment Amount - Tables. The State may pursue federal matching funds for Charter Oak. If, after receiving approval from the Connecticut Legislature, the State is successful in receiving federal match, the State will provide the actuarial basis for the Charter Oak capitation rates in a manner consistent with the agreement with CMS.

c. Capitation payments to the MCO shall be based on a passive billing system.

d. Payments to the MCO shall be based on each month's valid enrollment data as determined by the DEPARTMENT, including valid client eligibility and MCO membership. The DEPARTMENT will supply to the MCO, on a monthly basis a capitation roster, which includes all Members for whom capitation payments are made to the MCO.

e. The MCO will be responsible for detecting any inconsistency between the capitation roster and the MCO Membership records.

f. The MCO shall notify the DEPARTMENT of any inconsistency between enrollment and payment data. The DEPARTMENT agrees to provide to the MCO information needed to determine the source of the inconsistency within sixty (60) business days after receiving written notice of the request to furnish such information. The DEPARTMENT will recoup overpayments or reimburse underpayments. The adjusted payment for each month of coverage shall be included in the next monthly capitation payment and roster.

g. The DEPARTMENT will pay the MCO its capitation payments in the month following the month to which the capitation payments apply or for retroactive enrollments, the month following the enrollment-processing month in accordance with Conn. Gen. Stat. §§4a-71 through 4a-72.

h. Any retrospective adjustments to prior capitation payments will be made in the form of an addition to or subtraction from the next month's capitation payment.

i. The DEPARTMENT will be the final arbiter of Membership status and reserves the right to recover inappropriate capitation payments.

7.07 Retroactive Adjustments

a. When a Member loses Medicaid eligibility and managed care enrollment but regains coverage within sixty (60) days, and the coverage is made retroactive such that the entire coverage gap is eliminated, the DEPARTMENT will reinstate enrollment into the MCO retroactive to the time of disenrollment. The MCO will remain responsible for the cost of in-network contract services and the cost of emergency and family planning services received by the Member during this sixty (60) day period.

b. In instances where enrollment is disputed between the MCO and another managed care plan or the MCO and the Medicaid fee-for-service delivery system, the DEPARTMENT will be the final arbiter of membership status and reserves the right to recover inappropriate capitation payments. Capitation payments for retroactive

enrollment adjustments will be made to the MCO pursuant to rules outlined in 7.06(g), Capitation Payments to MCO.

7.08 Newborn Retroactive Adjustments

a. The DEPARTMENT will determine the eligibility of a newborn child retroactively to the date of his or her birth, for an application filed within thirty (30) days following birth.

b. For the purpose of determining the capitation payment to the MCO for the month in which the child was born, the effective date of enrollment shall be the first of the month in which the child was born.

7.09 Information

The DEPARTMENT will make known to each MCO complete and current information that relates to pertinent statutes, regulations, policies, procedures, and guidelines affecting the operation of this contract. This information shall be available either through direct transmission to the MCO or by reference to public resource files accessible to the MCO personnel.

7.10 Ongoing MCO Monitoring

a. To ensure access and the quality of care, the DEPARTMENT will undertake monitoring activities, including but not limited to the following:

   1. Analyze the MCO's access enhancement programs, financial and utilization data, and other reports to monitor the value the MCO is providing in return for the State's capitation payments. Such efforts shall include, but not be limited to, on-site reviews and audits of the MCO and its subcontractors and network providers.

   2. Conduct regular surveys of Members to address issues such as satisfaction with MCO services to include administrative services, satisfaction with treatment by the MCO or its providers, and reasons for disenrollment and access.

   3. Review the MCO certifications on a regular basis.

   4. Analyze encounter data, actual medical records, correspondence, telephone logs and other data to make inferences about the quality of and access to specific services.

   5. Sample and analyze encounter data, actual medical records, correspondence, telephone logs and other data to make inferences about the quality of and access to MCO services.

   6. Test the availability of and access to MCO services by attempting to make appointments.

   7. At its discretion, commission or conduct additional objective studies of the effectiveness of the MCO, as well as the availability of, quality of and access to its services.

7.11 Utilization Review and Control

The DEPARTMENT will waive, to the extent allowed by law, any current DEPARTMENT requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services provided by the MCO to Members.

8. STANDARD TERMS AND CONDITIONS (including declarations and miscellaneous provisions)

8.01 Construction

The Contractor agrees to comply with the following standard terms and conditions. If any of the standard terms and conditions in this section conflict with any requirement in an other section of the Contract t, the requirement in the other section of the Contract shall control.

8.02 Summary

The MCO shall comply with the following mandatory terms and conditions:

A. Member Related Safeguards
   1. Inspection of Work Performed;
   2. Safeguarding Client Information; and
   3. Reporting of Member Abuse or Neglect.

B. Contractor Obligations
   1. Credits and Rights in Data;
   2. Organizational Information, Conflict of Interest, IRS Form 990;
   3. Prohibited Interest;
   4. Offer of Gratuities;
   5. Related Party Transactions;
   6. Insurance;
   7. Reports;
   8. Delinquent Reports;
   9. Record Keeping and Access;
   10. Workforce Analysis;
   11. Audit Requirements;
   12. Litigation; and
   13. Lobbying.

C. Statutory and Regulatory Compliance
   1. Compliance with Law and Policy;
   2. Federal Funds;
   3. Facility Standards and Licensing Compliance;
   4. Suspension or Debarment;
   5. Non-discrimination Regarding Sexual Orientation;
   6. Executive Orders Nos. 3, 16 & 17;
   7. Nondiscrimination and Affirmative Action Provisions in Contracts of the State and Political Subdivisions Other Than Municipalities;
   8. Americans with Disabilities Act of 1990;
   9. Utilization of Minority Business Enterprises;

10. Priority Hiring;
11. Non-smoking;
12. Government Function; Freedom of Information; and
13. HIPAA Requirements.

D. Miscellaneous Provisions
   1. Liaison;
   2. Choice of Law and Choice of Forum;
   3. Subcontracts;
   4. Mergers and Acquisitions;
   5. Equipment;
   6. Independent Capacity of Contractor; and
   7. Settlement of Disputes and Claims Commission.

E. Revisions, Reduction, Default and Cancellation
   1. Contract Revisions and Amendments;
   2. Contract Reduction;
   3. Default by the Contractor;
   4. Non-enforcement not to constitute waiver;
   5. Cancellation and Recoupment;
   6. Transition after Termination or Expiration of Contract; and
   7. Program Cancellation.

8.03 Standard Terms and Conditions

A. Member Related Safeguards

1. Inspection of Work Performed: The DEPARTMENT or its authorized representative shall at all times have the right to enter into the Contractor's premises, or such other places where duties under the contract are being performed, to inspect, to monitor or to evaluate the work being performed. The Contractor and all subcontractors must provide all reasonable facilities and assistance for DEPARTMENT representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. The Contractor shall disclose information on clients, Members, applicants and their families as requested unless otherwise prohibited by federal or state law. Written evaluations pursuant to this section shall be made available to the Contractor.

2. Safeguarding Member Information: The DEPARTMENT and the Contractor agree to safeguard the use, publication and disclosure of information on all applicants for and all Members in compliance with all applicable federal and state law concerning confidentiality.

3. Reporting of Member Abuse or Neglect: The Contractor shall comply with all reporting requirements relative to Member abuse and neglect, including but not limited to requirements as specified in the following sections of the Conn. Gen. Stat. §§17a-101 through 103, 19a-216, 46b-120 (related to children), 46a-11b

(relative to persons with mental retardation), and 17b-407 (relative to elderly persons).

B. Contractor Obligations

1. Credits and Rights in Data:

a. Unless expressly waived in writing by the DEPARTMENT, all documents, reports and other publications 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 DEPARTMENT 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 the DEPARTMENT, unless the DEPARTMENT has co-authored said publication and said release is done with the prior written approval of the commissioner of the DEPARTMENT. Any publication shall contain the following statement: "This publication does not express the views of the DEPARTMENT or the State of Connecticut. The views and opinions expressed are those of the authors." The Contractor or any of its agents shall not copyright data and information obtained under the terms and conditions of this contract, unless expressly authorized in writing by the DEPARTMENT. The DEPARTMENT shall have the right to publish, duplicate, use and disclose all such data in any manner and may authorize others to do so. The DEPARTMENT 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 DEPARTMENT of such data.

b. "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, surveys, charts, recordings (video and/or sound), pictures, curricula, 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.

2. Organizational Information, Conflict of Interest, IRS Form 990: Annually during the term of the contract, the Contractor shall submit to the DEPARTMENT the following:

a. a copy of its most recent IRS Form 990 submitted to the federal Internal Revenue Service and

b. its most recent Annual Report as filed with the Office of the Secretary of the State or such other information that the DEPARTMENT deems appropriate with respect to the organization and affiliation of the Contractor and related entities.

3. Prohibited Interest: The Contractor warrants that no state appropriated funds have been paid or will be paid by or on behalf of the Contractor to contract with or retain any company or person, other than bona fide employees working solely for the Contractor, to influence or attempt to influence an officer or employee of any state agency in connection with the awarding, extension, continuation, renewal,

amendment, or modification of this agreement, or to pay or agree to pay any company or person, other than bona fide employees working solely for the Contractor, any fee, commission, percentage, brokerage fee, gift or any other consideration contingent upon or resulting from the award or making of this Agreement.

4. **Offer of Gratuities:** By its agreement to the terms of this contract, the Contractor certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this contract. The DEPARTMENT may terminate this contract if it is determined that gratuities of any kind were either offered or received by any of the aforementioned officials or employees from the Contractors or employees.

5. **Related Party Transactions:** The Contractor shall report all related party transactions, as defined in this Section, to the DEPARTMENT on an annual basis in the appropriate fiscal report as specified in Part II 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 exercise influence or control, directly or indirectly. "Related party transactions" between a Contractor, its employees, Board members or members of the Contractor's governing body 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.

6. **Insurance:** The Contractor will carry insurance, (liability, fidelity bonding or surety bonding and/or other), as specified in this agreement, during the term of this contract according to the nature of the work to be performed to "save harmless" the State of Connecticut from any claims, suits or demands that may be asserted against it by reason of any act or omission of the Contractor, subcontractor or employees in providing services hereunder, including but not limited to any claims or demands for malpractice. Certificates of such insurance shall be filed with the DEPARTMENT before the performance of services.

7. **Reports:** The Contractor shall provide the DEPARTMENT 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 agrees to provide the DEPARTMENT with such reports as the DEPARTMENT requests.

8. **Delinquent Reports:** The Contractor will submit required reports by the designated due dates as identified in this agreement. After notice to the Contractor and an opportunity for a meeting with a DEPARTMENT representative, the DEPARTMENT reserves the right to withhold payments for services performed under this contract if the DEPARTMENT has not received acceptable progress reports, expenditure reports, refunds and/or audits as required by this agreement or previous agreements for similar or equivalent services the Contractor has entered into with the DEPARTMENT.

9. **Record Keeping and Access:** The Contractor shall maintain books, records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices which sufficiently and properly

reflect all direct and indirect costs of any nature incurred in the performance of this contract. These records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the state or, where applicable, federal agencies. The Contractor shall retain all such records concerning this contract for a period of three (3) years after the completion and submission to the state of the Contractor's annual financial audit.

10. **Workforce Analysis:** The Contractor shall provide a workforce analysis affirmative action report related to employment practices and procedures.

11. **Audit Requirements:** 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 single audit standards as applicable.

12. **Litigation:**

    a. The Contractor shall provide written notice to the DEPARTMENT of any litigation that relates to the services directly or indirectly financed under this contract or that has the potential to impair the ability of the Contractor to fulfill the terms and conditions of this contract, including but not limited to financial, legal or any other situation which may prevent the Contractor from meeting its obligations under the contract.

    b. The Contractor shall provide written notice to the DEPARTMENT 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, executive orders Nos. 3 & 17 of Governor Thomas J. Meskill and any other provisions of federal or state law concerning equal employment opportunities or nondiscriminatory practices.

13. **Lobbying:** The Contractor agrees to abide by state and federal lobbying laws and further specifically agrees not to include in any claim for reimbursement any expenditures associated with activities to influence, directly or indirectly, legislation pending before Congress, or the Connecticut General Assembly or any administrative or regulatory body unless otherwise required by this contract.

C. Statutory and Regulatory Compliance

1. **Compliance with Law and Policy:** Contractor shall comply with all pertinent provisions of local, state and federal laws and regulations as well as policies and procedures of the DEPARTMENT applicable to Contractor's programs as specified in this contract. The DEPARTMENT shall notify the Contractor of any applicable new or revised laws, regulations, policies or procedures that the DEPARTMENT has responsibility to promulgate or enforce.

2. **Federal Funds:** The Contractor shall comply with requirements relating to the receipt or use of federal funds. The DEPARTMENT shall specify all such requirements in Part I of this contract.

3. **Facility Standards and Licensing Compliance:** The Contractor will comply with all 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.

4. Suspension or Debarment:

a. Signature on contract certifies the Contractor or any person (including subcontractors) involved in the administration of Federal or State funds:

i. is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any governmental department or agency (Federal, State or local);

ii. within a three year period preceding this contract, has not been convicted or had a civil judgment rendered against him/her 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; 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. is 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;

iv. has not within a three year period preceding this agreement had one or more public transactions terminated for cause or fault.

b. Any change in the above status shall be reported to the DEPARTMENT immediately.

5. Non-discrimination Regarding Sexual Orientation: Unless otherwise provided by Conn. Gen. Stat. § 46a-81p, the Contractor agrees to the following provisions required pursuant to § 4a-60a of the Conn. Gen. Stat.:

a. The Contractor agrees:

i. and warrants that in the performance of the contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or of the State of Connecticut and that employees are treated when employed without regard to their sexual orientation;

ii. to provide each labor union or representatives 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;

iii. to comply with each provision of this section and with each regulation or relevant order issued by said commission pursuant to § 46a-56 of the Conn. Gen. Stat.;

iv. 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 provisions of this section and § 46a-56 of the Conn. Gen. Stat.

b. The Contractor shall include the provisions of Subsection a 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 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 § 46a-56 of the Conn. Gen. Stat. provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the state and the state may so enter.

6. Executive Orders Nos. 3, 16 & 17:

a. Executive Order No. 3: Nondiscrimination: This contract is subject to the provisions of Executive Order No. Three of Governor Thomas J. Meskill promulgated June 16, 1971 and, as such, this contract may be canceled, terminated or suspended by the State Labor Commissioner for violation of or noncompliance with said Executive Order No. Three, or any state or federal law concerning nondiscrimination, notwithstanding that the Labor Commissioner is not a party to this contract. The parties to this contract, as part of the consideration hereof, agree that said Executive Order No. Three is incorporated herein by reference and made a part hereof. The parties agree to abide by said Executive Order and agree that the State Labor Commissioner shall have continuing jurisdiction in respect to contract performance in regard to nondiscrimination, until the contract is completed or terminated before completion. The Contractor agrees, as part consideration hereof, that this contract is subject to the Guidelines and Rules issued by the State Labor Commissioner to implement Executive Order No. Three and that the Contractor will not discriminate in employment practices or policies, will file all reports as required and will fully cooperate with the State of Connecticut and the State Labor Commissioner.

b. Executive Order No. 16: Violence in the Workplace Prevention Policy: This contract is also subject to provisions of Executive Order No. Sixteen of Governor John G. Rowland promulgated August 4, 1999 and, as such, this contract may be cancelled, terminated or suspended by the contracting agency or the State for violation of or noncompliance with said Executive Order No. Sixteen. The parties to this contract, as part of the consideration hereof, agree that:

i. Contractor shall prohibit employees from bringing into the state work site, except as may be required as a condition of employment, any weapon/dangerous instrument defined in Subsection ii to follow.

ii. Weapon means any firearm, including a BB gun, whether loaded or unloaded, any knife (excluding a small pen or pocket knife), including a switchblade or other knife having an automatic spring release device, a stiletto, any police baton or nightstick or any martial arts weapon or electronic defense weapon. Dangerous instrument means any instrument, article or substance that, under the circumstances, is capable of causing death or serious physical injury.

iii. Contractor shall prohibit employees from attempting to use, or threaten to use, any such weapon or dangerous instrument in the state work site and employees shall be prohibited from causing, or threatening to cause, physical injury or death to any individual in the state work site.

iv. Contractor shall adopt the above prohibitions as work rules, violation of which shall subject the employee to disciplinary action up to and including discharge. The Contractor shall require that all employees are aware of such work rules.

v. Contractor agrees that any subcontract it enters into in the furtherance of the work to be performed hereunder shall contain the provisions i through iv, above.

c. Executive Order No. 17: Connecticut State Employment Service Listings: This contract is also subject to provisions of Executive Order No. Seventeen of Governor Thomas J. Meskill promulgated February 15, 1973 and, as such, this contract may be canceled, terminated or suspended by the contracting agency or the State Labor Commissioner for violation of or noncompliance with said Executive Order Number Seventeen, notwithstanding that the Labor Commissioner may not be a party to this contract. The parties to this contract, as part of the consideration hereof, agree that Executive Order No. Seventeen is incorporated herein by reference and made a part hereof. The parties agree to abide by said Executive Order and agree that the contracting agency and the State Labor Commissioner shall have joint and several continuing jurisdiction in respect to contract performance in regard to listing all employment openings with the Connecticut State Employment Service.

7. Nondiscrimination and Affirmative Action Provisions in Contracts of the State and Political Subdivisions Other Than Municipalities: The Contractor agrees to comply with provisions of § 4a-60 of the Connecticut General Statues

a. Every contract to which the state or any political subdivision of the state other that a municipality is a party shall contain the following provisions: (1) The Contractor agrees and warrants that in the performance of the contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or of the State of Connecticut. The Contractor further agrees to take affirmative action to insure that applicants

with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation, or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved; (2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that is an "affirmative action-equal opportunity employer" in accordance with regulations adopted by the commission; (3) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining agreement or other contract or understanding and each vendor with which such Contractor has a contract or understanding, a notice to be provided by the commission advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment; (4) the Contractor agrees to comply with each provision of this section and Conn. Gen. Stat. §§46a-68e and 46a-68f and with each regulation or relevant order issued by said commission pursuant to Conn. Gen. Stat. §§46a-56, 46a-68e and 46a-68f; (5) the Contractor agrees to provide the commission of 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 Conn. Gen. Stat. §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 project.

b. For the purposes of this section, "minority business enterprise" means any small Contractor or supplier of materials fifty-one per cent or more of 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 Conn. Gen. Stat. § 32-9n; and "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations. "Good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements.

c. Determinations 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 action 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. Contractor shall include the provisions of Subsection a 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 provision 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 Conn. Gen. Stat. § 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 such litigation or negotiation prior thereto to protect the interests of the state and the state may so enter.

8. **Americans with Disabilities Act of 1990:** This clause applies to those Contractors which are or will come to be responsible for compliance with the terms of the Americans with Disabilities Act of 1990 (42 U.S.C.S §§12101-12189 and §§12201-12213) (Supp. 1993); 47 U.S.C.S §§225, 611 (Supp. 1993). During the term of the contract, 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 will 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 agrees to abide by provisions of Sec. 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. §794 (Supp. 1993), regarding access to programs and facilities by people with disabilities.

9. **Utilization of Minority Business Enterprises**: It is the policy of the state that minority business enterprises should have the maximum opportunity to participate in the performance of government contracts. The Contractor agrees to use best efforts consistent with 45 CFR § 74.160 et seq. (1992) and paragraph 9 of Appendix G thereto for the administration of programs or activities using HHS funds; and Conn. Gen. Stat. §§3a-95a, 4a-60, to 4a-62, 4b-95(b) and 32-9e to carry out this policy in the award of any subcontracts.

10. **Priority Hiring:** Subject to the Contractor's exclusive right to determine the qualifications for all employment positions, the Contractor shall use its best efforts to ensure that it gives priority to hiring welfare recipients who are subject to time limited welfare and must find employment. The Contractor and the DEPARTMENT will work cooperatively to determine the number and types of positions to which this paragraph shall apply. The Department of Social Services regional office staff or staff of Department of Social Service Contractors will undertake to counsel and screen an adequate number of appropriate candidates for positions targeted by the Contractor as suitable for individuals in the time limited welfare program. The success of the Contractor's efforts will be considered when awarding and evaluating contracts.

11. **Non-smoking:** If the Contractor is an employer subject to the provisions of § 31-40q of the Conn. Gen. Stat., the Contractor agrees to provide upon request the DEPARTMENT with a copy of its written rules concerning smoking. Evidence of compliance with the provisions of § 31-40q of the Conn. Gen. Stat. must be received before contract approval by the DEPARTMENT.

12. **Government Function; Freedom of Information:** If the amount of this contract exceeds two million five hundred thousand dollars ($2,500,000) and the contract is for the performance of a governmental function, as that term is defined in Conn. Gen. Stat. Sec. 1-200(11), as amended by Pubic Act 01-169, the

DEPARTMENT is entitled to receive a copy of the records and files related to the Contractor's performance of the governmental function and may be disclosed by the DEPARTMENT pursuant to the Freedom of Information Act.

13. HIPAA Requirements:

NOTE: Numbering in this Section may not be consistent with the remainder of this contract as much of it is presented verbatim from the federal source.

a. If the Contactor is a Business Associate under 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 Members in accordance "with all applicable federal and state law regarding confidentiality, which includes but is not limited to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), more specifically with the Privacy and Security Rules at 45 CFR Part 160 and Part 164, subparts A, C and E; *and*

c. The State of Connecticut Department named on page 1 of this contract (hereinafter "Department") is a "covered entity" as that term is defined in 45 CFR §§ 160.103; *and*

d. The Contractor, on behalf of the Department, performs functions that involve the use or disclosure of "individually identifiable health information," as that term is defined in 45 CFR §§ 160.103 ; *and*

e. The Contractor is a "business associate" of the Department, as that term is defined in 45 CFR §§ 160.103; *and*

f. The Contractor and the Department agree to the following in order to secure compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), more specifically with the Privacy and Security Rules at 45 CFR Part 160 and Part 164, subparts A, C and E:

I. Definitions

A. Business Associate. "Business Associate" shall mean the Contractor.

B. Covered Entity. "Covered Entity" shall mean the Department of the State of Connecticut named on page 1 of this contract.

C. Designated Record Set. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR §§ 164.501.

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

E. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and parts 164, subparts A and E.

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

G. Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR §§ 164.103.

H. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

I. More Stringent. "More stringent" shall have the same meaning as the term "more stringent" in 45 CFR §§ 160.202.

J. Section of Contract. "(T)his Section of the Contract" refers to the HIPAA Provisions stated herein, in their entirety.

K. Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR §§ 164.304.

L. Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Parts 164, subpart A and C.

II. Obligations and Activities of Business Associates

A. 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

B. 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.

B1. 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.

C. 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.

D. 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.

E. 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.

F. 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 CFR §§ 164.524.

G. 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 CFR §§ 164.526 at the request of the Covered Entity and in the time and manner agreed to by the parties.

H. 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.

I. 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 CFR §§ 164.528.

J. Business Associate agrees to provide to Covered Entity, in a time and manner agreed to by the parties, information collected in accordance with paragraph I 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 CFR §§ 164.528.

K. Business Associate agrees to comply with any state law that is more stringent than the Privacy Rule.

III. Permitted Uses and Disclosure by Business Associate

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

B. Specific Use and Disclosure Provisions:

1. 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.

2. 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.

3. 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 CFR §§ 164.504(e)(2)(i)(B).

IV. Obligations of Covered Entity

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

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

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

V. 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.

VI. Term and Termination

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

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

1. 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

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

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

C. Effect of Termination.

1. Except as provided in paragraph (ii) of this Subsection c, 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. This provision 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.

2. 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 of 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.

VII. Miscellaneous HIPAA Provisions

A. 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.

B. 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.

C. Survival. The respective rights and obligations of Business Associate under Section 6, Subsection c of this Section of the Contract shall survive the termination of this contract.

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

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

F. Disclaimer. Covered Entity makes no warranty or representation that compliance with this Section of the Contract will be adequate or satisfactory for Business Associate's own purposes. Covered Entity shall not be liable to Business Associate for any claim, 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 pursuant to paragraph II D of this Section of the Contract. Business Associate is solely responsible for all decisions made and actions taken, by Business Associate regarding the safeguarding, use and disclosure of PHI within its possession, custody or control.

G. Indemnification. The Business Associate shall indemnify and hold the Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees and costs of investigation, litigation or dispute resolution, relating to or arising out of any violation by the Business Associate, including subcontractors, of any obligation of Business Associate, including subcontractors, under this Section of the Contract.

D. Miscellaneous Provisions

1. Liaison: Each party shall designate a liaison to facilitate a cooperative working relationship between the Contractor and the DEPARTMENT in the performance and administration of this contract. 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 the contract.

2. **Choice of Law and Choice of Forum:** The Contractor agrees to be bound by the law of the State of Connecticut and the federal government where applicable and agrees that this contract shall be construed and interpreted in accordance with Connecticut law and federal law where applicable.

3. **Subcontracts**: For purposes of this clause subcontractors shall be defined as providers of direct human services. 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. The subcontractor's identity, services to be rendered and costs shall be detailed in PART I of this contract. Notwithstanding the execution of this contract before a specific subcontractor being identified or specific costs being set, no subcontractor may be used or expense under this contract incurred before identification of the subcontractor or inclusion of a detailed budget statement as to subcontractor expense, unless expressly provided in PART I of this contract. Identification of a subcontractor or budget costs for such subcontractor shall be deemed a technical amendment if consistent with the description of each contained in PART I of this contract. No subcontractor shall acquire any direct right of payment from the DEPARTMENT by virtue of the provisions of this paragraph or any other paragraph of this contract. The use of subcontractors, as defined in this clause, shall not relieve the Contractor of any responsibility or liability under this contract. The Contractor shall make available copies of all subcontracts to the DEPARTMENT upon request.

4. **Mergers and Acquisitions:**

   a. Contracts in whole or in part are not transferable or assignable without the prior written agreement of the DEPARTMENT.

   b. At least ninety (90) days before the effective date of any fundamental changes in corporate status, including merger, acquisition, transfer of assets and any change in fiduciary responsibility, the Contractor shall provide the DEPARTMENT with written notice of such changes.

   c. The Contractor shall comply with requests for documentation deemed necessary by the DEPARTMENT to determine whether the DEPARTMENT will provide prior written agreement as required by Section II.4.iii above. The DEPARTMENT shall notify the Contractor of such determination not later than forty-five (45) business days from the date the DEPARTMENT receives such requested documentation.

5. **Equipment:** In the event this contract is terminated or not renewed, the DEPARTMENT reserves the right to recoup any equipment, deposits or down payments made or purchased with start-up funds or other funds specifically designated for such purpose under this contract. For purposes of this provision, equipment means tangible personal property with a normal useful life of at least one year and a value of at least $2,500. Equipment shall be considered purchased from Contractor funds and not from DEPARTMENT funds if the equipment is purchased for a program that has other sources of income equal to or greater than the equipment purchase price.

6. **Independent Capacity of Contractor:** The Contractor, its officers, employees, subcontractors, or any other agent of the Contractor in the performance of this contract will act in an independent capacity and not as officers or employees of the State of Connecticut or of the DEPARTMENT.

7. **Settlement of Disputes and Claims Commission:**

   a. Any dispute concerning the interpretation or application of this contract shall be decided by the commissioner of the DEPARTMENT 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 commissioner pursuant to this provision, 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 DEPARTMENT shall proceed diligently with the performance of the contract.

   b. Claims Commission. 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 Conn. Gen. Stat. 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.

E. Revisions, Reduction, Default and Cancellation

1. Contract Revisions and Amendments:

   a. A formal contract amendment, in writing, shall not be effective until executed by both parties to the contract and, where applicable, the Attorney General. Such amendments shall be required for extensions to the final date of the contract period and to terms and conditions specifically stated in Part II of this contract, including but not limited to revisions to the maximum contract payment, to the unit cost of service, to the contract's objectives, services, or managed care plan, to due dates for reports, to completion of objectives or services and to any other contract revisions determined material by the DEPARTMENT.

   b. The Contractor shall submit to the DEPARTMENT in writing any proposed revision to the contract and the DEPARTMENT shall notify the Contractor of receipt of the proposed revision. Any proposal deemed material shall be executed pursuant to (a) of this section. The DEPARTMENT may accept any proposal as a technical amendment and notify the Contractor in writing of the same. A technical amendment shall be effective on the date approved by the DEPARTMENT, unless expressly stated otherwise.

   c. No amendments may be made to a lapsed contract.

2. Contract Reduction:

   a. The DEPARTMENT reserves the right to reduce the contracted amount of compensation at any time in the event that:

      i. the Governor or the Connecticut General Assembly rescinds, reallocates, or in any way reduces the total amount budgeted for the operation of the DEPARTMENT during the fiscal year for which such funds are withheld; or

      ii. Federal funding reductions result in reallocation of funds within the DEPARTMENT.

b. The Contractor and the DEPARTMENT agree to negotiate on the implementation of the reduction within thirty (30) days of receipt of formal notification of intent to reduce the contracted amount of compensation from the DEPARTMENT. If agreement on the implementation of the reduction is not reached within thirty (30) calendar days of such formal notification and a contract amendment has not been executed, the DEPARTMENT may terminate the contract sixty (60) days from receipt of such formal notification. The DEPARTMENT will formally notify the Contractor of the termination date.

3. Default by the Contractor:

a. If the Contractor defaults as to, or otherwise fails to comply with, any of the conditions of this contract the DEPARTMENT may:

i. withhold payments until the default is resolved to the satisfaction of the DEPARTMENT;

ii. temporarily or permanently discontinue services under the contract;

iii. require that unexpended funds be returned to the DEPARTMENT;

iv. assign appropriate state personnel to execute the contract until such time as the contractual defaults have been corrected to the satisfaction of the DEPARTMENT;

v. require that contract funding be used to enter into a sub-contract arrangement with a person or persons designated by the DEPARTMENT in order to bring the program into contractual compliance;

vi. terminate this contract;

vii. 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;

viii. any combination of the above actions.

b. In addition to the rights and remedies granted to the DEPARTMENT by this contract, the DEPARTMENT 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.

c. Prior to invoking any of the remedies for default specified in this paragraph except when the DEPARTMENT deems the health or welfare of service recipients is endangered as specified in Part II Section A.3 of this agreement or has not met requirements as specified in clause 8, the DEPARTMENT shall notify the Contractor in writing of the specific facts and circumstances constituting default or failure to comply with the conditions of this contract and proposed remedies. Within five (5) business days of receipt of this notice, the Contractor shall correct any contractual defaults specified in the notice and submit written documentation of correction to the satisfaction of the DEPARTMENT or request in writing a meeting with the commissioner of the DEPARTMENT or his/her designee. Any such meeting shall be held within five (5) business days of the written request. At the meeting, the Contractor shall be given an opportunity to respond to the DEPARTMENT's notice of default and to present a plan of correction with applicable time frames. Within five (5) business days of such meeting, the commissioner of the DEPARTMENT shall

notify the Contractor in writing of his/her response to the information provided including acceptance of the plan of correction and, if the commissioner finds continued contractual default for which a satisfactory plan of corrective action has not been presented, the specific remedy for default the DEPARTMENT intends to invoke. This action of the commissioner shall be considered final.

d. If at any step in this process the Contractor fails to comply with the procedure and, as applicable, the agreed upon plan of correction, the DEPARTMENT may proceed with default remedies.

4. Non-enforcement not to constitute waiver: The failure of either party to insist upon strict performance of any terms or conditions of this agreement shall not be deemed a waiver of the term or condition or any remedy that each party has with respect to that term or condition nor shall it preclude a subsequent default by reason of the failure to perform.

5. Cancellation and Recoupment:

a. This contract shall remain in full force and effect for the entire term of the contract period specified on page 1 of this agreement, unless either party provides written notice ninety (90) days or more from the date of termination, except that no cancellation by the Contractor may be effective for failure to provide services for the agreed price or rate and cancellation by the DEPARTMENT shall not be effective against services already rendered, so long as the services were rendered in compliance with the contract during the term of the contract.

b. In the event the health or welfare of Members is endangered, the DEPARTMENT may cancel the contract and take any immediate action without notice it deems appropriate to protect the health and welfare of Members. The DEPARTMENT shall notify the Contractor of the specific reasons for taking such action in writing within five (5) business days of cancellation. Within five (5) business days of receipt of this notice, the Contractor may request in writing a meeting with the commissioner of the DEPARTMENT or his/her designee. Any such meeting shall be held within five (5) business days of the written request. At the meeting, the Contractor shall be given an opportunity to present information on why the DEPARTMENT's actions should be reversed or modified. Within five (5) business days of such meeting, the commissioner of the DEPARTMENT shall notify the Contractor in writing of his/her decision upholding, reversing or modifying the action of the DEPARTMENT. This action of the commissioner shall be considered final.

c. The DEPARTMENT reserves the right to cancel the contract without prior notice when the funding for the contract is no longer available.

d. The DEPARTMENT reserves the right to recoup any deposits, prior payment, advance payment or down payment made if either party terminates the contract. Allowable costs incurred to date of termination for operation or transition of program(s)/Plan(s) under this contract shall not be subject to recoupment. The Contractor agrees to return to the DEPARTMENT 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 DEPARTMENT may recoup said funds from any future payments owing under this contract or any other contract between the state and the Contractor.

6. **Transition after Termination or Expiration of Contract:** In the event that this contract is terminated for any reason except where the health and welfare of Members is endangered or if the DEPARTMENT does not offer the Contractor a new contract for the same or similar service at the contract's expiration, the Contractor will assist in the orderly transfer of Members as required by the DEPARTMENT and will assist in the orderly cessation of operations under this contract. Prior to incurring expenses related to the orderly transfer or continuation of services to Members beyond the terms of the contract, the DEPARTMENT and the Contractor agree to negotiate a termination amendment to the existing agreement to address current program components and expenses, anticipated expenses necessary for the orderly transfer of Members and changes to the current program to address Member needs. The contractual agreement may be amended as necessary to assure transition requirements are met during the term of this contract. If the transition cannot be concluded during this term, the DEPARTMENT and the Contractor may negotiate an amendment to extend the term of the current contract until the transition may be concluded.
7. **Program Cancellation:** Where applicable, the cancellation or termination of any individual program or services under this contract will not, in and of itself, in any way affect the status of any other program or service in effect under this contract.

9. MANDATORY SPECIAL TERMS AND CONDITIONS

9.01 Construction

The Contractor agrees to comply with the following special mandatory terms and conditions. If any of the special mandatory terms and conditions in this section conflict with the terms and conditions in Section Eight of this Contract, these special mandatory terms and conditions shall control.

9.02 State of Connecticut Held Harmless

a. The MCO agrees to indemnify, defend and hold harmless the State of Connecticut as well as all Departments, officers, agents and employees of the State from all claims, losses or suits accruing or resulting to any contractors, subcontractors, laborers and any person, firm or corporation who may be injured or damaged through the fault of the MCO in the performance of the contract.

b. The MCO, at its own expense, shall defend any claims or suits which are brought against the DEPARTMENT or the State for the infringement of any patents, copyrights, or other proprietary rights arising from the MCO's or the State's use of any material or information prepared or developed by the MCO in conjunction with the performance of this contract; provided any such use by the State is expressly contemplated by this contract and approved by the MCO. The State, its Departments, officers, employees, contractors, and agents shall cooperate fully in the MCO's defense of any such claim or suit as directed by the MCO. The MCO shall, in any such suit, satisfy any damages for infringement assessed against the State or the DEPARTMENT, be it resolved by settlement negotiated by the MCO, final judgment of a court with jurisdiction after exhaustion of available appeals, consent decree, or any other manner approved by the MCO.

9.03 Financial Disclosure

If the MCO is not a federally-qualified health maintenance organization prior to the start date of the contract and annually thereafter, the MCO shall report to the State a description of transactions between the MCO and a party in interest. In addition, the MCO shall provide this information upon request to the Secretary of HHS, the Inspector General of HHS, and the Comptroller General.

9.04 DEPARTMENT's Data Files

a. The DEPARTMENT's data files and data contained therein shall be and remain the DEPARTMENT's property and shall be returned to the DEPARTMENT by the MCO upon the termination of this contract at the DEPARTMENT's request, except that any DEPARTMENT data files no longer required by the MCO to render services under this contract shall be returned upon such determination at the DEPARTMENT's request.

b. The DEPARTMENT's data shall not be utilized by the MCO for any purpose other than that of rendering services to the DEPARTMENT under this contract, nor shall

the DEPARTMENT's data or any part thereof be disclosed, sold, assigned, leased or otherwise disposed of to third parties by the MCO unless there has been prior written DEPARTMENT approval. The MCO may disclose material and information to subcontractors, as necessary to fulfill the obligations of this contract.

c. The MCO shall establish and maintain at all times reasonable safeguards against the destruction, loss or alteration of the DEPARTMENT's data and any other data in the possession of the MCO necessary to the performance of services under this contract.

9.05 Ownership

If this contract calls for the creation, production or writing by the MCO of any document, computer program, data, analyses or creation of whatever description, all rights of ownership and ownership of the copyright of these documents, computer program, data, analyses or creation of whatever description belongs to the State of Connecticut.

9.06 Severability

If any provision of this contract is declared or found to be illegal, unenforceable, or void, then both parties shall be relieved of all obligations under that provision. The remainder of this contract shall be enforced to the fullest extent permitted by law.

9.07 Waivers

Except as specifically provided in any section of this contract, no covenant, condition, duty, obligation or undertaking contained in or made a part of the contract shall be waived except by the written agreement of the parties, and forbearance or indulgence in any form or manner by the DEPARTMENT or the MCO in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation or undertaking to be kept, performed, or discharged by the DEPARTMENT or the MCO; and not withstanding any such forbearance or indulgence, until complete performance or satisfaction of all such covenants, conditions, duties, obligations and undertakings, the DEPARTMENT or MCO shall have the right to invoke any remedy available under the contract, or under law or equity.

9.08 Force Majeure

The MCO shall be excused from performance hereunder for any period that it is prevented from providing, arranging for, or paying for services as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.09 Federal Requirements and Assurances

a. General

1. The MCO shall comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B, which are applicable to the MCO. The MCO is responsible for determining which requirements and assurances are applicable to the MCO. Copies of the form are available from the DEPARTMENT.
2. The MCO shall provide for the compliance of any subcontractors with applicable federal requirements and assurances.
3. The MCO shall comply with all applicable provisions of 45 CFR § 74.48 and all applicable requirements at 45 CFR § 74.48 Appendix A.

b. Lobbying

1. The MCO, as provided by 31 U.S.C. § 1352 and 45 CFR § 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.
2. The MCO shall submit to the DEPARTMENT a disclosure form as provided in 45 CFR § 93.110 and Appendix B to 45 CFR Part 93, if any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress or an employee of a member of the U.S. Congress in connection with this contract.

c. Title XXI and SCHIP Regulations

The MCO shall comply with all applicable provisions of Title XXI of the Social Security Act and 42 CFR Part 457.

d. Balanced Budget Act and Implementing Regulations

The MCO shall comply with all applicable provisions of 42 U.S.C. § 1396u-2, 42 U.S.C. § 1396b(m) and 42 CFR Part 438.

e. Clean Air and Water Acts

The MCO and all subcontractors with contracts in excess of $100,000 shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act as amended, 42 U.S.C. §§7401, et seq. and §508 of the Clear Water Act (33 U.S.C. § 368), Executive Order 11738, and 40 CFR Part 15).

f. Energy Standards

The MCO shall comply with all applicable standards and policies relating to energy efficiency that are contained in the state energy plan issued in compliance with the federal Energy Policy and Conservation Act, 42 U.S.C. §§6231-46.

g. Maternity Access and Mental Health Parity

The MCO shall comply with the maternity access and mental health parity requirements of the Public Health Services Act, Title XXVII, Subpart 2, Part A, §2704, as added September 26, 1996, 42 U.S.C. §§300gg-4, 300gg-5, insofar as such requirements apply to providers of group health insurance.

h. CLIA

The MCO shall adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578, 42 U.S.C. § 1395aa et seq.

SECTION IV PROPOSAL CONTENTS
Part Four: BUSINESS COST PROPOSAL

No cost information or other financial information may be included in any other portion of the proposal. Any proposal that fails to adhere to this requirement may be disqualified as non-responsive. Financial Statements do not count toward the total page limit of the proposal. Each proposal must include cost information and other financial information in the following order:

1. Financial Capacity and Bonding

Financial Statements

The Bidder shall supply evidence of adequate financial stability including:

a. The most recent annual statement filed with an insurance department including all supplements, management, discussion and analysis and actuarial opinion.

b. the three most recent years of audited financial statements or equivalent, including

   1) the United State Securities and Exchange Commission, Form 10K,

   2) Annual Report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934, if applicable.

   3) an income statement for the last three fiscal years for the company, and/or parent company if it is controlled by another entity by the major line of business including Commercial (fully or self insured), State Employee, and Medicaid.

c. If the Bidder is either substantially or wholly owned by another corporate (or other) entity, the Bidder shall also include the most recent detailed financial report of the parent organization and a statement that the parent organization will unconditionally guarantee performance by the Bidder in each and every term, covenant, and condition of any contract as executed by the parties. If any change of ownership of the company is anticipated during the 12 months following the proposal due date, describe the circumstances of such change and indicate when the change is likely to occur.

2. Evidence of Financial Solvency

a. The Bidder shall provide a certified public accountant's statement of tangible net worth as of the Bidder's most recent three fiscal years. Included in the statement must be a description of any uncertainties and the potential impact of such uncertainties on tangible net worth.

b. Tangible net worth is defined as net worth less intangible assets. Net worth can include a parent company's assets if these assets have been pledged under the conditions below if a subsidiary is the MCO.

c. The Bidder shall certify that it is and will remain in full compliance with all applicable state and federal solvency requirements for its licensure.

d. The Bidder shall certify that it is currently compliant with state statutes, rules or regulations by the State Insurance Commissioner any other regulatory agencies

in states in which it currently is licensed, and if applicable, the Commissioner of the Connecticut Insurance Department or any other regulatory agencies.

3. Minimum Net Worth

a. The Bidder shall demonstrate a minimum net worth to the greater of:

1) 100% of the Authorized Control Level of the NAIC's Risk Based Capital Requirements; or

2) An amount that complies with the minimum net worth requirements of its state of domicile.

b. For purposes of this RFP, "minimum net worth" means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with applicable law.

4. Fidelity Bond and Deposit

a. The Bidder, if a resultant contract ensues, shall obtain and maintain a fidelity bond in its own name for its officers and employees to insure against criminal conduct or fraud by MCO employees.

1). The fidelity bond required by this section must:

a). Be issued by a surety or other entity duly licensed and authorized to conduct business in the State of Connecticut and rated "A" or better by a rating agency acceptable to DSS.

b). Be in an amount not less than $100,000.00.

c). Indemnify DSS and the State against any financial loss caused by the wrongful, fraudulent, or criminal conduct of the MCO's employees, officers, or directors.

d). Name DSS as the principal beneficiary of the bond.

b. The fidelity bond must be tendered to DSS within ten business days of Contract award. Any applicable renewals of the fidelity bond must be tendered to DSS within ten business days of issuance.

c. The Bidder agrees that prior to engaging in business under this agreement it will deposit with the Connecticut Insurance Department (CID) $100,000 in cash or securities for the benefit of the Husky/Charter Oak program. This amount will be restricted for the DSS Contract, plus an additional 12 months after the expiration of the Contract or any outstanding audits are completed, whichever is longer. The deposit will secure the MCO's faithful performance of the terms and conditions of the agreement.

5. Claims Reports

The Bidder shall provide evidence that it has the capacity to pay claims on a timely basis. For the most recent quarter for which the Bidder has complete information the Bidder shall provide:

a. Claims Aging Inventory Report. The Claims Aging Inventory Report will include for all major lines of business (Commercial (fully or self insured), State Employee, and Medicaid), the amount of claims outstanding and the volume of claims outstanding by time period. If a subcontractor is used to provide services and/or adjudicate claims, the MCO shall provide a Claims Aging Inventory Report in the required format for each subcontractor that has claims outstanding.

b. Claims Turn Around Time Report. If a subcontractor is used to provide services and/or adjudicate claims, the MCO shall provide a Claims Turn Around Time Report in the required format for each subcontractor that has claims outstanding.

6. Pricing

The Department of Social Services will issue an addendum to this RFP which shall serve to amend this RFP. The amendment shall include pricing templates that each Bidder will be required to complete for the provision of HUSKY A, HUSKY B and Charter Oak Services.

SECTION V - PROPOSAL EVALUATION

1. OVERVIEW OF THE EVALUATION OF PROPOSALS

The Department will conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. An Evaluation Team has been established to assist the Department in selection of resultant contractors. The Department reserves the right to alter the composition of the Evaluation Team. The Evaluation Team will be responsible for submitting a recommendation to the Commissioner of Social Services. The Commissioner of Social Services will notify the selected bidders that the organization has been awarded the right to negotiate a contract with the Department for the Non-emergency Medical Transportation Program.

The evaluation will be conducted in phases: Phase One: Evaluation of General Proposal Requirements and Structure, Phase Two: Evaluation of the Organizational Capacity and Structure, and the Scope of Services, Phase Three: Evaluation of the Business Cost Proposal, and Phase Four: Ranking of the Proposals.

2. PHASE ONE: EVALUATION OF GENERAL PROPOSAL REQUIREMENTS AND STRUCTURE

The purpose of this phase is to determine whether each proposal is sufficiently responsive to the General Proposal Requirements described above to permit a complete evaluation of the proposal. Proposals must comply with the instructions to bidders contained throughout. Failure to comply with the instructions may deem the proposal non-responsive and subject to rejection without further consideration. The Department reserves the right to waive minor irregularities.

3. PHASE TWO: EVALUATION OF THE ORGANIZATIONAL CAPACITY, STRUCTURE and SCOPE OF WORK

Only those proposals passing the General Proposal Requirements review will be considered in Phase Two. The Department reserves the right to reject any and all proposals.

The quality of the work plan and the program management will be evaluated including the organization, completeness, and logic of the proposed plan. The evaluation will consider how comprehensive and knowledgeable the bidder is in responding to the functional and technical requirements outlined in this RFP.

The Department will evaluate the experience of proposed key personnel, agency and individual resources, and qualifications and affirmative action achievement (as demonstrated on the Workforce Analysis Form) of the bidder and any subcontractors. The Department will determine to what extent the organization and its key personnel have the capacity to work effectively with the Department to successfully develop and implement a non-emergency Medical Transportation Program. The Department will also assess the capability of the organization to take on the additional workload that would be generated by the resultant contracts and the bidder's financial ability to undertake the contract. References will be checked.

The proposed Scope of Services will be evaluated for its responsiveness to the requirements of this RFP including its organization, appropriateness,

completeness, and logic. The evaluation will consider how innovative and creative the bidder is in responding to the functional and technical requirements outlined in this RFP.

4. **PHASE FOUR: EVALUATION OF THE BUSINESS COST PROPOSAL**

The Business Cost Proposal will be evaluated only for bidders who achieve a minimum of seventy-five percent of the total available points in Phases Two and Three.

5. **PHASE FIVE: RANKING OF THE PROPOSALS**

Upon completion of Phases One and Two, it is possible that Evaluation Team members will interview the finalists. After the Evaluation Team has scored the proposals, the points awarded will be totaled to determine the ranking. Recommendations, along with pertinent supporting materials, will then be conveyed to the Commissioner of Social Services. The Commissioner of Social Services, at his discretion, reserves the right to approve or reject the recommendations of the Evaluation Team

Appendices

Appendix A: HUSKY A Covered Services

Appendix B: HUSKY B Covered Services

Appendix C: Charter Oak Covered Services

Appendix D: HUSKY Plus Covered Services

Appendix E: EPSDT/Well Child Periodicity & Immunization

Appendix F: Standards for Internal Quality Assurance Programs for Health Plans

Appendix G: Claims Inventory, Aging Reports

Appendix H: Unaudited Quarterly Financial Reports

Appendix I: Provider Credentialing and Enrollment Requirements

Appendix J: HUSKY A Medicaid Coverage Groups

Appendix K: Abortion Reporting

Appendix L: Charter Oak Plan Design Worksheet

Appendix M: Capitation Payment Amount

Attachments

08

HUSKY A Covered Services

For purposes of this contract, the information contained in the Department's Medical Services Policy Manuals and Departmental regulations has been summarized to provide an overview for reference of the goods and services covered by the Medicaid program (see attached list of Medical Assistance Program policies and regulations). Any limitations or exclusions to these covered goods and services are also overviewed.

Plans should be advised that, notwithstanding the following summary overview, guidance issued by the Department in the form of policy transmittals, regulations, provider bulletins, provider manuals, letters, and other written correspondence is the final authority regarding covered goods and services. The intent of the summary is to provide a quick working guide. These policies are available at the Connecticut Medical Assistance Program website: www.ctmedicalprogram.com. Whenever any questions regarding Medicaid policy occur, health plans should consult with the Department's Medical Administration Policy Unit for clarification.

Health plans are required to cover identical goods and services that are covered under the Medicaid program. Health plans do not have the option of adding or subtracting from the 'benefit package'. These goods and services are included in plans' capitation rates.. Health Plans may provide unlisted support services when such services lead to either a better health outcome or result in a less restrictive and patient preferred treatment milieu.

Under current Medicaid Fee-For-Service (FFS) reimbursement methodology, various administrative procedures related to payment for covered goods and services are in place. These procedures are not incumbent upon health plans under Medicaid Managed Care (MMC). For example, currently Medicaid FFS has administrative procedures related to physical therapy provided in the home. When physical therapy exceeds two (2) sessions per any consecutive seven (7) day period, prior authorization is required.

Whether or not a given health plan requires prior authorization prior to physical therapy being provided in the home, or requires prior authorization after a certain number of visits, or does not require prior authorization at all is not prescribed. The management of the "benefit" is at the discretion of the health plan. However, a health plan cannot decide to limit a covered good or service (e.g., cut off all physical therapy home visits after a certain number of visits). The number of medically necessary visits will vary by member, and the health plan cannot set a limit for members unless the Medicaid "benefit" itself is specifically limited in Medical Services Policy.

The Behavioral Health Partnership (“BHP”) is responsible for providing services for behavioral health conditions. The Department is responsible for Dental and Pharmacy services.

The summary overview is divided into three (3) sections. Section A contains a listing of covered goods and services included in the capitation rates. It also lists the major limitations and exclusions to these covered goods and services.

08

Section B contains a listing of covered goods and services not included in the capitation rates. Section C contains a listing of non-covered services.

SUMMARY DESCRIPTION OF BENEFITS

A. Covered Services included in the Capitation Payment

1. **Hospital Inpatient Care** (acute care hospitals) - Medically necessary and medically appropriate hospital inpatient acute care, procedures, and services, as authorized by the responsible physician(s) or dentist, and covered under Department of Social Services (DSS) policies and regulations. The responsibilities of the MCO and the BHP for inpatient care are outlined in detail in Appendix N. In general, the MCO is responsible for inpatient hospital care when the medical diagnosis is primary.

    a. Administratively Necessary Days (ANDs) are covered when a nursing home placement delay is due to unavailability of beds. However, a patient is required to accept the first available, medically appropriate bed.

    b. Organ transplants are covered if they are of demonstrated therapeutic value, medically necessary and medically appropriate, and likely to result in the prolongation and the improvement in the quality of life of the applicant. The DEPARTMENT has developed, and continues to develop, medical criteria relating to particular organ transplant procedures. These criteria are available for use by health plans. The criteria are guidelines. However, a final decision to deny a transplant request is not to be rendered without considering the medical opinion of a qualified organ transplantation expert(s) in the community.

2. **Chronic Disease Hospital Inpatient Care** - Such medically necessary care, procedures, and services as covered under DSS policy and regulation.

3. **Nursing Facility** (Skilled Nursing and Intermediate Care) Inpatient Care - Such medically necessary care is covered while the patient remains in a managed care coverage group.

4. **Intermediate Care Facility** (Mentally Retarded) Inpatient Care - Such medically necessary care is covered while the patient remains in a managed care coverage group.

5. **Christian Science Sanitoria Service** - Such medically necessary care is covered while the patient remains in a managed care coverage group.

6. **Hospital Outpatient Care** (General Hospital, , and Chronic Disease Hospital and freestanding Medical/Primary Care Clinics) - Preventive, diagnostic, therapeutic, rehabilitative, or palliative medical services provided to an outpatient by or under the direction of a physician or dentist in a licensed hospital facility. Section 3.17 and Appendix N outline the

responsibilities of the MCO and the CT BHP. The MCO is responsible for coverage for all primary care and other medical services at hospital outpatient clinics, regardless of diagnosis and including all medical specialty and ancillary services. The MCO will maintain responsibility for primary care and other medical services provided by freestanding clinics, regardless of diagnosis.

7. **Physician Services** - Primary and specialty services provided by a licensed physician or doctor of osteopathy and performed within the scope of practice of medicine or osteopathy as defined by State law. As outlined in Section 3.17 and Appendix N, the MCO retains responsibility for all primary care services and charges regardless of diagnosis.

8. **Nurse-Midwifery Services** - Services provided by a licensed, certified nurse-midwife that are related to the care, and to the management of the care, of essentially normal mothers and newborns (only throughout the maternity cycle) and well woman gynecological care, including family planning services.

9. **Nurse Practitioner Services** - Services that are provided by a licensed Advanced Practice Registered Nurse (APRN) and that are within his or her scope of practice as defined by State law.

10. **Chiropractor Services** - Manual manipulation of the spine performed by a licensed chiropractor within the scope of chiropractic practice. Noncovered services:

    a. Prescription or administration of any medicine or drug or the performance of any surgery;

    b. X-rays furnished by a chiropractor.

    c. Manipulation of other parts of the body (e.g., shoulder, arm, knee, etc.) even when for subluxation of the spine; and

    d. Lab work ordered by a chiropractor.

    e. Chiropractor services provided by independently enrolled chiropractors for individuals who are 21 years of age or older.

11. **Naturopathic Services** - Services provided by a licensed naturopath that conform to accepted methods of diagnosis and treatment and that are within the scope of naturopathic practice.

    Naturopathic services provided by independently enrolled naturopaths are not covered for individuals who are 21 years of age or older.

12. **Podiatrist Services** - Services provided by a licensed podiatrist that conform to accepted methods of diagnosis and treatment and that are within the scope of podiatric practice.

    a. Limitations of Coverage

i. Orthotic and/or corrective arch supports for recipients under five years of age; and

ii. Orthotic and/or corrective arch supports only once every two (2) years.

b. Noncovered Services

i. Services of assistants at surgery;

ii. Simplified tests requiring minimal time or equipment and employing materials nominal in cost such as Clinitest, testape, Hematest, Bumintest, Dextrostix, nonphotolitric hemoglobin, etc.;

iii. Simple foot hygiene; and

iv. Repairs to devices judged to be necessitated by willful or malicious abuse on the part of the patient.

v. Podiatrist services provided by independently enrolled podiatrists are not covered for individuals who are 21 years of age or older.

13. **Laboratory Services** - Laboratory services: a) ordered by a duly licensed physician or other licensed practitioner of the healing arts; and b) performed in a laboratory that is certified according to the applicable provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and meets all applicable licensing, accreditation and certification requirements for the specific services and procedures it provides. The MCO maintains coverage responsibilities for ancillary services such as laboratory, regardless of diagnosis.

14. **Outpatient Medical Rehabilitation Services -** Medically necessary and medically appropriate outpatient rehabilitation services provided by a licensed or certified practitioner. Such services include: physical therapy, occupational therapy, speech therapy, audiology, inhalation therapy, social services, psychological services, traumatic brain injury (T.B.I.) day treatment, neuropsychological evaluation, electronystagmography, and early childhood intervention services.

a. Limitations include:

i. Sheltered workshop services for individuals who are primarily developmentally disabled are covered only if their need for this type of program stems from an etiology readily identifiable as medical or psychological in origin;

ii. T.B.I. treatment programs are limited to individuals who have sustained injury from interaction of any external forces resulting in the central nervous system (brain) dysfunctions. Developmental impairment primarily contributing to brain dysfunction is not included. The impairment must be readily identifiable as having been sustained through injury;

iii. The T.B.I. program is primarily a medical rehabilitation program, however, vocational, social, and educational services may be covered only when these services are: a) related to the individual's injury, b) are reasonable and necessary for the diagnosis or treatment of the injury, and c) are a part of the recipient's written individual plan of care; and

iv. Programs relating to the learning of basic living skills, or other activities of daily living, are limited to individuals who have lost or had impaired functions of daily living and require retraining to maximize restoration of these skills.

b. Noncovered Services include:

i. Services that are related solely to specific employment opportunities, work skills, work settings, and/or academic skills and are not reasonable or necessary for the diagnosis or treatment of an illness or injury;

ii. Speech services involving nondiagnostic, nontherapeutic, routine, repetitive, and reinforced procedures or services for the patient's general good and welfare; and

iii. Services ordinarily covered are not covered if an individual's expected restoration potential would be insignificant in relation to the extent and duration of rehabilitation services required to achieve such potential.

iv. Services provided by independently enrolled physical therapists, audiologists and speech pathologists for individuals who are 21 years of age or older.

15. **Vision Care** - Services performed by a licensed ophthalmologist, optometrist, or optician that conform to accepted methods of diagnosis and treatment.

a. Limitations of Coverage

i. Contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of Unilateral Aphakia, Keratoconus, Corneal Transplant, and High Anisometropia;

ii. Prescription sunglasses are covered when light sensitivity that will hinder driving or seriously handicap the outdoor activity of a patient is evident;

iii. Trifocals are covered when the patient has a special need due to job training program or extenuating circumstances;

iv. Extended wear contact lenses are covered for aphakia and for members whose coordination or physical condition make daily usage of contact lenses impossible;

v. Oversize lens are covered only when needed for physiological reasons, and not for cosmetic reasons; and

vi. A spare pair of eyeglasses is not covered.

16. **Durable Medical Equipment** - equipment that:

a Can stand repeated use;

b Is primarily and customarily used to serve a medical purpose;

c Is generally not useful to a person in the absence of an illness or injury; and

d Excludes items that are disposable.

Equipment covered includes: wheelchairs and accessories, walking aids, bathroom equipment (e.g., commode and safety equipment), hospital beds and accessories, inhalation therapy equipment (e.g., IPPR machines, suction machines, nebulizers, and related equipment), enteral/parenteral therapy equipment, and the repair and replacement of durable medical equipment (DME) and related equipment.

17. **Orthotic and Prosthetic Devices** - Mechanical appliances and devices for the purpose of providing artificial replacement of missing parts, and/or prevention or correction of disorders in involving physical deformities and impairments.

a. Devices covered include: braces, corsets, collars, arch supports, footplates, orthopedic shoes, orthopedic prostheses, hearing aids (including batteries, earmolds, and cords).

b. Limitations: i) orthotic and/or corrective arch supports are not provided for recipients under five years of age; ii) Metatarsus Adductus Shoes are limited to a congenital metatarsus adductus condition and are limited to children through age four as medically necessary.

18. **Oxygen Therapy** - oxygen, equipment, supplies, and services related to the delivery of oxygen.

19. **Respiratory Therapy** - services include: intermittent positive pressure breathing, ultrasonography, aerosol, sputum induction, percussion and postural drainage, arterial puncture, and withdrawal of blood for diagnosis.

20. **Dialysis** - hemodialysis and peritoneal dialysis services are covered, including the treatment of end stage renal disease.

21. **School-Based Clinics -** services provided at a facility: a) located on the grounds of a public school; b) serving enrolled recipients on a scheduled basis or for an emergency situation; and c) licensed as an outpatient medical facility to provide comprehensive care.

a. Covered services include: health assessments; family planning services; diagnosis and/or treatment of illness or injuries; laboratory testing (performed by the School-Based Health Clinic); follow-up visits; EPSDT services; one-on- one health education, medical social work services, and nutritional counseling;. The MCO is responsible for primary care services provided by school-based clinics, regardless of diagnosis, except for services described in Appendix N.

b. Noncovered services include: mandated school health screenings, simple intervention of a health problem such as nonmedical personnel could render, visits where the presenting health problem does not require a health or mental health assessment/evaluation, visits for the sole purpose of administering or monitoring medications, services that are not part of the written individual plan of care.

22. **Family Planning and Abortion** - medically approved diagnostic procedures, treatment, counseling, drugs, supplies, or devices that are prescribed or furnished by a provider to individuals of child bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

Noncovered services include: a) sterilizations for patients who are under age twenty-one (21), mentally incompetent, or institutionalized; and b) hysterectomies performed solely for the purpose of rendering an individual permanently incapable of reproducing.

23. **Ambulatory Surgery** - Services include preoperative examinations, operating and recovery room services, and all required drugs and medicine.

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

EPSDT Covered Services are described below:

a. Initial and Periodic Comprehensive Health Screenings - includes the following services provided at the intervals recommended in the Periodicity Schedule consistent with the standards of the American Academy of Pediatrics and Center for Disease Control:

   i. A comprehensive health and developmental history, including physical and nutritional assessments and mental health development screening;

   ii. A comprehensive unclothed physical examination;

   iii. Appropriate immunizations according to age and health history, unless medically contraindicated at the time;

iv. Appropriate laboratory tests (including blood lead level assessments appropriate for age and risk factors);

v. Health education (including anticipatory guidance and risk assessment);

vi. Diagnosis and treatment of problems found during the screening;

vii. Vision screenings - an objective vision screening is indicated beginning at three years of age as indicated in accordance with the Periodicity Schedule;

viii. Hearing screenings - an objective hearing screening is indicated beginning at four years of age according to the Periodicity Schedule; and

ix. Dental screenings are recommended in the Periodicity Schedule, for example, an initial direct referral to a dentist beginning at age two.

b. Dental Services - includes those dental services provided by or under the direction of a dentist, in addition to the dental screening, that are recommended in the Periodicity Schedule. Dental services also include relief of pain and infections, restoration of teeth, and maintenance of dental health.

c. Administration and Medical Interpretation of Developmental Tests - objective standardized tests, recognized by the Connecticut Birth-To-Three Council, for further diagnosis and treatment of problems found during a periodic comprehensive health screen or interperiodic encounter. Such tests include, but are not limited to, the Battelle, the Mullen, and the Bayley.

d. Case Management Services - The following services are determined to be necessary when a child evidences a need for such services as a result of a periodic comprehensive health screening or interperiodic encounter:

i. Initial case management assessment and periodic reassessment, including development of the plan of services and revision as necessary.

ii. Ongoing case management, including, at a minimum:

A) Assistance in implementing the plan of services, which includes: facilitating referrals, providing assistance in scheduling needed health or health-related services, and helping to identify and link with the child's health and social service providers. Particularly, the case management provider shall identify the child's health home or, if necessary, participate in linking the child with a quality health home, and encourage continuity of care;

B) Monitoring the delivery of and facilitating access to a periodic comprehensive health screening at the intervals recommended in the Periodicity Schedule, and other screening, diagnosis, and treatment services. Such activities also include follow-up on missed appointments, and, if necessary, assistance with arranging medical transportation, child care, and interpreter services;

C) Coordinating and integrating the plan of services, as necessary, through direct or collateral contacts with the family and members of their team of direct service providers, as appropriate;

D) Monitoring the quality and quantity of needed services that are being provided, and evaluating outcomes and assessing future needs which might support changes in the plan of services, including completing a quarterly progress note;

E) Providing health education, as needed, and in coordinating with a direct service provider, interpreting and reinforcing the service provider's recommendations for the health of the child; and

F) Providing client advocacy to ensure the smooth flow of information between the child, the child's representative, providers, and agencies, to minimize conflict between service providers, and to mobilize resources to obtain needed services.

e. Interperiodic Encounters

i. An encounter or visit to determine if there is a problem, or to treat a problem that was not evident at the time of the regularly scheduled periodic comprehensive screening but needs to be addressed before the next periodic comprehensive screening;

ii. Any screening, in addition to the screenings recommended in the Periodicity Schedule, to determine the existence of suspected physical, mental, or developmental conditions;

iii. An encounter or follow-up visit in the case of a child whose physical, mental, or developmental illness or condition has already been diagnosed prior to the child being Medicaid eligible (e.g., a pre- existing condition), but needs to be addressed before the next scheduled screening interval recommended in the Periodicity Schedule, if there are indications that the illness or condition may have become more severe or changed sufficiently so that further examination is medically necessary; and

iv. An encounter necessary to provide immunizations, vision, and/or hearing screenings (e.g., which had been deemed medically contraindicated at the time of the periodic comprehensive health screening).

f. Personal Care Services - services for a child who has a diagnosed disability and is judged to be able to benefit from one (1) or more personal care service activities as the result of a periodic comprehensive health screen or interperiodic encounter performed by a primary care provider.

   i. Covered personal care services include all tasks to assist a child with major life activities of self-care and instrumental activities as identified in the personal care services plan of care:

      A) Covered major life activities include, but are not limited to, dressing, bathing, eating, and personal health care maintenance; and

      B) Covered instrumental activities include, but are not limited to, cooking, cleaning, travel, and shopping.

   ii. The following services are not covered:

      A) Personal care services provided to an individual who does not reside at home;

      B) Personal care services provided by a family member;

      C) Home health services which duplicate personal care services (e.g., home health aide services are not covered when personal care services are appropriate);

      D) Transportation of the personal attendant to and from the child's home to provide services;

      E) Acute health care services that are covered under other DSS regulations;

      F) Personal care services when the child is eligible for or receiving comparable services from another agency or program; and

      G) Personal care services for the care or assistance that would routinely be given to a child in the absence of a disability.

g. **EPSDT Special Services** - other medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter, whether or not the good or service is included in the Connecticut Medicaid Program State Plan as a good or service available to all other Medicaid recipients. Such services include, but are not limited to, medically necessary and medically appropriate over-the-counter drugs and personal care services.

h. All medically necessary diagnosis and treatment services available to all Medicaid recipients under the Connecticut Medical Assistance Program.

08

25. **Diagnostic Services** - Medical procedures (e.g., radiology, cardiology, EEG, and ultrasound procedures) or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, to enable the identification of the existence, nature, or extent of illness, injury, or other health deviation. The MCO retains the responsibility for ancillary services such as radiology, regardless of diagnosis

26. **Home Health Care** - Medically necessary home health services ordered by the licensed practitioner and provided by a licensed home health agency on a part-time or intermittent basis to members who reside at home, as defined by Departmental policy, for the purpose of enabling the patient to remain at home or to provide a less costly alternative to institutional care. The MCO and BHP share responsibilities for home health services, as outlined in Section 3.17 and Appendix N. In general, the MCO must provide home health services for the treatment of medical diagnoses alone, and when a client has both medical and behavioral diagnosis, but the medical diagnosis is primary.

27. **Mental Health/Substance Abuse Services** – As outlined in Section 3.17, the BHP assumes coverage responsibility for most behavioral health services. The MCO retains responsibility for all primary care services and associated changes, regardless of diagnosis. This includes, but is not limited to behavioral health prevention and screening.

28. **Medical Transportation Services**

    a. Emergency and Nonemergency Ambulance Service is covered when:

        i The patient's condition requires medical attention during transit; or

        ii The patient's diagnosis indicates that the patient's condition might deteriorate in transit to the point where medical attention would be needed; or

        iii The patient's condition requires hand and/or feet restraints; or

        iv The ambulance is responding to an emergency; or

        v No alternative less expensive means of transportation is available. Ambulance trips to an emergency room, regardless of the outcome, nor ambulance trips in response to a 911 call, cannot be subject to prior authorization. The MCO is responsible for emergency medical transportation regardless of diagnosis. Hospital to hospital transportation of members with a medical condition is also covered.

    b. Air Transportation - when a medical condition or time constraint dictates its use.

    c. Critical Care Helicopter - when a medical condition or time constraint dictates its use.

    d. Other Nonambulance Transportation including Livery, Wheelchair van, Commercial Carrier, Taxi, Private Transportation, Service bus - when needed to obtain necessary medical services covered by Medicaid

including behavioral health services, and when it is not available from volunteer organizations, other agencies, personal resources, etc. To administer this benefit, DSS currently employs the following requirements and limitations on services:

i. Prior authorization;

ii. The use of the nearest appropriate provider of medical services when a determination has been made that traveling further distances provides no medical benefit to the patient; and

iii. The use of the least expensive appropriate method of transportation, depending on the availability of the service and the physical and medical circumstances of the patient.

e. Transportation for relatives, guardians, or foster parents of a Medicaid recipient - only under the following circumstances:

i. The person needs to be present at and during the medical service being provided to the patient (for example, in parent/child situations); and

ii. The person needs to be trained by hospital staff to provide unpaid health care in the home to the patient, and without this health care being provided the patient would not be able to return home.

iii. Children under twelve (12) years of age shall be escorted to medical appointments. Either the child's parent, foster parent, caretaker, legal guardian or the Department of Children and Families (DCF), as appropriate, shall be responsible for providing the escort.

iv. For children between the ages of twelve (12) to fifteen (15) years, a consent form signed by a parent, caretaker or guardian shall be required in order for a child to be transported without parental consent as specified by state statute (i.e., for family planning and mental health treatment).

For children sixteen (16) years or older, no consent form shall be required.

f. The MCO is not responsible for transportation to non-Medicaid services such as respite or DCF services that are designed to be provided at the client's location, such as home.

g. Out-of-State Transportation Services - when out-of-state- medical services are needed because of the following:

i. A medical emergency;

ii. The patient's health would be endangered if required to travel to Connecticut; and

iii. Needed medical services are not available in Connecticut.

08

29. **Medical Surgical Supplies** - those items that are prescribed by a physician to meet the needs or requirements of a specific medical and/or surgical treatment. They are generally disposable and not reusable.

    a. Covered services include: gauze pads, surgical dressing material, splints, tracheotomy tube, diabetic supplies, elastic hosiery, sterile gloves, incontinence supplies, thermometers, blood pressure kit (aneroid type including stethoscope, but limited to use in the home for patient's diagnosed to have complicated cardiac conditions and labile hypertension), enteral/parenteral feeding therapy supplies including solutions and manufacturing materials,

    b. Items considered first aid supplies such as, bandages, solutions, vaseline, etc., are not covered services.

30. **Emergency Services** - such inpatient and outpatient services in and out of the health plan's service area are covered services. As described in Section 3.05 and Appendix N, in general, the MCO maintains coverage responsibility for emergency department services, including emergent and urgent visits and al associated charges, regardless of diagnosis.

B. Covered Services Not Included In the Capitation Payment

1. **School-Based Child Health Services** - Medically necessary special education related diagnostic and treatment services provided to children by or on behalf of school districts pursuant to the Individuals with Disabilities Education Act (IDEA) and Connecticut General Statutes (CGS). Diagnostic services must be ordered by a Planning and Placement Team and treatment services must be prescribed in a child's Individualized Education Program (IEP)--and verified by a physician's signature.

2. **Connecticut Birth to Three Program Services** - The Connecticut Birth to Three Program, pursuant to the Individuals with Disabilities Education Act (IDEA) and Connecticut General Statutes (CGS), provides a range of early intervention services for eligible children from birth to three years of age with developmental delays and disabilities. Eligibility of children is determined by Department of Mental Retardation (DMR) staff or entities with which DMR contracts. Services are authorized in an Individualized Family Service Plan (IFSP) and verified by a physician's signature.

3. **All Medicaid covered behavioral health** and behavioral health related services are the responsibility of the BHP.

4. **Dental Care** - Services performed by a licensed dentist or dental hygienist that conform to accepted methods of diagnosis and treatment.

    a. The categories of covered services are as follows:

        1). Diagnostic Services are the procedures needed to diagnose the oral condition.

            a). Radiographs:

i Full mouth series or panoramic radiograph;

ii Bitewing films and

iii Periapical films.

b). Oral examinations:

i. Initial comprehensive oral examination, which includes a complete evaluation including medical history;

ii. Periodic oral exams and

iii. Emergency oral examination.

2). Preventive Services are the procedures used to help avoid oral disease.

a). Prophylaxis;

b). Fluoride treatment for children under 21;

c). Sealants for adult (secondary) teeth;

d). Space maintainers and

e). Night guards.

3). Restorative Services are the procedures performed to remove disease or repair broken teeth.

a) Amalgam (silver) fillings;

b) Composite (white) fillings and

c) Crowns.

4). Endodontic Services are the procedures used to treat infections or repair trauma that has reached deep into the tooth structure.

a) Pulpotomy in primary teeth;

b) Root canal therapy in adult teeth;

c) Apicoectomy in adult teeth and

d) Apexification in adult teeth

5). Periodontal Services are those procedures used to treat diseases of he gingival (gum) and supporting structures (periodontal ligament and bone) of the teeth.

a) Gingivectomy and

b) Gingivoplasty.

6). Prosthodontic Services are the procedures used to repair teeth when a great deal of tooth structure is lost due to disease or trauma or and/replaces missing teeth.

a) Crowns;

b) Removable complete upper and/or lower dentures and

c) Removable partial upper and or lower dentures.

7). Oral Surgery is the surgical and non surgical procedures used to restore the health of the mouth and surrounding structures.

a) Edxoodontia (extractions);

b) Biopsy;

c) Lesion and tissue removal

d) Surgery for trauma, and

e. Fracture reduction

8). Orthodontics are the procedures used to realign teeth in the proper position when the teeth are determined to be in a severe handicapping malocclusion.

a) Active treatment may extend up to but not exceeding thirty months per recipient.

9). Miscellaneous Services are procedures required for oral care utilized in conjunction with dental services.

a) Patient Management - in connection with dental services to individuals with cognitive disabilities as determined by the Department of Mental Retardation.

b) General Surgical Anesthesia;

c) Home visits.

b. The categories of Program Limitations are as follows:

1). Diagnostic Services:

a). Radiographs:

i. Full mouth series or panoramic radiograph once every three years;

ii. Bitewing films once every six months;

iii. Periapical films the single first film is not covered on the same date of service as bitewings, panoramic, or lateral jaw films.

b). Oral examinations:

i. Initial oral complete examination includes a complete history workup and is limited to one time per patient per three year (3) period;

ii. Periodic oral exams once six months after the initial oral exam and every six months thereafter;

iii. Emergency oral examination.

2). Preventive Services:

a) Prophylaxis once every six months;

i. Prophylaxis includes supra and sub gingival scaling and polishing by rotary, ultrasonic or other mechanical means as described as standard procedure by the American Dental Association.

ii. “Toothbrush” prophylaxis is not a Medicaid covered procedure in children over 48 months of age.

b) Fluoride treatment for children under 21 every six months (prior authorization is required for members over 21 years of age);

c) Sealants for adult (secondary) teeth for all molar teeth and for premolar teeth on children who are at moderate or severe risk for caries as assessed by the Caries Assesment Tool. A sealant may be placed from ages 5 through 16, only one time in a five year period per tooth.

d) Space maintainers cannot be unilateral and removable in form.

e) Occlusal guards.

3). Restorative Services:

a) Amalgam and composite fillings are limited to one per year to the same surface per tooth by the same provider unless prior authorization is obtained.

b) More than one amalgam filling on a single surface will be considered a single filling. Anterior or composite fillings involving more than one surface will be considered as a single filling. Only those fillings involving the incisal corner will be considered a two filling procedure.

c) Crowns may be used only in those cases where the breakdown of tooth structure is excessive or root canal therapy has been performed. Suitable types of crowns include:

i. Stainless steel, may be used for deciduous or permanent, anterior or posterior teeth.

ii. Preformed plastic may be used on anterior deciduous or permanent teeth.

iii. Acrylic or porcelain veneer, permanent anterior teeth only

iv. Porcelin fused to metal on permanent teeth only.

4). Endodontic Services:

a) Performed in anterior upper and lower six teeth only when the retention of the tooth in site is necessary to maintain the integrity of the dentition and when the prognosis is favorable.

b) Performed in the eight posterior teeth only in cases where there is a full dentition or when the tooth is the only source for an abutment tooth or the integrity of the bite would be seriously affected.

c) Apexification does not include root canal treatment but includes all visits to complete the service.

5). Periodontal Services:

a) Limited to givoplasty and

b) Limited to givectomy.

6). Prosthodontic Services:

a) Crowns (refer to Section 3b Restorative, Crowns);

b) Removable complete upper and/or lower dentures will be approved if the patient can tolerate and is expected to use them on a daily basis.

c) Removable partial upper and/or lower dentures will be approved if the patient can tolerate them and is expected to use them on a daily basis. There must less than eight posterior teeth in occlusion with missing anterior teeth.

d) Replacement of existing complete or partial dentures, may be reconstructed in any five (5) year period. Prior authorization must be requested with a documented need of medical necessity if the removable complete or partial denture(s) must be remade or replaced for any reason within the date of delivery of the initial prosthesis.

e) Relining or rebasing of existing complete or partial dentures may be performed one time in a two year period.

f) Denture labeling may be performed for patients residing in long term care facilities.

7). Oral Surgery:

a) Suturing of lacerations of the mouth is covered in accident cases only and not cases incidental to and connected with dental surgery.

b) The following services are not covered unless the procedure is used in conjunction with orthodontic therapy:

i. Uncovering of impacted or un-erupted teeth for orthodontic reasons;

ii. Ostoplasty/osteotomy of facial bones for midface hypoplasia or mandibular progngaathism without bone graft.

c) Reimplantation of an avulsed anterior tooth may not be billed in conjunction with root canal therapy on the same tooth.

d) Bone grafts of the mandible are restricted to the replacement of bone previously removed by a radical surgical procedure.

8). Orthodontics:

a) In cases where a severe handicapping malocclussion exists under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) and is limited to recipients under the age of 21.

i. Services must be rendered by providers who are qualified by Section 184.B in regulations.

b) Screening may be performed one time per provider for the same recipient

c) Consultation may be performed one time per provider for the same recipient;

d) Diagnostic Assessment:

i. Preliminary casts/study models one time per provider per recipient;

ii. Comprehensive casts/study models one time per provider per recipient.

e) Appliance:

i. Initial appliance is limited to one per provider per recipient ;

ii. Retainer appliance is limited to one replacement per dental arch for each recipient regardless of the reason.

9). Miscellaneous Services

a) Services covered under Husky are limited to the Department's fee schedule, which can be found on www.ctmedicalprogram.com;

b) Patient management - in conjunction with dental services when the provider has documented the specific diagnosis in the patient's chart. A diagnosis of moderate, severe, or profound mental retardation will satisfy the diagnosis requirement.

i. The provider's record of the patient must contain the signature of the physician or a professional staff member of the Department of Mental Retardation attesting to the authority of the diagnosis.

c. The categories of dental services that have noncovered procedures are as follows:

08

1) Preventive Services:
    i. Unilateral Removable Appliances.
2) Restorative Services:
    i. Cosmetic dentistry;
    ii. Unilateral Removable Appliances;
    iii. Procedures to teeth nearing exfoliation (ready to fall out).
3) Periodontal Services:
    i. Any surgical periodontal procedure;
    ii. Any non surgical periodontal therapies;
    iii. Scaling and root planning.
4) Prosthodontic Services:
    i. Cosmetic dentistry;
    ii. Dentures (partial) where there are more than 8 posterior teeth in occlusion and no missing anterior teeth;
    iii. Fixed Partial Dentures (Bridges);
    iv. Implants and associated abutments and /or attachments;
    iv. Implant sustained crowns;
    v. Office visits to obtain a prescription where the need for such prescription has already been ascertained and
    vi. Unilateral removable appliances.
5) Oral Surgical Services:
    i. Alveoplasty in conjunction with extraction (s);
    ii. Cosmetic surgery;
    iii. I.V. Sedation (conscious sedation);
    iv. Implant placement;
    v. Nitrous Oxide (inhalation conscious sedation);
    vi. Vestibuloplasty .
6) Miscellaneous:
    i. Broken or cancelled appointments;

5. **Dental Hygienist Services** - Services that are provided by a licensed dental hygienist and that are within his or her scope of practice as defined by State Law.

6. **Pharmacy Services**

a. Covered services

i. Drugs prescribed by a licensed authorized practitioner. The MCO maintains responsibility for all pharmacy services and associated charges, regardless of diagnosis The MCO may use a prescription drug formulary as is described in Section 3.15, Pharmacy Access of the contract. CT BHP providers are required to follow the MCO's pharmacy program requirements

ii. Over-The-Counter (OTC) Drugs on the State of Connecticut's OTC Formulary, including liquid generic antacids, birth control products, calcium preparations, diabetic-related products, electrolyte replacement products, heratinics, nutritional supplements and vitamins (prenatal, pediatric, high potency).

b. Noncovered Services

i. Drugs included in the Food and Drug Administration's Drug Efficacy Study Implementation Program;

ii. Alcoholic liquors;

iii. Items used for personal care and hygiene or cosmetic purposes;

iv. Drugs solely used to promote fertility;

v. Drugs not directly related to the patient's diagnosis, when diagnosis is required by the DEPARTMENT to be written on the prescription;

vi. Any vaccines and/or biologicals which can be obtained free of charge from the CT. State Department of Health Services. The DEPARTMENT will notify pharmacists of such vaccines or biologicals;

vii. Any drugs used in the treatment of obesity unless caused by a medical condition;

viii. Controlled substances dispensed to HUSKY members that are in excess of the product manufacturer's recommendation for safe and effective use for which there is no documentation of medical justification in the pharmacy's file; and,

ix. Drugs used to promote smoking cessation.

x. Drugs used to treat sexual or erectile dysfunction,

C. Noncovered Services

1. Institutions for Mental Disease (IMD) - The federal definition of an IMD is a hospital, nursing facility, freestanding alcohol treatment center, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

a. IMD Exclusion - Medicaid does not cover IMD services (i.e., these services are excluded). States, rather than the Federal Government, have principle responsibility for funding inpatient psychiatric services; therefore, State funding of IMD)s is not through the Medicaid program.

08

b. Exceptions - certain individuals are not part of the IMD exclusion (i.e., they are covered by Medicaid for services in IMDs):

   i. inpatient psychiatric services for individuals under age 21;

   ii. individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs.

2. Services and/or procedures considered to be of an unproven, experimental, or research nature or cosmetic, social, habilitative, vocational, recreational, or educational.

3. Services in excess of those deemed medically necessary to treat the patient's condition.

4. Services not directly related to the patient's diagnosis, symptoms, or medical history.

5. Any services or items furnished for which the provider does not usually charge.

6. Medical services or procedures in the treatment of obesity, including gastric stapling. When obesity is caused by an illness (hypothyroidism, Cushing's disease, hypothalamic lesions) or aggravates an illness (cardiac and respiratory diseases, diabetes, hypertension) services in connection with the treatment of obesity could be covered services.

7. Services related to transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis.

8. Services for a condition that is not medical in nature.

9. Routine physical examinations requested by third parties, such as employers or insurance companies.

10. Drugs that the Food and Drug Administration (FDA) has proposed to withdraw from the market in a notice of opportunity for hearing.

11. Tattooing or tattoo removal.

12. Punch graft hair transplants.

13. Tuboplasty and sterilization reversal.

14. Implantation of nuclear-powered pacemaker.

15. Nuclear powered pacemakers.

16. Inpatient charges related to autopsy.

17. All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to lipectomy, hair transplant, rhinoplasty, dermabrasion, and chernabrasion.

18. Drugs solely used to promote fertility.

19. Drugs used to promote smoking cessation.

08

20. Services that are not within the scope of a practitioner's practice under state law.

21. Drugs used to treat sexual or erectile dysfunction,

MEDICAL ASSISTANCE PROGRAM POLICIES AND REGULATIONS BY PROVIDER AREA

Provider Area	Policy or Regulation Sections
Birth to Three	Sections 17b-262-597 through 17b-262-605 of the Regulations of Connecticut State Agencies
Case Management Services to Persons Under 21	Proposed Regulations
Chiropractic Services	Sections 17b-262-535 through 17b-262-545 of the Regulations of Connecticut State Agencies
Clinics	Sections 171 through 171 B. XI of Medical Services Policy and Sections 17-134d-7 through 17-134d-8, 17-134d-56 and 17-134d-70 through 17-134d-78 of the Regulations of Connecticut State Agencies
Rehabilitation Clinics	Sections 171.2 through 171.2l.lll.k.of Medical Services Policy
Dental Clinics	Sections 171.3 through 171.3l.lll.f. of Medical Services Policy
Medical Clinics	Sections 171.4 through 171.4l.lll.i. of Medical Services Policy
Dental Services	Sections 184 through 184l.lll.h. of Medical Services Policy and Section 17-134d-35 of the Regulations of Connecticut State Agencies
Dialysis	Sections 17b-262-651 through 17b-262-660 of the Regulations of Connecticut State Agencies
Early and Periodic Screening, Diagnostic and Treatment Services (Health Track Services)	Included in Regulations with Other Providers
Family Planning, Abortions and Hysterectomies	Sections 173 through 173l. of Medical Services Policy
Home Health Services	Sections 185 through 185l.lll.b.4. of Medical Services Policy and Sections 17-134d-37, 17-134d-48, 17-134d-60, 17-134d-62 and 17b-262-1 through 17b-262-9 of the Regulations of

	Connecticut State Agencies
Hospital Inpatient Services	Sections 150.1 through 150.1I.VI.d of Medical Services Policy and Sections 19a-630, 17b-225, 17b-238 through 17b-247, 17b-262, 19-13D, 19a-490 through 19a-493, 19a-495 of the Regulations of Connecticut State Agencies
Hospital Outpatient Services	Sections 150.2 through 150.2J.V.n of Medical Services Policy and Sections 4-67c (fees), 17-311 (payments), 17-312 (payments), 19a-490 (licensing), 19a-493 (licensing) of the Connecticut General Statutes and Sections 19-13D, 17-134d-2 (Medical Care), 17-134d-40 (payments – clinic), 17-134d-63 (out-of-state hospitals), 17-134d-86 (emergency room) of the Regulations of Connecticut State Agencies.
Intermediate Care Facility	Sections 156 through 156l.l.b.6. of Medical Services Policy and Section 17-134d-47 of the Regulations of Connecticut State Agencies.
Independent Radiology and Ultrasound Centers	Sections 17b-262-512 through 17b-262-520 of the Regulations of Connecticut State Agencies.
Independent Therapy Services	Sections 17b-262-630 through 17b-262-640 of the Regulations of Connecticut State Agencies.
Laboratory Services	Sections 17b-262-641 through 17b-262-650 of the Regulations of Connecticut State Agencies.
Medical Equipment, Devices and Supplies (MEDS)	See Below.
Medical Surgical Supplies	Sections 188 through 188J. of Medical Services Policy
Durable Medical Equipment	Sections 17b-262-672 through 17b-262-682 of Medical Services Policy
Orthotic and Prosthetic Devices	Sections 190 through 190l.iii.k. of Medical Services Policy
Oxygen Therapy	Section 196 of Medical Services Policy

	and 17-134d-83through 17-134d-85 of the Regulations of Connecticut State Agencies
Natureopathic Services	Sections 17b-262-547 through 17b-262-557 of the Regulations of Connecticut State Agencies
Nurse-Midwifery Services	Sections 17b-262-573 through 17b-262-585 of the Regulations of Connecticut State Agencies
Nurse Practitioner Services	Sections 17b-262-607 through 17b-262-618 of the Regulations of Connecticut State Agencies
Pharmacy	Sections 174 through 174H.IV.a.4. of Medical Services Policy and Section 17-134d-81 of the Regulations of Connecticut State Agencies
Physician's Services	Sections 17b-262-337 through 17b-262-449 of the Regulations of Connecticut State Agencies
Podiatric Services	Sections 179 through 179l.ll.b. of Medical Services Policy
Provider Participation	Sections 17b-262-522 through 17b-262-533 of the Regulations of Connecticut State Agencies
School Based Child Health Services	Sections 17b-262-213 through 17b-262-224 of the Regulations of Connecticut State Agencies
Skilled Nursing Facility	Sections 154 through 154l.l.b.6. of Medical Services Policy and Sections 17-134d-46, 17-134d-68 and 117-134d-79 of the Regulations of Connecticut State Agencies
Transportation Services	Section 17b-134d—33 of the Regulations of Connecticut State Agencies
Vision Care Services	Sections 17b-262-559 through 17b-262-571 of the Regulations of Connecticut State Agencies, DSS Policy Transmittal MS 93-18 and DSS Policy Bulletin 98-19.

APPENDIX B: HUSKY B Covered Benefits

A. Covered Benefits

Benefit Features	HUSKY Coverage	
Outpatient Physician Visits	$5 co-pay	*
Preventive Care	No co-pay Periodic and well child visits, immunizations, WIC evaluations as applicable, and prenatal care covered in full with $5 co-pay on other visits. **Periodicity schedule** and reporting based on the American Academy of Pediatrics (AAP) as amended from time to time: **Age Category** — **# of Exams** Birth to Age 1 — 6 exams Ages 1-5 — 6 exams Ages 6-10 — 1 exam every 2 years Ages 11-19 — 1 exam every year. **Immunization schedule** per the Advisory Committee on Immunization Practices (ACIP), as amended from time to time. As of January 1, 2001, the schedule is as follows: **Age Category** — **Vaccine Type** Birth — Hepatitis B-1st dose 1-4 months — Hepatitis B-2nd dose 2 months — Diphtheria, Tetanus, Pertussis (DTP) 1st dose; Haemophilus Influenza Type B (hib)-1st dose; Polio (OVP)-1st dose 4 months — Diphtheria, Tetanus, Pertussis (DTP) 2nd dose; Haemophilus Influenza Type B (hib)- 2nd dose; Polio (OVP)- 2nd dose 6 months — Diphtheria, Tetanus, Pertussis (DTP) 3rd dose; Haemophilus Influenza Type B (hib)-3rd dose 6-12 months — Hepatitis B-3rd dose; Polio (OVP)-3rd dose 12-15 months — Haemophilus Influenza Type B (hib)-3rd dose; Measles, Mumps, Rubella (MMR)-1st dose 12-18 months — Chicken Pox (Var)-single dose; Diphtheria, Tetanus, Pertussis (DTP) 4th dose 4-6 years — Diphtheria, Tetanus, Pertussis (DTP) 5th dose; Measles, Mumps, Rubella (MMR)-2nd dose; Polio (OVP)-4th dose 11-12 years — Tetanus Diphtheria (Td) **Influenza**: Every year beginning at 6 months for children who have serious long-term health problems such as heart disease, lung disease, kidney disease, metabolic disease, diabetes, asthma,	*

	anemia, and/or are on long term aspirin treatment **Pneumococcal:** Vaccinate children 2 years and older who are at risk of pneumococcal disease or its complications	
Family Planning	100% Family Planning Services include: Reproductive health exams; Patient Counseling; Patient Education; Lab tests to detect the presence of conditions affecting reproductive health; Screening, testing and treatment; Pre and post-test counseling for sexually transmitted diseases and HIV; Abortions that are necessary to save the life of the mother or if the pregnancy resulted from rape or incest or if pregnancy resulted from rape or incest.	
Preventative Family Planning Services	100%	*
Inpatient Physician	100%	*
Inpatient Hospital	100%	
Outpatient Surgical Facility	100%	
Ambulance	100% if determined to be an emergency in accordance with state law	
Pre-Admission /Continued Stay	Arranged through provider.	
Short Term Rehabilitation	100% For conditions where significant improvement is expected within 60 days including: Physical Therapy; Speech Therapy; Occupational Therapy; and Skilled Nursing Care (excludes private duty nursing)	
Home Health Care	100% Includes Disposable medical supplies for homebound members Excludes: Custodial care, homemaker care or care that may be provided in a medical office, hospital or skilled nursing facility and offered to the member is such setting.	
Hospice	100% provided to members who are diagnosed as having a terminal illness with a life expectancy of six months or less. Covered care includes	

	Nursing care; Physical therapy, Speech therapy, and Occupational therapy; Medical social services; Home health aides and homemakers; Medical supplies; Drugs; Appliances; DME; Physician services; Short-term inpatient care, including respite care and care for pain control and acute and chronic symptom management; services of volunteers and other benefits when ordered by a physician. Limitations on short-term therapies do not apply.	
Lab and X-Ray	100%	
Pre-Admission Testing	100%	
Emergency Care	100% if determined to be an emergency in accordance with state law. $25 co-pay if determined a non-emergency. $25 co-pay waived if the patient is admitted.	*
Durable Medical Equipment (DME)	DME means equipment that is furnished by a supplier or home health agency that: 1. can withstand repeated use; 2. is primarily and customarily used to serve a medical purpose; 3. is generally not useful to an individual in the absence of an illness or injury; and 4. is appropriate for use in the home 100 % covered except DME does not include: • Power wheelchairs for members who are eligible for HUSKY Plus Physical; • Devices not medical in natures such as: • whirlpools, • saunas, • elevators, • vans, • van lifts, • home convenience items (e.g., air cleaners, filtration units and related apparatus, exercise bicycles and other types of exercise equipment), • insulin injectors, • non-rigid appliances and supplies, such as, sheets, self-help devices, experimental or investigational research	

	equipment, and • items for personal comfort and or usefulness to the member's household. Supplemental coverage available under HUSKY Plus Physical for medically eligible children.	
Hearing Aids	Hearing aids for children twelve years of age or younger, limited to $1,000.00 within a 24-month period. Supplemental coverage available under HUSKY Plus for medically eligible children	
Prosthetics	100% for devices whether worn anatomically or surgically implanted, which replace all or part of a body organ or structure and which correct, strengthen or provide necessary support to the body will be covered when medically necessary. Excludes: orthopedic shoes, foot orthotics, wigs or hairpieces. Supplemental coverage available under HUSKY Plus Physical for medically eligible children	
Eye Care Eye Exams	5$ co-pay	*
Hearing Exam	$5 co-pay	*
Nurse Midwives	$5 co-pay (except for preventative services)	*
Nurse Practitioners	$5 co-pay (except for preventative services)	*
Podiatrists	$5 co-pay	*
Chiropractors	$5 co-pay	*
Naturopaths	$5 co-pay	*

B. Limited Benefits

Benefit Features	HUSKY Coverage	
Eye Care Eyeglass frames and lenses or contact lenses	Once every 2 consecutive Continuous Eligibility (CE) periods with an allowance of $100 toward the purchase of these goods. The optical hardware must be provided without charge under the following conditions: (i) One pair of contact lenses every 2 consecutive eligibility periods when such lenses are determined to be the primary and the best method for aiding the member vision and the lenses are not needed solely for the correction of vision; (ii) Eyeglass frames and lenses and contact lenses that are determined to be medically necessary after eye surgery, the initial pair only; and (iii) Contact lenses, as needed, for the treatment of Keratonconus.	
Nutritional Formulas	100% limited to medically necessary amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases when ordered by a participating physician	*

Annual co-payments cannot exceed $760/$1350 (Income Band 1/Income Band 2) including premiums, per year.

C. Exclusions and Limitations

1. Services and/or procedures considered to be of an unproven, experimental, or research nature or cosmetic, social, habilitative, vocational, recreational, or educational.
2. Services in excess of those deemed medically necessary to treat the patient's condition.
3. Services for a condition that is not medical in nature.
4. Devices required by third parties, such as school or employment physicals, physicals for summer camp, enrollment in health, athletic, or similar clubs, premarital blood work or physicals, or physicals required by insurance companies or court ordered alcohol or drug abuse course.
5. Cosmetic and reconstructive surgery is excluded, except when surgery is required for:
   a) reconstructive surgery in connection with the treatment of malignant tumors or other destructive pathology that causes dysfunction;
   b) reduction mammoplasty in females when Medically Necessary and breast surgery in males only in cases of suspected malignancy. Surgery must be necessary to achieve normal physical or bodily function.
6. Routine foot care rendered:

a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the foot.
b) in the cutting, trimming or other non-operative partial removal of toenails, except when Medically Necessary in the treatment of neuro-circulatory conditions.

7. Evaluation, treatment and procedures related to, and performance of, sex-change operations.
8. Surgical treatment or hospitalization for the treatment of morbid obesity except where prior authorized Medically Necessary.
9. Care, treatment, procedures, services or supplies that are primarily for dietary control including, but not limited to, any exercise weight reduction programs, whether formal or informal, and whether or not recommended by an In-network Physician or Out-of-Network Physician.
10. Acupuncture, biofeedback, or hypnosis.
11. Treatment at pain clinics unless determined to be Medically Necessary.
12. Ambulatory blood pressure monitoring.
13. Any court order for testing, diagnosis, care, or treatment deemed not Medically Necessary.

D. Covered Services Not Included In the Capitation Payment

Dental	100% Dental Services include: Exams, 1 every 6 months; X-rays, Fillings; Fluoride Treatments; Oral Surgery
Oral Contraceptives	$5 co-pay (included in prescription drugs)
Prescription Drug	$3 co-pay on generics $5 co-pay on oral contraceptives $6 co-pay on brand-name formularies
Mental Health Inpatient	100% except for the following conditions; additional limitations apply: Mental Retardation; Learning disorders; Motor skills disorders; Communication disorders; Caffeine-related disorders; Relational problems; and Other conditions that may be the focus of clinical attention that are not defined as mental disorders in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental*

	Disorders. These limitations are: 60 day maximum exchangeable with alternate levels of care.
Mental Health Outpatient	Limited to Evaluation, Crisis intervention, and Treatment. No co-pay except for the following conditions: Mental Retardation; Learning disorders; Motor skills disorders; Communication disorders; Caffeine-related disorders; Relational problems; and Other conditions that may be the focus of clinical attention that are not defined as mental disorders in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. The following limitations apply for the conditions listed above: 30 visits. 1-10 100% 11-20 $25 co-pay 21-30 Lesser of $50 co-pay or 50% Separate limit for substance abuse. Supplemental coverage available under HUSKY Plus Physical for medically eligible children.
Substance Abuse Detoxification Inpatient	100% 100% except for the following conditions additional limitations apply: Mental Retardation; Learning disorders; Motor skills disorders; Communication disorders; Caffeine-related disorders; Relational problems; and Other conditions that may be the focus of clinical attention that are not defined as mental disorders in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. These limitations are: Drug: 60 days Alcohol: 45 days

Substance Abuse Outpatient	100% - Individual and group counseling and family therapy Except for the following conditions. Additional limitations apply: Mental Retardation; Learning disorders; Motor skills disorders; Communication disorders; Caffeine-related disorders; Relational problems; and Other conditions that may be the focus of clinical attention that are not defined as mental disorders in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. These limitations are: 60 visits per calendar year. Supplemental coverage available under HUSKY Plus Physical for medically eligible children
Short and Long Term: Rehabilitation	Covered services include home and community based rehabilitation services.
Home Health Care	100% Includes Medication administration Excludes: Custodial care, homemaker care or care that may be provided in a medical office, hospital or skilled nursing facility and offered to the member is such setting.

E. Limited Benefits Not Included In the Capitation Payment

Dental Orthodontia	 $725 allowance per orthodontia case.
Bridges or crowns; root canals; full or partial dentures; or extractions	$50 allowance per procedure, per member but no more than an aggregate allowance for all such procedures of $250 per eligibility period.
Contraceptives Intruterine Devices (IUD) and insertion of the IUD	 $50 allowance per member
Internally implantable time-release devices and their insertion	$50 allowance per member
Time-released contraceptive injections	$15 allowance per member per injection

CHARTER OAK

PLAN DESIGN WORKSHEET – SUMMARY

	CHARTER OAK PLAN DESIGN
INCLUDED BENEFITS:	
Eligibility	Individuals that have been Uninsured for at Least 6 Months(Exclusion list will be added) (No Asset Test) 0 - 150% FPL Monthly Premium $75
	151 - 185% FPL Monthly Premium $100
	186-235% FPL Monthly Premium $175
	236-300% FPL Monthly Premium $200
	301% FPL and Above 100% of Monthly Premium with a Target @ $250
Underwriting	No Pre-Existing Condition Limitations No Waiting Periods
Annual (based on Eligibility Period) Medical Deductible	0 - 150% FPL $150 Individual $300 Family
	151 - 185% FPL $200 Individual $350 Family
	186 - 235% FPL $400 Individual $600 Family
	236% FPL to 300 $750 Individual $1,400 Family
	301% and above $900 Individual $1,750 Family

CHARTER OAK

PLAN DESIGN WORKSHEET – SUMMARY

	CHARTER OAK PLAN DESIGN
Annual (based on Eligibility Period) Out-of-Pocket Maximum	0 - 150% FPL $150 Individual $300 Family
	151 – 185% FPL $200 Individual $350 Family
	186 – 235% FPL $400 Individual $600 Family
	236% FPL and Above $750 Individual $1,400 Family
	301% and above $900 Individual $1,750 Family
Lifetime Benefit Maximum	$1,000,000
Office Visits	
Preventive	100% Covered
PCP	$25 co-pay
Specialist	$35 co-pay
Urgent Care	$35 co-pay
Emergency Room Services	$100 (waived if admitted/deemed emergency)
Ambulatory Surgery	20% After Deductible
Inpatient Acute Admission	10% After Deductible
Inpatient Rehabilitation / Skilled Nursing Facility	Limited to 14 Days per Year With Prior Authorization (PA) 20% After Deductible
Outpatient Rehab	Limited to 30 Visits per Year $35 co-pay
Outpatient Lab and X-rays	20% After Deductible

CHARTER OAK

PLAN DESIGN WORKSHEET – SUMMARY

	CHARTER OAK PLAN DESIGN
Durable Medical Equipment (DME)	$4,000 Annual Limit with PA* **Excludes Diabetic and Ostomy Supplies*
Behavioral Health (BH) BH Outpatient visits	Subject to Limits* **Specialty BH Provided by ASO* Mental Health: with stipulations Substance Abuse: 30 Visits per Year Both with PA and $35 co-pay
BH Inpatient admissions	Subject to Limits* **Specialty BH Provided by ASO* Mental Health: with limitations Drug: 20 Days Alcohol: 15 Days Both with PA and 10% After Deductible
Prescription Drugs Tier 1 (generic)	$7,500 Annual Limit* **Pharmacy Provided by DSS* $10 Generics
Tier 2 (preferred brand)	$35 Brand Name Formulary
Tier 3 (non-preferred brand)	Full cost or $35 with Medical Exception
EXCLUDED BENEFITS:	
Maternity	EXCLUDED For Medicaid-eligible enrollees
Dental	EXCLUDED for ALL
Vision	EXCLUDED for ALL
Chiropractic Care	EXCLUDED for ALL

EXCLUSIONS AND LIMITATIONS

1. Services and/or procedures considered to be of an unproven, experimental, or research nature or cosmetic, social, habilitative, vocational, recreational, or educational.
2. Services in excess of those deemed medically necessary to treat the patient's condition.
3. Services for a condition that is not medical in nature.
4. Devices required by third parties, such as school or employment physicals, physicals for summer camp, enrollment in health, athletic, or similar clubs, premarital blood work or physicals, or physicals required by insurance companies or court ordered alcohol or drug abuse course.
5. Cosmetic and reconstructive surgery is excluded, except when surgery is required for:
   a) reconstructive surgery in connection with the treatment of malignant tumors or other destructive pathology that causes dysfunction;

CHARTER OAK

PLAN DESIGN WORKSHEET – SUMMARY

b) reduction mammoplasty in females when Medically Necessary and breast surgery in males only in cases of suspected malignancy. Surgery must be necessary to achieve normal physical or bodily function.

6. Routine foot care rendered:
   a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the foot.
   b) in the cutting, trimming or other non-operative partial removal of toenails, except when Medically Necessary in the treatment of neuro-circulatory conditions.
7. Evaluation, treatment and procedures related to, and performance of, sex-change operations.
8. Surgical treatment or hospitalization for the treatment of morbid obesity except where prior authorized Medically Necessary.
9. Care, treatment, procedures, services or supplies that are primarily for dietary control including, but not limited to, any exercise weight reduction programs, whether formal or informal, and whether or not recommended by an In-network Physician or Out-of-Network Physician.
10. Acupuncture, biofeedback, or hypnosis.
11. Treatment at pain clinics unless determined to be Medically Necessary.
12. Ambulatory blood pressure monitoring.
13. Any court order for testing, diagnosis, care, or treatment deemed not Medically Necessary.

HUSKY PLUS
SUPPLEMENTAL INSURANCE COVERAGE

I. HUSKY Plus Plan Overview

The HUSKY Plus Physical program, is designed to provide coverage to children with intensive physical health needs. The HUSKY Plus Physical (HPP) Plan is a supplemental benefit package for children who are eligible for and enrolled in HUSKY, Part B, with household incomes under 300% of the federal poverty limit (Income bands 1 and 2 only). Children may not apply for coverage under HUSKY Plus unless they have already been determined to be eligible under HUSKY, Part B, and have enrolled in HUSKY, Part B.

Children who are eligible under HPP will be **dually eligible.** That is, children who are determined to be eligible under HPP will continue to receive benefits under HUSKY, Part B, including those physical health services for their special needs diagnoses or conditions that are covered under Part B.

As described below, these services will be coordinated by a case management/treatment team composed of case managers from both HUSKY, Part B and one or both of the HUSKY Plus Physical plan, which will maximize the coordination of benefits under both plans and other sources of coverage through federal, state and private support. The case management/treatment team will need to coordinate the development of the Global Plan of Care (GPC) so that services included do not replicate special education services authorized under an Individual Education Plan (I.E.P.) or Individualized Family Service Plan (I.F.S.P.).

In the event that the child is eligible for HUSKY, Part B and HPP, the case management team leader of HPP will need to coordinate with the HUSKY, Part B case manager to assure that the HPP GPC's complements services provided under HUSKY, Part B**.**

However, ultimate utilization management decisions will rest with the utilization managers of the plan that is financially at risk; i.e., HUSKY, Part B utilization managers will have final decision making authority for those services for which they are at risk and HPP utilization managers will have the decision making authority for those supplemental services included in their benefit package.

In the event there is a dispute between the participating HUSKY, Part B managed care plan and the HPP concerning the responsibility for reimbursement of a service authorized under the treatment plan, the dispute will be referred to the Commissioner (or his/her designee) for resolution**.**

Eligible children will be able to receive services under both the basic and one or both supplemental benefit package simultaneously in order to allow both plans to provide services to the child to the fullest extent possible in the least restrictive setting.

HPP services may supplement HUSKY, Part B services once a child has exhausted his or her annual benefit limits under Part B. However, HPP will always be the payer of last resort. The case management/treatment team will

always look to exhaust all medically necessary coverage benefits under HUSKY, Part B, including conversion options when appropriate, before these services are supplanted or replaced by services available under HPP .

II. HUSKY Plus Plan for Children with Special Physical Health Care Needs

Program Administration

The HUSKY Plus Plan for Children with Special Physical Health Care Needs (HPP) will be administered by the Connecticut Children's Medical Center. The advisory committee established by the Department of Public Health for Title V of the Social Security Act will be the Steering Committee for the HPP plan along with representatives from the Departments of Social Services (DSS) and Children and Families (DCF). The Steering Committee shall be named the Steering and Advisory Committee for Children with Special Health Care Needs and HUSKY Plus Physical (SASH).

Eligibility

Children enrolled in HUSKY, Part B, Income Bands 1 and 2, who have intensive physical health needs that cannot be met within the Part B benefit package will be eligible for supplemental services under the HPP plan if they meet the clinical eligibility standard. The clinical eligibility standard is based on diagnostic and/or acuity criteria and shall be the same as those for the Title V program currently operating in the state.

Clinical eligibility will be determined:

1. By documentation of clinical information which meets the "Medical Eligibility Criteria" of the Department of Public Health Title V Program; or
2. By meeting the approved definition of Children with Special Health Needs with documentation of clinical evidence. The definition adopted by the Steering Committee but subject to change is as follows:

"Children with Special Health Care Needs are those who have or are at elevated risk for (biologic or acquired) chronic physical or developmental conditions and who also require health and related (not educational and not recreational) services of a type and amount not usually required by children of the same age (beyond Connecticut's EPSDT periodicity schedule). The age of eligibility is birth to 18 years, but may include those to age 21 (for those determined eligible before age 18) for purposes of transition to adult services." . In addition, eligibility for HPP will end at age 19, when eligibility for HUSKY, Part B also ends.

For the purposes of determining acuity of a child who meets the Medical Eligibility Criteria or who may qualify as a Child with Special Health Care Needs, the HPP Center will use the Children with Special Health Care Needs Screening Tool, or others as approved by the Department (See attached).

Referral and Application Process

Children who may be at risk may be identified by their parents, their primary care provider, or another provider in the HUSKY, Part B Plan in which the child is enrolled. Referral made by made in writing or by telephone by any of the above parties. However, the application process for HPP will be coordinated by the HUSKY, Part B Plan.

Children will be assessed for eligibility consistent with the practices and procedures currently in place under the Title V Program.

Covered Services

All children determined eligible for HPP will receive care coordination, advocacy, family support and case management services as well as comprehensive multidisciplinary evaluation once a year and up to 3 follow-up visits per year with members of the multidisciplinary group as needed. In addition, the range of services will include the following to the extent that they are not covered under the HUSKY, Part B benefit package:

- ***Adaptive Seating, Specialized:*** One evaluation, fabrication and completion per year. Fees are inclusive of one adjustment every 2 weeks until family is satisfied.
- ***Audiometry:*** Includes BAER, OAE; two per year.
- ***Cast Room:*** Cast room visits as necessary to maintain integrity of cast or to implement treatment plan.
- ***Diagnostic Imaging (i.e., MRI, CT):***
- ***Durable Medical Equipment:*** Exclusive of the basic HUSKY B plan and include items that assist in the activities of daily living
- ***EEG/telemetry:*** Two per year.
- ***EKG/Holter:*** Two per year.
- ***Emergency Care:*** Exclusive of the basic plan; directly related to condition that qualifies child for HPP.
- ***Gait Analysis:*** One per year.
- ***General Dental, Orthodontic:*** Only for children who have malocclusive disorders or periodontal disease resulting from their underlying qualifying condition or related treatment.
- ***Hearing Aids:*** One (or one pair) analog hearing aid(s) as prescribed per year; One (or one pair) digital hearing aid(s) as prescribed every 5 years
- ***Home Health Aide:*** Total of ten hours/week
- ***Laboratory***
- ***Medical and Surgical Supplies***
- ***Medical Nutrition Services***

- ***Medical 23 Hour and Day Surgery***
- ***Occupational, Physical and Speech Therapies***
- ***Orthotic Devices:*** No more than one a year or one pair per year per prescribed type, including all delivery fees, fittings and adjustments.
- ***Pharmacy:*** Over the Counter medications will be covered if medically necessary and directly related to the condition that qualifies the child for the program. Prior authorization by DSS required.
- ***Physician Fees for Inpatient Care:*** Visits must be requested as consultations by the admitting physician and be specifically related to the qualifying condition.
- ***Physician Fees for Outpatient Care:*** Covered as per care plan.
- ***Prosthetics/Prosthetic Devices:*** No more than one per year including all delivery fees, fittings and adjustments/repairs. Excludes myoelectric devices.
- ***Pulmonary Function Testing:*** One per year.
- ***Radiology***
- ***Skilled Intermittent Nursing:*** One visit per day for evaluation, treatment, and education. Must be provided by a licensed home health agency.
- ***Sleep Study/Polysomography:*** One per year.
- ***Special Nutritional Formulas or Supplements/ PKU Foods:*** Nutritional habilitative and/or rehabilitative sustenance of a type or amount not usually required by children. Prescribed by an authorized professional within acceptable standards of the American Dietetic Association.
- ***Transportation:*** 2 round trips per year to any health care appointment by ambulance, chair-vans and/or other licensed medical transportation for non-emergent visits.
- ***Wheelchairs:*** One new manual wheelchair no more than every three years. One new motorized wheelchair no more than every five years.

This list may be revised from time to time as recommended by the Steering Committee and approved by the Department.

Service Providers

The Connecticut Children's Medical Center will serve as the coordinating organization. but services will be provided by the entities under contract to provide Title V services.

Service Utilization Management

Service utilization will be managed through a clear definition of medical necessity. "Medical Necessity" or "medically necessary" is defined as health care provided to correct or diminish the adverse effects of a medical condition or

mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

All services will be subject to prior authorization by the utilization management staff at the Connecticut Children's Medical Center. These decisions will be subject to the process for Grievances and Appeals (see below).

Coordination of HPP Services with HUSKY, Part B

In order to ensure that HPP will be the documented payer of last resort, the HPP Center shall assign each enrollee with a case manager and provide care coordination services. The HPP case manager shall coordinate with the HUSKY, Part B case manager to ensure that all medically necessary HPP covered services identified in the global plan of care (GPC), which are also covered in the HUSKY, Part B basic benefit package, are exhausted first under HUSKY, Part B.

The HPP Center shall designate a Lead Case Manager who will be responsible for convening a case management/treatment team that will develop an individualized GPC for each enrollee. The case management/treatment team may be composed of, but not limited to, the enrollee or enrollee's parent(s), treating clinicians and/or providers, the HUSKY, Part B Case Manager, and the Lead Case Manager. The case management/treatment team will coordinate the development of the GPC so that covered services included in the GPC do not replicate special education services authorized under an I.E.P. or I.F.S.P.

In the event that the enrollee is also eligible for HPB, the case management/treatment team shall include the case manager from HPB. The case management/treatment team shall develop a GPC that integrates services from HUSKY, Part B, HPP and HPB as appropriate.

Global Plan of Care (GPC)

HPP will ensure that the case management/treatment team completes the GPC for each enrollee within 30 days of the date of eligibility determination. The case management/treatment team on at least a semi-annual basis will reassess the GPC. The GPC will be based on the comprehensive need assessment, periodic reassessments, and treatment plans from the HUSKY, Part B Plan and HPP Contractor providing services to the child. The GPC will include medical management recommendations reflecting the level of involvement of the HPP staff and the scope of clinical practice of the clinical staff, estimates of the need and frequency of specific clinical services and a designation of who is responsible for the specific elements of the GPC.

The GPC will be mailed or faxed to the enrollee's HUSKY, Part B Plan and to the child's primary care physician. A written copy of the GPC will be kept on file at HPP, as part of the child's case file.

Program Quality

Both HPP will be reviewed annually by an external quality review organization (EQRO) pursuant to the goals identified in the Title XXI State Plan. Pursuant to this review, the Commissioner will submit a report to the Governor and the

General Assembly on the HUSKY Plus Programs which will include an evaluation of the special health outcome and access measures identified for HUSKY Plus enrollees.

In addition, the Department will review the HPP Center at least annually. Based on the EQRO report and the Department review, recommendations for program quality improvement will be identified. Corrective action plans and quality improvement projects will be initiated by the Centers in conjunction with the Department.

Grievance and Appeals Process

In accordance with 42 CFR 457 part(s) 1120 – 1180, a HUSKY Plus applicant has the right to request an administrative review regarding a decision made on their HUSKY Plus application. Whenever possible, HPP will attempt to resolve grievances informally. However, parents and providers will be encouraged and supported in the filing of appeals without fear of compromised service. A copy of the appeals procedure, written in a manner easily understood by the lay public, will be distributed to every family at the time of their application to HPP.

The state ensures that all enrollees and applicants receive timely written notice of any determinations required to be subject to review, as outlined below. Written notices at each level include the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review. *However, the State will not provide an opportunity for review of a matter if the sole basis for the decision is a provision in this plan or in federal or State law requiring automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.*

The following decisions can be appealed through the grievance process:

- Denial of eligibility for Income Bands One and Two only;
- Failure to make a determination of eligibility within 21 days of application;
- Suspension or termination of enrollment in HPP for enrollees enrolled in Income Band One or Income Band Two of HUSKY B;
- Delay, denial, reduction, suspension or termination of goods or services, including determination regarding level of services;
- Failure to approve, furnish or provide payment for services in a timely manner;
- Medical necessity of a type of service or setting; and
- Choice of provider

While an appeal regarding suspension or termination of eligibility or enrollment is being considered, the enrollee will remain eligible for HPP and their goods and/or

services will be continued until the grievance is decided, so long as the enrollee remains in Income Band 1 and 2. An enrollee who has been enrolled in Income Band 3 of the HUSKY B program shall be disenrolled from HPP.

While an appeal regarding delay, denial, reduction, suspension or termination of goods and/or services is being considered, the enrollee will continue to receive such goods and/or services until the appeal is decided, so long as the child remains in Income Band 1 or 2.

Applicants or enrollees requesting to review their files or other information relevant to the appeal review will be provided access to their files at a mutually convenient date and time, but no later than four days prior to the decision being issued. *Additionally, the State will ensure that applicants or enrollees have opportunities to represent themselves or have representatives of their choosing in the review process, and to fully participate in the review process.*

The grievance and appeals process will have three levels of appeal: the first to HPP's medical director (who was not involved in the prior decision), the second to a sub-group of the Steering Committee, and the third to the Commissioner.

Whenever a decision is made regarding an enrollee's eligibility, enrollment or goods and/or services, a letter is sent from the HPP Center to the parent describing the decision. Letters, which deny, reduce, suspend or terminate eligibility or enrollment, or goods and/or services (as listed above), will also include a one page Appeal Form and a copy of the Appeals Procedure Summary. To begin the appeals process, the parent or provider should complete the Appeals Form. The form should be mailed or delivered to the HPP Center but must be received by the Center within 45 days of the date of the letter describing the decision that is being appealed.

Level One Appeal:

The HPP Center will send a letter that acknowledges receipt of the appeal form to the parent or provider. The letter will identify a HPP staff member as the Appeals Manager. The Appeals Manager will track the appeal, act as the contact person for questions and updates, and will attempt to resolve the appeal within ten days. If the appeal is resolved to the satisfaction of the parent or provider by the Appeals Manager, a letter will be sent describing the resolution, and there will be no further action. If the appeal cannot be resolved at this level, the Appeals Subcommittee will review the appeal.

Level Two Appeal:

The Appeals Subcommittee of the Steering and Advisory Committee for Children with Special Health Care Needs and HUSKY Plus Physical (SASH) for HPP has three members, one each from:

- The Department of Social Services (DSS)
- The Department of Public Health (DPH) and
- The Connecticut Children's Medical Center

No one directly involved in the decision being appealed will be a member of this subcommittee. The Appeals Manager is not a member of this subcommittee but will attend to provide needed information.

A letter will be sent to the parent or provider that gives the time and date of the Appeals Subcommittee meeting. The meeting will be scheduled to occur within ten business days of receipt of the written appeal. The parent or provider may reschedule this meeting, for any reason, once. However, the Appeals Committee meeting must occur within 25 business days of the receipt of the appeal.

The parent or provider may bring support persons to the Appeals Subcommittee meeting, including legal counsel, a person with special knowledge or training with respect to the problems of the enrollee, and one or two individuals for support.

In the Appeals Subcommittee, the Appeals Manager will present the appeal; along with any documents involved in the initial decision. The Appeals Manager will also present a summary of the efforts to this point to resolve the appeal. The parent, provider or accompanying support persons may also present arguments and documents, which support the appeal. Once all appeal arguments are completed, the Appeals Subcommittee will either make a decision regarding the appeal, or if necessary, continue the case until more information is obtained or until documents are reviewed. The Appeals Subcommittee must render a final decision no later than 30 days from the date of the Appeals Subcommittee meeting. The Appeals Subcommittee chairperson will send the parent or provider a letter describing the Appeal Committee's decision no later than 30 days from the date of the Appeals Subcommittee meeting.

Level Three Appeal:

If the parent or provider does not agree with the Appeal Subcommittee's decision, he/she may continue the appeal process by writing a letter to the Commissioner of the Department of Social Services (DSS) or designee. In this case, the parent or provider must send a copy of the original Appeal Form, the Appeals Subcommittee letter and any other pertinent documents to the Commissioner or designee within ten business days of the date of the Appeals Subcommittee letter. The Appeals Manager will continue to help the parent or provider with this next step. The DSS Commissioner or designee shall make a determination and provide a written decision to the parent no later than 90 days from the initial request date.

If the enrollee has been enrolled in the HPP program and is found to be ineligible for HPP, and this decision is appealed, the enrollee will continue to be eligible for HPP services so long as the child remains eligible for and enrolled in HUSKY, Part B, Income Bands 1 and 2, until the appeal process is completed. Enrollees of HUSKY, Part B who are in Income Band 3 are not eligible for the HUSKY Plus Program and shall be immediately disenrolled from HPP

Expedited Appeal:

Pursuant to 42 CFR 457.1160, the appeal process for HPP must allow for expedited review. This process applies to both eligibility and enrollment matters

as well as for goods and/or services. If an enrollee requests an expedited review, HPP must determine within one business day of receipt of the request, whether to expedite the review or whether to perform the review according to the standard timeframes. The review may be expedited if the Medical Director of HPP determines that the standard time frame could seriously jeopardize life or health or ability to attain, maintain or regain maximum function. If the Medical Director of HPP determines that the appeal should be expedited, the Level One review must be completed within 72 hours of receipt of the appeal request by HPP. A Level Two review of an expedited appeal must be completed within 72 hours after completion of the Level One review. An expedited Level Three review must be completed within 72 hours after completion of the Level Two expedited review. The above timeframe may be extended upon request of the parent up to a maximum of 14 days.

Connecticut Department of Social Services
Medical Assistance Program
Provider Bulletin

PB 2007-28 **April 2007**

TO: Physicians, Nurse Practitioners, Freestanding Clinics, Hospitals and Managed Care Organizations (MCOs)

SUBJECT: Revised Immunization Schedule

This bulletin is being sent to inform you that the Department of Social Services has revised the Childhood Immunization Schedule in the Provider Manual for providers listed above to be consistent with the latest immunization schedule of the American Academy of Pediatrics, the American Academy of Family Physicians and the Centers for Disease Control.

Changes to the Immunization Schedule include:

1) The Immunization Schedule grid is now a two-page document with the first page covering Birth-age 6 and the second page covering ages 7-18.
2) MMRV is now a two-dose series with dose two to be given at age 4-6 years.
3) The Human Papillomavirus (HPV) vaccination has been added as a three-dose series to be given at two month intervals starting at age 11.
4) A Rotavirus Vaccination has been added as a three-dose series to be given at ages 2-months, 4-months and 6- months.
5) Influenza vaccines are recommended annually for all children age 6 months-5 years.

A revised Immunization Schedule is attached. Further information about these changed recommendations is available at http://www.cispimmunize.org.

As a reminder, medically-appropriate vaccines for Medicaid-eligible clients age 0-18 are available free of charge from the Vaccine for Children Program administered by the Department of Public Health's Immunization Program. More information is available at http://www.dph.state.ct.us/BCH/infectiousdise/pdf/2007_Vaccine_Eligibility_Criteria.pdf. The CT Medicaid program and HUSKY A MCOs will reimburse medical providers for medically-appropriate vaccines not covered by VFC, including those for Medicaid clients over age 18.

MCOs are requested to send this information to their network providers and subcontractors.

This bulletin and other program information can be found at **www.ctmedicalprogram.com**. Questions regarding this bulletin may be directed to the EDS Provider Assistance Center - Monday through Friday from 8:30 a.m. to 5:00 p.m. at:
In-state toll free..... **800-842-8440** or
Out-of-state or in the
Local Farmington, CT area …….**860-409-4500**

EDS
PO Box 2991
Hartford, CT 06104

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Ages 0–6 Years UNITED STATES • 2007

Vaccine ▼ / Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		*see footnote 1*	HepB	HepB	HepB	HepB	HepB Series	HepB Series	HepB Series
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP		DTaP	DTaP	DTaP	DTaP	DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib	Hib	Hib	Hib	Hib	Hib
Pneumococcal[5]			PCV	PCV	PCV	PCV	PCV	PCV	PCV	PCV	PCV
										PPV	PPV
Inactivated Poliovirus			IPV	IPV	IPV	IPV	IPV	IPV	IPV	IPV	IPV
Influenza[6]					Influenza (Yearly)	Influenza (Yearly)	Influenza (Yearly)	Influenza (Yearly)	Influenza (Yearly)	Influenza (Yearly)	Influenza (Yearly)
Measles, Mumps, Rubella[7]						MMR	MMR	MMR	MMR	MMR	MMR
Varicella[8]						Varicella	Varicella	Varicella	Varicella	Varicella	Varicella
Hepatitis A[9]						HepA (2 doses)	HepA (2 doses)	HepA (2 doses)	HepA (2 doses)	HepA Series	HepA Series
Meningococcal[10]										MPSV4	MPSV4

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children through age 6 years. For additional information see www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:

- Administer monovalent HepB to all newborns prior to hospital discharge.
- If mother is HBsAg-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mothers' negative HBsAg laboratory report documented in the infant's medical record.

Following the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of 3 or more doses in a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose of HepB:

- It is permissible to administer 4 doses of HepB when combination vaccines are given after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*

- Administer the first dose between 6 and 12 weeks of age. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by 32 weeks of age. Do not administer a dose later than age 32 weeks.
- There are insufficient data on safety and efficacy outside of these age ranges.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHiBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in ≥12 months olds.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for Pneumococcal Conjugate Vaccine (PCV); 2 years for Pneumococcal Polysaccharide Vaccine (PPV))*

- Administer PCV at ages 24-59 months in certain high-risk groups. Administer PPV to certain high-risk groups aged ≥2 years. See *MMWR* 2000; 49(RR-9):1-35.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine (TIV); 5 years for live, attenuated influenza vaccine (LAIV)*

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006; 55(RR-10);1-41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- Administer the second dose of MMR at age 4–6 years. MMR may be administered prior to age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. *(Minimum age: 12 months)*

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered prior to age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- HepA is recommended for all children at 1 year of age (i.e., 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children including in areas where vaccination programs target older children. See *MMWR* 2006; 55(RR-7):1-23.

10. Meningococcal polysaccharide vaccine (MPSV4). *(Minimum age: 2 years)*

- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups. See *MMWR* 2005;54 (RR-7):1-21.

The Childhood and Adolescent Immunization Schedule is approved by:

Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org

SAFER • HEALTHIER • PEOPLE™

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Ages 7–18 Years UNITED STATES • 2007

Vaccine ▼ / Age ▶	7-10 years	11–12 YEARS	13–14 years	15 years	16–18 years
Tetanus, Diphtheria, Pertussis[1]	see footnote 1	Tdap	Tdap		
Human Papillomavirus[2]	see footnote 2	HPV (3 doses)	HPV Series		
Meningococcal[3]	MPSV4	MCV4	MCV4	MCV4[3]	
Pneumococcal[4]	PPV				
Influenza[5]	Influenza (Yearly)				
Hepatitis A[6]	HepA Series				
Hepatitis B[7]	HepB Series				
Inactivated Poliovirus[8]	IPV Series				
Measles, Mumps, Rubella[9]	MMR Series				
Varicella[10]	Varicella Series				

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. For additional information see **www.cdc.gov/nip/recs/child-schedule.htm**. Any dose not administered at the recommended earlier age should be administered at any subsequent visit when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **www.vaers.hhs.gov** or by telephone, **800-822-7967**.

FOOTNOTES

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)
- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose.
- Adolescents 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. *(Minimum age: 11 years for meningococcal conjugate vaccine (MCV4); 2 years for meningococcal polysaccharide vaccine (MPSV4))*
- Administer MCV4 at age 11–12-years and to previously unvaccinated adolescents at high school entry (~15 years of age).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups. See *MMWR* 2005;54 (RR-7):1-21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). *(Minimum age: 2 years)*
- Administer for certain high-risk groups. See *MMWR* 1997; 46(RR-08); 1–24 and *MMWR* 2000; 49(RR-9):1-35.

5. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine (TIV); 5 years for live, attenuated influenza vaccine (LAIV)*
- Influenza vaccine is recommended annually for persons with certain risk factors, healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006; 55(RR-10);1-41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children including in areas where vaccination programs target older children. See *MMWR* 2006; 55(RR-7):1-23.

7. Hepatitis B vaccine (HepB). *(Minimum age: birth)*
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for 11–15 year olds.

8. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*
- If not previously vaccinated, administer 2 doses of MMR during any visit with ≥4 weeks between the doses.

10. Varicella vaccine. *(Minimum age: 12 months)*
- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged ≤13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days following the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org
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State of Connecticut
Department of Social Services
Medical Care Administration
25 Sigourney Street
Hartford, CT 06106-5033

PB 2006-62

Policy Transmittal 2006-18
August 2006

Contact: Hilary Silver
860-424-5130

Michael P. Starkowski
Deputy Commissioner

July 30, 2006
Effective Date

TO: **Physicians, Nurse Practitioners, Freestanding Clinics, Hospitals, Dentists, Dental Hygienists and Managed Care Organizations (MCOs)**

SUBJECT: **New EPSDT (Early and Periodic Screening, Diagnosis and Treatment Services) Periodicity Schedule and WIC Coordinators Contact Sheet**

The Department of Social Services is revising the EPSDT Periodicity Schedule to more clearly reflect national guidelines and state policy, particularly regarding dental and hearing screenings. The revised EPSDT Periodicity Schedule that is to be effective as of 7/30/2006 is attached. Changes to the periodicity schedule include the following:

- The new Periodicity Schedule clarifies that dental exams with fluoride treatments are to be provided every 6 months following an initial dental referral which should occur by age 3 and that bitewing X-rays are to be provided annually.

- All newborns in CT receive hearing screening at birth. Infants and children with risk factors for hearing loss or parents or others with concerns about the child's speech, language or hearing should be referred for audiological assessment.

A new Women, Infants and Children (WIC) Coordinators contact sheet is also included.

Posting Instructions: Provider Bulletins can be downloaded from the web site at www.ctmedicalprogram.com.

Distribution: This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by Electronic Data Systems. Managed Care Organizations are requested to send this information to their network providers and subcontractors.

Responsible Unit: DSS, Medical Care Administration, HUSKY Unit, Hilary Silver, Lead Planning Analyst, 860-424-5130.

Date Issued: August 2006

EPSDT PERIODICITY SCHEDULE OF PREVENTIVE HEALTH SERVICES

Department of Social Services **revised – 6/06**

	INFANCY								EARLY CHILDHOOD					
Age:	**NB**	**2-4 DAYS (1)**	**2 Weeks**	**2** mo.	**4** mo.	**6** mo.	**9** mo.	**12** mo.	**15** mo.	**18** mo.	**24** mo.	**3** yr.	**4** yr.	**5 yr.**
Screening Components:														
History: Initial/Interval	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Examination (2)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Height/Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X	X			
Blood Pressure												X	X	X
Health Education (3) Anticipatory Guidance	SEE ATTACHED RECOMMENDATIONS													
Developmental / Beh. Assessment (4)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunizations (5)	SEE ATTACHED IMMUNIZATION SCHEDULE													
Hereditary Metabolic Screening (6)	X→													
Lead Screening (7)							X→				X			
Hematocrit/ Hemoglobin							X→		W-HR	W-HR	X	W-HR	W-HR	W-HR
Cholesterol Screening											HR	HR	HR	HR
Tuberculin Test								HR	HR	HR	HR	HR	HR	HR
Hearing Screening	O	S	S	S	S	S	S	S	S	S	S	S	O*	O
Vision Screening	S	S	S	S	S	S	S	S	S	S	S	O*	O	O
Initial Dental Referral (9)											X→			
Evaluate Dental Fluoride Access						X	X	X	X	X	X	X	X	X
Dental Exam (13)											X→		X	X
Bitewing Films											X→		X	X

Key: X = To be performed; HR = To be performed for patients at risk; S = Subjective, by history or parental concern; O = By Objective Standardized Test (SNELLEN; AUDIOMETRIC); ←→ = The range during which a service may be provided, * If child uncooperative, re-screen within 6 months. W-HR= Required by WIC. Covered for WIC clients or high-risk clients.

Footnotes: (1) For Newborns discharged less than 48 hours after delivery; (2) At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped; (3) Age appropriate/patient specific health education and counseling should be part of every visit; (4) By history and appropriate physical examination; if suspicious, by specific objective developmental testing. Infants and children with risk factors for hearing loss or whose parents or others have concerns about the child's speech, language or hearing should be referred for audiological assessment; (5) Childhood immunizations are based on age and health history, and should be screened each visit; (6) Metabolic Screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to State law. Sickle Cell Screening if appropriate; (7) Further venous blood level measurement is required for children showing elevated lead level (greater than or equal to 10 ug/deciliter of whole blood); Children aged 2-5 should be screened at annual exam if there is no record of a negative lead screen. (9) Referral should be made no later than the third birthday. Earlier referral should be made if problem indicated. (13) Dental exam twice yearly at 6 month intervals, including cleaning and fluoride treatment.

EPSDT PERIODICITY SCHEDULE OF PREVENTIVE HEALTH SERVICES

Department of Social Services **revised – 6/06**

	MIDDLE CHILDHOOD			ADOLESCENCE										
Age:	**6 yr.**	**7-8 yr.(b)**	**9-10 yr.(b)**	**11 yr.**	**12 yr.**	**13 yr.**	**14 yr.**	**15 yr.**	**16 yr.**	**17 yr.**	**18 yr.**	**19 yr.**	**20 yr.**	**21 yr. ***
Screening Components:														
History: Initial/Interval	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Examination (2)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Height/Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health Education (3) Anticipatory Guidance	SEE ATTACHED RECOMMENDATIONS													
Developmental / Beh. Assessment (4)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunizations (5)	SEE ATTACHED IMMUNIZATION SCHEDULE													
Hematocrit / Hemoglobin				←——— (9) ———→										
Urinalysis				←——— (10) ———→										
Cholesterol Screening	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR
Tuberculin Test	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR	HR
Pelvic Exam/PAP Smear				←——— (11-HR)										
STD Screenings				←——— (12-HR)										
Hearing Screening	O (8)	O (8)	O	S	O	S	S	O	S	S	O	S	S	S
Vision Screening	O (8)	O (8)	O	S	O	S	S	O	S	S	O	S	S	S
Evaluate Dental Fluoride Access	X	X	X	X										
Dental Exam (13)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Bitewing Films	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Key: X = To be performed; HR = To be performed for patients at risk; S = Subjective, by history or parental concern; O = By Objective Standardized Test; ←→ = The range during at which a service may be provided; * Appropriate provision of EPSDT services is required through age 20, up to, but not including, the 21st birthday. (b) Biannually, at 2 year intervals.

Footnotes:(2) At each visit, a complete physical examination is essential with infant totally undressed and older child undressed and suitably draped; (3) Age appropriate and patient specific health education and counseling should be a part of every visit; (4) By history and appropriate physical examination, if suspicious, by specific objective developmental testing or parental concern; (5) Childhood Immunizations are based on age and health history and should be screened each visit. (8) State law requires screening at school. Screening should be done if there is evidence it was not done at school. (9) Hemoglobin or Hematocrit to be administered x1 during adolescence, annually for menstruating females that are at risk for anemia; (10) Urinalysis to be administered x1 during adolescence, annually for sexually active clients at risk for STD's (i.e. gonorrhea, syphilis/serology, chlamydia, HIV, etc.); (11) All sexually active females should have a pelvic examination and a routine pap smear annually. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between 18-21 years. (12) All sexually active patients should be screened for sexually transmitted diseases (STD's); (13) Dental exam twice yearly at 6 month intervals, including cleaning and fluoride treatment.

CONNECTICUT WIC LOCAL AGENCY COORDINATORS 3/06

BRIDGEPORT	752 East Main Street	Bridgeport 06608	**Roslyn Epstein**	(203) 576-8071 Fax 576-7348
BRISTOL/	9 Prospect Street	Bristol 06010	**Shoreh Rassekh**	(860) 585-3280 Fax 585-3977
NEW BRITAIN	450 Main Street	New Britain 06051		(860) 225-8695 Fax 225-8698
DANBURY	13 Main Street	Danbury 06810	**Martha Montana**	(203) 797-4629 Fax 796-1567
DAY KIMBALL	320 Pomfret Street	Putnam 06260	**Wendy Osborn**	(860) 928-3660 Fax 963-6325
EAST HARTFORD	754 Main Street 740 Main St. **(MAIL)**	East Hartford 06108	**James Cordier**	(860) 291-7323 Fax 291-7229
HARTFORD	131Coventry St. **(MAIN)**	Hartford 06112	**Elsa Smith-Pleasant**	(860) 543-8835 Fax 722-8062
Santa Marquez WIC Center	547 Park Street	Hartford 06106		(860) 722-8030 Fax 722-8044
MERIDEN	165 Miller Street	Meriden 06450	**Patricia Sullivan**	(203) 630-4245 Fax 630-4249
MIDDLETOWN	62 Washington Street	Middletown 06457	**Cynthia Cohen**	(860) 344-8014 Fax 343-6043
NAUGATUCK	98 Bank Street	Seymour 06483	**Ann Noonan**	(203) 888-1271 Fax 888-1275
NORWALK	137 East Avenue	Norwalk 06851	**Shabnam Gill**	(203) 854-7885 Fax 854-7926
New Haven WIC Programs (4): **HOSPITAL OF ST. RAPHAEL**	1401 Chapel Street 1450 Chapel St. **(MAIL)**	New Haven 06511	**Mary Chervenak**	(203) 789-3563 Fax 867-5208
FAIR HAVEN	374 Grand Avenue	New Haven 06513		(203) 773-5007 Fax 777-8506
HILL HEALTH	428 Columbus Avenue	New Haven 06519		(203) 503-3080 Fax 503-3090
YALE/ NEW HAVEN	789 Howard Avenue 20 York St. **(MAIL)**	New Haven 06504		(203) 688-5150 Fax 688-7264
STAMFORD	888 Washington Blvd. P.O. Box 10152	Stamford 06904	**Merle Rickles**	(203) 977-4385 Fax 977-5882
T.V.C.C.A.	81 Huntington Street	New London 06320	**Christine Mullin x124**	(860) 444-0006 Fax 444-0061
	401 W. Thames Street Unit 201	Norwich 06360		(860) 889-1365 Fax 885-2738
TORRINGTON	350 Main Street Suite C	Torrington 06790	**Jackey Dieli** **Acting Coordinator**	(860) 489-1138 Fax 489-2888
VERNON/ ROCKVILLE	11 Park Street	Rockville 06066	**Joanne White**	(860) 875-0602 Fax 871-1109
WATERBURY	95 Scovill Street	Waterbury 06706	**Nancy Braz**	(203) 574-6785 Fax 573-6677
	232 North Elm Street	Waterbury 06702		(203) 574-8384 (203) 756-7322
WINDHAM/ ACCESS	1315 Main Street	Willimantic 06226	**Karen Lechene**	(860) 450-7405 Fax 450-7477

STANDARDS FOR INTERNAL QUALITY ASSURANCE PROGRAMS FOR HEALTH PLANS

Standard I: Written QAP Description

The organization has a written description of its Quality Assurance Program (QAP). This written description meets the following criteria:

A. *Goals and objectives* - There is a written description of the QA program with detailed goals and annually developed objectives that outline the program structure and design and include a timetable for implementation and accomplishment.

B. *Scope* -

1. The scope of the QAP is comprehensive, addressing both the quality of clinical care and quality of non-clinical aspects of services, such as and including: availability, accessibility, coordination, and continuity of care.
2. The QAP methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings (e.g. inpatient, ambulatory, [including care provided in private practice offices] and home care), and types of services (e.g. preventive, primary, specialty care and ancillary) are included in the scope of the review. This review should be carried out over multiple review periods and not on just a concurrent basis.

C. *Specific activities* - The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. *Continuous activity* - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. *Provider review* - The QAP provides:

1. Review by physicians and other health professionals of the process followed in the provision of health services;
2. Feedback to health professionals and health plan staff regarding performance and patient results.

F. *Focus on health outcomes* - The QAP methodology addresses health outcomes to the extent consistent with existing technology.

Standard II: Systematic Process of Quality Assessment and Improvement

The QAP objectively and systematically monitors and evaluates the quality and appropriateness of care and service provided members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

A. *Specification of clinical or health services delivery areas to be monitored*

1. Monitoring and evaluation of clinical issues reflects the population served by the health plan, in terms of age groups, disease categories, and special risk status.
2. For the Medicaid population, the QAP monitors and evaluates at a minimum, care and services in certain priority areas of concern selected by the State. It is recommended that these be taken from among those identified by the Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau and jointly determined by the State and the Managed Care Organization (MCO).
3. At its discretion and/or as required by the State Medicaid agency, the MCO's QAP also monitors and evaluates other aspects of care and service.

B. Use of quality indicators

Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process of outcomes of care delivered in that area.

1. The MCO identifies and uses quality indicators that are measurable, objective, and based on current knowledge and clinical experiences.
2. For the priority area selected by the State from the CMS Medicaid Bureau's list of priority clinical and health service delivery areas of concern, the MCO monitors and evaluates quality of care through studies, which include, but are not limited to, the quality indicators also specified by the CMC Medicaid Bureau.
3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of clinical care standards/practice guidelines

1. The QAP studies and other activities monitor quality of care against clinical care or health services delivery standards or practice guidelines specified for each area identified.
2. The clinical standards/practice guidelines are based on reasonable scientific evidence and are developed or reviewed by plan providers.

3. The clinical standards/practice guidelines focus on the process and outcomes of health care delivery, as well as access to care.
4. A mechanism is in place for continuously updating the standards/practice guidelines.
5. The clinical standards/practice guidelines shall be included in provider manuals developed for use by HMO providers or otherwise disseminated to the providers as they are adopted.
6. The clinical standards/practice guidelines address preventive health services.
7. The clinical standards/practice guidelines are developed for the full spectrum of populations enrolled in the plan.
8. The QAP shall use these clinical standards/practice guidelines to evaluate the quality of care provided by the MCO's providers, whether the providers are organized in groups, as individuals, as IPAs, or in a combination thereof.

D. Analysis of clinical care and related services

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care and through studies analyzing patterns of clinical care and related service. For quality issues identified in the QAP's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.
2. Mulitdisciplinary teams are used, where indicated, to analyze and address system issues.
3. For the D.1. and D.2. above, clinical and related services requiring improvement are identified.

E. Implementation of remedial/corrective actions

The QAP includes written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, or services that should have been furnished were not.

These written remedial/corrective action procedures include:

1. Specification of the types of problems requiring remedial/corrective action.
2. Specification of the person(s) or body responsible for making the final determinations regarding quality problems.
3. Specific actions to be taken.
4. Provision of feedback to appropriate health professionals, providers and staff.
5. The schedule and accountability for implementing corrective actions.

6. The approach to modify the corrective action if improvements do not occur.
7. Procedures for terminating the affiliation with the physician, or other health professional or provider.

F. Assessment of effectiveness of corrective actions

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
2. The MCO assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. Evaluation of continuity and effectiveness of the QAP

1. The MCO conducts a regular and periodic examination of the scope and content of the QAP to ensure that it covers all types of services in all settings, as specified in standard I-B-2.
2. At the end of each year, a written report on the QAP is prepared which addresses: QA studies and other activities completed, trending of clinical and services indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QAP
3. There is evidence that QA activities have contributed to significant improvements in the care and services delivered to members.

Standard III: Accountability to the Governing Body

The QA committee is accountable to the governing body of the managed care organization. The governing body should be the board of directors, or a committee of senior management may be designated in instances in which the board's participation with QA issues is not direct. There is evidence of a formally designated structure, accountability at the highest levels of the organization, and ongoing and/or continuous oversight of the QA program. Responsibilities of the Governing Board for monitoring, evaluating, and making improvements to care include:

A. Oversight of the QAP - There is documentation that the governing body has approved the overall QAP and the annual QAP.

B. Oversight of entity - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

C. QAP progress reports - The Governing body routinely receives written reports from the QAP describing actions taken, progress in meeting QA objectives, and improvements made.

D. *Annual QAP review* - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess the QAP's continuity, effectiveness and current acceptability.

E. *Program modification* - Upon receipt of regular written reports from the QAP delineating actions taken and improvements made, the Governing Body takes actions when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within the MCO. Minutes of the meetings of the Governing Board demonstrate that the Board has directed and followed up on necessary actions pertaining to QA.

Standard IV: Active QA Committee

The QAP delineates an identifiable structure responsible for performing QA functions within the MCO. The committee or other structure has:

A. *Regular meeting*s - The structure/committee meets on a regular basis with specified frequency to oversee QAP activities. This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions, but in no case are such meetings less frequent than quarterly.

B. *Established parameters for operating* -The role, structure and function of the structure/committee are specified.

C. *Documentation* - There are contemporaneous records documenting the structure's/committee's activities, findings, recommendations and actions.

D. *Accountability* - The QAP committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

E. *Membership* - There is active participation in the QA committee from health plan providers, who are representative of the composition of the health plan's providers.

Standard V: QAP Supervision

There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QA activities.

Standard VI: Adequate Resources

The QAP has sufficient material resources, and staff with the necessary education, experience, or training; to effectively carry out its specified activities.

Standard VII: Provider Participation in the QAP

A. Participating physicians and other providers are kept informed about the written QA plan.

B. The MCO includes in all its provider contracts and employment agreements, for both physicians and nonphysician providers, a requirement securing cooperation with the QAP.

C. Contracts specify that hospitals, physicians, and other contractors will allow the MCO access to the medical records of their members.

Standard VIII: Delegation of QAP Activities

The MCO remains accountable for all QAP functions, even if certain functions are delegated to other entities. If the MCO delegates any QA activities to contractors.

A. There is a written description of delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the MCO.

B. The MCO has written procedures for monitoring the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

Standard IX: Enrollee Rights and Responsibilities

The MCO demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. Written policy on enrollee rights

The MCO has a written policy that recognizes the following rights of members:

1. To be treated with respect, and recognition of their dignity and need for privacy;
2. To be provided with information about the MCO, its services, the practitioners providing care, and members' rights and responsibilities;
3. To be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners;
4. To participate in decision-making regarding their health care;
5. To voice grievances about the MCO or care provided;
6. To formulate advance directives; and

7. To have access to his/her medical records on accordance with applicable Federal and State laws.

B. *Written policy enrollee responsibilities* - The MCO has a written policy that addresses members' responsibility for cooperating with those providing health care services. This written policy addresses members' responsibility for:

1. Providing, to the extent possible, information needed by professional staff in caring for the member; and
2. Following instructions and guidelines given by those providing health care services.

C. *Communication of policies to providers* - A copy of the organization's policies on members' rights and responsibilities is provided to all participating providers.

D. *Communication of policies to enrollees/members* - Upon enrollment, members are provided a written statement that includes information on the following:

1. Rights and responsibilities of members;
2. Benefits and services included and excluded as a condition of memberships, and how to obtain them, including a description of:
    a. Any special benefit provisions (example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system; and
    b. The procedures for obtaining out-of-area coverage;
3. Provisions for after-hours and emergency coverage;
4. The organization's policy on referrals for specialty care;
5. Charges to members, if applicable, including:
    a. Policy on payment of charges; and
    b. Co-payment and fees for which the member is responsible.
6. Procedures for notifying those members affected by the termination or change in any benefit services, or service delivery office/site;
7. Procedures for appealing decisions adversely affecting the members' coverage, benefits, or relationship with the organization;
8. Procedures for changing practitioners;
9. Procedures for disenrollment; and
10. Procedures for voicing complaints and/or grievances and for recommending changes in policies and services.

E. *Enrollee/member grievance procedures* - The organization has a system(s) linked to the QAP, for resolving members' complaints and formal grievances. This system includes:

1. Procedures for registering and responding to complaints and grievances in a timely fashion (organizations should establish and monitor standards for timeliness);
2. Documentation of the substance of the complaint or grievances, and actions taken;
3. Procedures to ensure a resolution of the compliant or grievance;
4. Aggregation and analysis of complaint and grievance data and use of the data for quality improvement; and
5. An appeal process for grievances.

F. *Enrollee/member suggestions* - Opportunity is provided for members to offer suggestions for changes in policies and procedures.

G. *Steps to assure accessibility of services* - The MCO takes steps to promote accessibility of services offered to members. These steps include:

1. The points of access to primary care, specialty care and hospital services are identified for members;
2. At a minimum, members are given information about:
    a. How to obtain services during regularly hours of operation
    b. How to obtain emergency and after-hours care; and
    c. How to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.

H. *Written information for members*

1. Member information is written in prose that is readable and easily understood; and
2. Written information is available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10% of plan's membership.

I. *Confidentiality of patient information* - The MCO acts to ensure that the confidentiality of the specified patient information and records is protected.

1. The MCO has established in writing, and enforced, policies and procedures on confidentiality of medical records.
2. The MCO ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization.

3. The MCO shall hold confidential information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:
    a. it is required by law;
    b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
    c. it is necessary in compelling circumstances to protect the health or safety of an individual.
4. Any release of information in response to a court order is reported to the patient in a timely manner; and
5. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

J. *Treatment of minors* - The MCO has written policies regarding the appropriate treatment of minors.

K. *Assessment of member satisfaction* - The MCO conducts periodic surveys of member satisfaction with its services.

1. The surveys include content on perceived problems in the quality, accessibility and availability of care.
2. The surveys assess at least a sample of:
    a. All Medicaid members;
    b. Medicaid member requests to change practitioners and/or facilities; and
    c. Disenrollment by Medicaid members.
3. As a results of the surveys, the organization:
    a. Identifies and investigates sources of dissatisfaction;
    b. Outlines action steps to follow-up on the findings; and
    c. Informs practitioners and providers of assessment results.
4. The MCO reevaluates the effects of the above activities.

Standard X: Standards for Availability and Accessibility

The MCO has established standards for access (e.g. to routine, urgent and emergency care; telephone appointments; advice; and member service lines). Performance on these on these dimensions of access are assessed against the standards.

Standard XI: Medical Records Standards

A. *Accessibility and availability of medical records* - The MCO shall include provision in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof.

B. *Record keeping* - Medical records may be on paper or electronic. The plan takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

1. Medical records standards- The MCO sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall at a minimum, include requirements for:

    a. Patient identification information - Each page or electronic file in the record contains the patient's name or patient ID number.

    b. Personal/biographical data - Personal/biographical data includes: age, sex, address; employer; home and work telephone numbers; and martial status.

    c. Entry date - All entries are dated.

    d. Provider identification - All entries are identified as to author.

    e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.

    f. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies-NKA) is noted in an easily recognizable location.

    g. Past medical history - (for patients seen 3 or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history relates to prenatal care and birth.

    h. Immunizations- For pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date.

    i. Diagnostic information

    j Medication information

    k. Identification of current problems - Significant illness, medical conditions and health maintenance concerns are identified in the medical record.

    l. Smoking/ETOH/substance abuse - Notation concerning cigarettes and alcohol use and substance abuse is present (for patients 12

years and over and seen three or more times). Abbreviations and symbols may be appropriate.

m. Consultations, referral and specialist reports - Notes from consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physicians initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record and follow-up plans.

n. Emergency care

o. Hospital discharge summaries - Discharge summaries are included as part of the medical record for (1) all hospital admissions which occur while the patient is enrolled in the MCO and (2) prior admissions as necessary.

p. Advance directives - For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

2. Patient visit data - Documentation of individual encounters must provide adequate evidence of, at a minimum;

   a. History and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints.

   b. Plan of treatment

   c. Diagnostic tests

   d. Therapies and other prescribed regimens; and

   e. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.

   f. Referrals and results thereof; and

   g. All other aspects of patient care, including ancillary services.

3. Record review process-

   1. The MCO has a system (record review process) to assess the content of medical records for legibility, organization, completion and conformance to its standards.

   2. The record assessment system addresses documentation of the items listed in B, above.

Standard XII: Utilization Review

A. Written program description- The MCO has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to detect underutilization as well as overutilization.

C. Preauthorization and concurrent review - For MCO with preauthorization or concurrent review programs:

1. Preauthorization and concurrent review decisions are supervised by qualified medical professionals;
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate;
3. The reasons for decisions are clearly documented and available to the member.
4. There are well-publicized and readily available appeals mechanisms for both providers and patients. Notification of a denial includes a description of how file an appeal;
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation;
6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate; and
7. If the MCO delegates responsibilities for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

Standard XIII: Continuity of Care System

The MCO has put a basic system in place which promotes continuity of care and case management.

Standard XIV: QAP Documentation

A. *Scope* - The MCO shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QAP.

B. *Maintenance and availability of documentation* - The MCO must maintain and make available to the State, and upon request to the Secretary of HHS, studies, reports, appropriate, concerning the activities and corrective actions.

Standard XV: Coordination of QA Activity with other Management Activity

The findings, conclusions, recommendations, actions taken, and results of actions taken as a result of QA activity, are documented and reported to appropriate individuals within the MCO and through established QA channels.

A. QA information is used in recredentialing, recontracting, and/or annual performance evaluations.

B. QA activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

C. There is a linkage between QA and other management functions of the MCO, such as: network changes, benefit redesign, medical management systems, practice feedback to providers, patient education and member services.

Report #2
HUSKY A & B Volume of Unprocessed Claims

Plan Name
Qtr. Ending:

Claim Type	Claims In Process During Qtr. (# of claims) (1)						Total Claims In Process During Qtr.
	01-30 Days	31-45 Days	46-60 Days	61-90 Days	91-120 Days	>120 Days	
UB92 Claims							
HCFA 1500 Claims							
Subtotal MCO Claims							
Pharmacy							
Dental							
Vision							
~~Mental Health~~							323
Subtotal Vendor Claims							
Total							

Claim Type	Unpaid Adjudicated Claims (# of claims) (2)						Total Unpaid Adjudicated Claims (# of claims) At The End Of The Qtr.
	01-30 Days	31-45 Days	46-60 Days	61-90 Days	91-120 Days	>120 Days	
UB92 Claims							
HCFA 1500 Claims							
Subtotal MCO Claims							
Pharmacy							
Dental							
Vision							
~~Mental Health~~							0
Subtotal Vendor Claims							
Total							

Claim Type	Total Unprocessed And Unpaid Adjudicated Claims (3)						Total Unprocessed & Unpaid Adjudicated Claims
	01-30 Days	31-45 Days	46-60 Days	61-90 Days	91-120 Days	>120 Days	
UB92 Claims							
HCFA 1500 Claims							
Subtotal MCO Claims							
Pharmacy							
Dental							
Vision							
~~Mental Health~~							323
Subtotal Vendor Claims							
Total							

Claims Inventory	**EQUAL TO OR Less than 45 Days**	**Greater than 45 Days**
MCO Claims	%	%
Pharmacy	%	%
Dental	%	%
Vision	%	%
Mental Health	%	%
Total	%	%

Claim Type	Estimated Claims Received but not in system (# of claims) (4)						Total Claims Received But Not In System
	01-30 Days	31-45 Days	46-60 Days	61-90 Days	91-120 Days	>120 Days	
UB92 Claims							
HCFA 1500 Claims							
Subtotal MCO Claims							
Pharmacy							
Dental							
Vision							
~~Mental Health~~							
Subtotal Vendor Claims							
Total							

Tick Mark Legend:

1. **Claims in process**-all claims that are in a pending status (data, medical, COB edits) and require review by a claim examiner prior to being released for adjudication.
2. **Unpaid adjudicated claims**-claims which have been adjudicated and have a known pay amount, however, a check has not been issued for these claims.
3. **Total** of estimated claims in process, and unpaid adjudicated claims.
4. Estimated claims received but not in system-includes any claim that has been received and not input in the system (I.e. claims in the mailroom).

Unaudited Quarterly Financial Reports

	Current Assets:	Current Year	Previous Year
1	Cash and Cash Equivalents		
2	Short-Term Investments		
3	Premiums Receivable		
4	Investment Income Receivables		
5	Health Care receivables		
6	Amounts Due from Affiliates		
7	Aggregate Write-Ins for Current Assets		
8	TOTAL CURRENT ASSETS (items 1-7)		
	Other Assets		
9	Restricted Cash and Other Assets		
10	Long Term Investments		
11	Amounts Due from Affiliates		
12	Aggregate Write-Ins for Other Assets		
13	TOTAL OTHER ASSETS (items 9-12)		
	Property and Equipment		
14	Land, building and Improvements		
15	Furniture and Equipment		
16	Leasehold Improvements		
17	Aggreate Write-Ins for Other Equipment		
18	TOTAL PROPERTY (items 7-14)		
19	TOTAL ASSETS 9items 8, 13, and 18)		
	Details of Write-Ins Aggregated at item 7 for Current Assets		
701			
702			
703			
704			
705			
798	Summary of remaining write-ins for item 7 from overflow page		
799	TOTALS: (items 701 through 705 plus 798 page 2, item 7)		
	Details of Write-Ins Aggregated at item 12 for Other Assets		
1201			
1202			
1203			
1204			
1205			
1298	Summary of remaining write-ins for item 12 from overflow page		
1299	TOTALS: (items 1201 through 1205 plus 1298 page 2, item 12)		
	Details of Write-Ins Aggregated at item 17 for Other Equipment		
1701			
1702			
1703			
1704			
1705			

Unaudited Quarterly Financial Reports

1798	Summary of remaining write-ins for item 17 from overflow page		
1799	TOTALS: (items 1701 through 1705 plus 1798 page 2, item 17)		
	Current Liabilities		
1	Accounts Payable (Schedule G)		
2	Claims Payable (Reported and Unreported) (Schedule H)		
3	Accrued Medical Incentive Pool (Schedule H)		
4	Unearned Premiums		
5	Amounts Due to Affiliates (Schedule J)		
6			
7	Aggregate Write-Ins for Current Liabilities		
8	TOTAL CURRENT LIABILITIES (items 1-7)		
	Other Liabilities		
9	Loans and Notes Payable (Schedule I)		
10	Amounts Due to Affiliates (Schedule J)		
11	Aggregate Write-Ins for Other Liabilities		
12	TOTAL OTHER LIABILITIES (items 9-11)		
13	TOTAL LIABILITIES (items 8 and 12)		
	Net Worth		
14	Common Stock		
15	Preferred Stock		
16	Paid in Surplus		
17	Contributed Capital		
18	Surplus Notes (Schedule K)		
19	Contingency Reserves		
20	Retained Earnings/Fund Balance		
21	Aggregate Write-Ins for Other Net Worth Items		
22	TOTAL NET WORTH (items 13 and 22)		
23	TOTAL LIABILITIES AND NET WORTH (items 13 and 22)		
	Details of Write-Ins Aggregated at item 7 for Current Liabilities		
701	Payroll and Related Liabilities		
702	Accrued Audit and Actuarial Fees		
703			
704			
705			
798	Summary of Remaining Write-Ins for item 7 from overflow page		
799	TOTALS (items 0701 through 0705 plus 0798 Page 3, item 7)		
	Details of Write-Ins Aggregated at item 11 for Other Liabilities		
1101			
1102			
1103			
1104			
1105			
1198	Summary of remaining write-ins for item 11 from overflow page		
1199	TOTALS: (items 1101 through 1105 plus 1198 page 3, item 11)		
	Details of Write-Ins Aggregated at item 21 for Other Net Worth Items		
2101			

Unaudited Quarterly Financial Reports

2102			
2103			
2104			
2105			
2198	Summary of remaining write-ins for item 21 from overflow page		
2199	TOTALS: (items 2101 through 2105 plus 2198 page 3, item 21)		
	Member months		
	Revenues		
1	Premium		
2	Fee-For-Service		
3	Title XVIII - Medicare		
4	Title XIX - Medicaid		
5	Investment		
6	Aggregate Write-Ins for Other Revenues		
7	TOTAL REVENUES (items 1-6)		
	Expenses		
8	Medical and Hospital		
9	Other Professional Services		
10	Outside Referrals		
11	Emergency Room and Out-of-Area		
12	Occupancy, Depreciation and Amortization		
13	Inpatient		
14	Incentive Pool and Withhold Adjustments		
15	Aggregate Write-Ins for other Medical and Hospital Expenses		
16	Subtotal (items 8-15)		
17	Reinsurance Expenses of Net of Recoveries		
	Less		
18	Copayments		
19	COB and Subrogation		
20	Subtotal (items 18 and 19)		
21	Total Medical and Hospital (items 16 and 17 less 20)		
	Administration		
22	Compensation		
23	Interest Expense		
24	Occupancy, Depreciation and Amortization		
25	Marketing		
26	Aggregate Write-Ins for Other Administration Expenses		
27	TOTAL ADMINISTRATION (items 22-26)		
28	TOTAL EXPENSES (items 21 and 27)		
29	Income (LOSS) (item 21 and 27)		
30	Cumulative Effect of Accountin Change)		
31	Provision for Federal Income Taxes		
32	NET INCOME (item 29, less items 30 and 31)		
	Details or Write-Ins Aggregated at item 6 for other Revenues		
601	Other Income		
602			
603			

Unaudited Quarterly Financial Reports

604			
605			
698	Summary of remaining write-ins for item 6 from overflow page		
699	TOTALS: (items 601 through 605 plus 698 page 4, item 6)		
	Member months		
	Details of Write-Ins Aggregated at Item 6 for Other Revenues		
1501	Drugs		
1502	Outpatient		
1503			
1504			
1505			
1598	Summary of remaining write-ins for item 15 from overflow page		
	Details of Write-Ins Aggregated at Item 26 for Other Administration Expenses		
2601	MGMT Fee Income - SWWA		
2602	MGMTFee Expense GOHS		
2603	Other Administration Expense		
2604	MGMT Fee Expense Corp.		
2605	Accrued Audit and Actuarial Expense		
2698	Summary of remaining write-Ins for item 26 from ovrflow page		
2699	TOTALS (items 2601 through 2605 plus 2698) (page 4, item 26)		

HUSKY and Charter Oak
Provider Credentialing and Enrollment Requirements

1. Provider Credentialing, and Enrollment Distinction

Provider Credentialing and provider enrollment are separate and distinct processes in the HUSKY Programs. However, credentialing and enrollment are linked in that these requirements affect direct service providers as well as the manner in which MCOs submit provider network information to the Department of Social Services.

2. Credentialing Definition

For the purpose of the HUSKY programs, the term credentialing means the requirements for provider participation specified in the contracts between the Department of Social Services (DSS or the Department) and the MCO (Part II, 3.11, Provider Credentialing and Enrollment). In this section of the contract, the Department specifies the minimum criteria that the MCOs must require for provider participation in a health plan. The MCOs must ensure that their providers meet the Department's credentialing requirements.

3. Other Sources Credentialing

Credentialing is sometimes used to refer to a variety of requirements or entities, which issue credentialing standards. Examples include: the MCO's individual credentialing requirements; the managed care subcontractor's credentialing requirements; an accreditation organization requirements, such as the National Committee on Quality Assurance (NCQA); the licensure process; a trade organization or association such as the Joint Commission on Accreditation of Health Organizations (JCAHO).

4. DSS Requirements and Other Credentialing Sources

DSS credentialing requirements represent the minimum criteria for provider participation in a health plan. The Department will allow flexibility to the MCOs to use more stringent criteria, particularly as it concerns quality level of care for clients. While the MCOs may require additional, more stringent criteria, the Department is concerned with the impact on access to care. Therefore, DSS expects the MCOs to balance the need for stringent credentialing standards with the need to assure accessibility and continuity of care.

5. Delegated Credentialing

The contract between the Department and the MCOs permits the plan to delegate credentialing of individual providers to a facility. However, the MCO is ultimately responsible and accountable to DSS for compliance with the Department's credentialing requirements.

For the purpose of HUSKY, delegated credentialing means that the MCO entrusts the Department's credentialing requirements to another entity. MCOs delegate credentialing to a variety of entities depending on the nature of the services and the type of provider.

In delegated credentialing, the MCO remains responsible to DSS to verify and monitor compliance with the Department's credentialing requirements. The Department views delegated credentialing as a form of subcontract, therefore, similar oversight issues arise in the performance of the credentialing requirements. The Department requires the plans to demonstrate and document to DSS the plan's strong oversight of its delegated credentialing facilities. (Part II, Section 3.41 in B 3.44 in A, Subcontracting for Services).

6. Implications of Delegated Credentialing

In some instances, the MCO credentials the individual provider directly or delegates credentialing of the providers to the following entities:

- A subcontractor providing specific services (e.g., dental care);
- A credentialing subcontractor; or
- A facility (e.g., a freestanding clinic or hospital)

The relationship between the MCO and the delegated entity as well as the interplay with various credentialing requirements may take any number of configurations. Currently, the Department reiterates that the MCO may delegate credentialing of individual providers to a facility (e.g., a school based health center, freestanding clinic or hospital). However, the Department emphasizes that the MCO is ultimately responsible and accountable to DSS for compliance with all of the Department's credentialing requirements.

7. Oversight of Delegated Credentialing

The Department requires the MCO to demonstrate strong oversight of their delegated credentialing facilities, as with any subcontract. - Therefore, the Department reiterates that these arrangements are subject to the Department's review and approval. For the purpose of delegated credentialing, the MCOs must provide assurances to DSS at a minimum of the following:

- The MCO and the delegated entity should clearly identify in detail each party's responsibility for credentialing of providers.
- The Department's credentialing requirements should be clearly identified as well as each party's role in adhering to these requirements.
- The *credentialing files must be available to the plan in order to perform its oversight of the credentialing requirements. The Department must also have adequate access to credentialing files for the purposes of administering the managed care contracts.

(DSS/MCO HUSKY A Contract, Part II, Section 3.45 “Subcontracting for Services; HUSKY B 3 .42 “Subcontracting for Services”.)

8. Provider Enrollment Clarifications

For the purpose of HUSKY, the Department refers to provider enrollment as the process of capturing information on providers participating with MCOs contracted by DSS to provide services to clients. This process results in a profile of an MCO's provider network. The MCOs submit the provider network information to DSS via the Department's agent on a continuous basis. The Department utilizes the provider network information to facilitate the administration of managed care contracts and- the Medicaid program.

Provider enrollment information serves the following purposes:

a) To evaluate each MCO's service area and access to services which are used to establish enrollment ceiling or cap (currently summarized by plan submittals of provider tables);

b) To provide accurate information to clients for the purpose of client enrollment in an MCO; and

c) To maintain each plan's provider network information consistent with the provider directory.

Based on the previous discussion of credentialing, the Department clarifies the relationship between credentialing or delegated credentialing and provider enrollment as follows:

a) Enrollment for purposes of cap determination.

- The MCO must credential and enroll individual providers when the providers are counted towards the member enrollment ceiling.
- DSS credentialing requirements and provider enrollment processes also apply to individual providers in a facility when the individual provider is included in the count for cap determination.
- The MCO may delegate credentialing of individual providers to a facility (e.g., a clinic or hospital) and enroll the facility as such. In this case, - neither neither the facility nor the individual providers are provided in the count for cap determination.

b) Enrollment for purposes of accurate information to clients

- The MCO must enroll and credential individual providers as well as facilities in order to maintain accurate and updated information on the providers participating with a health plan. The Department’s enrollment broker uses the provider network information during enrollment.
- The Department stresses the importance of maintaining provider network information accurate and up-to-date. It is crucial that clients should have access to provider network information during the MCO select-ion process.

c) Enrollment for purposes of inclusion in the provider network directory.

- The MCO must credential and enroll individual providers when the providers are included and listed as individual providers in the health plan's provider directory.
- DSS credentialing requirements and provider enrollment processes also apply to individual providers in a facility when the individual provider is included and listed in the provider directory.
- If the 14CO delegates credentialing of individual providers to a facility and enrolls the facility, the facility is included and listed in the provider directory. The facility's individual providers are listed in the provider directory. The facility's providers are not listed in the provider directory.

9. Specific Issues and DSS Credentialing Requirements

a) Medicaid participation

The MCO or the delegated credentialing entity is responsible for the determination and verification that the provider meets the minimum requirements for Medicaid participation. The MCO or its -subcontractors may not delegate this provision to the Department nor require providers to enroll or participate in fee-for-service Medicaid to fulfill the requirement. While the Department encourages the MCO to contract with traditional and existing Medicaid providers, Medicaid participation in itself is not a requirement of the HUSKY contracts.

b) Allied Health Professional Licensed Clinics or Hospitals

The Department pays freestanding clinics participating in the Medicaid program for a variety of services. In Connecticut, clinic services include for example, medical services, well-child care, dental care, mental health and substance abuse services, rehabilitation services and other services. Clinic providers must meet federal and state requirements for participation in the Medicaid program. In accordance with Title 42 of the Code of Federal Regulations, Part 440.90 and Section 171 of the Medical Services Policy of the Connecticut Medical Assistance Program, clinic services are provided by or under the direction or a physician, dentist or psychiatrist.

The physician direction requirement means that the free-standing clinic's services may be provided by the clinic's allied health professionals whether or not the physician is physically present at the time that the services are provided. An allied health professional is further defined as an individual, employed in a clinic, who is qualified by special education and training, skills, and experience in providing care and treatment. The clinic is staffed by physicians and allied health professionals who are directly involved in the facility's programs. The allied health professionals provide services under the direction of a physician who is a licensed practitioner performing within the scope of his/her practice.

Based on the Department's definition of clinic services, the services provided by allied health professionals are included under the terms of the contracts between the Department and the MCOs.

As with all services, clinic services must be properly credentialed according to the Department's requirements, including licensure and certification standards. Allied health professionals may have licensure or certification requirements, such as Certified Addition Counselors or Licensed Social Workers. In accordance with the Department's definition, other allied health professions may qualify by virtue of their skills or experience and must function under the direction of a physician. In this case- the directing physician, as opposed to the allied health professional, is subject to the credentialing requirements as well as provider enrollment. The MCO may credential the physician directly or may delegate credentialing.

The Department's provisions for credentialing, delegated and provider enrollment would remain in effect for the directing physician (please refer to Section 8, Provider Enrollment Clarifications).

c) NCQA Standards and DSS requirements

While NCQA standards do not address credentialing of allied health professionals, services provided by allied health professionals may qualify for reimbursement by virtue of their skills or experience; however, the allied health professionals must function under the direction of a physician. In this case, the directing physician is subject to the credentialing requirements.

Appendix J – MCO Contract

HUSKY A Medicaid Coverage Groups

Eligibility Code	Description
F 01	Temporary Assistance to Needy Families (TANF)
F 03	Transitional Work Extension
F 04	Child Support Extension
F 05	Work Supplementation
F 07	Family Coverage (150 % FPL)
F 08	Special Child Care Deduction
F 09	Eligible for TANF except for Non-Medicaid Requirements
F 10	Newborn Coverage
F 11	Newborn Children
F 12	CN Ribicoff Children
F 13*	Children < 1, under 185 9 of the Federal Poverty Level (FPL)
F 20*	Children 1-6, under 185 % of the Federal Poverty Level (FPL)
F 25	Children under 185 % of the Federal Poverty Level (FPL)
F 95	Children under 18, 18-21, and caretaker Relatives
P 01	Pregnant Women -who meet TANF Financial Requirements
P 02	Pregnant Women under 185 % of the Federal Poverty Level (FPL)
P 95	Pregnant Women Coverage
M 01/M 02	Pregnant Women Extension (Post-Partum)
D 01, D 02, D 03, D 04	DCF Children

Deleted: MCO Contract 1/06

Appendix K
HUSKY Non-Hyde Amendment Abortions

Name of MCO:_____

Quarter Ended:_____

This report shall include all abortions that do not meet the HYDE Amendment criteria, and that are paid by the MCO during the quarter (e.g. July 1 - September 30). These reports shall be submitted by the 15th of the month following the end of the quarter (e.g. October 15). The reports shall be submitted in hard copy, as well as electronically to Lee Voghel, Division of Fiscal Analysis.

Date of Service	CPT Code	Medicaid Recipient ID#	Provider ID#	Provider Name	Date Paid	Amount Paid
			Total			

I hereby certify that to the best of my knowledge the information contained herein is true and accurate.

Signature:_____

Printed Name:_____

Title:_____

Date:_____

Appendix I: Capitation Rate Tables