June, 2009

Re: HUSKY Primary Care / PCCM Pilot Program

Dear Provider,

I am writing to invite you to join HUSKY Primary Care, Connecticut's Primary Care Case Management (PCCM) Pilot Program for clients in our HUSKY A (Medicaid for children and families) Program. The Pilot pays participating primary care providers $7.50 per member per month (in addition to fees paid for direct service) to coordinate the care of patients who enroll with their primary care provider (PCP) directly, rather than with a Medicaid managed care health plan.

On February 1, 2009, the Pilot began providing services to some HUSKY A clients who were existing patients in seven participating practices in the Waterbury and Windham areas. More than 50 PCPs already participate. With the following upcoming expansions planned for the program, we hope that you too will consider becoming a primary care provider in HUSKY Primary Care / PCCM:

- For July, we are expanding the pilot as an option for all HUSKY A clients living in Waterbury, Windham, and contiguous towns. We hope that additional primary care providers in these areas will join in the near future so that HUSKY A members will have additional options.
- Later this year, we will expand the pilot to New Haven, Hartford, and contiguous towns. We will be contacting primary care providers in these areas who already applied for the program in late 2008, and are looking for additional providers to apply for and join the program.

HUSKY Primary Care is a different type of Medicaid managed care. HUSKY A clients enroll directly with their primary care providers, who in turn coordinate their care. PCCM is used successfully in other states' Medicaid Programs to improve patients' clinical outcomes, and both client and provider satisfaction, while at the same time controlling health care costs. Several states conduct PCCM programs exclusively; others such as Massachusetts operate PCCM programs in parallel with traditional managed care.

HUSKY Primary Care, Connecticut's PCCM Pilot Program, seeks to determine whether PCCM can be a successful care option for HUSKY A clients. Instead of choosing one of the HUSKY managed care health plans (Aetna Better Health, AmeriChoice by United Healthcare, and Community Health Network of CT), clients enroll directly with their PCP. PCPs then provide case management services in addition to their direct patient services. Case management services include activities such as care coordination, developing care plans for enrolled clients, managing patients' diseases, and offering after hours availability to patients for telephone advice. The available specialists, hospitals, and other providers are the same in HUSKY Primary Care as in Title 19 / fee-for-service Medicaid, and the "carve-outs" (behavioral health, dental, and pharmacy) are the same as in the rest of HUSKY A.

HUSKY Primary Care is a collaborative effort between the Medicaid Program and its providers; therefore an important part of the program is the Provider Advisory Committee, which is helping develop and implement the pilot program. The Advisory Committee has three sub-committees on Care Coordination, Disease Management, and Data Transfer/Pilot Evaluation which are intimately involved in the development of the program. Recognizing that provider's time is scarce, all meetings are held via conference call either around lunch time or in the late afternoon right after providers' office hours.

Please note that your participation in the HUSKY Primary Care program does not affect you participation in the HUSKY managed care health plans.

I would appreciate the opportunity to discuss your potential participation in HUSKY Primary Care / PCCM. Please contact me at Robert.Zavoski@ct.gov or by telephone at 860-424-5583 to discuss this exciting opportunity.

Attached please find the provider application and contract. Applications and contracts can be sent via mail to Attorney Julia Lentini, Contract Administration, 9th Floor, Department of Social Services, 25 Sigourney Street, Hartford, CT 06106, or via email at Julia.Lentini@ct.gov, or via fax to her attention at 860-424-4953.

Sincerely yours,

Robert W. Zavoski, M.D., M.P.H.
Medical Director
Medical Care Administration

Cc: Michael Starkowski, Commissioner
David Parrella, Director, Medical Care Administration
Frances A. Freer, Acting Deputy Commissioner
Rose Ciarcia, Director, HUSKY Program
Rivka Weiser, PCCM Pilot Coordinator
Julia Lentini, Staff Attorney, Contract Administration

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
APPLICATION FOR ENROLLMENT/RE-ENROLLMENT IN
HUSKY PRIMARY CARE (PCCM) PROGRAM
(Rev. 06/09)

The following provider wishes to enroll as a Primary Care Provider (PCP) in HUSKY Primary Care, Connecticut's Primary Care Case Management (PCCM) program. If approved, the provider will be responsible for approving and monitoring the care of eligible HUSKY A beneficiaries, for a case management fee of $7.50 per member/per month in addition to fee-for-service reimbursement for medical services and treatment. The case management fee pays for such things as locating, coordinating and monitoring the health services provided by physicians or other high level clinicians. PCPs can be pediatricians, internists, family medicine practitioners, OB-GYNs, nurse practitioners, physician assistants (PAs), and, with prior approval in individual cases, specialists (see 6b below for a note on PA enrollment).
Each provider who would like to participate in the program must fill out an application.

1. Provider Name_____

2. NPI ☐☐☐☐☐☐☐☐☐☐

3. Practice Name_____
(if group practice or clinic, please complete question 5)

4. Locations and contact information:
4a. List all locations where you will provide direct patient care in descending order by the number of hours you spend providing care in each location.

	Street Address	City	State & ZIP	Your office hours at this location	Office Phone #
Primary					
Secondary					
Tertiary					

4b. Additional provider contact information:

Provider's direct office phone number: _____

Provider's e-mail address: _____

Provider's/office's fax number: _____

4c. **(If different from the provider him/herself -)** Who should we contact with any questions about this application and your participation (for example, a practice manager)?

Name: _____

Title/role: _____

Phone: _____

E-mail address: _____

If different from above:

Address: _____

Fax: _____

5. If this is a group practice, clinic, or FQHC, please list:

5a. Organization Name_____

_____

5b. Billing Provider NPI_____

(note: if Provider participates in multiple groups, Provider may list only one billing provider for purposes of HUSKY Primary Care [PCCM] participation)

5c. Billing Address:

_____

Street

_____

City & State Zip Code + Four

6. Provider Specialty (check all that apply):

- ☐ Family medicine practitioner
- ☐ General practitioner
- ☐ Internist
- ☐ PCP affiliated with a FQHC
- ☐ Pediatrician
- ☐ Osteopath
- ☐ Obstetrician/Gynecologist
- ☐ APRN (Specialty: _____)
- ☐ Nurse Midwife
- ☐ Physician Assistant (see 6b)
- ☐ Other Specialist (indicate specialty): _____

6a. If the applicant is an APRN or nurse-midwife, who is the collaborative physician?

Name_____

Address_____

_____

Phone Number _____

Collaborative Physician's NPI _____

6b. If the applicant is Physician Assistant (PA), who is the supervising physician?

(**Note**: Because of existing Medicaid policies and our enrollment system, the supervising physician must enroll in the HUSKY Primary Care program in order for the PA to participate. HUSKY A members who join the program will technically enroll with the supervising physician, though members can also be seen by the PA. While we welcome participation of PAs in the program, PAs do not need to sign individual contracts with the Department.)

Name_____

Address_____

_____

Phone Number _____

Supervising Physician's NPI _____

Note: Supervising Physician's signature is required for Physician Assistant applicants.

7. Is the applicant a current Medicaid provider? Yes ☐ No ☐
   7a. If yes, what is your Medicaid ID #? _____

8. List the name and NPI of the provider who would be available to serve your HUSKY A PCCM patients when you are not on-site at any of the locations listed in #4 above.

   Name: _____

   NPI: _____

9. Do you have hospital admitting privileges? Yes ☐ No ☐
   9a. If yes, list the hospital(s) where you have admitting privileges:

   _____

   9b. If you do not have hospital admitting privileges, describe provisions that allow for hospital admission of patients.

   _____

   _____

   _____

10. How will case management / care coordination services be provided?

Check all applicable		Name of contractor or employee	Phone number (and e-mail, if available)
	By contract with		
	By employee		

10a. What are the Credentials/Degree/Title of individuals providing case management / care coordination services?

_____

11. Do you have an Electronic Medical Record system or an electronic disease management data registry? Yes ☐ No ☐

11a. If yes, describe the system (system name, scope, etc.)

_____

_____

11b. If no, indicate plans and timeframe for obtaining a system:

_____

12. Do you have the ability to receive data and reports from the Department electronically? Yes ☐ No ☐

13. Are you able to receive membership files in the HIPAA-compliant 834 format? Yes ☐ No ☐

13a. If not, are you willing to take the necessary steps to begin receiving membership files in the 834 format within 3 months of PCCM participation? Yes ☐ No ☐

14. What is the maximum number of HUSKY A members you would be willing to have enroll with you in the HUSKY Primary Care program (Primary Care Case Management)?
_____ (**Note**: This number is per individual provider. In your contract, you will indicate to us a total number of members you are willing to have enroll with you. This number includes HUSKY A members who are existing patients and those who would be new patients.)

In order for us to get a better sense of your practice and the members you serve, please answer the following (approximate):

14a. What is your current patient caseload? _____

14b. What is your current Medicaid fee-for-service (Title 19) caseload? _____

14c. What is your current HUSKY A caseload? _____

14d. How many additional HUSKY A members would you be willing to accept as new patients in the HUSKY Primary Care program? _____

15. List any specific enrollment restrictions, such as age or gender:

_____

_____ _____
Provider Signature Date

_____
Print Name

_____
Title

_____ _____
Supervising Physician's Signature, if applicant is a PA Date

_____
Print Name

_____
Title

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
HEALTH CARE FINANCING
HUSKY PRIMARY CARE,
CONNECTICUT'S PRIMARY CARE CASE MANAGEMENT (PCCM) PROGRAM
PROVIDER AGREEMENT (Rev. 6/09)

_____
(Name of Applicant)

(hereinafter "Provider") is currently enrolled as a provider in the Connecticut Medical Assistance program ("CMAP") as one of the following provider types: family medicine, general practitioner, internist, primary care physician affiliated with a federally qualified health center, pediatrician, osteopath, obstetrician-gynecologist, advanced practice registered nurse ("APRN"), nurse-midwife, or other specialist approved by the Department of Social Services (the "Department" or "DSS"); or in the case of a physician assistant (PA), is enrolled by and through his/her supervising physician, who is ultimately responsible for the care of PCCM Members; or in the case of an FQHC-based provider who is not yet individually enrolled in CMAP, is a provider at an FQHC that is enrolled. Provider is hereby contracting to function as a Primary Care Provider ("PCP") in the Connecticut Primary Care Case Management ("PCCM") Program. By signing this PCCM Provider Agreement (the "Agreement"), the Provider is agreeing to its terms and conditions, as set forth herein.

Additionally, if Provider is an FQHC-based provider not yet individually enrolled in CMAP, the Provider agrees to enroll individually with the Department as a Provider in the Connecticut Medical Assistance Program, or in the case of an FQHC-based PA, shall enroll by and through his/her supervising physician, who is ultimately responsible for the care of PCCM Members. Provider's participation as a Primary Care Provider in PCCM is contingent on Provider's individual enrollment in CMAP.

PCCM is a system in Connecticut to manage care through the use of a PCP. The role of the PCP is to approve and monitor the care of enrolled HUSKY A beneficiaries, in exchange for a monthly case management fee from the Department. The case management fee is in addition to the fee-for-service reimbursement for medical services and treatment the PCP receives from the Department and pays for such things as locating, coordinating, and monitoring the health care services provided by a physician, physician group practice, or other high level clinician.

The opening of Provider's panel for enrollment of Members is contingent on the Department's opening of PCCM in Provider's geographic region.

A. Definitions:

Case Management/Coordination Fee: The amount paid to the Provider, per member per month, for each Member who has chosen the Provider as a PCP.

Department: The Connecticut Department of Social Services.

Member: A Medicaid HUSKY A client who has been certified by the Department to be enrolled in PCCM.

Primary Care Case Management (PCCM): The practice of providing, directing and coordinating the receipt of, health care services for Members. Health care services are medically necessary medical services, as defined by the Department's Fee-for-Service Policy, which are either authorized or

arranged for, or provided directly by, the PCP. Connecticut's PCCM program is also known as the HUSKY Primary Care program.

Preventive Services: Services rendered for the prevention of disease in adults and children, as defined by Connecticut Fee-for-Service Policy.

Primary Care: The ongoing care that is provided by the PCP to a Member, which includes the direct provision of medical care (including diagnosis and/or treatment), regardless of the presence or absence of disease. It includes health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, rendering continuous care to chronically ill patients and referring the Member to another provider, when necessary.

Primary Care Provider (PCP): The participating physician or physician extender (APRN, nurse-midwife, physician assistant) selected by the Member to provide or coordinate all of the Member's health care needs and to initiate and monitor referrals for specialized services when required.

Specialist: A physician whose practice is limited to a particular branch of medicine or surgery, especially one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit it.

Urgent Visit: A visit for treatment of an illness or injury that is less serious than an emergency, but is required to prevent serious deterioration in the patient's health status and cannot be delayed without imposing undue risk to the patient's well-being.

B. Functions and Duties of the Provider

The Provider agrees to maintain enrollment as a provider in the Connecticut Medical Assistance Program and comply with all of the provisions in the previously executed and currently effective Connecticut Medical Assistance Program Provider Enrollment Agreement, or by and through the agreement entered into by his/her supervising physician, in their role as a PCCM Provider. In addition, the Provider agrees to do the following as a PCP in the PCCM Program:

1. Consent to being listed with the Department and its agents as a PCP in the PCCM Program for the purpose of providing primary care and PCCM services to Members.
2. Accept up to_____ PCCM Members, with exceptions as approved by the Department. The maximum number of Members per Provider may not exceed 1200 and each case manager may not handle more than 2000 Members. The Department reserves the right to increase enrollment limitations, but will not permit additional enrollment without prior consent from the Provider. The Department also reserves the right to limit total Member enrollment within a group practice based on the Department's programmatic goals, however the Department shall not impose a limit of less than 2,000 Members if the practice's PCPs are willing to see that volume of Members.
3. Provide primary care and PCCM services to Members in accordance with the provisions of this Agreement and comply with relevant policies set forth in Medicaid provider manuals and relevant state and federal laws, including but not limited to laws about Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
4. Develop an ongoing relationship with Members for the purpose of providing continuity of care.
5. Provide or arrange for primary care coverage for "on-call" services, consultation or referral, and treatment for urgent medical conditions, twenty-four (24) hours per day, seven (7) days

per week, with a mechanism of support to be determined by the Department. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

6. Provide care for or schedule an appointment with the Member within 6 weeks of calling for an appointment for a well-care visit, within 10 days of calling for an appointment for a non-urgent, symptomatic visit and within 48 hours for an Urgent Visit. In-office waiting times for scheduled appointments shall be kept to a minimum (i.e. – under one hour).
7. Maintain hospital admitting privileges or arrange for and maintain a collaborative relationship with a practice that has hospital admitting privileges to ensure that Members may be hospitalized, as necessary and appropriate.
8. Assess all patients' risk factors and identify high risk conditions or needs by performing a risk assessment and developing a written care plan for all Members using the "at-risk" screening tool selected by the Department, with input from the provider advisory committee, which identifies Members' medical and social risk factors.
9. Coordinate Members' access to needed services, including preventive care and EPSDT services, which includes making referrals for medically necessary health care services and specialty care, and documenting these services in the medical record.
10. Provide patient education designed to assist Members in managing their own care and appropriately using their medical equipment and pharmaceutical products.
11. Refer Members for second opinions, in response to their requests.
12. Review emergency department utilization - integrating appropriate outreach, follow-up, and educational activities based on emergency department use by Members.
13. With support from the Department, refer patients to community-based non-medical services and support systems, as appropriate.
14. Identify inappropriate high costs and high users for the purpose of developing and implementing activities that lower inappropriate utilization and cost.
15. Participate in the Department's program evaluation, including but not limited to collecting and reporting data on process and outcomes measures, such as data on EPSDT completion, immunization status, completion of the personal risk assessment, and other measures to help evaluate the PCCM program.
16. Participate in, be represented on, or provide feedback to the provider advisory committee, in collaboration with the Department, to do the following, as well as implement and use the following once they have been developed:
    a. Develop and implement quality initiatives and disease management programs, including the measurement of outcomes;
    b. Develop and test protocols and reports;
    c. Submit information, such as clinical or process data, to the Department for PCCM program management purposes;
    d. Participate in performance measurement and review;
    e. Develop reporting methodologies that will support best practices to improve patient outcomes and meet the needs of the Medicaid waiver authority; and

f. Establish practice guidelines, including those regarding assessments of patients and development of written care plans.

17. Implement, within 1 year of signing this Agreement, an Electronic Medical Record (EMR) system or an electronic disease management data registry which satisfies the Department's data requirements, according to standards developed with the provider advisory committee.

18. Provide case management services, within the permitted enrollment limitations, either through direct employees or contracted services, to PCCM Members in the method approved by the Department during the Provider's application process.

19. Coordinate with the Connecticut Behavioral Health Partnership ("CT-BHP") and with the Dental Benefits Manager ("DBM") to:

    a. Make appropriate referrals to the CT-BHP and DBM for patients assessed as requiring either behavioral health or dental services;

    b. Provide medication management; and

    c. Coordinate care with the Member's behavioral health or dental providers.

20. Obtain from the Department and interpret the Provider's monthly enrollment file, to be sent in a HIPAA compliant 834 data transaction set or other format and made available via the EDS WEB mailbox at the end of each month.

21. Receive data and reports electronically from the Department in Excel or other mutually agreed upon format via e-mail or mail using a CD Rom.

22. Refrain from discriminating against Members on the basis of their health status or their need for health care services.

23. Offer hours of operation to Members that are no less than the hours of operation offered to commercial enrollees, and provide direct patient care for a minimum of 30 hours per week, to include at least two hours per week of weekend, evening, or other non-traditional hours that are not between 9 am and 5 pm Monday to Friday. The provision of non-traditional hours may be shared among a practice group.

24. Comply with the HUSKY Marketing Guidelines outlined in the Policy Memoranda provided by the Department for any marketing activities undertaken.

25. Comply with all applicable laws, regulations, and policies regarding language access for Members, including making written information available in the prevalent non-English languages the Provider's particular service area and by making oral interpretation services available in all non-English languages free of charge to each Member. Provider must also notify Members about the availability of said written information and oral interpretation services.

26. Comply with all federal and state laws, regulations, and policies that are applicable to the services to be provided under this agreement.

27. Submit information and documentation to the Department relating to the administration and implementation of PCCM, including, but not limited to, client service utilization, as requested by the Department. Pursuant to Section 29 below, such information and documentation, excluding any individually identifiable health information, once received by

the Department, may be subject to disclosure by the Department pursuant to the Freedom of Information Act.

28. In performing any acts required or described by this Contract and without regard to the dollar amount received for the performance of the acts required or described by this Contract, for purposes of this agreement, the Provider, as a PCP in the PCCM Program 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. As such the Department is entitled to receive a copy of records and files related to the performance of the governmental function. Such records and files may be 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 Provider is the improper recipient of a request made pursuant to the Freedom of Information Act to inspect or copy such records or files, the Provider shall forward that request to DSS.

    a. 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 that may be performed by the Provider for the Department, the Department shall send such request to the Provider. The Provider shall review the request and, with reasonable promptness, search its records and files for documents that are responsive to the request. The Provider 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 Provider 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 Provider's search for responsive documents, the Provider shall notify the Department in writing that the search and production of documents is complete. If, upon review of the request, the Provider determines that it will require more than fourteen (14) days to search for and provide copies of responsive documents to the Department, the Provider shall contact the Department within seven (7) days of the receipt of the request from the Department.

    b. If the Provider 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 Provider 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 Provider's conclusion and explanation and, as necessary, discuss said conclusion with the Provider. 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 Provider that said documents should not be disclosed, the Department shall notify the Provider, in writing, that it intends to release the documents fourteen (14) days from the date of the notice. The Provider 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.

c. If the Provider concludes that a document is protected by attorney-client or work product privilege, the Provider 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.

d. If the Provider asserts an exemption under paragraph b or a privilege under paragraph c of this Contract, and the Department honors said claim, the Provider 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.

C. Functions and Duties of the Department

The Department agrees to do the following:

1. List the Provider's name as a PCP in the Connecticut PCCM program.
2. Pay the Provider a case management/coordination fee of $7.50 per member per month to perform the agreed functions and duties, in addition to the standard Medicaid rate for visits and procedures. Conditions of enrollment addressed in this contract, including enrollment and the right to disenrollment, are subject to any terms and conditions of an 1115 or 1915(b) Freedom of Choice waiver obtained by the Department. Funding for this program is contingent upon the Department's continued receipt of Federal funds.
3. Provide the Provider with an accurate and up-to-date enrollment file in HIPAA compliant 834 format or other format on a monthly basis, which will contain the names and other information concerning those Members who have selected the Provider as their PCP and will serve as the basis for payment of the case management/coordination fee.
4. Provide training and technical assistance to providers concerning the PCCM program.
5. Provide the Provider with periodic utilization and cost reports.
6. Gather and analyze data relating to service utilization by Members to determine whether providers are within acceptable PCCM peer comparison parameters.
7. Provide an ongoing quality assurance program to evaluate the quality of health care services rendered to Members.
8. Provide information about the PCCM program to potential Members so that they may decide whether to enroll in the program.
9. Provide information to Members concerning their rights and responsibilities and the availability of the complaint and grievance process in the PCCM program.
10. Provide written materials to Members and potential Members in a manner that is easily understood, in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
11. Provide support for or provide Members with access to a nurse advice line at a future date.
12. Notify the Provider prior to enrollment if a Member was previously disenrolled for cause from another PCCM Provider or MCO.

D. Miscellaneous Provisions

1. The Provider shall not discriminate, within the scope of their practice, against individuals eligible to enroll on the basis of race, creed, color, national origin, ancestry, sex, sexual orientation, marital status, age, lawful source of income, mental retardation, or mental or physical disability and will not use any policy or practice that has the effect of discriminating on any such basis. The Provider shall not discriminate in enrollment activities on the basis of health status or the individual's need for health care services, and shall not attempt to discourage or delay enrollment with the provider of prospective Members or encourage disenrollment from the provider of current Members.

2. The Provider shall conduct continuous open enrollment, up to the agreed upon level, during which time the Provider shall accept individuals eligible for coverage under this agreement in the order in which they are enrolled without regard to the need for health services or the health status of the individual.

3. Special Disenrollment

   a. The Provider may request in writing and the Department may approve disenrollment of

   specific Members upon evidence of "good cause" but only based upon evidence of good cause as defined in section (b) of this subsection. The request shall cite the specific event(s), date(s) and other pertinent information substantiating the Provider's request. Additionally, the Provider shall submit any other information concerning the Provider'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 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 Provider's ability to furnish services to either the particular Member or others.

   c. 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 Provider files the disenrollment request. If the Department fails to make the determination within this timeframe, the disenrollment shall be deemed approved.

   d. The Department will notify the Provider prior to enrollment if a Member was previously disenrolled for cause from another PCCM Provider or MCO pursuant to this section.

E. Violations of the Agreement

1. If the Provider fails to comply with the terms of this Agreement, the Department may take one or more of the following actions:

   a. Notify the Provider of the deficiency and require the development and implementation of a corrective action plan, specifying a date when such corrective action must be completed;

   b. Limit member enrollment with the Provider;

   c. Withhold all or part of the Provider's monthly PCCM management/coordination fee;

d. Refer the Provider to the Department's Fraud Unit or to the State Attorney General;

e. Refer the Provider to the Connecticut Medical Examining Board; and/or

f. Terminate the Agreement and recover payment for case management services not rendered.

2. If the Department determines that it is necessary to take one or more of the above-listed action against a Provider, the Department will notify the Provider of its decision by certified mail, return receipt requested, or via email, read receipt requested. If the Department determines that the health or welfare of a Member(s) is endangered, the action may be taken immediately; otherwise, the action will be taken within the time specified in the notice. If the Provider disagrees with the Department's determination, the Provider may request a meeting, as set forth in the PCCM Policy. The Department may initiate one or more sanctions against the Provider simultaneously, at its discretion and based on the severity of the violations of the Agreement.

3. Failure of the Department to take action against a Provider for a violation of the Agreement does not prohibit the Department from exercising its right to do so for subsequent violations.

F. <u>Term of the Agreement and Termination</u>

The Provider's participation in PCCM is concurrent with and contingent on enrollment as a provider in the Connecticut Medical Assistance Program, or is contingent by and through the supervising physician's enrollment. Should enrollment in the Connecticut Medical Assistance Program lapse, the Provider will also lose eligibility to be a PCP in PCCM. Should the provider reenroll, the Provider can reenroll as a PCP in PCCM, subject to approval by the Department. Additionally, this Agreement may be terminated in accordance with the following:

1. If the Provider decides to terminate this Agreement, the Provider must:

   a. Notify the Department, in writing, of its intent to terminate the Agreement at least 60 days in advance of the proposed date of the termination; and

   b. Notify his or her Members of the termination at least 30 days in advance of the proposed termination date in order to allow Members to find other providers.

2. Termination of the Agreement by the Provider does not disqualify the Provider from continuing to participate as a provider of Medicaid services.

3. If the Department decides to terminate the Agreement for a reason other than those listed below, it must notify the Provider, in writing, of its intention do so at least 60 days in advance of the effective date of the termination.

4. The Department may terminate this Agreement immediately if the Provider:

   a. violates the terms of this Agreement for any reason other than illness;

   b. violates applicable state or federal law or Department policy; or

   c. fails to maintain the required State certifications or licensures.

5. **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.

The effective date of this agreement shall be the date of signature by the Commissioner of the Department, or the effective date of Provider's individual enrollment in CMAP, whichever is later.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

_____

Provider Entity Name (doing business as)

_____

Name of Authorized Representative (typed) (Must be an Authorized Officer, Owner, or Partner)

_____

Signature Date

_____

Primary Care Provider (typed)

_____

Primary Care Provider Signature: Date:

_____

Title: Commissioner for the Department of Social Services

_____

Date of Signature

HUSKY Primary Care program (PCCM) Marketing Guidelines

The following marketing guidelines for PCCM are intended to protect the integrity of the clients' decision making process in selecting a managed care program or PCCM. While the provisions may not be wholly applicable to all PCCM providers, they are to be utilized by those providers wishing to engage in marketing activities, as defined below.

Definitions:

"Cold-call marketing" means any unsolicited personal contact by the PCCM with a potential enrollee for the purpose of marketing as defined in this section.

"Marketing" means any communication, from a PCCM to a Medicaid recipient who is not already enrolled as a PCCM patient in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular PCCM's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's, PIHP's, or PCCM's Medicaid product.

"Marketing materials" means materials that—

(1) Are produced in any medium, by or on behalf of a PCCM; and

(2) Can reasonably be interpreted as intended to market to potential enrollees.

"PCCM" includes the PCCM provider and any of its employees, affiliated providers, agents, or contractors.

Guidelines:

a. The PCCM shall obtain prior approval from the Department for all PCCM marketing activities and materials targeting the HUSKY population including, but not limited to marketing materials or information that mention HUSKY PCCM or materials that use the HUSKY logo or name and mention PCCM. Examples of such materials include signs about PCCM in the PCCM's office, brochures, and other materials. The use of the HUSKY logo and name in PCCM marketing materials is subject to the Department's guidelines and approval. No approval is required of PCP marketing that exclusively promotes the PCP and does not mention HUSKY PCCM. The Department may provide pre-approved marketing materials. Any material changes to said materials will require approval by the Department.

b. The PCCM shall not market or promote itself through any means of telemarketing, mass mailings or any other means by which the PCCM may establish unsolicited personal contact with potential Members; however, the PCCM may respond with permitted information to unsolicited in-person questions and telephone calls from potential Members and may return calls to them when the potential Member requests a return call. The PCCM may also provide Department-approved materials when requested by a potential Member. Approved marketing materials may be displayed in the PCCM's office and other approved locations

c. The Department will review materials submitted for Department approval and respond to review requests from the PCCM 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 PCCM 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.

d. PCCM shall not engage in unsolicited active marketing at provider sites.

e. PCCM 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 PCCM may provide its materials to the Department, who will display those materials.

f. The PCCM shall not promote itself through misleading, inaccurate or deceptive marketing characterized by the following:

1. Accuracy: The PCCM 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 PCCM, about the disadvantages of competing PCCMs or MCOs or implying that a given PCCM is the only option for enrollment in HUSKY;

2. Misleading or exaggerated claims: The PCCM shall not present misleading or exaggerated claims about the PCCM's positive attributes. Misleading references include, but are not limited to, any PCCM 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 PCCM provides free services. The PCCM may differentiate itself by promoting its legitimate positive attributes;

3. Endorsements: The PCCM shall not present false or misleading statements or assertions that the PCCM or any of its products is endorsed by the Department or CMS or any other governmental entity;

4. Threatening messages: The PCCM shall not create, advertise, or present threatening implications about the Department's mandatory assignment process for HUSKY A Members or other aspects of HUSKY A or create, advertise, or present threatening scenarios that do not accurately depict the consequences of choosing a different PCCM or MCO including, but not limited to those messages that suggest that a potential Member by not selecting a particular PCCM or MCO or the failure to join a particular PCCM or MCO would lose or not qualify for HUSKY 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 PCCM shall not engage in deceptive, fraudulent or abusive practices for any purpose including but not limited to enticing prospective members to change PCCM or MCO membership or to retain PCCM or MCO plan membership;

6. Discrimination: The PCCM shall not discriminate against any eligible individual on the basis of health status or need for future health care services; and

7. Parallel promotions: The PCCM shall not influence or promote enrollment in HUSKY A or the PCCM in conjunction with the sale or offering of any private insurance

g. Providers may inform their patients of the managed care plans and PCCM option in which they participate and may explain that the patients must enroll in one of these options if they wish to preserve their existing relationship.

h. The PCCM shall not conduct promotional group meetings or individual solicitation with potential members at:

1. The offices of the PCCM;

2. Private clubs;

3. Private residences including, but not limited to, situations where the potential Member desires and/or requests a home visit. PCCM staff may visit Member homes after enrollment becomes effective, as part of their orientation/education efforts, or visit patients (whether Members or non-Members) at home due to clinical care-related reasons; and

4. Employer sites including, but not limited to, soliciting employees directly or soliciting employers to promote the PCCM to their employees or customers.

i. The PCCM may market its PCCM program 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 PCCM:

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.

j. The PCCM 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 about non-patients for the purposes of potential marketing of PCCM: social security numbers, birth dates, or children's names or any other individual information related to family members or potential Members.

k. The PCCM shall not coerce or intimidate Members from changing their PCCM or MCO through enticements or performing the action on behalf of the Member.

l. For any PCCM that conduct marketing activities:

1. The PCCM 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 MCO/PCCM 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.

2. The PCCM shall implement policies and procedures to manage the actions of PCCM office and marketing staff to ensure compliance with marketing guidelines.

3. The PCCM 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.

m. The PCCM may disseminate PCCM promotional token gifts of nominal value (magnets, pens, bags, jar grippers, etc.) at approved events and sites, 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.

n. The PCCM may provide "welcome" packets to Members about PCCM when the Department has approved the items and the criteria for distributing the items before the PCCM distributes them.

o. The PCCM 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.

p. The PCCM shall follow Department approved procedures when approached by Members or potential Members including:

1. A PCCM shall use a script or informational materials which comply with the above guidelines when promoting the PCCM.

2. PCCM may provide potential Members the use of their 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 PCCM shall advise the potential Member that the potential Member has a choice of which managed care plan or PCCM to select.

3. A PCCM may dial the telephone number to the enrollment broker, however, when the enrollment broker answers the telephone, the PCCM shall identify him/herself by name and PCCM affiliation to the enrollment broker and then hand the phone over to the potential Member. The PCCM 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 PCCM shall remove himself/herself physically from the area so he/she cannot overhear the conversation between the Potential member and enrollment broker.

5. A PCCM shall not call the enrollment broker or utilize a third party and change the PCCM or managed care plan on behalf of a potential Member.

6. A PCCM shall not coach or coerce potential Members during or after the use of the telephone for a call with the enrollment broker

7. A PCCM may attempt to contact a potential Member not more than twice following an initial contact at a marketing event to follow-up.

q. 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**
	Marketing materials and approaches:			
1	PCCM unsolicited active marketing in provider care sites		**X**	
2	PCCM advertising in Department- eligibility offices, including hospital-based			**X**
3	Face to face allowed marketing activities			**X**
4	Potential Member-initiated telephone conversations with PCCM staff	**X**		
5	Mailings by PCCM in response to potential Member requests			**X**
6	Unsolicited PCCM mailings		**X**	
7	Cold calling and telemarketing		**X**	
8	PCCM group meetings held at PCCM		**X**	
9	PCCM marketing at public facilities such as churches, health fairs			**X**
10	PCCM group marketing meetings held in private clubs or private homes		**X**	
11	Individual solicitation at residences		**X**	
12	Marketing at employer sites and employer solicitation		**X**	
13	Gifts, cash, incentives, or rebates to potential Members			**X**
14	Raffles to prospective members		**X**	
15	HUSKY PCCM-specific gifts to Members for specific health events			**X**
16	Phoning by potential Members from health care provider locations, as specified	**X**		
17	Beverages and light refreshments for potential Members at meetings		**X**	

18	Use HUSKY name and logo (contact Department for logo guidelines)			**X**
19	Generic Health Education materials	**X**		
20	HUSKY PCCM-specific Health Education materials			**X**
21	Health education and prevention activities at providers sites	**X**		
22	Soliciting contact information from members, prospective members, as specified			**X**
23	Communication with Members by marketing/outreach staff, telephone use, as specified only			**X**