DENTAL ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

Dental Benefit Management, Inc. d/b/a BeneCare Dental Plans

and

the Department of Social Services

Dated August 1, 2008

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[TO BE REVISED UPON COMPLETION]

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Whereas the settlement of the lawsuit Carr v. Wilson-Coker requires the Department of Social Services to "carve out" dental services from its managed care contracts; and

Whereas the Department of Social Services ("the Department") seeks to improve access to and delivery of public sector oral health services to improve access to and quality of dental care; and

Whereas the Department has increased dental provider rates and established a uniform dental fee schedule effective 7/1/08; and

Whereas the Department released a competitive request for proposals to provide dental administrative services to the Medicaid clients of Connecticut on February 28, 2008 and issued Addendum 1 on March 20, 2008; and

Whereas the Department entered into contract negotiations with Dental Benefit Management, Inc. d/b/a BeneCare Dental Plans ("BeneCare" or the "Contractor"); and

Whereas the Department accepted BeneCare's proposal contents in their entirety;

Therefore this First day of August, 2008 the Department of Social Services and BeneCare have entered into a contractual relationship consisting of the terms and conditions set forth below.

PART I

1. Objectives

The primary objective of the redesigned oral health service program, hereinafter referred to as the Dental Initiative, is to provide enhanced access to, and coordination of, a more complete and effective system of community-based oral health service and to improve individual oral health outcomes by modifying client behavior. Secondary objectives of this contract include better management of state resources and the delivery of standardized dental benefits.

In order to obtain this objective, the Contractor shall emphasize the patient as an integral partner in their health care and in the importance of receiving consistent dental care through a single provider network and uniform fee schedule for provider reimbursement.

2. Administrative Integration

The Department and the Contractor shall develop a common administrative infrastructure to support the goals of Connecticut's Statewide Dental Initiative. The shared infrastructure will support the efficient management of oral health services provided to members of the Medicaid fee-for-service, State Administered General Assistance (SAGA) and HUSKY A and B.

In this administrative infrastructure the Department and BeneCare will share two administrative functions in claims processing and data management. BeneCare will perform the following primary functions: network recruitment, member services, member outreach, prior authorization of services, utilization management and quality assurance and improvement. They will also perform supportive functions as required by the Department. The Department's fiscal intermediary, currently EDS but subject to change at the discretion of the Department, will process all dental claims and will also process the enrollment of all providers into the Medicaid Management Information System (MMIS).

As part of the administrative infrastructure, the Contractor shall manage all dental services listed on the Department's dental fee schedule, with the exception of hospital Emergency Department services related to dental emergencies, operating room services or same day surgery suites and/or oral surgery services performed by an oral and maxillofacial surgeon.

3. General Matters
Contractor Responsibilities

1. Components of the Dental Initiative- The Contractor shall provide the following components of the dental initiative:

   A. Expansion and enhancement of access to dental services;

   B. Member compliance with Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services;

   C. Early intervention, evidence – based strategies for children identified as being high – risk for decay;

   D. A strong preference for delivery and management of services within local communities including public health settings;

   E. Simplification of administrative processes for dental providers; and

   F. Prevention and interceptive model versus one that focuses on disease treatment.

2. Child Services

   The Contractor shall administer two levels of benefits for children. The Core Service level shall include services currently covered under Connecticut's federal Title XIX Medicaid Program for HUSKY A and the Medicaid Title XIX fee-for-service system. The second level of benefits, HUSKY B, has co-payments for benefits as well as a slightly different benefit package from the HUSKY A and Medicaid fee-for-service programs. The Department shall provide descriptions of the Medicaid dental benefit package and the HUSKY B dental benefit package to the Contractor.

   To achieve improvements in oral health care for children and their families, the Contractor must utilize a service delivery process that engages parents as partners in their children's oral health care. The education provided to children and their families must focus on age appropriate oral hygiene and intervention strategies, dietary and anti – tobacco counseling and the importance of keeping regularly scheduled dental appointments with a dental home or primary care dentist.

3. Adult Services

   Currently, adults receive dental services through the SAGA and Medicaid (including HUSKY A) programs. Members who are adults in HUSKY A Program may be either the parents or the caretaker relative of a HUSKY A member who is under the age of twenty one (21). Medicaid FFS clients are primarily the elderly, disabled adults and adults in long-term care facilities. FFS also includes HUSKY A families enrolled in FFS. SAGA is a state funded program which provides medical and dental services

to individuals that do not qualify for Medicaid and includes primarily adults age 18 and over. The benefits package for adults is slightly different from the benefits for children and youth under the age of twenty one (21). The Department shall provide a description of Medicaid dental benefit package for adults to the Contractor.

4. Coordination with Members' Medical Plans

   The Contractor and the Medical plans will work together on primary care education and initiatives to improve ease of referral between primary medical care and dental care.

   The HUSKY medical plans will continue to be responsible for 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.

5. Staffing and Department Approval

   The Contractor must receive the written approval of the Department for the initial staffing of Key Positions as well as staffing changes in Key Positions prior to such changes being made. BeneCare shall submit to the Department for its approval, the name and credentials of any staff members who are proposed to replace existing or previously proposed staff for Key Positions or other personnel identified by the state. 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 contract. Key Positions include: Project Manager; and the Director and/or Supervising Manager of the following operational areas: Member Services – (Connecticut located); Provider Services– (Connecticut located); Quality Assessment and Performance Improvement; Utilization Management; and Data systems.

4. Contract Management and Administration

The Department shall:

1. Designate a representative to oversee the management of the contract, including the performance of the Contractor. This individual will be the first point of contact regarding issues that arise related to Contract implementation, operations and program management.
2. Establish a Dental Advisory Committee that shall be chaired by the DSS representative with staff support provided by the Contractor. The membership of the Dental Advisory Committee shall include designees of the Department, dental provider community, advocates and other stakeholders.
3. The Department will monitor contractor performance with focus on access, quality, and clinical management including the review of related data and reports, the Contractor's quality management program plan and the progress of BeneCare in implementing its Quality Management Plan and achieving performance targets in the areas of access, quality and care management in integration with community based and public health systems.

The Contractor shall:

1. Designate lead staff as liaisons to the Department for key functional areas;
2. Through its chief executive officer, or other senior executive, attend meetings of the Medicaid Managed Care Council when on the agenda and as specified by the Department;
3. Through its key person, and other assigned Contractor staff, coordinate with the Department in the preparation for the Dental Advisory Committee meeting agenda;
4. Through its representative, attend the Dental Advisory Committee meetings on a regular basis; and
5. Support the Dental Advisory Committee activities, including at a minimum:
   a. scheduling meetings;
   b. drafting and distributing meeting agendas and minutes; and
   c. providing updates and progress reports at mutually agreeable times.

5. Staff Credentials and Training

The Contractor shall employ:

Directors or managers of the Quality Assurance and Utilization Management functions with the following minimum relevant training and experience including:

1. Licensure as dentists or dental specialists;
2. Licensure in the State of Connecticut or have licensure in another State with Connecticut reciprocity; and
3. Experience and demonstrated competency with performing utilization management functions.

6. Systems Design and Architecture

A. General Requirements

1. The success of the integrated Connecticut Statewide Dental Initiative for adults, children, and families in part, relies on a secure integrated data system. The Contractor's system must be able to integrate data from several sources, including data from the Department's EMS system and data from its agents.

The Contractor Shall:

1. Establish and maintain a HIPAA compliant computer system to accommodate all operational and reporting functions required by the contract;
2. Maintain information integrity through controls at appropriate locations within the Contractor's system and process flow to ensure quality control of all

operational components impacting Contractor's performance of functions required by contract;

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 contract;
4. Prepare and maintain a HIPAA compliant Disaster Recovery Plan;
5. Assemble an eligibility database;
6. Ensure the appropriate and correct use of the Department's data; and
7. Build a comprehensive provider file from the MMIS vendor's provider file and additional relevant provider data from the integrated provider applications.

B. Client Eligibility –System Application

Introduction

1. Eligibility for medical assistance covers from the first to the end of the month. Eligibility for Medicaid can be made retroactive to a previous month; consequently some services may need to be reviewed for authorization after the fact.

The Department Shall:

1. Provide, and have its enrollment broker provide, the Contractor daily "adds and deletes files" and monthly roster files for the SAGA, Medicaid (including HUSKY A) and HUSKY B programs. These files will be translated into a HIPAA compliant 834 enrollment transaction format. The SAGA and Medicaid files will be made available to the Contractor via an EDS web mailbox. The enrollment broker will provide the HUSKY B files via an FTP secure site.
2. Provide files that may contain retroactive enrollments and disenrollments. A retroactive disenrollment in HUSKY B most often will be due to a decision that established a retroactive enrollment in HUSKY A.
4. Provide a third party liability (TPL) file with the month end roster file (for SAGA and Medicaid only).

The Contractor Shall:

1. Run daily downloads of the eligibility/enrollment files and maintain an enrollment database of members reflecting up to date enrollment changes.
2. Verify the eligibility of members not yet showing in the monthly eligibility file utilizing the Department's Automated Eligibility Verification System (AEVS); and
3. Implement a process for authorizing services retroactively.

7. Project Timetable - Implementation

A. Introduction

The Department requires a fully operational oral health administrative system for managing oral health benefits for all HUSKY, SAGA and Medicaid Title XIX fee-for-service members by such date mutually agreed to by the parties and for each day of the contract period thereafter. The failure of the Contractor to provide an operational system on or before such date or the failure of the Contractor to maintain a fully operational system thereafter will cause considerable harm to the Department and their eligible members. To mitigate such harm the Department requires the Contractor to obtain either a performance bond or a statutory deposit as further described below.

During start-up, the Department and the Contractor will work together to support initiation of essential Contractor functions to enable the Contractor to manage the oral health benefits for HUSKY MCO members.

B. The Department Shall:

1. Engage in good faith negotiations to execute a contract by August 1, 2008 or as soon thereafter as possible.
2. If the Department determines that the Contractor has failed to make sufficient progress to become operational and to perform administrative services in accordance with the terms hereof and so notifies the Contractor, the Contractor shall have five (5) business days from the date of such notice to propose a corrective action plan to the Department's satisfaction.
3. May, at its option, take such additional steps as they deem necessary to provide seamless delivery of dental administrative services for its clients including, but not limited to, calling for execution of the performance bond and terminating the contract, as provided herein.
4. Objectively evaluate the on-going performance of the Contractor during the term of the contract.
5. Exercise its right to invoke the provisions of the termination subsection, when it determines the Contractor has failed to perform satisfactorily.
6. Require the Contractor to provide complete oral health authorization files and lists of individuals who are receiving orthodontic treatment services as of the effective date of the dental carve-out.
7. Provide a complete claims file extract for SFY06 and SFY07 dental services provided by the HUSKY and SAGA MCOs and the Medicaid Title XIX fee-for-service system.

C. The Contractor Shall:

1. Perform administrative services and become operational to perform core requirements of the contract for all or a portion of the eligible members by such date as the Contractor and the Department shall agree in writing.

2. Be liable to the Department for resulting harm if the Contractor is not "Operational" by the date specified in such writing. The Contractor shall not be liable for such harm if the Department has failed to meet their obligations under this contract and that failure of the Department was a direct cause of a delay of the Contractor's ability to perform its administrative services by the required date.

3. Participate in a formal review of the Contractor's ability to perform its administrative services in accordance with the terms hereof.

4. Obtain a performance bond or statutory deposit account in the amount of $1,000,000 within 120 days following the execution of the contract in accordance with the following:
   a. The purpose of the bond or statutory deposit amount is to mitigate harm caused by any failure of the Contractor to perform services required in the contract.
   b. The bond shall be provided by an insurer, which has been previously approved by the Department.
   c. The bond shall name the State of Connecticut as the Obligee.
   d. The bond or statutory deposit amount shall remain in effect until the latter of:
      1). The duration of the contract and any extensions to the contract.
      2). The work to be performed under the contract has been fully completed to the reasonable satisfaction of the Department.

8. Contract Term.

This contract shall be effective for an initial term of three (3) years beginning on August 1, 2008 (the "Effective Date") unless terminated sooner in accordance with Section 6, Corrective Action and Contract Termination, or as otherwise permitted hereunder. The Department shall have one option to renew the contract for an additional period of two (2) years, provided that it gives notice of such renewal to the Contractor at least 200 days prior to the expiration of the initial term (the "Notice Date"). If the Department fails to exercise its option to renew by the Notice Date, such option shall terminate and the Contractor shall be entitled to reimbursement for any unamortized leasehold improvements (as indicated in the Year Three Budget included in Appendix C hereto), payable no later than 30 days after the last day of the initial term.

If the Department elects to renew the contract, it shall so notify the Contractor at least ten days prior to the Notice Date and shall provide the Contractor with those contract modifications, if any, including payment terms, that it wishes to incorporate into the contract upon renewal. If the proposed new contract terms are materially adverse to the Contractor's rights or obligations hereunder, the parties shall negotiate in good faith in an attempt to reach agreement on the new terms within thirty (30) days after receipt of such notice from the Department, failing which the Contract shall not renew and the Contractor shall be entitled to reimbursement for any unamortized leasehold improvements (as indicated in the Year Three Budget included in Appendix C hereto), payable no later than 30 days after the last day of the initial term.

9. No Third Party Beneficiaries

The terms and provisions of this contract shall be binding upon and inure to the benefit of the parties and their respective successors and assigns, and is made solely and specifically for their benefit. No other person shall have any rights, interest or claims hereunder or be entitled to any benefits under or on account of this contract, whether as a third-party beneficiary or otherwise, except those prescribed by law.

Part II: Scope of Work

1. DEFINITIONS

As used throughout this contract, the following terms shall have the meanings set forth below.

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

ACS, Inc.:
The company contracted by the Department of Social Services to perform certain administrative and operational functions for the HUSKY A and B programs. As of this writing, contracted functions include HUSKY application processing, HUSKY B eligibility determinations, passive billing and enrollment brokering.

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.

Acute Services:
Medical, behavioral health or dental health services needed for an illness, episode, or injury that requires care.

Ad-hoc Report:
A report that may either be part of the Contractor's standard reporting package or a report that can be obtained from the Contractor's system without the use of any special programming effort.

Administrative Hearing:
A formal review by DSS that occurs after the Contractor and the SAGA or Medicaid member have failed to find mutual satisfaction concerning treatment issues such as denials, reductions, suspensions or terminations of services.

Administrative Services Organization:
An organization providing statewide utilization management, benefit information and care management services within a centralized information system framework.

Adult:
A person who is over the age of 21 years of age.

Agent:
An entity with the authority to act on behalf of DSS.

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 formal procedure through which members can request a re-determination of an Contractor decision concerning but not limited to service authorization. An appeal request may be initiated by a provider, client or advocate to the contractor to review the contractor's service authorization.

Appointment Scheduling Assistance:
Assistance provided to Medicaid clients to secure dental appointments and find a primary dental provider, with the goal of the assistance to result in teaching the client how to make their own appointments to foster independence of the client and encourage continuity of care between provider and client.

Authorized Representative:
An individual over the age of eighteen, who has written authorization to act on the behalf of a member of an assistance unit, of which he or she is not currently a member, and would otherwise not be eligible to act without such authorization.

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

Care Coordination:
A service provided by a primary care dentist for members with complex dental and/or medical needs that requires close monitoring.

Care Management:

Care management refers to specialized care management techniques that are activated by the Contractor when an individual is experiencing early childhood caries or high levels of caries or other oral conditions which places the member at risk for future oral disease as identified by the contractor.

Care Management Plan:
A plan that is developed and activated when a member is identified to receive Care Management.

CDT:
Current Dental Terminology published by the American Dental Association

Centers for Medicare and Medicaid Services (CMS):
The Centers for Medicare and Medicaid Services (CMS), formally known as the Health Care Financing Administration (HCFA), is a division within the United States Department of Health and Human Services. CMS oversees the Medicaid and SCHIP programs.

Children (or children and youth):
Individuals under twenty one (21) years of age.

Children With Special Health Care Needs (CSHCN):
Children up to age nineteen (19) who have, or are at elevated risk for chronic physical, developmental, behavioral or emotional conditions, whether biologic or acquired. They require health and related services (not educational or recreational) of a type and amount not usually required by children of the same age. CSHCN also includes children who are blind or disabled (eligible for SSI under Title XVI; in foster or other out-of-home placement; are receiving foster care or adoption assistance; or are receiving services funded through Section 501(a)(1)(d) of Title V.

Client:
A person eligible for services under HUSKY A, HUSKY B, SAGA or Medicaid. For purposes of this contract, the term "client" is synonymous with beneficiary, recipient and enrollee (which are terms used in other jurisdictions).

Coinsurance:
The sharing of expenses for specified contract services by the insured and an insurer in a specified ratio.

Collaborative:
A Community Collaborative is a local consortium of health care Providers who are proactive in oral health and service and education agencies that have organized to develop coordinated, comprehensive community resources for children or youth for improving access to oral health care.

Commissioner:
The Commissioner of the Department of Social Services, as defined in Section 17b-3 of the Connecticut General Statutes.

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

Contract Administrator:

The Department employee responsible for fulfilling the administrative responsibilities associated with the contract.

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

Contractor:
The Administrative Services Organization providing a single source for clinical management, benefit information, member services, quality management, and other administrative services outlined in the contract within a centralized information system framework.

Co-payment:
A payment made by or on behalf of a Member for a specified covered benefit under HUSKY B, as defined in Section 17b-290 of the Connecticut General Statutes.

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, which may include co-payments, premiums, deductibles and coinsurance.

CPT:
Current Procedural Terminology codes published by the American Medical Association.

Data Warehouse:
A data storage system constructed by consolidating information currently being tracked on different systems by different vendors.

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

Day:
Except where the term "business day" is expressly used, all references to "day" in this contract will be construed as a calendar day.

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.

Dental Health Care Specialist:
An employee of the contractor who identifies members who are candidates for care coordination and case management. The DHCS works with the member and family, dental professionals and community to reduce the member's risk for developing future disease.

Dental Hygienist:
A professional operating within the provisions of the Connecticut General Statutes Sec. 20-126-l.

Department or DSS:
The Department of Social Services, State of Connecticut

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 its services.

Electronic Data Systems, Inc. (EDS):
Department of Social Service's fiscal agent contracted to process and adjudicate claims to support the Connecticut Medical Assistance Program.

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

Eligible:
For purposes of this contract, eligible means that the individual has been approved or is entitled to HUSKY A, HUSKY B or Medicaid Title XIX fee-for-service benefits.

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 services including, but not limited to, physical health, behavioral health and detoxification needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

Enrollment Broker:

The organization contracted by the Department to perform the following administrative and operational functions for the Department: HUSKY B application processing, HUSKY B eligibility determinations.

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

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

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

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

Health Care Professional:
A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

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

Home Health Care Services:
Services provided by a home health care agency (as defined in Subsection d of section 19A-4890 of Connecticut General Statutes) that is licensed by the Department of Public Health, meets the requirements for participation in Medicare, and meets all DSS enrollment requirements.

HUSKY, Part A or HUSKY A:
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 Section 17b-266 of the Connecticut General Statutes.

HUSKY, Part B or HUSKY B:
The health insurance plan for children established pursuant to Title XXI (SCHIP) of the Social Security Act, the provisions of Sections 17b-289 to 17b-303, inclusive, of the Connecticut General Statutes, and Section 16 of Public Act 97-1 of the October special session. This program provides federally subsidized health insurance for uninsured children in families earning from 185% to 300% of the federal poverty level. Unsubsidized coverage is available under HUSKY B for families earning more than 300% of the federal poverty level.

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.

In-Network Providers or Network Providers:
Providers who have contracted with the Department to provide services to Members.

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

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 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;

Maximum Annual Aggregate Cost-sharing:
The maximum amount that a Member is required to pay (out-of-pocket) for services under HUSKY B and such payments include co-payments and 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 State and Federal rules and regulations.

Medicaid Management Information System (MMIS):

The Department's automated claims processing and information retrieval system certified by CMS. It is organized into six function areas--Member, Provider, Claims, Reference, MARS and SUR.

Medicaid Program Provider Manuals:
Service-specific documents created by the Connecticut Medicaid Program 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 as cited in Connecticut Medicaid Program regulations.

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 to prevent a medical condition from occurring as cited in Connecticut Medicaid Program regulations.

Member:

An individual who is eligible for Medicaid, SAGA, HUSKY A or HUSKY B and is qualifies for services under the resultant contract.

National Committee on 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.

Network Providers:
Providers who have contracted with the Department through its Medical Assistance Program to provide medical services to Members.

Non-risk Contract
A contract under which the contractor—

a. Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §447.362; and
b. May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Normal Business Hours:
The normal business hours for this contract will be 8 AM through 5 PM, Monday through Friday except for six (6) state holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas).

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

Payment:
The term "payment" means any payment (including a commitment for future payment, such as a loan guarantee) that is—

a. Made by a Federal agency, a Federal contractor, or a governmental or other organization administering a Federal program or activity; and
b. Derived from Federal funds or other Federal resources or that will be reimbursed from Federal funds or other Federal resources.

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 cost of coverage or capitation rate under HUSKY B.

Prepaid Inpatient Health Plan (PIHP):
An entity that—
a. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
b. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
c. Does not have a comprehensive risk contract.

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

PCDP (PCD):
A licensed dental health care professional responsible for performing or directly supervising the primary care services of members.

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.

Primary Care:
All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Prior Authorization:
The process of obtaining prior approval as to the medical necessity and appropriateness of a service or plan of treatment. contractor approval of covered services to be provided, prior to their delivery.

Procedure Codes:
A broad term to identify systematic numeric or alphanumeric designations used by healthcare providers and medical suppliers to report professional services, procedures and supplies.

Provider:
A person or entity under an agreement with DSS to provide services for the HUSKY A or B or Medicaid Title XIX fee-for-service members.

Qualified Service Organization Agreement:
Contractual arrangement between a provider and a third party, that is in compliance with federal law, and that allows the sharing of confidential client information.

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

Random Retrospective Audit:
Audits conducted for the purpose of determining a provider's continued qualification as a high performing provider for the purpose of the prior authorization waiver program.

Requestor:
The individual for whom services are intended even though others may formally request the service on behalf of the member.

Retroactive Medical Necessity Review:
A retroactive medical necessity review resulting in an authorization or denial of a service for individuals who are retroactively granted eligibility, when the effective date of eligibility spans the date of service and the service requires authorization.

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

Retrospective Utilization Review:
A retrospective review is a component of utilization management that involves the analysis of historical utilization data and patterns of utilization to inform the ongoing development of the utilization management program.

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.

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.

Special Report:
A report that has not been previously produced and requires consultation with multiple sources, specifications to be written, development and testing prior to production to complete. A request for such a report will require agreement on part of Contractor given available resources.

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

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

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

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 Contractor and another party to fulfill requirements of this contract.

Subcontractor:
The party contracting with the Contractor to fulfill any requirements of this contract.

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

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 United States Code Section 1396 et seq., including any amendments thereto, which established the Medicaid program. (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.

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

Unique Provider Identifier (UPI):

A single number or code assigned to each provider in a data system and used to individually identify that provider.

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.

Utilization Management (UM):
The prospective, retrospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to an individual within the State of Connecticut. (Referred to as Utilization Review in Section 38a-226, Connecticut General Statutes.)

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

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

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

Well-child Visits: *See EPSDT.*

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, and the SCHIP program. No delegation by either party in administering this contract shall relieve either party of responsibility for carrying out the terms of the contract.

3. FUNCTIONS AND DUTIES REQUIRED OF THE CONTRACTOR IN THE CONTRACT

The Contractor shall perform the following contractual obligations including, but not limited to, the specific services for HUSKY A, HUSKY B, or Medicaid Members.

3.01 Provision of Services

a. The Contractor shall provide Members, directly or through arrangements with others, the services as more fully described below.

b. The Contractor 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.

c. The Contractor shall ensure that utilization management/review and coverage decisions concerning dental services for 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, the Contractor shall adopt practice guidelines as approved by the Department, as part of its quality improvement program. The Contractor shall disseminate the guidelines to affected providers and to Members, upon request. The Contractor's utilization management decisions shall be consistent with any applicable practice guidelines approved by the Department. The Contractor shall only use such criteria or guidelines in conjunction with the Department's medical necessity and medical appropriateness definitions. The medical necessity and medical appropriateness definitions take precedence over any guidelines or criteria and are mandatory and binding on all Contractor utilization management decisions.

d. The Contractor shall ensure that members in need of urgent or emergent care have access to qualified dental personnel during normal business hours. A taped telephone message shall instruct Members to go directly to an emergency room if the Member needs emergency care after normal business hours.

3.02 Member Rights

a. The Contractor shall have written policies regarding member rights. The Contractor shall comply with all applicable state and federal laws pertaining to member rights and privacy. The Contractor shall further ensure that the Contractor's employees and subcontractors consider and respect those rights when providing services to Members. The Contractor shall document and track and report to the Department client concerns

related to potential violations of members' rights, including those related to Connecticut Medical Assistance Program (CMAP) dental network providers.

b. Member rights shall 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 dental/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 Contractor or the Contractor's subcontractors or CMAP dental network providers.

The Contractor shall:

Provide the Department, for its review and approval, written policies about Members' rights at the times and in the form mutually agreed to by the parties.

3.03 Provider Network

Introduction:

The development of an adequate dental network will require the active collaboration between the dental Contractor and the Department's fiscal intermediary (EDS). The Contractor shall support and coordinate network management functions including network adequacy analysis, provider recruitment and network development. The Contractor will manage the program in a manner that ensures an adequate network of qualified dental providers. These providers will render high quality, medically necessary, cost effective dental care.

The Department's fiscal intermediary will be responsible for provider enrollment, claims processing, and provider bulletin/policy transmittal distribution.

The "Provider Network" includes all dental providers enrolled in the Connecticut Medical Assistance Program Provider Network. The EDS provider manual located at www.ctmedicalprogram.com/publications represents the foundation for the CMAP Dental Provider Network. The Contractor shall expand this network to include some or all HUSKY providers; and additional providers that are not currently enrolled in the CMAP Dental Provider Network prior to implementation.

Providers in the CMAP Dental Provider Network will not contract with the Contractor. Contractor will interact with the providers as an administrative agent on behalf of the Department. In this capacity, the Contractor shall assist the Department in developing and

maintaining the dental provider network capacity for the delivery of all covered services to all members.

The Contractor shall:

a. Recruit and maintain a provider network capable of delivering or arranging for the delivery of all covered dental services to all of its Members. The provider dental network shall have a sufficient mix of general dentists and specialists to meet access and geographic standards as identified in section 3.04 below. Recruitment efforts shall include, at a minimum:
    1. Direct mailings to non-enrolled providers;
    2. Informational seminars, including annual meetings with dental professional groups; and
    3. Inform qualified providers about how to enroll with the Department's fiscal intermediary.

b. Establish and maintain the Medicaid Dental provider network considering the following factors:
    1. Anticipated enrollment;
    2. Expected utilization of services, taking into consideration the characteristics and health care needs of Medicaid, SCHIP and SAGA 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 Medicaid, SCHIP and SAGA 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. Review and propose provider enrollment processes and procedures to the Department for its approval. (Distribution and maintenance – EDS)

d. Support EDS' enrollment of dental providers. All willing providers meeting Connecticut's Medicaid enrollment criteria shall be accepted and enrolled in CMAP.

e. Establish a relationship with the Department's fiscal intermediary to help facilitate any provider issues that may arise such as enrollment, billing and policy clarification.

f. Access EDS' on-line paid claims history, provider eligibility, and prior authorization module.

g. Develop and implement protocols in collaboration with the Department's fiscal intermediary to exchange provider network change information. The Contractor shall report to the Department all changes to the Medicaid dental provider network.

3.04 Network Adequacy

The Department Shall:

a. Review provider applications to determine if the provider is under any disciplinary, administrative, criminal or civil action in any way as related to health care services.

b. Provide notification to the provider and Contractor of acceptance into the CMAP Provider Network.

c. Provide the Contractor with electronic access to the provider file maintained by the MMIS vendor.

d. Evaluate the adequacy of the Contractor's effort to manage and improve the Medicaid dental provider network on a quarterly basis using the 2000 to 1 member to primary care dental providers (PCDPs) ratio.

e. Evaluate the adequacy of the dental provider network on a monthly basis when the number of Members in a given county equals or exceeds ninety percent (90%) of the established capacity.

g. Evaluate adequacy of PCDP access within a 20 mile radius of member's town of residence.

f. Measure access to dental providers, in addition to the network adequacy measures described in subsections (d) and (g) above, by examining and reviewing confirmed complaints received by the Contractor, the Enrollment Broker, the Department, the HUSKY Infoline and taking other steps as more fully described below:

   1. For purposes of this section 3.04(f), 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 primary care dentist or a dental 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 CMAP 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. Refer to the Contractor all complaints for resolution.

   3. Send the Contractor 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 Contractor's number of Members factored by the ratio of one complaint per 50,000 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 Contractor 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 PCDP 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 dental specialty;

4) Whether the access problem is related to a broader access or provider availability problem that is not within the Contractor's control;

5) The Contractor's diligence in attempting to address the Member's complaint; and

6) Whether both the Member and the Contractor have reasonably attempted to obtain an appointment that will meet the Member's dental/medical needs.

Sanctions:

a. In the event the Department deems that the dental provider network lacks adequate access to providers as described in (d) 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 Monetary Sanctions.

b. In the event the Department determines that it has received sufficient confirmed complaints regarding specialist access problems to initiate sanctions, the Department will advise the Contractor in the Complaint Report that it has received confirmed complaints and that it will impose a monetary sanction on the Contractor in thirty (30) days unless the Contractor submits a satisfactory resolution of the access issue in a corrective action plan.

1. The Contractor may request an opportunity to meet with the Department prior to the imposition of the monetary sanction;

3. The Contractor shall submit a corrective action plan to the Department when the Department formally notifies the Contractor that the number of confirmed dental complaints has passed the report threshold for that Contractor 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 Contractor does not develop a corrective action plan satisfactory to the Department, the Department may impose an immediate monetary sanction in accordance with Section 6.04, Monetary Sanctions,.

The Contractor Shall:

a. Develop a comprehensive dental network of community based providers with a member to general dentist provider ratio of 2000:1 as follows:

1. Full time Public Health Hygienist shall count as ½ of a provider;

2. General dentists and pediatric dentists shall count as primary care dental providers;

3. Dental specialist networks shall be maintained at a ratio of 2400 members to specialist;

b. Develop a comprehensive provider specific database from such sources as the Department's CMAP Network file, the Contractor's provider recruitment and maintenance efforts and others that will include at a minimum the following data elements:

   1. Admitting privileges,
   2. services provided,
   3. age groups served,
   4. location(s) of services including site-specific service availability, handicap accessibility; cultural and linguistic specialties.

c. Assist existing and prospective dental providers with enrollment information and provider service and performance standards;

d. Recruit providers for the network

e. Coordinate with the Department's fiscal intermediary as necessary for the fiscal intermediary to enroll out-of-state providers serving eligible Connecticut residents who are temporarily out-of-state and in need of services.

f. Evaluate the adequacy of the dental provider Network on a quarterly basis as follows:

   1. Network adequacy shall, at a minimum, be based upon the results of a geographic access survey(s) conducted by the Contractor and the ratio of network providers to members;
   2. Network adequacy shall also consider cultural and linguistic capacity, specialty services, and appointment wait times consistent with the performance measures identified in this contract.

3.05 Care Coordination and Care Management

Young children with early childhood caries or other acute or chronic medical conditions that meet criteria established by the Contractor and the Department may benefit from care coordination and case management services. These services may include, but are not limited to, education, counseling, and specialized oral health care and intervention strategies with children and their parents or legal guardian to provide immediate treatment of current decay and to decrease the incidence of future decay.

Typically, a PCDP will coordinate dental and medical (as necessary) care for his/her patients who meet the criteria for care coordination and case management. The PCDP will develop a written care plan and prior authorization request to submit for review and approval by the Contractor prior to billing the Department's Fiscal Intermediary for a case management fee. Case management will require prior authorization by the Contractor's dental director. With prior authorization, the dental provider will be able to bill and receive a monthly case management fee. Case management services require renewal, with submission of a new prior authorization request to the Contractor every 6 months.

When a PCDP requires assistance or support to manage treatment of complex needs or to assist with patient compliance or to coordinate support services (Intensive Care Management), the PCDP may propose in the care plan, assistance from the Contractor's Dental Health Care Specialist (DHCS).

The Contractor shall identify from claims data individuals who may meet the criteria for case management or care coordination. The Contractor shall offer care coordination or case management services to individuals who are not already receiving case management services from their PCDP.

The DHCS will establish a local presence and build collaborative relationships with dental and pediatric or primary care medical providers and community organizations (such as oral health collaboratives, community groups, faith based organizations, etc.). The DHCS will provide educational outreach and information concerning evidence - based dental practices to these groups and providers. Furthermore, the DHCS will marshal resources to improve oral health outcomes for specific individuals for whom PCDPs have requested DHCS assistance and the Contractor has approved.

The Department Shall:

a. Review and approve the Contractor's plan to identify children at risk including criteria for care coordination and case management.

b. Review and approve the Contractor's plan and requirements for prior authorization of case management by the PCDP.

The Contractor Shall:

a. Propose a detailed description of Care Coordination and Case Management services and criteria to apply to individual case reviews for approving case management requests from providers.

b. Propose for approval by the Department, criteria to identify high risk children, adolescents and adults who may be candidates for the care coordination and/or case management services.

c. Accept referrals from PCDPs or other health care professionals of individuals who may need care coordination or case management services.

d. Assign a DHCS to members who meet the approved criteria for receiving the care coordination services and are not receiving case management services from their PCDP. The DHCS shall perform, at a minimum, following:

    1. Notify the member's primary medical care provider that the member has been identified for Care Coordination.

    2. Establish a plan, in consultation with the PCDP and other providers as necessary for addressing barriers to care. Such plan may be agreed to verbally but shall be documented in the Contractor's UM system.

    3. Refer (and assist as necessary) members to appropriate services in accordance with the plan.

4. Monitor the progress of the members care and treatment and adjust update care plan accordingly.

e. Report to the Department in a form, format and frequency as required by the Department, on the progress toward meeting the goals of the plan of care for those individuals who receive Intensive care coordination.

f. Report to the Department in a form, format and frequency as required by subsequent written agreement of the Department and the Contractor on the following Care Coordination and Case Management performance issues:

1). Access difficulties for specific levels of care (PCDP or dental home, referral to specialist, ability to receive care in the Operating Room, etc);

2). Availability of services that are culturally sensitive;

3). Gaps in services in local areas (may include ancillary services such as transportation, etc.);

4). Successful and creative treatment interventions;

5). Need for specialized treatments or interventions;

6). Innovative and/or specialized programs that promote improved clinical outcomes; and

7). Recommendations to resolve issues.

3.06 Second Opinions, Specialist Providers and the Referral Process

The Contractor shall:

a. Provide for a second opinion from a qualified health care professional within the CMAP provider network,

b. Make specialist referrals available to its Members when it is medically necessary and medically appropriate.

c. Implement and maintain policies and procedures for the arrangement and documentation of all referrals to specialty providers.

3.07 PCDP and Specialist Selection, Scheduling, and Capacity

The Contractor shall:

a. Implement procedures to ensure that each Member has an ongoing source of primary dental 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. The Contractor shall assign a Member to a PCDP when providing introductory information to the Member following enrollment. The assignment shall be appropriate to the Member's age, gender and residence. Members may change PCDP assignment no more often than once every thirty (30) days.

c. Monitor access and provide feedback and education to CMAP Dental Providers to educate providers about the following scheduling standards:

   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 PCDP notification;
   3. Preventive and non-urgent or emergent care visits shall be scheduled within eight (8) weeks of PCDP notification;
   4. Specialists shall provide treatment within the scope of their practice and within professionally accepted promptness standards for providing such treatment;
   5. New Members shall receive an initial PCDP appointment in a timely manner; (for those SAGA, HUSKY A, HUSKY B, and Title XIX Members who do not access contract services within the first six (6) months of enrollment, the Contractor shall conduct outreach to ensure the Member can access services in accordance with the access standards of the contract and to offer appointment scheduling assistance to Members who have not received a dental screen and cleaning during this time); and
   6. Waiting times at PCDPs are kept to a minimum.

d. Maintain a record of each Member's PCDP assignments for a period of two (2) years.

e. Track each Member's use of primary dental care services. In the event that a Member does not regularly receive primary dental care services from the PCDP or the PCDP's group, the Contractor shall contact the Member and offer to assist the Member in obtaining such services.

f. Offer Members scheduling assistance for a preventive care visit when a Member's last preventive care visit was not within the appropriate guidelines for his or her age and gender or if the Member has not received any primary dental care.

g. When assisting a member with scheduling an appointment with a PCDP, obtain the appointment for the member within a 20 mile radius of member's town of residence.

3.08 Coordination of Dental Services with Managed Medical Care Organizations

The Department shall require its MCO's to:

a. Continue responsibility for the following oral health services after the initiation of the dental carve out:

   1. Hospital based care (i.e. Emergency Department and the hospital services for Care delivered in the Operating Room) and
   2. Treatment of oral health disorders which require the specialty of Oral and Maxillofacial Surgeons.
   3. Non-emergency medical transportation,
   4. Laboratory and emergency Department services, regardless of the member's primary diagnosis or presenting problem.

b. Collaborate with the Contractor to provide primary dental care education, initiatives and facilitate communication between primary care dental providers and primary care dentists.

c. Promote and support coordination of physical health and dental health care.

The Contractor Shall:

a. Communicate and collaborate with the MCOs and/or Medical Administrative Services Organizations and PCPs as necessary on primary dental care education and initiatives to improve ease of referral from and coordination between PCDPs and the medical providers.

b. Coordinate with the HUSKY and SAGA MCOs or Contractors in the development of guidelines for primary care based treatment of oral health disease, including indications for referral to a specialist and procedures for referring.

3.09 Preventive Care and Services for Children

Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Program

Introduction:

Connecticut Medicaid members (HUSKY A) under the age of twenty-one (21) are entitled to the benefits of the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program including regularly scheduled age appropriate oral health screening examinations and all necessary diagnostic and treatment services.

Medicaid regulations require the State Medicaid programs provide an assessment of a child's oral health and inter-periodic screening exams when medically necessary to determine the existence of dental disease or condition(s). Prior authorization cannot be required for either a periodic or inter-periodic screening examination.

State Medicaid programs are also required to send out appointment reminders to their members based upon their birthdates and utilization data.

The Department Shall:

a. Provide EPSDT information to families with children at time of initial eligibility grant and annual eligibility reviews including:

   1. The availability of EPSDT screening, diagnostic and treatment services;
   2. The importance and benefits of EPSDT screening services;
   3. How to obtain EPSDT screening services

The Contractor Shall:

a. Implement an approved prevention and intervention strategy for identified members and their families to reduce poor oral health habits and prevent oral disease such as dental decay and periodontal disease. The prevention and intervention strategy shall include provision of both written and oral information concerning EPSDT services to families of EPSDT eligible children.

b. Develop prevention protocols to:

1. Identify children who are overdue for dental prevention visits, and those who have missed such visits.
2. Facilitate member access to and receipt of medically necessary dental care, diagnostic services, oral health services recommended pursuant to an EPSDT examination, and treatment for members under twenty-one (21) years of age covered under the federal Medicaid program and described in Section 1905(a) of the Social Security Act regardless of whether the dental care, diagnostic services, and treatment are specified in the list of covered services and regardless of any limitations on the amount, duration, or scope of the services that would otherwise be applied.
3. Track members who are due for EPSDT screening services, those who are overdue for EPSDT screening services and those who have missed EPSDT screening services.
4. Support access by its members under the age of twenty-one (21) to EPSDT screening services and any necessary diagnostic and treatment services by:
   a). Assisting members arrange appointments;
   b). Assisting members arrange or schedule transportation to their appointments;
   c). Following up on missed appointments;
   d). Arranging interpreter services to members with limited English proficiency and members who are hearing and visually impaired; and
   e). Sending out due or overdue for appointment reminders to their members based upon their birthdates and utilization data.
5. Monitor and track coordination of prevention and intervention efforts;
6. Promote oral health as a part of systemic health and educate and engage families on the importance of achieving good oral health;
7. Provide outreach to EPSDT Eligible Clients (Medicaid Only) to meet the requirements of the EPSDT program as set forth in Sections 1902(a)(43) and 1905(r) of the Social Security Act,
8. Encourage members to receive EPSDT screening services in accordance with the periodicity schedule (Provider Bulletin 01-18) which can be found on the DSS website at www.ctmedicalprogram.com.
9. Encourage members to receive interperiodic screening examinations when medically necessary.
10. Educate parents and providers that EPSDT screening services must, at a minimum, include:
    a). Dental assessments and cleanings as set forth in the periodicity schedule and
    b). Health education, including anticipatory guidance.
11. Coordinate and enhance the services provided to members under twenty-one (21) years of age through outreach to and collaboration with the organizations that provide services through the following programs:

a). Nurturing Families Network;

b). The Special Supplemental Food Program for Women, Infants, and Children (WIC);

c). Birth-to-Three;

d). Head Start;

e). InfoLine's Maternal and Child Health Project; and

f). Other programs operated by the Departments of Children and Families, Education, Public Health, Mental Health and Addiction Services and Developmental disabilities Services as designated by the Department.

3.10 Linguistic Access

a. The Contractor 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 Contractor staff and subcontractors;
2. Identification of a single individual at the Contractor 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 Contractor shall provide Member educational materials in languages other than English and Spanish if more than five percent (5%) of the 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 have limited reading proficiency. The Contractor 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 Contractor shall inform members that written materials are available in these alternative languages.

c. The Contractor 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 Member information concerning primary language, visual impairments and hearing disabilities through the daily and monthly enrollment files.

3.11 Services for Members

a. The Contractor shall develop, implement and maintain an ongoing process of Member information and education that shall include, but is not necessarily limited to:

   1. Call Center
   2. A Member Brochure;
   3. Website;

   and

   4. Other Member materials.

b. The Contractor shall maintain an adequately staffed Member Services office to provide information, receive telephone calls, answer questions, assist members with finding providers, provide appointment and transportation scheduling assistance, respond to complaints and resolve problems informally. Appointment scheduling assistance shall be made available in compliance with the appointment scheduling standards identified in section 3.07 above.

c. The Contractor'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.

d. Beginning March 1, 2009 and after receiving the Department's written approval, one week from a Member's initial enrollment, the Contractor shall provide the Member a new brochure, except that no brochure shall be required when a Member loses eligibility and re-enrolls in less than one hundred and twenty (120) days after losing eligibility.

e. The Contractor 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 Brochure; and
   2. All communications to Members regarding Medicaid, SAGA, HUSKY A, or HUSKY B information.

f. The Contractor shall revise the Member Brochure as required by the Department. The Contractor shall distribute the revised Member Brochure within six (6) weeks from receiving the Department's written approval of changes.

g. At the time of enrollment and at least annually thereafter, the Contractor shall inform Members of the applicable procedural steps for filing an appropriate appeal and requesting an administrative hearing for SAGA, Medicaid and HUSKY A Members or the Department of Insurance external review process applicable for HUSKY B. When Members contact the Member Services Department to ask questions about, or complain about, the Contractor's failure to respond promptly to a request for covered services, or the denial, reduction, suspension or termination of services, the Contractor shall:

   1. Attempt to resolve such concerns informally;

2. Inform Members of the appropriate appeal and administrative hearing processes applicable for Medicaid, HUSKY A, HUSKY B and SAGA.
3. Upon request, mail to Members, within one business day, forms and instructions for filing a grievance.

h. The Contractor shall monitor and track PCDP transfer requests and follow up on complaints made by Members as necessary.

i. The Contractor shall make appropriate referrals for Members who express the need for or may require other health services. The Contractor shall develop appropriate procedures for managing urgent or crisis calls and communicating Member specific crisis management information.

j. Develop operational procedures, manuals, forms, and reports necessary for the operation of Member Services. The operational procedures related to requirements of subsection b of this section, shall include offering a list of providers for the member to contact for appointment scheduling assistance.

k. Develop and implement a formal training program and curriculum for staff that respond to member inquiries.

l. Develop a reference manual for member service representatives to use during daily operations.

3.12 Telephone Call Management

The Contractor Shall:

a. Provide automatic voice response system (AVR) and staffed lines that enable members and providers to efficiently access information and services.

b. Provide and operate a telephone call system that connects callers to appropriate staffed lines while minimizing wait times through menu selections and call distribution management that meet the following minimum requirements:

1. Two (2) nationwide toll free lines, one dedicated line for member issues and one dedicated line for provider issues;
2. One (1) nationwide toll free line dedicated to fax communication;
3. The limited menu automated voice response system (AVR) shall have the functionality to:
    i. Receive transferred calls from other AVR Systems;
    ii. Transfer calls to other Departmental offices;
    iii. Link to the Department's telecommunications systems;
    iv. Transfer calls immediately to a direct contact with a service representative on a priority basis without the caller having to listen to AVR menu options;
    v. Conference calls;

vi. Provide text-telephone device (TTD) or equivalent system to communicate by telephone with hearing-impaired Members;

vii. Accommodate over flow;

viii. Provide voicemail. (The Contractor shall guarantee return calls with no greater than four (4) hours delay in returning messages during normal operational business hours; and response to late day and all after hours voice mail messages by the close of business on the next business day;

ix. Record calls; and

x. Provide English and Spanish instructions for emergencies.

c. Provide sufficient staff available during core business hours of 8:00 a.m. to 5:00 p.m. on Mondays through Fridays except for six (6) state holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas) to answer all AVR transferred calls with the following standards:

i. Staff shall answer 90% of calls in a given month for Member Services and Provider Services separately within forty-five (45) seconds and ninety-seven percent (97%) of calls in a given month to the Member Services or Provider Services number separately within one-hundred twenty (120) seconds;

ii. When calls are not answered within the first fifteen (15) seconds, the AVR shall initiate a recorded message encouraging a caller to remain on the line and assuring a caller that a qualified staff person will answer the call momentarily;

iii. The daily abandonment rate shall not exceed 5%;

iv. During non-business hours when a staff person is not available for routine calls, the AVR shall respond with the option to leave a message;

v. The AVR shall not ring "busy";

vi. The AVR system shall provide the options menu to all calls within two (2) rings; and

vii. The AVR may provide 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.

d. The Contractor shall communicate in English and Spanish on an as needed basis and shall provide access to translation services for other languages when necessary.

e. Member Services staff shall greet the caller by first identifying themselves by first name when answering and always treat the caller in a responsive and courteous manner. The Department reserves the right to request Member Services Training Material for review and request revisions or changes in the material at any time.

f. Establish and maintain a functioning automatic call distribution (ACD) and call reporting system with the capacity to record and aggregate the following information by AVR line:

1. Number of incoming calls;

2. Number of answered calls by Contractor staff;

3. Average number of calls answered by Contractor staff within the response time standards;
4. Average call wait time;
5. Average talk time;
6. Percent of routine member services calls answered by staff less than thirty (30) seconds after the selection of a menu option;
7. Percent of provider services calls answered by staff less than thirty (30) seconds after the selection of a menu option;
8. The number of calls placed on hold and length of time on hold; and
9. The number and percent of abandoned calls. (For purposes of this subsection abandonment refers to those calls abandoned after the entire menu selection has been played). The call abandonment rate shall be measured by each hour of the day and averaged for each month.

g. The phone statistics shall be maintained daily and tallied and submitted to the Department in accordance with a fixed reporting schedule and format to be agreed upon in writing by the Department and the Contractor at a later date. The Department reserves the right to make reasonable changes in the reporting timeframe for these reports with reasonable advance notice to the Contractor. Additionally, the Department may request ad hoc reports, to be produced within a reasonable timeframe as necessitated and defined by circumstance.

h. 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.

Sanction: If the Contractor does not meet the incoming call response or call abandonment standards set forth in this section the Department may impose a strike towards a Class A sanction pursuant to Section 6.04, 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 6.04, Monetary Sanctions.

3.13 Content of Member Brochure

The Contractor shall:

a. Produce, print and distribute brochures according to an approved plan, an informational Member brochure written at no greater than a seventh grade reading level in both English and Spanish. The Contractor shall submit brochures to the Department for its review and approval prior to distribution. The content of the brochure shall include descriptions or explanations of:

1. Scope of Coverage: Oral Health benefits for members in layman's terminology;
2. Access to Services: Procedures to independently access providers;
3. Member Services contact information;

4. Procedures for selecting and changing PCDPs;
5. Procedures to access transportation (HUSKY A), pharmacy, translation services and appointment scheduling assistance;
6. Member rights and responsibilities, including grievances and appeals;
7. Cost-Sharing: An overview of financial obligations of the Member (if any);
8. Appeal Procedures;
9. EPSDT

3.14 Website for Members and Providers

a. The Contractor shall provide a transparent, easy-to-navigate website for Medicaid, SAGA, HUSKY A, HUSKY B Members and Connecticut dental network providers.

b. The Contractor shall collaborate with the Department to determine the Website content. The final content and format of the Contractor's website(s) for Members and Providers shall be subject to the Department's approval and applicable Federal regulations.

c. The Contractor shall structure the website(s) for easy navigation and easy identification. If the Contractor embeds the website(s) within a more complex corporate website, the Contractor shall ensure that the Connecticut Dental Initiative link(s) is clearly accessible from the corporate main site.

d. At minimum, the Contractor's Member website(s) shall include the following elements:
   1. Contact service information through links to the Department's primary websites (e.g., www.ctmedicalprogram.com, www.huskyhealth.com, www.ctbhp.com).
   2. Member surveys and feedback options;
   3. The Member brochures and other printed material in English and Spanish.
   4. Member information concerning oral health conditions and strategies for improving or maintaining the oral health condition;
   5. Oral health information during Children's Dental Health Month (February); and
   6. Provide a secure web based e-mail box for members to communicate with the Contractor; and

e. At minimum, the Contractor's provider secure website(s) shall include the following functions:
   1. Link to the prior authorization request module of the Department's claims processing system, known as InterChange.
   2. Provide a secure web based e-mail box for providers to send and receive e-mail including reminder notices.

f. The Contractor 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/.

3.15 Marketing Guidelines

The Contractor shall not engage in marketing activities.

3.16 Health Education Outreach

The Contractor shall routinely, but no less frequently than annually, remind and encourage Members to utilize benefits. The Contractor shall also offer periodic screening programs that, in the opinion of the dental staff, would effectively identify conditions indicative of an oral health problem. The Contractor shall keep a record of all activities it has conducted to satisfy this requirement.

The Contractor shall submit to the Department, for review and approval all media announcements, notices, newsletters and similar communication for providers and members. The Department shall respond to review requests from the Contractor 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 Contractor 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.

3.17 Provider Relations

The Department expects the Contractor to provide efficient administrative services that pose the least restrictive and the least cumbersome administrative burden on providers as possible.

The Contractor shall:

a. Develop and implement effective and efficient mechanisms for outreach and communication between providers and the Contractor including
   1. Web based inquiry site as more fully described under Section 3.15, Website for Members and Providers
   2. A publication - ready newsletter published and distributed annually during Dental Health Month (February), posted on – line and in print.
   3. A telephone call center and staffing with the capability to respond timely and accurately to provider inquiries.

b. Develop and implement an orientation program and provide technical assistance for providers including:
   1. An initial state wide provider orientation initiative to be scheduled in conjunction with the Connecticut State Dental Association;
   2. Targeted technical assistance for those providers who are identified as needing further technical assistance and education regarding the Dental Initiative program parameters and goals.

3.18 Internal and External Quality Assurance

a. The Contractor shall require that its staff and subcontractors render consistently high-quality services. The Contractor shall implement a quality assessment and performance improvement (QAPI) program to monitor and strive to continuously improve the quality of care rendered by dental providers. In addition, the Department and its External Quality Review Organization (EQRO) will monitor the Contractor's compliance with all requirements in this section.

b. The Contractor shall comply with applicable federal and state regulations and Department policies and requirements concerning quality assessment and program improvement. The Contractor will develop and implement an internal QAPI program consistent with the guidelines as provided in **Appendix C Standards for Internal Quality Assurance Programs for Health Plans.** The Contractor's QAPI program shall include provisions that:

1. Detail the review process by appropriate health professionals regarding the delivery of dental services;
2. Detail the Contractor's systems and processes to collect performance and Member outcomes;
3. Describe the process for circulating these data and related findings among the participating dental providers;
4. Describe the process for amending the QAPI and making needed changes;
5. Include at least three performance improvement projects; and
6. Detail the Contractor's systems and other mechanisms to detect both under utilization and over utilization of services.

c. The Contractor shall provide descriptive information on the operation, performance and success of its QAPI program to the Department or its agent upon request.

d. The Contractor shall maintain and operate a QAPI program that includes at least the following elements:

1. A QAPI plan.
2. A half-time Quality Improvement Management Assistant, 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 the dental program.
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. primary care and dental specialists, 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 Contractor.

(d) The Department.

e. The Quality Assurance Committee shall be organized operationally within the Contractor 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 Quality Assurance Committee shall meet at least quarterly and produce written documentation of committee activities to be shared with the Department.

h. The results of the QAPI activities shall be reported in writing at each meeting of the Board of Directors, Quality Assurance and Dental Advisory Committees.

.i. The Contractor shall have a written procedure for following up on the results of QAPI activities to determine success of implementation. The Contractor shall document its follow-up efforts in writing.

j. Where the Department determines that a QAPI plan does not meet the above requirements, the Department may provide the Contractor with a model plan. The Contractor agrees to modify its QAPI plan based on negotiations with the Department.

k. The Contractor 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.

l. The Contractor shall comply with EQRO and other external review activities scheduled by an organization contracted by the Department. The Contractor'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.

m. The Contractor shall commission and pay for an annual Member satisfaction survey to be conducted by an independent vendor selected by the Contractor and approved by the Department, which approval shall not be unreasonably withheld, in accordance with specifications to be agreed upon by the Contractor and the Department. The Contractor shall provide a copy of the survey and survey results to the Department.

3.19 Records

a. The Contractor shall establish a confidential, centralized record, for each Member, which includes relevant information about dental goods and services received.

b. The Contractor shall make the record available upon request and reasonable notice, to the Department at a centralized location.

c. The Contractor shall also simultaneously maintain 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.

e. The Contractor shall share information and provide copies of records pertaining to a Member to the CT BHP Contractor or Medical MCO upon request and in accordance with HIPAA regulations and other applicable laws regarding privacy and confidentiality.

3.20 Clinical Data and Other Reporting

The Contractor Shall:

a. Store all operational data in an information system that is compliant with Open Database Connectivity Standards (ODBC);

b. Create a data base with data elements from different functions or processes with report programming flexibility to easily retrieve, sort and summarize, at a minimum, the following:

1). EMS Unique Client Identifier;

2). Age;

3). Gender;

4). Program (HUSKY A, B, and Medicaid Title XIX fee-for-service) and special population identifier if any;

5). Ethnicity/Race;

6). Provider type/specialty;

7). Service type care;

8). Procedure code/revenue code;

9). Fiscal Year and Calendar Year;

10). Service date;

12). Geographic data:

a). Client's town of residence.

b). Provider service location;

13). Prior authorization data;

14). Provide Department access to all data including detailed and summary information.

15). Ad-hoc reporting capability

c. Submit all reports requested in accordance with the agreed-upon due dates and, where applicable, in the prescribed format and medium (i.e. electronic and/or hardcopy).

d. Advise the Department when the Contractor identifies a material error in a submitted report within one (1) business day and resubmit the corrected report within five (5) business days of becoming aware of an error that impacts a line item within a report period.

e. Identify a key person who will coordinate report production and submission to the Department, and correction of errors associated with the reports;

f. The Department will consult with the Contractor, through a workgroup comprised of Department and Contractor 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.

g. The Department will provide the Contractor with final specifications for submitting all reports no less than ninety (90) days before the reports are due. The Contractor 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 Contractor 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. Notwithstanding the foregoing, on or before December 15, 2008 the Department and the Contractor shall enter into a written agreement establishing the specifications for all reports required hereunder, including the format, frequency, content, and due dates for such reports, and the Department shall provide reasonable advance written notice prior to the effective date of any change to such reporting specifications.

h. In the event that the Department requires ad hoc reports, Contractor will work with the Department to produce such reports in a reasonable time frame, as necessitated by circumstance.

i. The Contractor shall maintain a log and report of grievances from Members that the Contractor resolved informally. The Contractor shall make the log available to the Department upon request. The Contractor shall include in the log a short dated summary of the problem, the response and the resolution.

3.21 Utilization Management (UM)

Introduction

Utilization Management (UM) is a set of contractor processes which seeks to assure that eligible members receive the most appropriate, least restrictive and most cost effective treatment to meet their identified oral health needs. Utilization Management as used in this contract includes practices such as notification, prior authorization, concurrent review, retroactive medical necessity review and retrospective utilization review (see glossary for a definition of terms).

All authorization decisions must conform to the Department's definitions of medical necessity and appropriateness.

Retroactive medical necessity review may include provider chart reviews to ensure that documentation supports the medical necessity and medical appropriateness of services and treatments rendered and that the documentation is consistent with the provider's claims. These chart reviews may be random or targeted based on information available secondary to the utilization management process.

The Department Shall:

a. Review and approve the Contractor's specific UM policies and procedures.

b. Review and approve the Contractor's methodology for identifying cases for retrospective chart review.

c. Review and approve the Contractor's program to enable high performing provider offices (not clinic or facility locations) to bypass, in part, the prior authorization requirements to ensure continued performance as a high performing provider. The standards for determining which providers are "high performing" will be established by subsequent agreement of the Contractor and the Department.

d. Review and approve the Contractor's program plan to monitor provider performance to ensure unnecessary procedures or upcoding practices are not being performed/billed.

The Contractor Shall:

Design and conduct cost efficient and quality based utilization management processes that:

a. Are minimally burdensome to the provider.

b. Effectively monitor and manage the treatment services and provider performance.

c. Utilize state of the art technologies, which must include automated telephone and web - based applications for notification, prior authorization and retroactive medical necessity review. (Web and telephone applications are further described in the Call Center section.)

d. Promote care management, provider education and outreach support based on utilization management data.

3.22 Prior Authorization of Services:

The Contractor Shall:

a. Develop a method to establish a prior authorization request process based on current regulations.

b. Develop a procedure with monitoring capacity to allow high performing community – based dental providers to avoid submitting requests for selected prior authorizations. Prior authorizations chosen as optional for high performing providers shall be determined by the Contractor in conjunction with the Department.

c. Render decisions regarding the prior authorization request and communicate the decisions to providers electronically, FAX or telephone (provider preference) within timeframes no greater than those specified in state and federal UM licensing regulations.

d. The Contractor shall be required to conduct retroactive medical necessity reviews resulting in a retroactive authorization or denial of service for individuals who are retroactively granted eligibility, when the effective date of eligibility spans the date of service and the service requires authorization. This retroactive medical necessity review would be initiated by a provider to enable payment for services.

e. Review and authorize, as appropriate, requests for services outside of the State when the service is not available in Connecticut or when a member is temporarily out-of-state and

requires urgent dental health services, for which treatment cannot wait until the client's return to Connecticut.

f. The Contractor shall be required to inform out-of-state non-enrolled providers that they must enroll in Connecticut Medicaid to receive payment and provide them with enrollment instructions.

g. Conduct monthly reviews of a random sample of authorizations issued by each staff member to monitor the timeliness, completeness, and consistency with UM criteria of the authorizations. Individual staff performing at less than 90% proficiency in any month shall receive additional training and be more closely monitored, until they show consistent (i.e. at least two (2) months in a row) proficiency at the 90% or greater level. Three (3) months of consecutive audits at below 90% proficiency following the remedial training period shall result in the removal of the staff person from UM responsibilities for this account. The selected contractor shall report the review results to the Department as part of the Quality Management program.

h. Utilize the Department's claims processing system's prior authorization module to accept and review prior authorization requests.

3.23 Provider Appeal Process

Introduction

The Contractor shall have an internal appeal process through which an oral health care provider may appeal the Contractor's decision concerning service authorization on behalf of the member. The oral health care provider appeal process shall not include any appeal rights to the Department or any rights to an administrative hearing. The procedures identified below detail the appeal processes required under this contract.

The Contractor Shall:

Implement a two-step provider appeal process with the following provisions:

a. First Level of Appeal

   1. Upon receipt of the decision from the Contractor, a provider may initiate the appeals process by providing a rebuttal with additional information or justification of need. The provider shall initiate the appeal no later than seven (7) calendar days after receipt of the decision to deny, partially deny, reduce, suspend or terminate an oral health service.

   2. The Contractor shall mail notice of the determination to the provider no later than forty – eight (48) business hours after receipt of information deemed necessary and sufficient to render a determination on the appeal.

b. Second Level of Appeal

   1. The provider may initiate a second level appeal if dissatisfied with the first level appeal determination. The provider shall submit the second appeal to the Contractor no later than seven (7) calendar days after the first level appeal denial.

2. The provider shall be sent notice of the determination no later than two (2) business days after receipt of information deemed necessary and sufficient to render a determination on the second appeal.

3.24 Fraud and Abuse

a. The Contractor shall not knowingly take any action or fail to take action that could result in an unauthorized benefit to the Contractor, its employees, or its subcontractors or to a Member.

b. The Contractor commits to exert its commercially-reasonable efforts in preventing, detecting, investigating, and reporting potential fraud and abuse occurrences, and shall assist the Department and the Department of Health and Human Services (HHS) in preventing and prosecuting fraud and abuse in the Medicaid, SAGA, HUSKY A and HUSKY B programs..

c. The Contractor acknowledges that the HHS, Office of the Inspector General has the authority to impose civil monetary penalties on individuals and entities that submit false and fraudulent claims to DSS.

d. The Contractor shall 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 to qualify for HUSKY A or HUSKY B.

e. Upon receipt of written notification from the Department, the Contractor shall cease any conduct that the Department deems to be abusive of HUSKY A, HUSKY B, Medicaid, or SAGA, and to take any corrective actions requested by the Department.

f. The Contractor attests to the truthfulness, accuracy, and completeness of all data submitted to the Department, based on the Contractor's best knowledge, information, and belief. This data certification requirement includes encounter data and applies to the Contractor's subcontractors.

g. The Contractor shall have administrative and management procedures and a mandatory compliance plan to guard against fraud and abuse. The Contractor's compliance plan shall include but not necessarily be limited to, the following efforts:

   1. Designating a compliance officer and a compliance committee, responsible to senior management;
   2. Establishing written policies, procedures and standards that demonstrate compliance with all applicable federal and state fraud and abuse requirements. These include but are not limited to the following:

(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 Contractor employees, subcontractors, and providers;
4. Conducting regular reviews and audits of operations to guard against fraud and abuse;
5. Assessing and strengthening internal controls;
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 Contractor shall examine publicly available data, including but not limited to the OIG's List of Excluded Individuals/Entities (LEIE) database to determine whether any potential or current employees or 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 Contractor 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 Contractor shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest, five percent (5%) or more, in the managed care plan, or any subcontractor in which the Contractor has a five percent (5%) or more ownership interest.

j. The Contractor shall immediately provide full and complete information when it becomes aware of any employee or subcontractor who has been convicted of a civil or criminal offense related to that person's involvement under Medicare, Medicaid, or any other federal or state assistance program prior to entering into or renewing this contract.

k. The Contractor shall not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations or from participating in non-procurement activities under regulations or guidelines implementing Executive Order 12549.

Sanction: The Department may impose a sanction, up to and including a Class B 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.

3.25 Member Charges for Non-Covered Services

a. The Contractor shall not prevent a provider from charging a Member for services, goods or items that are not covered under the SAGA, Medicaid or HUSKY B programs 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, SAGA or SCHIP State Plan;
   2. Services that are provided in the absence of appropriate authorization; and
   3. Services that are provided out-of-network.

3.26 Limited Coverage of Some Benefits (HUSKY B)

a. Some program services are covered only up to a specified dollar or quantity limit.

b. The Contractor shall educate providers about the limitations on cost-sharing and the requirement that the Member not be charged the amount of the covered allowance for the limited covered services under the Medicaid, SAGA and HUSKY B programs. The Contractor also shall educate Members to comply with the applicable cost-sharing requirements of the HUSKY B program.

c. The Member is responsible for paying any remaining balance beyond the covered allowance consistent with this section.

3.27 Pay-for-Performance

The Contractor shall cooperate and participate in a provider Pay-for-Performance (P4P) incentive program. The goal of P4P is to enhance access to dental care services by Medicaid and HUSKY Members and improve program quality and efficiency of the service delivery system through provider practice improvements. The Department and the Contractor will work together to establish appropriate P4P performance measures.

The Department will calculate the P4P performance measures and will be responsible for funding and making incentive payments to providers.

The Contractor 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; and

c. Encourage participation in P4P by Connecticut Medicaid enrolled Dental providers.

3.28 Audit Liabilities:

In addition to and not in any way in limitation of the obligations pursuant to this contract, it is understood and agreed by the Contractor that the Contractor shall be liable for any State or Federal audit findings requiring the refund to the State or the United States of sums paid to the Contractor hereunder, provided that such refund results from the actions of Contractor under this contract, and Contractor 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; provided, however, that the Contractor shall not be liable under this Section 3.28 if the Contractor's actions were in full compliance with the provisions of this contract or were otherwise at the direction of the Department.

3.29 Insurance

a. The Contractor shall procure and maintain such insurance as is required by currently applicable federal and state law and regulation. Such insurance should include, but not necessarily 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 Contractor 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 Contractor shall name the State of Connecticut as either a loss payee or additional insured for fidelity bonding or coverage.

3.30 Audit and Inspection of Facilities

a. The Contractor 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 Contractor'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 Contractor 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 Contractor or subcontractor shall upon reasonable 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 Department will give the Contractor 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.

3.31 Examination of Records

a. The Contractor and its subcontractors shall develop and keep such records as are required by federal or state law or other authority or as the Department reasonably determines necessary or useful for assuring quality performance of this contract. The Department shall have an unqualified right of access to such records. All information so obtained will be accorded confidential treatment as provided under applicable law.

b. The Contractor and its subcontractors shall permit audits or reviews by the Department and HHS or their agent(s) of the Contractor's records related to the performance of this contract.

c. The Contractor shall provide the Department with reasonable access to records the Contractor maintains for the purposes of this contract. The Department will request access in writing except in cases of suspected fraud and abuse. Any contract with a subcontractor shall include a provision specifically authorizing access in accordance with the terms set forth in Section 3.30, Inspection of Facilities.

d. The Contractor shall grant the Department access to and use of any data files retained or created by the Contractor for systems operation under this contract.

e. The Contractor, 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 Contractor's materials and information pertinent to the services provided under this contract, at reasonable times and upon reasonable advance notice, 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 Contractor 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 seven (7) years from the completion date of this contract. If any litigation, claim or audit commences before the expiration of the seven (7) year period, the Contractor shall retain all records which are or likely will be sought in connection therewith, until all litigation, claims or audit findings involving the records have been resolved.

3.32 Financial Records and Reports

a. The Contractor shall maintain for the purpose of this contract, an accounting system that conforms to generally accepted accounting principles (GAAP).

b. The Contractor shall provide all reports in formats developed by the Department to allow for proper oversight of fiscal issues related to HUSKY.

3.33 Confidentiality

a. The Contractor shall maintain the confidentiality of applicant and Members records (including but not limited to medical records) in conformance with this contract and applicable federal and state law, including but not limited to, and in all cases to the extent

applicable, 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 Contractor 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 Contractor in performance of the contract, whether in verbal, written, recorded magnetic media, or other form.

c. The Contractor 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 Contractor or outside parties, shall be subject to approval by the Department.

d. The Contractor shall not release any information provided by the Department or providers or any information generated by the Contractor without the express consent of the Contract Administrator, except as specified in this contract and as permitted by applicable federal and state law.

3.34 Security and Privacy

Introduction

The Department of Social Services is required by state and federal law to protect the privacy of applicant and client information. The Department is a "covered entity," as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Accordingly, the Department requires that the Contractor similarly comply with all applicable state and federal laws concerning privacy and security of all client information provided to the Contractor by the Department or acquired by the Contractor in performance of the contract. This includes all client information whether maintained or transmitted verbally, in writing, by recording, by magnetic tape, or electronically. Compliance with privacy laws includes fulfillment with the HIPAA Privacy Rule business associate obligations and also conformance to other federal and state confidentiality statutes and regulations that apply to the Contractor. The Department also requires the Contractor to continually update and improve its privacy and security measures as client data becomes more vulnerable to external technological developments.

The Contractor Shall:

a. Develop policies and procedures that comply with applicable state and federal law concerning the use, disclosure, and security of client data. These policies and procedures shall be consistent with state and federal laws that pertain to the Department.

b. Develop systems for managing the occurrence of a breach.

3.35 Compliance with Applicable Laws, Rules, Policies, and Bulletins

The Contractor 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 Contractor. This shall include but not be limited to compliance with licensing requirements. In the provision of services under this contract, the Contractor 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.

3.36 Contractor Licensure Requirements

If the Contractor is licensed by the Connecticut Insurance Department, it shall maintain such licensure at all times during the period of this contract.

3.37 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 Contractor 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 Contractor or a subcontractor to the Department and the Contractor 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 Contractor to state generally that the material is proprietary in nature and therefore, not subject to release to third parties. If the Contractor or the Contractor'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 Contractor 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 Contractor'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 Contractor 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 Contractor or the subcontractor if said materials or documents are not identified in accordance with the above-described procedure.

b. The Contractor understands the Department's need for access to eligibility and paid claims information and is willing to provide such data relating to the Contractor to accommodate that need. The Contractor 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 population compares to the Contractor's enrolled population as a whole. The Contractor and the Department each understand and agree that the systems, procedures and methodologies and practices used by the Contractor, its affiliates and agents in connection with the underwriting, claims processing, claims payment and utilization management functions of the Contractor, together with the underwriting, provider network, claims processing, claims history and utilization data and information related to the Contractor, may constitute information which is proprietary to the Contractor and/or its affiliates (collectively, the "Proprietary Information"). Accordingly, the Department acknowledges that the Contractor 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 Contractor'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 to monitor contract compliance or to fulfill, Sections 3.18, Internal and External Quality Assurance and 3.30, 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 Contractor 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.

3.38 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 Contractor shall not maintain or provide for its employees any segregated facilities at any of its establishments. Further, the Contractor shall not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained.

c. The Contractor agrees that a breach of this certification is a violation of Equal Opportunity in Federal employment. In addition, the Contractor 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 Contractor has obtained identical certifications from proposed subcontractors for specific time periods, the Contractor 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).

3.39 Civil Rights

a. The Contractor 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 Contractor shall also comply with Conn. Gen. Stat. §§4a-60, 4a-61, 31-51d, 46a-64, 46a-71, 46a-75 and 46a-81.

b. The Contractor 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 Contractor and its providers shall not discriminate between Members under this contract and other members of the Contractor.

c. The Contractor 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 Contractor 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 Contractor 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 Contractor shall:

   1. Require that its subcontractors render services to Members in a non-discriminatory manner.

   2. Require, to the extent within the Contractor's control, that Members are not excluded from participation in or denied the benefits of HUSKY A or HUSKY B 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 Contractor, although delivery sites, services and provider payment levels may vary.

6. To the extent within the Contractor's control, make reasonable efforts to ensure that the recruited 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. To the extent within the Contractor's control, make reasonable efforts to ensure that its network providers offer hours of operation that are no less than those offered to the Contractor'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 Contractor acknowledges that 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 Contractor, to do the same. The Contractor 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 Contractor, subject to the Department's prior, written approval.

4. PROVISIONS APPLICABLE TO MEDICAID, HUSKY A, HUSKY B AND/OR SAGA

4.01 Specialized Outpatient Services for Children under DCF Care and Out-of-State Residential Treatment – (HUSKY A)

The Contractor shall be responsible for identifying appropriate dental providers to serve children placed by DCF in out-of-state residential treatment facilities. Contractor may collaborate with DCF to identify an appropriate provider.

4.02 Persons with Special Health Care Needs

a. The Department will provide the Contractor information that identifies 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 Contractor shall have a mechanism in place to assist HUSKY A Members with special health care needs to locate and access a specialist appropriate for the Member's condition and identified dental/oral needs.

4.03 Grievances (Medicaid, HUSKY A, SAGA and HUSKY B)

a. The Contractor shall implement and maintain procedures to manage grievances for its Members. For purposes of this Section 4.03, 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 Contractor staff person or failure to respect a HUSKY A Member's rights.

b. The Contractor shall maintain adequate records to document the filing of a grievance, the actions taken, the Contractor personnel involved and the resolution. The Contractor shall report grievances in a mutually agreed upon format as requested by the Department.

c. A Member, or a provider acting on a Member's behalf, may file a grievance either orally or in writing. The Contractor 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. The Contractor shall review and resolve the grievance as expeditiously as possible, especially when delay could jeopardize the life or health of the Member. If the Member filed the grievance orally, the Contractor may resolve the grievance orally within three (3) days of receipt 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 the decision-making process. Each grievance shall be disposed of in ninety (90) days or less.

4.04 Notices of Action and Continuation of Benefits (Medicaid and HUSKY A)

a. The Contractor or its subcontractor (as duly authorized by the Contractor) shall mail a written notice of action (NOA) to a HUSKY A Member whenever the Contractor takes action upon a request for dental services from the Member's treating PCDP, 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 3.21, Utilization Management and Section 3.22, Prior Authorization Requirements, and
5. The failure to provide access to services in a timely manner as required by Section 3.07, PCDP and Specialist Selection, Scheduling, and Capacity, or the failure to provide access to consultations and specialist referrals

b. The Notice of Action (NOA) requirements shall apply to all categories of medically necessary/dental services. The NOA requirements apply equally to requests for contract services and non-contract services.

c. The Contractor will issue notices of action for oral health utilization review decisions. When a Member has both medical and oral health conditions that necessitate operating room dental surgical care or services by an Oral and Maxillofacial Surgeon and a CONTRACTOR action affects both conditions, the CONTRACTOR shall, as necessary, consult with the Member in preparation for the hearing. If the Contractor issues a NOA related to a request for services and the issue was requested by a Medicaid enrolled oral health provider, the Contractor shall send the NOA to the Member and the oral health provider.

d. The Contractor 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 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 3.25, Member Charges for Non-Contract Services.

e. The Contractor 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.

(In these circumstances, coverage of the service is not at issue and the Member may not be held financially liable for the services).

Nothing herein shall relieve the Contractor from its responsibility to advise network providers that they must hold a Member harmless for the cost of contract services.

f. The Contractor shall issue an NOA for actions described in (a)(5) above only if the Member notifies the Contractor of his or her inability to obtain timely access to services.

1. The Contractor shall provide the Member with immediate assistance in accessing the services.

2. If the Member has been unable to access emergency services, the Contractor shall issue an NOA immediately.
3. The Contractor shall issue an NOA for non-emergent services, if a Member contacts the Contractor 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 Contractor shall issue an NOA if the Contractor 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 Contractor shall identify Members who are unable to read English and are only able to read a language other than English. For Members who are unable to read English, the Contractor shall provide an NOA in accordance with Section 3.10, Linguistic Access, and Section 3.11, Services for Members..

i. The Contractor 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 Contractor may shorten the period of advance notice to five (5) days before the date of action if:

1. The Contractor 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 Contractor 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 Contractor intends to take or has taken;
2. The reason 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 Contractor'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 Contractor mailed the initial NOA;

9. That the Contractor 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 Contractor representative who will decide the appeal. The Member is entitled to submit additional documentation or written material for the Contractor's consideration;
11. That the Member may proceed automatically to an administrative hearing if he or she is dissatisfied with the Contractor's appeal decision concerning the denial of contract services or a reduction, suspension, or termination of ongoing contract services, or if the Contractor 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 Contractor 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 Contractor'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 Contractor 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 Contractor 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 Contractor.

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 Contractor 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.

n. 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 Contractor 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.

o. The Contractor shall follow the requirements for continuation of services set forth in 42 CFR § 438.420.

1. The right to continuation of ongoing contract services applies to the scope of services previously authorized.
2. 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 Contractor shall treat such requests as a new service authorization request and provide a denial notice.

p. The Contractor is not required to issue an NOA when decisions regarding the treatment of a Member do not constitute an action by the Contractor. This would include

situations in which the Member's oral health practitioner or primary care dentist, using his or her professional judgment,:

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.

q. The Contractor shall conduct an expedited review of a HUSKY A Member's request when the Member disagrees with the provider and contacts the Contractor to request authorization for the service 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 (p) above and contacts the Contractor to request authorization for the service.

1. The Contractor shall issue an NOA if the Contractor 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 Contractor shall continue authorization for the services, to the extent services were previously authorized, unless the Contractor determines that continued provision of the services could be harmful to the Member.
3. The Contractor shall also advise the HUSKY A Member of his or her right to a second opinion from another provider equal or greater training. Because only a licensed health care provider, and not the Contractor, 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 Contractor approves the HUSKY A Member's request for the good or service, the Contractor shall inform the Member of the approval and shall inform the Member of the right to a second opinion.

r. The Department will provide standardized NOA and appeal/hearing request forms to be used by the Contractor and its subcontractors. The Contractor and its subcontractors shall not alter the standard format of either form without prior, written approval of the Department.

s. The Department will conduct random reviews and audits of the Contractor and its subcontractors, as appropriate, to ensure that the Contractor sends accurate, complete and timely NOAs to Members.

Sanction: If the Department determines during any audit or monitoring visit to the Contractor 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 in accordance with Section 6.02, Monetary Sanctions.

4.05 Appeals and Administrative Hearing Processes (Medicaid and HUSKY A)

The purpose of the Administrative Hearing process is to allow the requester of the Administrative Hearing to present his or her case to an impartial hearing officer if the requester claims that the Department or its representative has either acted erroneously or has failed to take a necessary action within a reasonable period of time.

The Department hosts the Administrative Hearings at the central or regional offices. After the Administrative Hearing has taken place in the presence of an impartial Administrative Hearing officer, the officer then has a specified amount of time to review and render a decision on a hearing. This period starts with the date the Department receives the request for an Administrative Hearing and for all programs

a. The Contractor shall have a timely and organized appeals process. The appeals process shall be available for resolution of disputes between the Contractor and its HUSKY A Members concerning the Contractor's actions.

b. The Contractor 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 Contractor shall not be excused from providing the elements specified in this contract pending the Department's written approval of the Contractor's policies and procedures.

c. The Contractor 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 Contractor must clearly specify in its Member handbook/packet the procedural steps and timeframes for filing an appeal and administrative hearing request, including the timeframe for maintaining benefits pending the conclusion of the appeal and administrative hearing processes. The Member handbook/packet shall also list the addresses, office hours and toll-free telephone numbers for the Member Services Unit.

e. The Contractor shall make reasonable efforts to ensure that network providers and subcontractors are familiar with the appeal process and shall provide information on the process to providers and subcontractors. The Contractor shall provide information on the appeal process to its subcontractors at the time it enters into subcontracts. The Contractor shall make reasonable efforts to 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.

f. Consistent with Section 3.10, Linguistic Access, and Section 3.11, Services for Members, the Contractor shall develop and make available to HUSKY A Members and potential HUSKY A Members appropriate alternative language and format 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.

g. 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 Contractor 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 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 to continue previously authorized services pending the appeal and hearing. In all other respects, the Contractor shall use a unified process for pursuing an appeal and for requesting an administrative hearing. The Contractor and the Department shall treat the filing of a written appeal as a simultaneous

request for an administrative hearing. The Contractor shall attempt to resolve appeals at the earliest point possible. If the Contractor 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.

h. 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 Contractor 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 Contractor or it's subcontractor receive an appeal directly from a HUSKY A Member or the HUSKY A Member's authorized representative or conservator, the Contractor shall date stamp and fax the appeal to the appropriate fax number at the Department within two (2) business days.

i. Within thirty (30) days of receipt of a written appeal, the Department will schedule an administrative hearing and notify the HUSKY A Member and Contractor 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.

j. The Department will date stamp and forward the appeal by fax to the Contractor within two (2) business days of receipt. The fax to the Contractor will include the date the 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.

k. An individual or individuals with clinical subject matter training and expertise having final decision-making authority shall conduct the Contractor'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.

l. The Contractor 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 Contractor 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 Contractor 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.

m. 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 Contractor shall invite a representative of the Department to attend any such meeting.

n. The Contractor 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 Contractor's decision regarding the denial, reduction, suspension, or termination of contract services, or if the Contractor does not render a decision by the time of the administrative hearing, the Member may automatically proceed to the administrative hearing.

o. The Contractor's written appeal decision shall include:
   1. The HUSKY A Member's name and address;
   2. The provider's name and address;
   3. the Contractor name and address;
   4. A complete description of the information or documents reviewed by the Contractor;
   5. A complete statement of the Contractor'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
   6. A clear statement of the Contractor disposition of the appeal.

p. The Contractor shall remind the HUSKY A Member with its written appeal decision, that:

   1. The Department has already reserved a time to hold an administrative hearing concerning that decision if the HUSKY A Member is dissatisfied with the Contractor's appeal decision and wishes the Department to conduct an administrative hearing,

   2. The HUSKY A Member has the right to automatically proceed to the administrative hearing, and that the Contractor 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 Contractor'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 Contractor'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 Contractor's appeals decision.

q. If the HUSKY A Member proceeds to an administrative hearing, the Contractor 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 Contractor and the Member or representatives of a deceased Members estate.

r. The Department will hold an administrative hearing as originally scheduled If the Contractor 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,.

s. At the hearing, the Contractor shall prove good cause for having failed to issue a timely decision regarding the appeal. Good cause for the Contractor's failure to issue a timely decision shall include, but not be limited to, documented efforts to obtain additional medical records necessary for the Contractor'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 Contractor'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 Contractor 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.

t. The individual who issued the Contractor'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. The Contractor shall present proof of all facts supporting its initial action if the administrative hearing proceeds in the absence of an appeal decision. The Contractor shall submit a draft hearing summary seven (7) business days prior to the scheduled hearing date and a final, signed hearing summary to the Department and the 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.

u. If the HUSKY A Member is represented by legal counsel at the hearing and has not notified either the Department or the Contractor of the representation, the Contractor 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.

v. If a representative of the Contractor fails to attend a scheduled session of an administrative hearing, the Contractor'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 Contractor receives notice of the hearing at least five (5) business days prior to the administrative hearing.

w. 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 Contractor and the Department liaison.

x. The Contractor representative attending the administrative hearings should either be the individual who issued the Contractor's final decision or another individual with appropriate medical training.

y. The Contractor shall designate one primary and one back-up contact person for its appeal/administrative hearing process.

z. If the Department's hearing officer reverses the Contractor's decision to deny, limit or delay services that were not furnished while the appeal was pending, the Contractor 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 (Medicaid and HUSKY A)

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 Contractor 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 Contractor receives an oral request for expedited appeal, the Contractor shall notify the DSS liaison by fax or telephone within one business day of the oral request.

b. The Contractor 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 Contractor determines that the appeal meets the criteria for expedited review, the Contractor shall notify the Department immediately that the Contractor will be conducting the appeal on an expedited basis.

c. The Contractor 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 Contractor 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 Contractor to conduct an expedited review because the Department believes a specific case meets the criteria for expedited review.

d. If the Contractor denies a request for expedited review, the Contractor 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 Contractor 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 Contractor.

f. The Contractor 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 Contractor 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 Contractor.

g. The Contractor shall ensure that no punitive action is taken against a provider who requests an expedited appeal or supports a Member's appeal.

h. The Contractor shall issue a written appeal decision for expedited appeals. The written notice of the resolution shall meet the requirements of Section 4.05 Appeals and Administrative Hearing Processes. The Contractor 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 Contractor, 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 Contractor fails to provide expedited appeals in appropriate circumstances, the Department may impose a Class B sanction pursuant to Section 6.02, Monetary Sanctions.

5. PROVISIONS APPLICABLE TO HUSKY B

5.01 Internal Appeal Process

a. HUSKY B Members shall have the opportunity to request an internal appeal of a decision made by the Contractor regarding any actions. The internal appeal process shall be available for resolution of disputes between the Contractor or Contractor subcontractors and HUSKY B Members concerning any denials. The Contractor shall be responsible for ensuring compliance with the internal appeal process requirements set forth herein, independent of whether the Contractor or one of its subcontractors is responsible for the denial(s) in question.

b. The Contractor shall permit the HUSKY B Member, the Member's authorized representative, or the Member's conservator to file appeals through the Contractor's internal appeals process within sixty (60) days of the date that the Contractor mailed the denial notice.

c. The Contractor shall date stamp the appeal request to indicate the date on which the Contractor received the request. The Contractor shall use the postmark date on the

original denial notice envelope determine whether the HUSKY B Member, the Member's authorized representative or the Member's conservator filed a timely appeal.

d. The Contractor shall have a timely and organized internal appeal process for receiving and acting upon request for review. The Contractor shall develop written policies and procedures for each component of its internal appeals process. The Contractor's policies and procedures shall include the elements specified in this contract and must be prior approved by the Department in writing. The Contractor 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 Contractor shall follow the procedure described in Section 5.03, Expedited Review. Additionally, if the internal appeal contains a request for expedited review, then the Contractor shall follow the procedure described in Section 5.03, Expedited Review.

f. The Contractor'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 Contractor's review. One or more dentists 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 Member may request an opportunity to meet with the individual or individuals conducting the internal appeal on behalf of the Contractor and/or may request an opportunity to submit additional written documentation or other written material. If the HUSKY B Member wishes to meet with the decision maker, the Contractor shall hold the meeting via telephone or at a location accessible to the Member, whichever the Member prefers.

h. The Contractor shall inform the HUSKY B Member that the Contractor's review may be based solely on information available to the Contractor and its providers, unless the Member requests a meeting or the opportunity to submit additional information.

i. In the absence of a request from the Member to meet, the Contractor shall decide an appeal on the basis of written documentation available to the Contractor at the time of the request.

j. The Contractor shall maintain a record-keeping system for each level of its appeal process, which shall include a copy of the HUSKY B Member's request for review and the response and the resolution. The Contractor shall make these materials available to the Department upon request.

k. The Contractor shall provide information to HUSKY B Members concerning its internal appeals process as well as the external appeal process available through the State of Connecticut Insurance Department (CID). In its Member Handbook/packet and in written decision notices required in Section 5.02, Written Decision for Appeals, the Contractor 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 Contractor 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 Members.

l. Consistent with Sections 3.10, Linguistic Access, and 3.11, Services for Members, the Contractor shall develop and make available to HUSKY B 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.

m. The Contractor shall designate one primary and one back-up contact person for its internal appeal process.

5.02 Written Decision for Appeals

a. The Contractor shall issue a written decision for each level of its internal appeals process. The Contractor shall mail each decision to the HUSKY B Member. The Contractor shall send a copy of each decision to the Department. The Contractor 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 Contractor received the appeal.

b. The Contractor's written decision shall include:

1. The HUSKY B Member's name and address;
2. The provider's name and address;
3. The Contractor name and address;
4. A complete statement of the Contractor'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 Contractor's disposition of the appeal;
6. A statement that the HUSKY B Member has exhausted the Contractor'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 5.04, External Appeal Process through the CDI.

c. For each level of its internal appeals process, the Contractor shall issue a decision within thirty (30) days of receiving the appeal. If the Contractor fails to issue a decision within thirty (30) days, the Department will deem the decision to be a denial and the HUSKY B Member may file an external appeal with the CDI, as more fully discussed in Section 5.04, External Appeal Process through the CDI.

d. The Contractor shall include a copy of the CDI appeal form when issuing written decision that advises a HUSKY B Member that the Contractor determined that an admission, service, procedure, or extension of stay was not medically necessary.

e The Contractor 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.

5.03 EXPEDITED REVIEW

a. The Contractor's internal appeals process shall allow for expedited review. If a HUSKY B Member requests an expedited review, the Contractor 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 Contractor shall perform an expedited review when the standard timeframes for determining an appeal could jeopardize the life or health of the HUSKY B Member or the Member's ability to regaining maximum functioning. The Contractor shall expedite its review in all cases in which such a review is requested by the Member's treating physician or primary care dental provider, functioning within his or her scope of practice as defined under state law, or by the Department.

5.04 External Appeal Process through the CDI

a. HUSKY B Members who have exhausted the internal appeal mechanisms of the Contractor and are not satisfied with the outcome of the Contractor's final decision may file an appeal with the CDI pursuant to Conn. Gen. Stat. § 38a-478.

b. The Contractor shall be bound by the CDI's external appeal decision.

The Contractor shall:

Submit to the Department, for review and approval, its proposed internal appeals process.

6. CORRECTIVE ACTION AND CONTRACT TERMINATION

6.01 Settlement of Disputes

Settlement of disputes arising under the contract shall be governed by Section 8.03(D)(7) hereof.

6.02 Monetary Sanctions

The Department and the Contractor agree that if by any means, including any report, filing, examination, audit, survey, inspection or investigation, the Contractor is determined to be out of compliance with this contract, damage to the Department may or could result. Consequently, the Contractor 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 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, 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 Contractor shall receive a strike for each time the Contractor fails to comply with the contract on an issue warranting a Class A sanction. Prior to issuing the strike however, the Department shall provide the Contractor with a 45 day cure period. Upon notification by the Department to the Contractor of such deficiency, Contractor shall present a written action plan to the Department, illustrating remedial action to be taken to correct the deficiency. The Department shall approve or reject this plan within 48 business hours, and if the plan is rejected, the parties shall work collaboratively to mitigate the deficiency. In the event that the deficiency is not remedied within 45 days, such strike shall be imposed. Such protocol shall be followed for each subsequent deficiency.

b) The Department will notify the Contractor 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 one year, each beginning with the anniversary of the Effective Date of the contract.

c) The Contractor will be notified in writing at least forty-five (45) 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.

b. Class B Sanctions. Sanctions Warranted Upon Single Occurrence or Related to Noncompliance Potentially Resulting in Harm to an Individual Member

1. The Department may impose a Class B sanction on the Contractor for noncompliance potentially resulting in harm to an individual Member, including, but not limited to, the following:

   a) Failing to substantially authorize medically necessary covered services that are required (under law or under this contract) to be provided to a Member;

   b) Failing to comply with any other requirements of 42 U.S.C. §§ 1396b(m) or 1396u-2.

2. Class B sanctions for noncompliance with the contract under this subsection include the following:

   a) Withholding the next month's contract payment to the Contractor in full or in part;

   b) Assessment of liquidated damages:

      1) For each determination that the Contractor fails to substantially authorize medically necessary services, not more than $25,000;

   c) Appointment of temporary management as described in 6.03.

3. Prior to imposition of any Class B sanction, the Contractor 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 B Sanction. For any contract violation under this subsection, at the Department's discretion, the Contractor may be permitted to submit a corrective action plan within twenty (20) days of the notice to the Contractor 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 Contractor. If any sanction issued under this subsection is the functional equivalent of the termination of this contract, the Contractor 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 Contractor 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 Contractor 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 Contractor 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 payments to the Contractor will be denied so long as payment for those Members is denied by CMS.

6.03 Temporary Management

The Department may impose temporary management upon a finding by the Department that: (1) there is continued egregious behavior by the Contractor; (2) there is a substantial risk to the health of the Department's clients as a result of the Contractor's failure to comply with its obligations hereunder; or (3) temporary management is necessary to ensure the health of the Department's clients while improvements are made to remedy the violations or until there is an orderly termination or reorganization of the Contractor. For purposes of this section, "egregious behavior" shall include but not be limited to any of the violations described in Section 6.02b, Monetary Sanctions. Nothing in this subsection shall preclude the Department from proceeding under the termination provisions of the contract rather than imposing temporary management. In an emergency, the Department may impose temporary management without a hearing, provided that the Contractor shall then be entitled to a hearing to determine whether the appointment of a temporary manager was appropriate.

6.04 Payment Withhold, Class B Sanctions or Termination for Cause

a. The Department may withhold payments, impose sanctions including Class B Sanctions set forth in Section 6.02(b), 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 the contract; (2) failure to detect fraud or abuse by the Contractor and to notify the Department of such fraud or abuse, as required by Section 3.24; 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. on the part of Contractor is brought on behalf of the Department.

b. Whenever the Department determines that the Contractor has failed to provide one or more of the contracted services, the Department may withhold an estimated portion of the Contractor's payment in subsequent months, such withhold to be equal to the amount of money the Department pays the Contractor for such services, plus any administrative costs incurred by the Department. Failure to provide required services will place the Contractor 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 Contractor shall be given at least seven (7) days written notice prior to the withholding of any contract payment.

d. The Department may also adjust payment levels accordingly if the Contractor has failed to maintain or make available any records or reports required under this contract which the Department needs to determine whether the Contractor is providing required contract services. The Contractor will be given at least thirty (30) days notice prior to taking any action set forth in this paragraph.

6.05 Termination For Default

a. The Department may terminate performance of work under this contract in whole, or in part, whenever the Contractor 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) following receipt of notice of termination for default from the Department. 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 Contractor was not in default or the Contractor has made satisfactory progress toward performance in accordance with subsection (a) above, 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 Contractor's failure to perform or make progress in performance was due to causes beyond the control and without the fault or negligence of the Contractor, or any subcontractor, the notice of termination shall be deemed to have been issued as a termination for convenience pursuant to Section 6.08, Termination for Convenience, 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 Contractor shall be liable to the Department for any excess costs for such similar services for any calendar month for which the Contractor has been paid to provide services to Members. In addition, the Contractor shall be liable to the Department for out-of-pocket administrative costs paid to third parties by the Department in procuring such similar services. Provided, however, that notwithstanding any other provision in this contract, the Contractor 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 fault or negligence of the Contractor or any of its subcontractors.

e. 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.

6.06 Termination for Mutual Convenience

The Department and the Contractor 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 Contractor shall, upon such mutual agreement being reached, be paid according to the terms hereof through the termination of the contract.

6.07 Termination for Financial Instability of the Contractor

In the event of financial instability of the Contractor that materially and adversely affects the Contractor's ability to perform hereunder, the Department shall have the right to terminate the contract upon the same terms and conditions as a Termination for Default.

6.08 Termination for Unavailability of Funds

a. The Department at its discretion may terminate this contract at any time in whole or in part, and 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 to reduce expenditures under the contract. Whenever possible, the Contractor will be given thirty (30) days prior notification of termination or proposed modification.

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 payment that is agreed upon in writing by the parties or any subsequent termination of this contract by the Department in accordance with this provision shall only affect payments or portions thereof for contract services to be

provided 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 Contractor with those contract modifications, including payment revisions, it would deem acceptable.

c. Notwithstanding the foregoing, the Contractor shall have the right to terminate this contract in the event that any modification under this Section 6.08 is not acceptable to the Contractor. In the event of the termination of the contract, in whole or in part, for any reason under this Section 6.08, the Contractor shall be entitled to reimbursement for all third-party, out-of-pocket costs incurred by the Contractor up through the date of termination.

6.09 Termination for Collusion in Price Determination

a. The Contractor has previously certified that the prices presented in its proposal and now contained herein 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 Contractor, prior to bid opening, directly or indirectly to any other Bidder or to any competitor; and that no attempt has been made by the Contractor 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.

6.10 Termination Obligations of Contracting Parties

a. The Contractor 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 Contractor written notice of its intent to terminate, the reason for the termination and the date and time of the hearing. The Contractor will have a reasonable time to prepare for the hearing. After the hearing, the Department will give the Contractor 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 permit Members to disenroll immediately without cause during the hearing process.

b. Upon non-renewal or termination of this contract, the Contractor shall promptly 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 Contractor shall allow the Department full access to the Contractor's facilities and records to the extent necessary for the Department 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 Contractor:

1. The Department will be responsible for notifying all Members and Providers of the date of termination and process by which the Members will continue to receive services; and
2. The Contractor shall be responsible for all expenses related to notification to providers, subcontractors and Members.

e. If this contract is terminated for any reason other than cause or default by the Contractor, then:

1. The Contractor shall submit a written transition plan to the Department sixty (60) days in advance of the scheduled termination;
2. The Department will be responsible for notifying all Members and Providers of the date of termination and process by which the Members will continue to receive services;
3. The Department will be responsible for all expenses relating to said notification to members and providers; and
4. The Department may withhold a reasonable portion, not to exceed $100,000, of the last payment due hereunder for a six (6) month period or until the Contractor has completed its obligations under this Section 6.10, whichever is sooner.

6.11 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 the Contractor and an authorized representative of the Department, and attached to the original contract.

6.12 Termination by Contractor.

Notwithstanding anything in the contract to the contrary, the Contractor may terminate this contract at any time if the Department defaults in performance of any of its material obligations hereunder and fails to cure such default within forty-five (45) days after notice thereof from the Contractor. In the event of any such default in the Department's payment obligations hereunder, the Contractor shall be required to permit the Department only one (1) such period of forty-five (45) days to cure such default within any twelve (12) month period and, in the event of a second payment default within such period, the Contractor shall be entitled to terminate this contract if such default is not cured within ten (10) days after notice thereof from the Contractor.

7. FUNCTIONS AND DUTIES OF THE DEPARTMENT

7.01 Eligibility Determinations

The Department will determine the initial and ongoing eligibility of each Member enrolled in the Dental Initiative in accordance with the Department's eligibility policies.

7.02 ONGOING CONTRACTOR 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 Contractor's access enhancement programs, financial and utilization data, and other reports to monitor the value the Contractor is providing in return for the State's payments. Such efforts shall include, but not be limited to, on-site reviews and audits of the Contractor and its subcontractors.
2. Conduct regular surveys of Members and Providers to address issues such as satisfaction with Contractor services to include administrative services, satisfaction with treatment by the Contractor.
3. Review the Contractor certifications on a regular basis.
4. Analyze encounter data, actual medical records maintained by providers, correspondence, telephone logs and other data to make reasonable inferences about the quality of and access to specific services.
5. Sample and analyze encounter data, actual medical records maintained by providers, correspondence, telephone logs and other data to make reasonable inferences about the quality of and access to Contractor services.
6. Test the availability of and access to services by attempting to make appointments.
7. At its discretion, commission or conduct additional objective studies of the effectiveness of the Contractor, as well as the availability of, quality of and access to its services.

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 another section of the contract, the requirement in the other section of the contract shall control.

8.02 Summary

The Contractor shall comply with the following mandatory terms and conditions, as set forth in detail below:

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, 7c, 14, 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;
   13. Whistleblowing
   14. Campaign Contribution Restrictions; and
   15. 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 applicable 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:** Annually during the term of the contract, the Contractor shall submit to the Department the following:

   a. 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.

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 related 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 materially and adversely 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 that are specified 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 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, 7c, 14, 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:

      (1) 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.

         i. 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.

         ii. 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.

iii. 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.

iv. 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. 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 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.

D. **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.

E. **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 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. **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.

14. **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.

15. **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 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 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 applicable 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, *i.e.*, services that involve in-person contact with clients participating in the Dental Initiative. 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 thirty (30) 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 subsection (a) above. The Department shall notify the Contractor of such determination as quickly as practicable, but not later than twenty-five (25) 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 another purpose or program of the Contractor 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 (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. Anything to the contrary in the contract notwithstanding, such amendments shall be required for extensions to the final date of the contract period and to any modification, elaboration or more detailed expression of any of the terms and conditions specifically stated in Part II of this contract (whether or not the Department is expressly given the authority to establish such provisions), 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 the form, substance and 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.

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, then such reduction shall not be implemented and the Department may terminate the contract effective sixty (60) days from receipt of such formal notification.

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 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 8.03 of this contract 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 thirty (30) 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 in 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. Subject to Section 6.08 hereof, 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 payments, or advance payments made if either party terminates the contract. Sums due hereunder with respect to the operation or transition of program(s)/Plan(s) under this contract prior to the date of termination 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.

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 a written 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 Part II, Section Eight of this Contract, these special mandatory terms and conditions shall control.

9.02 State of Connecticut Held Harmless

a. The Contractor agrees to indemnify, defend and hold harmless the State of Connecticut as well as all Departments, officers, agents and employees of the State from and against all claims, losses or suits to the extent accruing or resulting from injury or damage to any contractors, subcontractors, laborers or other persons, firms or corporations caused by the gross negligence or unlawful conduct of the Contractor in the performance of the contract.

b. The Contractor, 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 Contractor's or the State's use of any material or information prepared or developed by the Contractor 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 Contractor. The State, its Departments, officers, employees, contractors, and agents shall cooperate fully in the Contractor's defense of any such claim or suit as directed by the Contractor. The Contractor 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 Contractor,

final judgment of a court with jurisdiction after exhaustion of available appeals, consent decree, or any other manner approved by the Contractor.

c. Anything in this contract to the contrary notwithstanding, except for any liability of the Contractor under the foregoing Sections a. and b., the maximum liability of the Contractor to the Department or the State for all breaches of this contract during any contract year (*i.e.*, any twelve-month period beginning on the Effective Date or any anniversary thereof) shall not exceed three (3) times the aggregate sums paid or payable to the Contractor by the Department for services rendered or to be rendered during such contract year.

9.03 Financial Disclosure

If the Contractor is not a federally-qualified health maintenance organization prior to the start date of the contract and annually thereafter, the Contractor shall report to the State a description of transactions between the Contractor and a party in interest. In addition, the Contractor 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 Contractor upon the termination of this contract at the Department's request, except that any Department data files no longer required by the Contractor 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 Contractor 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 Contractor unless there has been prior written Department approval. The Contractor may disclose material and information to subcontractors, as necessary to fulfill the obligations of this contract.

c. The Contractor 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 Contractor necessary to the performance of services under this contract.

9.05 Ownership

All rights of ownership and ownership of the copyright of documents and data required to be produced pursuant to this contract belongs to the State of Connecticut. The Contractor retains all rights with respect to documents, computer programs, data, analyses and other intellectual property created by the Contractor prior to or after the Effective Date and used by the Contractor in the performance of services hereunder, provided that such intellectual property is not created after the Effective Date to fulfill an express requirement of this contract.

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 Contractor 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 Contractor; 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 Contractor shall have the right to invoke any remedy available under the contract, or under law or equity.

9.08 Force Majeure

The Contractor shall be excused from performance hereunder for any period during which it is prevented from providing, arranging for, or paying for services as a result of a catastrophic occurrence, an act of war, natural disaster or other acts of God, national emergency, failures of public utilities (including gas, electric, water and telephone), any action or inaction taken or not taken by the Department or by any contractor and excluding labor disputes on behalf of the Department, which is necessary for the Contractor to perform its obligations hereunder.

9.09 Federal Requirements and Assurances

a. General

1. The Contractor shall comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B, which are applicable to the Contractor. The Contractor is responsible for determining which requirements and assurances are applicable to the Contractor. Copies of the form are available from the Department.
2. The Contractor shall provide for the compliance of any subcontractors with applicable federal requirements and assurances.
3. The Contractor 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 Contractor, 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 Contractor 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 Contractor 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 Contractor 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 Contractor 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 Contractor 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 Contractor 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 Contractor.

h. CLIA

The Contractor shall adhere to any applicable provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578, 42 U.S.C. § 1395aa et seq.

Part Three: BUDGET AND PAYMENT PROVISIONS

1. The Department shall pay the Contractor on a monthly basis for the Contractor's direct and indirect costs arising from and related to the Contractor's performance of its obligations under this contract. The Contractor will submit a monthly invoice to the Department reflecting such costs and payment shall be due within ten (10) days of receipt thereof.

2. The Contractor's anticipated costs for providing the services hereunder in each of years 1, 2 and 3 of the initial term are set forth in the attached Schedule 1, Schedule 2, and Schedule 3, respectively. If at any time the Contractor anticipates that such costs will exceed by more than fifteen (15) percent the total budgeted amount as reflected on the applicable Schedule plus any additional amounts then agreed upon by the parties as the result of the modification of the Contractor's obligations hereunder, the Contractor shall so notify the Department and, prior to invoicing the Department for any such excess amount, shall provide supporting documentation and obtain approval from the Department, such approval not to be unreasonably withheld.

3. The Department shall withhold ten percent (10%) of each month's payment (the "Annual Withhold"), which will be released to the Contractor as incentive payments based on meeting annual performance standards as follows:

   a. During the first, second and third years, one-half of the Annual Withhold (the "Clause A Amount") will be reimbursed for increasing Member participation as described in this subsection (a), such determination to be made, and such sum paid, within sixty (60) days after each year end.

      i. Year 1: The Contractor will strive to attain, by the end of the twelve month period commencing on the Effective Date, at least a twenty percent (20%) increase over the Base Year in the number of Medicaid and SCHIP children ages 3-21 receiving preventative dental services. The Base Year number (the "Base Year Number") will be determined by mutual written agreement of the parties within 30 days following execution of this contract. The Department shall release to the Contractor twenty percent (20%) of the Clause A Amount for every four percent (4%) increase over the Base Year actually achieved.

      ii. Year 2: The Contractor will strive to attain, by the end of Year 2, at least a ten (10) percent increase over the Base Year Number in the number of Medicaid and SCHIP children ages 3-21 receiving preventative dental services. At the conclusion of Year 2, the Department shall release to the Contractor twenty percent (20%) of the Clause A Amount for every two percent (2%) increase actually achieved in Year 2.

      iii. Year 3: The Contractor will strive to attain, by the end of Year 3, at least a ten (10) percent increase over the Base Year Number in the number of Medicaid and SCHIP children ages 3-21 receiving preventative dental services. At the conclusion of Year 3, the Department shall release to the

services. At the conclusion of Year 3, the Department shall release to the Contractor twenty percent (20%) of the Clause A Amount for every two percent (2%) increase actually achieved in Year 3.

b. During the first, second and third years, one-half of the Annual Withhold (the "Clause B Amount") will be reimbursed for retaining provider network size to equal or less than a 5% attrition rate. Such attrition will be calculated on a basis of voluntary termination and shall not include attrition based on deportation, illness, bankruptcy, retirement, or death. The Baseline Number shall be the number of unduplicated individual dental providers enrolled in the Medicaid fee-for-service program as of January 1, 2009.

c. Performance standards and incentive payments for years 4 and 5 of the contract in the event of renewal will be negotiated in year 3 of the contract and must be set forth in writing, signed by the Department and the Contractor.

4. In addition to the payments referred to above in this Part III, the Contractor shall be paid a monthly claims management fee at the rate of $0.34 per Member per month. Such payment shall be due on the fifteenth day of each month and shall be based on the number of Members as of the first of that month. Any retroactive adjustments to the number of Members in a given month shall be reflected in the claims management fee payment for the month following the date of determination.

[Schedules 1, 2 and 3 to be attached.]

PART IV: Appendices

Appendix A: HUSKY A Covered Dental Services

Appendix B: HUSKY B Covered Dental Services

Appendix C: Quality Standards

Appendix A – HUSKY A Covered Services

CONNECTICUT MEDICAL ASSISTANCE PROGRAM

Dental Services Regulation/Policy

Chapter 7

Medical Services Policy 7.1

This section of the Provider Manual contains the Medical Services Policy and Regulations of Connecticut State Agencies pertaining to dental services.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Requirements for Payment of Dental Services

Dental Services (Medical Services Policy)	184.
Clinics (Medical Services Policy)	171.
Dental Clinics (Medical Services Policy)	171.3.

Requirements for Payment of Public Health Dental Hygienist Services (Regulations of Connecticut State Agencies)

Scope	17b-262-693
Definitions	17b-262-694
Provider Participation	17b-262-695
Eligibility	17b-262-696
Services Covered and Limitations	17b-262-697
Services Not Covered	17b-262-698
Payment Rate and Billing Procedure	17b-262-699
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Dental Services	

184 Dental Services

For the purposes of this section, dental services are diagnostic, preventive, or restorative procedures, performed by a licensed dentist in a private or group practice or in a clinic; a dental hygienist, trained dental assistant or, or other dental professionals employed by the dentist, group practice or clinic, providing such services are performed within the scope of their profession in accordance with State law. These services relate to:

I. The teeth and other structures of the oral cavity; and

II. Disease, injury, or impairment of general health only as it relates to the oral health of the recipient.

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 440.100

II. Connecticut General Statutes: Section 17b-262

III. Regulations of Connecticut State Agencies: Sections 17-134-2(10), 17-134d-35

B. Definitions

I. Dentist:

"Dentist" means an individual licensed by the State Department of Health Services to practice dentistry or dental surgery.

II. Dental Clinic:

For the purpose of this section, "Dental Clinic" means a clinic not associated with a hospital which has been issued a permit from the Connecticut State Dental Commission to operate a clinic for the purpose of providing diagnostic, preventive, or corrective dental procedures to outpatients. Services are performed by or under the supervision and control of a licensed dentist who assumes the primary responsibility for any dental procedures performed, as limited by State law, by licensed dental hygienists, trained dental assistants or dental students. The dentist need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

III. Dental Services:

"Dental Services" means those services provided by or under the supervision and control of a licensed dentist. The dentist assumes the primary responsibility for any dental procedures performed.

IV. Emergency Service:

"Emergency Service" means a service provided to a recipient for the relief from pain or treatment of infection or injury.

V. Treatment Plan:

"Treatment Plan" means a detailed list of dental services which a patient requires to return to or maintain oral health as determined and recorded in the patient's file by the dentist.

VI. Dentures:

"Dentures" means artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

VII. Home:

"Home" means the recipient's place of residence which includes a boarding home or Home for the Aged. Home does not include a hospital, Skilled Nursing Facility, or Intermediate Care Facility.

VIII. Qualified Dentist: Orthodontics

"Qualified Dentist: Orthodontics" means a dentist who:

(a) holds himself out to be an orthodontist in accordance with Section 20-106a of the Connecticut State Statutes, or

(b) documents completion of an American Dental Association accredited post graduate continuing education course consisting of a minimum of two (2) years of orthodontic seminars, and/or submitting three (3) completed case histories with a comparable degree of difficulty as those cases meeting the Department's requirements in Section (F) of this manual if requested by the orthodontic consultant.

IX. The Department:

"The Department" means the state Department of Social Services.

X. Preliminary Handicapping Malocclusion Assessment Record (PHMAR):

"Preliminary Handicapping Malocclusion Assessment Record" means the method of determining the degree of malocclusion and eligibility for orthodontic services. Such assessment is completed prior to performing the comprehensive diagnostic assessment.

XI. Comprehensive Diagnostic Assessment (CDA):

"Comprehensive Diagnostic Assessment" means a minimum evaluative tool for an orthodontic case which determines the plan of treatment necessary to correct the malocclusion. The assessment includes, but it is not limited to, the following diagnostic measures: radiographs, full face and profile photographs or color slides.

C. Provider Participation

I. The provider must meet all applicable state licensing and certification requirements.

II. The provider must meet all departmental enrollment requirements.

D. Eligibility

Payment for Dental Services is available for all persons eligible for Medicaid, subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

Except for the limitations and exclusions listed below, the Department will pay for the professional services of a licensed dentist or dental hygienist which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's diagnosis, symptoms or medical history.

I. Dental Services Covered and Limitations

a. Diagnostic Services, including

1. Home visits

2. Radiographs

(a) Intraoral, complete series (full mouth) consisting of at least ten (10) periapical films plus bitewings, limited to once during any three (3) year period.

(b) Bitewing films, only once during any six (6) month interval per provider.

(c) Periapical films, but the single first film is not covered on the same date of service as bitewings, panoramic, or lateral jaw films.

3. Oral examinations, available to all Title XIX clients with the following limitations:

(a) Initial Oral Exam, includes a complete history workup and is limited to one per patient in a three year period.

(b) Periodic Oral Exam, initiated 6 months subsequent to an Initial Oral Exam and may be utilized every six months thereafter.

(c) Emergency Oral Exam, may be used when diagnosing a palliative (emergency) treatment.

b. Preventive Services, subject to the following:

1. Prophylaxis, once every six (6) months per provider. Prophylaxis includes cleaning, supra and subgingival scaling, and polishing teeth. (Refer to Section I.III.f.)

2. Fluoride treatment for children under 21 years of age will be paid for no more than twice a year (at 6 month intervals) per provider. Prior authorization is required for recipients 21 years of age and over.

3. Space maintainers.

4. Night Guard.

5. Pit and fissure sealants for children ages 5 through 16, once in a five year period per tooth, limited to first and second permanent molars.

c. Restorative services, limited to the restoration of carious, permanent, and primary teeth, with

1. Fillings

(a) Permanent fillings using silver amalgam or composite resin material are limited to one (1) per year to the same surface by the same provider unless authorized by the dental consultant.

(b) Temporary sedative fillings, only when done to treat dental pain requiring emergency treatment.

(c) 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.

2. Crowns, of the following materials and only in those cases where the breakdown of tooth structure is excessive:

(a) Stainless steel, deciduous or permanent, anterior or posterior teeth

(b) Preformed plastic, anterior teeth only, deciduous or permanent

(c) Acrylic or porcelain veneer, permanent anterior teeth only

d. Endodontics with the following limitations:

1. Root canal therapy and/or apicoectomy shall be covered as follows:

(a) For upper and lower six (6) anterior teeth and then only when the retention of the tooth in site is necessary to maintain the integrity of the dentition and the prognosis is favorable.

(b) For posterior teeth only in cases with 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.

2. Apexification (not including root canal treatment but includes all visits to complete the service).

e. Prosthodontics with the following limitations:

1. Prostheses will only be approved if the patient can tolerate and is expected to use them on a regular basis.

2. Removable, complete and partial denture prostheses only

3. Replacement of existing dentures, only once in any five (5) years from the date of service of the existing dentures. Exceptions will be considered where the absence of dentures would create an adverse condition jeopardizing the patient's medical health.

4. Relining or rebasing the existing dentures not more than once in any two (2) year period.

5. Denture labeling, for patients in long term care facilities only

f. Dental Surgery with the following limitations:

1. Suture of laceration of the mouth, in accident cases only and not cases incidental to and connected with dental surgery

2. Gingivectomy, for severe side effects caused by medication

3. Replant avulsed anterior tooth, not in conjunction with a root canal

4. Bone grafts, mandible, restricted to the replacement of bone previously removed by radical surgery procedure.

g. Exodontia (extractions)

h. Orthodontics under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program with the following limitations:

1. Orthodontic Screening, one (1) per provider for the same recipient

2. Orthodontic consultation, one (1) per provider for the same recipient

3. Preliminary Diagnostic assessment casts/study models, one (1) per provider for the same recipient

4. Comprehensive Diagnostic Assessment, one (1) per provider for the same recipient

5. Initial appliance, one (1) per provider for the same recipient
6. Active treatment, up to a maximum of thirty (30) months per recipient
7. Retainer appliances, may be replaced only once per dental arch for the same recipient regardless of the reason
8. Orthodontic services are limited to recipients under twenty-one (21) years of age
9. All orthodontic services must be provided by a qualified dentist as defined in Section 184.B.

i. Outpatient hospital services by licensed dental personnel performing within the scope of their profession

j. Alveolectomy (Alveoplasty), only when an edentulous ridge is involved (not in conjunction with extractions)

k. Patient Management, a patient management fee may be claimed in connection with a dental service to individuals who, because of cognitive disabilities, are limited in their ability to understand directions and thus require additional time on the part of the dentist to deliver services. In order to access the patient management fee, the dental provider must satisfy two documentation requirements:

1. The provider must document the specific diagnosis in the patient's record. A diagnosis of moderate or severe or profound mental retardation will satisfy the diagnosis requirement.
2. The provider must have in the patient's record the signature of a physician or a professional staff member of the Department of Mental Retardation, attesting to the authenticity of the diagnosis.

l. General Surgical Anesthesia

m. Services covered are limited to those listed in the Department's Dental Fee Schedule

II. Dental Services Not Covered

a. Fixed bridges

b. Periodontia

c. Implants

d. Transplants

e. Cosmetic dentistry

f. Vestibuloplasty

g Unilateral removable appliances

h. Partial dentures where there are at least eight (8) posterior teeth in occlusion, and no missing anterior teeth

i. Restorative procedures to deciduous teeth nearing exfoliation

j. Information provided the recipient by telephone

k. Office visits to obtain a prescription, the need for which has already been ascertained

l. The following surgical procedures are not covered unless orthodontia has been prior authorized: surgical exposure of impacted or unerupted teeth for orthodontic reasons; osteoplasty (osteotomy) of maxilla and/or other facial bones for midface hypoplasia or retention (LeFort type operation), without bone graft.

m. Canceled office visits or for appointments not kept.

n. Admitting services or any inpatient dental services performed by the admitting dentist if the admission was not approved by the Department or its designate as medically necessary in either a preadmission or retrospective review (CONNCUR).

F. Need for Service and Authorization Process

I. Need for Service

The Department will pay for any dental services which are deemed by the Department to be medically necessary and that

a. the services are within the scope of the dentist's profession, and

b. the services are made part of the recipient's medical record.

c. Orthodontia

1. The need for orthodontic service shall be determined on the basis of the magnitude of the malocclusion. Accordingly, the qualified dentist must fully complete the "Preliminary Handicapping Malocclusion Assessment Record" in accordance with the instructions section of the form. The Department deems orthodontic services to be medically necessary when a correctly scored total of twenty-four (24) points or greater is calculated from the preliminary assessment. However, if the total score is less than twenty-four (24) points, the Department shall consider additional information of a substantial nature about the presence of severe deviations affecting the mouth and underlying structures. Other deviations shall be considered to be severe if, left untreated, they would cause irreversible damage to the teeth and underlying structures.

2. If the total score is less than twenty-four (24) points, the Department shall consider additional information of a substantial nature about the presence of severe mental, emotional, and/or behavior problems, disturbances or dysfunctions, as defined in the most current edition of the Diagnostic Statistical Manual of the American Psychiatric Association, and which may be caused by the recipient's daily functioning. The Department will only consider cases where a diagnostic evaluation has been performed by a licensed psychiatrist or a licensed psychologist who has accordingly limited his or her practice to child psychiatry or child psychology. The evaluation must clearly and

substantially document how the dentofacial deformity is related to the child's mental, emotional, and/or behavior problems, that orthodontic treatment is necessary and, in this case, will significantly ameliorate the problems.

3. A recipient who becomes Medicaid eligible and is already receiving active orthodontic treatment must demonstrate that the need for service requirements specified in Subsection 184F.I.c.1. were met before orthodontic treatment commenced, meaning that prior to the onset of treatment the recipient would have met the need for services requirements.

II. Prior Authorization

The following treatment and/or services require prior authorization by the Department.

a. Radiographs
   1. Intraoral, complete series
   2. Any film in addition to four (4) periapical films
   3. Any films in addition to bitewings and three (3) periapicals

b. Crowns, other than stainless or preformed plastic

c. Dentures
   1. Full or partial dentures
   2. Reline or rebase lower or upper denture (chairside and/or laboratory)

d. Root canal therapy, excluding apicoectomies, post and core, and canal preparation procedures when performed in conjunction with a root canal

e. Change in dentists during a course of treatment

f. Impactions

g. Elective impactions require special consideration and will require xrays supporting the need for service.

h. Gingevectomy

i. Reposition forming tooth bud to another socket

j. Apexification

k. Permanent fillings in excess of one (1) per year to the same surfaces by the same provider.

l. Alveolectomy (Alveoplasty) and/or drainage of an extra-oral alveolar abscess

m. Osteoplasty (osteotomy)

n. Orthodontic services following the initial Orthodontic Consultation and Preliminary Assessment including the following: Comprehensive Diagnostic Assessment, Initial Appliance, and Active Treatment.

o. Pit and fissure sealants on first permanent molars (Tooth # 3, 14, 19 and 30), all ages other than 5-10 inclusive.

p. Pit and fissure sealants on second permanent molars (Tooth # 2, 15, 18 and 31) all ages other than 10-16 inclusive.

q. Patient management

r. Fluoride treatment for recipients 21 years of age and over

s. All services listed in the fee schedule identified by a single asterisk.

t. Admission to an acute care hospital. This authorization is not necessary under the CONNCUR program if the recipient is also on Medicare.

III. Authorization Procedure

a. CONNCUR (Connecticut Case Program) Authorization

CONNCUR is a utilization and quality review program for Medicaid (Title XIX) designed by the Department of Social Services in compliance with the Code of Federal Regulations, 42 CFR 431.

CPRO will review hospital admissions for medical necessity provided in the appropriate setting.

For all cases meeting DSS coverage policies (except those also on Medicare) and appropriateness of the admission (using ISD and other criteria developed by CPRO) a unique eight digit authorization number will be issued beginning with "W" followed by seven numerics to be included on the hospital's bill. Confirmation of the number will be sent by CPRO to both the dentist and the hospital.

1. Authorization for admission to and subsequent dental services performed in an acute care general hospital by the admitting dentist needs authorization of the admission from the agency's designate, the Connecticut Peer Review Organization (CPRO; 1-800-628-7337).
2. Non-emergency admissions require review prior to hospital admission.
3. Emergency admissions require review within two business days of admission.

b. Prior Authorization

The procedure of course of treatment must be initiated within twelve (12) months of the date of authorization. The "EDS Dental Claim Form" is used to request prior authorization. Such authorization and requests for authorization must be approved prior to the onset of treatment. The form is submitted to:

Department of Social Services
Attn: Dental Consultant
25 Sigourney St.
Hartford, Connecticut 06106-5033

Prior authorizations are subject to the following conditions:

1. The initial authorization period is valid up to twelve (12) months from the date service is authorized, providing that the patient remains eligible for Medicaid.

   (a). When prior authorization is given for twelve (12) orthodontic active treatments it will be for a period of twenty-four (24) months.

2. Treatment plan procedures which have been prior authorized but treatment was not begun prior to the lapse of the twelve (12) month limit (for twelve (12) active treatments of orthodonture the limit is twenty-four (24) months), must be reauthorized by submitting a new claim form for those procedures remaining from the original treatment plan, documenting the necessity for an extension. The request will be reviewed by the Dental Consultant. If no portion of the original treatment was completed, submit the original form for an authorization update.

3. Only authorization for emergency care will be granted by telephone during normal working hours. In emergency situations which occur after working hours or on nonworking days, the dentist is to call the Dental Consultant in Central Office for verbal approval the following working day. When such authorization is given, a complete report of emergency care and the treatment must be submitted to the Department in every case within 48 hours using the Dental Claim Form and stating the name of the Dental Consultant giving verbal approval, and the date the approval is given.

4. A complete description must be included with a request for the following procedures:

   (a) Denture repair

   (b) All oral surgical procedures

   (c) Emergency care

5. Orthodontics

   Requests for authorization for orthodontic services must be submitted to the Department by a qualified dentist in the following sequence:

   (a) To obtain the initial authorization the orthodontist first submits the authorization request for the Comprehensive Diagnostic Assessment, together with the Preliminary Assessment Form (W-1428), study models, and other supporting documentation.

   (b) The study models must clearly show the occlusal deviations and support the total point score of the preliminary assessment. For approved cases, to initiate the first period of twelve active treatments the orthodontist must submit the authorization request for the Initial Appliance and Active Treatment along with

      (1) a written treatment plan detailing estimated length of active treatment and retention period

      (2) the diagnosis

(3) a description of the appliance to be utilized

(4) a list of all other medical or dental treatment which is necessary in preparation for, or completion of, the orthodontic treatment.

(c) For each additional period of active treatment and/or retention the qualified dentist must submit the authorization form with study models and/or photographs which clearly show the progress of treatment. No authorization shall be given if there is evidence that little or no progress has been made at the end of twelve treatments. In this case, the qualified dentist shall be required to resubmit the authorization request. The authorization shall be based on reasonable progress made in active treatment as deemed by the Department. There will be no monthly payment allowed during this period.

(d) All requests for replacement of retainers must be accompanied by appropriate justification.

(e) Any requests for modifications of the authorized treatment plan must include supporting documentation; however, no authorization shall be given beyond thirty (30) months of active treatment.

(f) Address all requests for authorization for orthodontic services to:

Department of Social Services
Attn: Orthodontic Consultant
25 Sigourney St.
Hartford, Connecticut 06106-5033

6. X-rays

(a) X-rays must be submitted with requests for impacted teeth, multiple extractions, crowns, root canals, reposition of tooth bud and other unusual instances in other procedures that require prior authorization.

(b) Right and left bitewings are necessary for all root canal requests involving posterior teeth.

(c) X-rays that have been taken for services requiring prior authorization must be attached to the EDS Dental Form. These X-rays will be returned to the provider of service if the provider's name and address appear on them.

G. Other

I. Modification of Treatment Plan

The Department reserves the right to alter, amend, or otherwise modify treatment plans, where such changes shall be in the best interest of the State, and when they do not deny proper service to the patient. Reconsideration of such decisions may be requested in writing to the Department providing evidence in support of such request. In disputed decisions, the matter will be referred to the appropriate Review Committee of the Connecticut State Dental Association, and the Department will be guided by the decision of the Review Committee.

II. X-Rays

Full mouth X-rays for which prior authorization has been granted must be presented, properly mounted, and readable. Unreadable films and those having no diagnostic value will be returned and new film requested at no cost to the Department. Such X-rays are to be made available on request to any other practitioner treating the same recipient, as authorized by the recipient.

III. Extractions

All necessary extractions must be recorded on one Treatment Plan, together with any other necessary procedures. The removal of hard and/or soft tissue and suturing following multiple extractions and surgical removals are considered sound surgical procedures and not an alveolectomy.

IV. Payment to Salaried Dentists

A dentist who is fully or partially salaried by a General Hospital, Public or Private Institution, Physicians' Group or Clinic may not receive payment from the Department unless that dentist maintains an office for private practice at separate location from the hospital, institution, physician group, or clinic in which the provider is employed. Dentists who are solely hospital, institution, physician group, or clinic based either on a full time or part time salary are not entitled to payment from the Department for services rendered to Title XIX recipients.

V. Subject to the above limitations, the dentist's service may be performed at:

a. The dentist's private or group practice location, or

b. Hospital or long-term care facility, or

c. The recipient's home.

VI. Admission Exam/Annual Exam - PHC Section 19-13D8t If the patient's physician deems it medically unnecessary, or the patient refuses to have all or any part of the dental examination performed, the exam need not be carried out.

VII. Orthodontics

a. The recipient, together with the parent or guardian, should have the desire and the ability to complete an extended treatment plan as determined by the qualified dentist performing the treatment or other professionals involved with the recipient or family.

b. When an orthodontic case is authorized by the Department, local Early Periodic Screening, Diagnostic and Treatment (EPSDT) staff will contact the recipient and the qualified dentist to help facilitate the recipient's participation in the completion of the treatment plan.

c. The course of orthodontic treatment must be completed prior to the recipient's twenty-first (21st) birthday.

d. The qualified dentist shall maintain a specific record for each recipient eligible for Medicaid reimbursement including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information and X-ray, a current treatment plan, pertinent treatment notes

signed by the qualified dentist; and documentation of the dates of service. Records or documentation must be maintained for a minimum of five (5) years. For the retention period the qualified dentist shall submit, prior to initiating placement of retainers, study models and/or photographs clearly showing the case is ready for retention.

H. Billing Procedures

I. All dental services performed on behalf of eligible patients and not requiring prior authorization must be recorded on the EDS Dental Claim Form and submitted to the Department's claims processing agent:

Electronic Data Systems Corporation (EDS)
Dental Claims
P.O. Box 2971
Hartford, CT 06104

II. Usual and Customary Charge

It is required that the amount billed to the Department represents the provider's usual and customary charge for the services delivered.

III. The Dental Claim Form serves as a combined treatment plan record, a request for authorization, and a bill.

I. Payment

I. Payments will be made at the lower of:

a. The usual and customary charge to the public

b. The fee as contained in the dental fee schedule published by the Department.

c. The amount billed by the provider.

II. Payment Rate

The Commissioner of Social Services establishes the fee contained in the Dental Fee Schedule. The fees are based on moderate and reasonablerates prevailing in the respective communities where the service is rendered.

III. Payment Limitations

a. When dental treatment is necessary, the examination and charting of the oral cavity (including filling out the EDS Dental Claim Form) will be included in the total cost of treatment.

b. The fee for root canal treatment and/or apicoectomies includes all pre and post-operative X-rays, but not the final restoration.

c. Fees listed in the dental fee schedule for oral surgery and exodontia include pre-operative and post-operative care.

d. Fees for amalgam restoration include local anesthesia, base and polishing where necessary.

e. Fees for exodontia include local anesthesia.

f. Dental cleaning for children under 21 years of age is paid at the lower rate for this service as stipulated in the Dental Fee Schedule.

g. Orthodontics

1. An initial payment and monthly payments are made for active treatment and orthodontic services.
2. The initial payment covers the placement of the initial appliances.
3. No payment is made for monitoring growth and development.
4. A dentist, other than a qualified dentist as defined in these regulations, may receive payment for an orthodontic screening. The screening includes oral examination and/or examination of the patient's records for the purposes of completing Sections I, II and IIIA-D of the Preliminary Handicapping Malocclusion Assessment Record Form, W-1428.
5. The fee for the orthodontic consultation includes a dental screening and the completion of the preliminary assessment form. No separate payment shall be made to a qualified dentist for the orthodontic screening.
6. The number of monthly payments is limited to the number of months of active treatment stipulated in the treatment plan as approved by the Department.
7. The monthly installment rate for active treatment is based on the average of one (1) visit per month and will be payable once a month during the authorized active treatment period no matter how many times the orthodontist sees the patient during this period.
8. Payment for the comprehensive diagnostic assessment includes all diagnostic measures, e.g., X-rays, photographs or slides, and the written treatment plan. No separate payment is made for individual diagnostic materials except the preliminary assessment study models.
9. For a recipient who becomes ineligible for Medicaid during the authorized term of active treatment, the final payment from the Department shall be made for the month in which the recipient becomes ineligible for Medicaid or EPSDT services, whichever comes first.
10. The cost of the initial retainer appliance, including fitting, adjustments and all necessary visits, is included in the first twenty-four (24) monthly active treatment installments.
11. The fee for the replacement of retainer appliances includes the fitting and all necessary visits.

h. Payment may not be made or may be taken back from the admitting dentist retrospectively if it is determined by CPRO during a retrospective review that the admission was inappropriate.

171 Clinics

For the purposes of this Section, clinics are facilities not associated with a hospital. They provide medical or medically-related services for diagnosis, treatment and care of persons with chronic or acute conditions.

This section is divided into four (4) subsections comprising the major fields of medical and medically-related provider groups associated with clinic-based services. The descriptions, citations, and definitions in sections 171A. and 171B. below, apply to all of the clinic types described herein.

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 440.2a, 440.90, 440.130

II. Connecticut General Statutes: Section 17b-262

III. Regulations of Connecticut State Agencies:

B. Definitions

I. Free Standing Clinic

"Free Standing Clinic" means a facility providing clinic and off-site medical services by or under the direction of a physician or dentist, in a facility that is not part of a hospital.

II. Medical or Medically-Related Services

"Medical or Medically-Related Services" means services which are required in the diagnosis, treatment, care, or prevention of some physical or emotional problem which affects the health of an individual.

III. Clinic Services

"Clinic Services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that

a. Are provided to outpatients;

b. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

c. Are furnished by or under the direction of a physician or dentist.

d. Are performed at the clinic, a satellite site, school, or community center.

IV. Off-Site Medical Services

"Off-Site Medical Services" means diagnostic, preventive, and rehabilitative services furnished by or under the direction of a physician or dentist employed by or under contract to a free-standing clinic to a Medicaid eligible recipient at a location other than the locations listed elsewhere in this subsection. Such off-site locations are the recipient's home, acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded. Off-site services (as may be restricted by location in accordance with each clinic subsection herein) include: Mental Health Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Audiological

Services, Physician's Services, Respiratory Therapy Services, Primary Care Services, and Dental Services.

V. All-inclusive fee

"All-inclusive fee" means a fee which covers any and all services provided by the clinic for a particular visit or program. No additional payment will be made by the Department for services rendered during that visit.

VI. Outpatient

"Outpatient" means a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, which is not providing him with room and board and professional services on a continuous 24 hour-a-day basis.

VII. Patient

"Patient" means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

VIII. By or Under the Directions of a Physician or Dentist

"By or under the direction of a physician or dentist" means a free-standing clinic's services may be provided by the clinics' allied health professionals (as defined in Sections 171.1 through 171.4) whether or not a physician is physically present at the time that medical services are provided. The physician

a. must assume professional responsibility for the services provided;

b. must assure that the services are medically appropriate, i.e., the services are intended to meet a medical need, as opposed to needs which are clearly only social, recreational or educational;

c. need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

IX. Plan of Care

"Plan of Care" means a written individualized plan. Such plan shall contain the diagnosis, type, amount, frequency, and duration of services to be provided and the specific goals and objectives developed and based on an evaluation and diagnosis for the maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level.

X. Satellite Site

"Satellite Site" means a location separate from the primary clinic facility at which clinic services are furnished by clinic professionals on an ongoing basis meaning with stated hours per day and days per week.

XI. Home

"Home" means the recipient's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing

facility, intermediate care facility, or intermediate care facility for the mentally retarded.

171.3 Dental Clinics

A dental clinic provides diagnostic, preventive, or restorative procedures to outpatients in a clinic staffed by dentists, dental hygienists, dental assistants and other dental professionals performing within the scope of their profession in accordance with State law. Services performed relate to

I. The teeth and other structures of the oral cavity; and

II. Disease, Injury, or impairment of general health only as it relates to the oral health of the recipient.

(Refer to Section 171. for other applicable clinic services policy).

A. Legal Bases

I. Code of Federal Regulations: 42 CFR 440.100, 440.130

II. Connecticut General Statutes: Section 17b-262

III. Regulations of Connecticut State Agencies: Sections 17-134d2(9) and (10), 17-134d-35, 17-134d-56

B. Definitions

I. Dentist:

"Dentist" means an individual licensed by the State Department of Health Services to practice dentistry or dental surgery.

II. Dental Clinic:

For the purpose of this section, "Dental Clinic" means a clinic not associated with a hospital which has been issued a permit from the Connecticut State Dental Commission to operate a clinic for the purpose of providing diagnostic, preventive, or corrective dental procedures to outpatients. Services are performed by or under the supervision and control of a licensed dentist who assumes the primary responsibility for any dental procedures performed, as limited by State law, by licensed dental hygienists, trained dental assistants or dental students. The dentist need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

III. Emergency Service

"Emergency Service" means a service provided to a recipient for the relief from pain or treatment of infection or injury.

IV. Treatment Plan

"Treatment Plan" means a detailed list of dental services which a patient requires to return to or maintain oral health as determined and recorded in the patient's file by the dentist.

V. Dentures

"Dentures" means artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

C. Provider Participation

I. The provider must meet all applicable state licensing and certification requirements.

II. The provider must meet all Departmental enrollment requirements.

III. The following are requirements for satellite sites operated by dental clinics:

a. All satellite sites operated by dental clinics must have received a permit from the Connecticut State Dental Commission to provide dental services at such locations and document to the Department the Commission's approval of such sites;

b. All clinics must document to the Department the names and titles of satellite clinical staff and scheduled hours of operation (hours per day/days per week) and description of services provided at such sites;

c. All such sites must otherwise comply with the provisions of this section of the Department's Medical Services Manual covering dental clinic services;

d. In cases in which the clinic has a special arrangement to provide services in another organized facility, the clinic must submit to the Department a copy of a written agreement between the clinic and such facility stipulating the services to be provided at such facility;

e. There must be adequate private office space in which to conduct direct patient care and treatment and administrative services.

D. Eligibility

Payment for clinic dental services is available for all persons eligible for Medicaid subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

Except for the limitations and exclusions listed below, the Department will pay for clinic dental services which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's diagnosis, symptoms or medical history.

I. Dental Clinic Services Covered and Limitations

a. Diagnostic Services, including

1. Radiographs

(a) Intraoral, complete series (full mouth) consisting of at least ten (10) periapical films plus bitewings, limited to once during any three (3) year period.

(b) Bitewing films, only once during any six (6) month interval per provider.

(c) Periapical films, but the single first film is not covered on the same date of service as bitewings, panoramic, or lateral jaw films.

(d) Temporomandibular Joint

(e) Sialography

(f) Panoramic or lateral jaw

2. Dental screenings, limited to

(a) the Early and Periodic Screening and Diagnosis Treatment Program (EPSDT) for children under 21 years of age

(b) once yearly (at twelve (12) month intervals) per provider

3. Oral examination, limited to patients in Intermediate Care and Skilled Nursing Facilities pursuant to Public Health Code Section 19-13D8t, as revised October 1981, and subject to the following:

(a) Admission Exam. For each patient, the Department will pay the same dental clinic for only one admission exam, regardless of the number of individual admissions. For example, if a patient moves from one facility to another and retains the dental clinic which performed the admission exam at the first facility, that clinic cannot get paid for another admission exam;

(b) Annual Exam, limited to one per year, meaning no sooner than one year from the date of the admission exam, and only one and annual exam per year will be paid for each patient;

(c) The examination is performed in the facility only.

b. Preventive Services, subject to the following:

1. Prophylaxis, once every six (6) months per provider. Prophylaxis includes cleaning, supra and subgingival scaling, and polishing teeth. (Refer to Section I.III.f.)

2. Fluoride treatment for children under 21 years of age will be paid for no more than once a year (at 12 month intervals) per provider. Fluoride treatment must be an application of Acidulate Phosphate Fluoride.

3. Space maintainers

4. Night Guard

c. Restorative services, limited to the restoration of carious, permanent, and primary teeth, with

1. Fillings

(a) Permanent fillings using silver amalgam or composite resin material are limited to one (1) per year to the same surface by the same provider unless authorized by the dental consultant.

(b) Temporary sedative fillings, only when done to treat dental pain requiring emergency treatment.

(c) More than one amalgam filling on a single surface will be considered a single filling. Anterior, synthetic 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.

2. Crowns, of the following materials and only in those cases where the breakdown of tooth structure is excessive:

(a) Stainless steel, deciduous or permanent, anterior or posterior teeth

(b) Preformed plastic, anterior teeth only, deciduous or permanent

(c) Acrylic or porcelain veneer, permanent anterior teeth only

d. Endodontics with the following limitation:

1. Root canal therapy and/or apicoectomy shall be covered as follows:

(a) For upper and lower six (6) anterior teeth only when the retention of the tooth in site is necessary to maintain the integrity of the dentition and the prognosis is favorable.

(b) For posterior teeth only in cases with 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.

2. Apexification

e. Prosthodontics with the following limitations:

1. Prostheses will only be approved if the patient can tolerate and is expected to use them on a regular basis.

2. Removable, complete and partial denture prostheses only

3. Replacement of existing dentures, only once in an five (5) years from the date of service of the existing dentures. Exceptions will be considered where the absence of dentures would create an adverse condition jeopardizing the patient's medical health.

4. Relining or rebasing existing dentures not more than once in any two (2) year period.

5. Denture labeling, for patients in long term care facilities only.

f. Oral Surgery with the following limitations:

1. Antibiotic injections in connection with oral surgery, only in those special cases requiring a rapid buildup of blood levels.

2. Suture of laceration of the mouth, in accident cases only and not cases incidental to and connected with dental surgery.

3. Gingivectomy, for severe side effects caused by medication

4. Replant avulsed anterior tooth, not in conjunction with a root canal

5. Bone grafts, mandible, restricted to the replacement of bone previously removed by radical surgery procedure.

g. Exodontia (extractions)

h. Orthodontia

i. Alveolectomy (Alveoplasty), only when an edentulous ridge is involved (not in conjunction with extractions)

j. Services covered are limited to those listed in the Department's Dental Fee Schedule.

II. Clinical Services Not Covered

a. Fixed bridges

b. Periodontia

c. Implants

d. Transplants

e. Cosmetic dentistry

f. Vestibuloplasty

g. Unilateral removable appliances

h. Partial dentures where there are at least eight (8) posterior teeth in occlusion, and no missing anterior teeth

i. Restorative procedures to deciduous teeth nearing exfoliation

j. Oral examinations to persons age 21 or older

k. Information provided the recipient by telephone

l. Clinic or off-site visits to obtain a prescription, the need for which has already been ascertained

m. Canceled office visits or for appointments not kept.

n. Oral examination or survey of patients in nursing facilities, or recipients over twenty (20) years of age, except as limited under Section E of this policy.

F. Need for Service and Authorization Process

I. Need for Service

The Department will pay for any dental clinic or off-site services which are deemed by the Department to be medically necessary and that

a. the services furnished by the clinic are within the scope of the dental profession under State law; and

b. the services are made part of the recipient's dental record;

c. The services are recommended by a dentist.

II. Prior Authorization

The following treatment and/or services require prior authorization by the Department.

a. Radiographs
   1. Intraoral, complete series
   2. Any film in addition to four (4) periapical films
   3. Any films in addition to bitewings and three (3) periapicals

b. Crowns, other than stainless or preformed plastic

c. Dentures
   1. Full or partial dentures
   2. Duplicate upper or lower complete denture
   3. Reline or rebase lower or upper denture (chairside and/or laboratory)

d. Root canal therapy, including apicoectomy performed in conjunction with root canal

e. Space maintainers

f. Any combination of more than three (3) surgical procedures, for example, more than three (3) extractions

g. Change in dentists during a course of treatment

h. Impactions

i. Elective impactions require special consideration and will require Xrays supporting the need for service

j. Gingivectomy

k. Night Guard

l. eposition forming tooth bud to another socket

m. pexification

n. ermanent fillings in excess of one (1) per year to the same surfaces by the same provider

o. ll dental services for recipients residing in medical facilities needing transportation by chaircar or ambulance (See below, III.g.)

p. ll cases for which the dentist is requesting hospital operating room services on an inpatient or same day surgery basis. Documentation of medical necessity is required.

III. Authorization Procedure

The procedure of course of treatment must be initiated within six (6) months of the date of authorization. The "EDS Dental Claim Form" is used to request prior authorization. Such authorizations and requests for authorization must be approved prior to the onset of treatment. The form is submitted to:

Department of Social Services

Attn: Dental Consultant

25 Sigourney St.

Hartford, Connecticut 06106-5033

Prior authorizations are subject to the following conditions:

a. The initial authorization period is valid up to six (6) months from the date service is authorized, providing that the patient remains eligible for Medicaid.

b. Treatment plan procedures which have been prior authorized but treatment was not begun prior to the lapse of the six (6) month limit, must be reauthorized by submitting a new claim form for those procedures remaining from the original treatment plan, documenting the necessity for an extension. The request will be reviewed by the Dental Consultant.

c. Only authorization for emergency care will be granted by telephone during normal working hours. In emergency situations which occur after working hours or on non-working days, the dentist is to call the Dental Consultant in Central Office for verbal approval the following working day. When such authorization is given, a complete report of emergency care and the treatment must be submitted to the Department in every case within 48 hours using the Dental Claim Form and stating the name of the Dental Consultant giving verbal approval, and the date the approval is given.

d. A complete description must be included with a request for the following procedures:

   1. Denture repair
   2. All oral surgical procedures
   3. Emergency care

e. Request for orthodontic treatment due to a cleft palate must have a report from a licensed orthodontist which includes a diagnosis, prognosis, and estimated fee for adequate minimum correction. The orthodontist submits his report to the Department on the EDS Dental Form.

f. X-rays

   1. X-rays must be submitted with requests for impacted teeth, multiple extractions, crowns, root canals, reposition of tooth bud and other unusual instances in other procedures that require prior authorization.
   2. Right and left bitewings are necessary for all root canal requests involving posterior teeth.
   3. X-rays that have been taken for services requiring prior authorization must be attached to the EDS Dental Form. These X-rays will be returned to the provider of service if the provider's name and address appear on them.

g. Transportation requests to obtain dental services must be indicated in the remarks section of the dental form.

G. Other

I. Modification of Treatment Plan

The Department reserves the right to alter, amend, or otherwise modify treatment plans, where such changes shall be in the best interest of the State, and when they do not deny proper service to the patient. Reconsideration of such decisions may be requested in writing to the Department providing evidence in support of such request. In disputed decisions, the matter will be referred to the appropriate Review Committee of the Connecticut State Dental Association, and the Department will be guided by the decision of the Review Committee.

II. X-Rays

Full mouth X-rays for which prior authorization has been granted must be presented, properly mounted, and readable. Unreadable films and those having no diagnostic value will be returned and new film requested at no cost to the Department. Such X-rays are to be made available on request to any other practitioner treating the same recipient, as authorized by the recipient.

III. Extractions

All necessary extractions must be recorded on one Treatment Plan, together with any other necessary procedures. The removal of hard and/or soft tissue and suturing following multiple extractions and surgical removals are considered sound surgical procedures and not an alveolectomy.

IV. Dentists who are fully or partially salaried by a clinic will not receive payment from the Department unless the dentist maintains an office for private practice at separate location from the clinic. Dentists who are solely clinic-based either on full time or part time salary are not entitled to payment from the Department for services rendered to Title XIX recipients. Services are billed by the provider clinic. Dentists who maintain an office for private practice separate from the clinic may bill for services provided at the private location or for services provided to the dentist's private practice patients at the clinic only if the patient is not a clinic patient.

V. Documentation Requirements

a. A record of each service performed must be on file in the recipient's individual dental record.

1. the specific services rendered;
2. the date the services were rendered;
3. for therapy services, the amount of time it took to complete the session on that date;
4. the name and title of the person performing the services on that date;
5. the location at which the services were rendered;

6. the recipient's individual dental record must contain a progress note for each encounter.

b. All documentation must be entered in ink and incorporated into the patient's permanent dental record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by Federal law.

c. In the case of off-site services, all individual dental records must be on file at the clinic.

H. Billing Procedures

I. All dental services performed on behalf of eligible patients and not requiring prior authorization must be recorded on the EDS Dental Claim Form and submitted to the Department's claims processing agent:

Electronic Data Systems Corporation (EDS)

Dental Claims

P.O. Box 2971

Hartford, Connecticut 06104

II. The Dental Claim Form serves as a request for authorization and a bill.

I. Payment

I. Payment will be made at the lower of:

a. The usual and customary charge to the public

b. The fee as contained in the dental fee schedule published by the Department.

c. The amount billed by the provider.

II. Payment Rate

a. The Commissioner of Social Services establishes the fee contained in the Dental Fee Schedule. The fees are based on moderate and reasonable rates prevailing in the respective communities where the service is rendered.

b. Subject to the service limitations stated in this policy, dental clinics shall be reimbursed by the Department for services covered in accordance with the Department's fee schedule covering dental clinic services regardless of the site where the service is provided.

III. Payment Limitations

a. When dental treatment is necessary, the examination and charting of the oral cavity (including filling out the EDS Dental Claim Form) is included in the total cost of treatment.

b. The fee for root canal treatment and/or apicoectomies includes all pre- and post-operative X-rays, but not the final restoration.

c. Fees listed in the dental fee schedule for oral surgery and exodontia include pre-operative and post-operative care.

d. Fees for amalgam restoration include local anesthesia, base and polishing where necessary.

e. Fees for exodontia include anesthesia.

f. Dental cleaning for children under 21 years of age is paid at the lower rate for this service as stipulated in the Dental Fee Schedule.

REGULATIONS OF CONNECTICUT STATE AGENCIES

Department OF SOCIAL SERVICES

Concerning

Requirements for Payment of Public Health Dental Hygienist Services

Section 17b-262-693

Scope

Sections 17b-262-693 to 17b-262-700, inclusive, set forth the requirements for payment of public health dental hygienist services for persons determined eligible for Connecticut's Medicaid Program pursuant to Section 17b-262 of the Connecticut General Statutes.

Section 17b-262-694

Definitions

As used in sections 17b-262-693 to 17b-262-700, inclusive, the following definitions shall apply:

(1) "Client" means a person eligible for services under the department's Medicaid program;

(2) "Clinic" means an "outpatient clinic" as defined in section 19-13-D45 of the Regulations of Connecticut State Agencies;

(3) "Commissioner" means the Commissioner of Social Services or his or her agent;

(4) "Community health center" means a "community health center" as defined in section 19a-490a of the Connecticut General Statutes;

(5) "Dental examination" means inspecting and charting of the oral structures;

(6) "Dental hygienist" means a dental hygienist licensed to practice dental hygiene pursuant to sections 20-126h to 20-126x, inclusive, of the Connecticut General Statutes;

(7) "Dental hygienist services" means "the practice of dental hygiene" as defined in section 20-126l(a)(3) of the Connecticut General Statutes;

(8) "Dentist" means a dentist licensed to practice dentistry pursuant to section 20-108 of the Connecticut General Statutes or who is licensed to practice dentistry in another state;

(9) "Department" means the Department of Social Services or its agent;

(10) "Group home" means a "community residential facility" as defined in section 17a-220 of the Connecticut General Statutes or a "community residence" as defined in section 19a- 507a of the Connecticut General Statutes;

(11) "Hospital" means a "general hospital" or "special hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101 as amended from time to time;

(13) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and, is the least costly of multiple, equally effective alternative treatments or diagnostic modalities;

(15) "Medical necessity" or "medically necessary" means 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 to prevent a medical condition from occurring;

(16) "Medical record" means a medical record as set forth in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(17) "Nursing facility" means an institution as defined in 42 USC 1396(r)(a), as amended from time to time;

(18) "Provider" means a "public health dental hygienist" as defined in subsection (19) of this section;

(19) "Public health dental hygienist" means a dental hygienist who is providing services in accordance with section 20-1261(b)(1)(B) of the Connecticut General Statutes;

(20) "School" means any preschool, elementary or secondary school or any college, vocational, professional or graduate school; and

(21) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" means the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Provider Participation

(a) In order to participate in Medicaid and receive payment from the department, all providers shall meet and maintain all departmental enrollment requirements as set forth in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) All dental hygienists who participate in Medicaid shall be public health dental hygienists.

Section 17b-262-696

Eligibility

Payment for public health dental hygienist services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

Section 17b-262-697

Services Covered and Limitations

(a) Services Covered

(1) The department shall pay for medically necessary and medically appropriate public health dental hygienist services provided to clients subject to the limitations listed in subsection (b) of this section.

(2) The department shall pay providers only for those procedures listed in the provider's fee schedule.

(b) limitations

(1) Dental examination is limited to one (1) every six (6) calendar months per client.

(2) The department shall not pay for fluoride treatment except for the following clients, and shall limit treatment to one (1) time every six (6) calendar months per client:

(A) clients under age twenty one (21); and

(B) clients over age twenty one (21):

(i) using radiology services as oncology treatment on a regular basis; or

(ii) residing in nursing facilities or intermediate care facilities for the mentally retarded who have six (6) or more natural teeth.

(3) Pit and fissure sealant is limited to:

(A) clients between the ages of five (5) through sixteen (16), inclusive;

(B) first and second permanent molars that are decay and restoration free; and

(C) one every five (5) calendar years per tooth.

(4) A public health dental hygienist who is salaried at a practice location shall not bill the department for dental hygienist services for clients seen at this location.

(5) Payment for dental hygienist services is available to all clients who have a need for these services, subject to the limitations in this subsection, when provided at the following locations only:

(A) a nursing facility;

(B) an ICF/MR;

(C) a group home;

(D) a school that does not have a dental clinic on site;

(E) a clinic or community health center that does not have a dental clinic on site; or

(F) a hospital outpatient department that does not have a dental clinic on site.

Services Not Covered

The department shall not pay for:

(1) anything not explicitly allowed pursuant to section 17b-262-697 of the Regulations of Connecticut State Agencies;

(2) information provided to the client over the telephone;

(3) cancelled visits or services not provided;

(4) any services provided by a public health dental hygienist free of charge to non-Medicaid clients;

(5) anything of an unproven, experimental or research nature, or for services in excess of those deemed medically necessary or medically appropriate by the department to treat a client's condition, or for services not directly related to the client's diagnosis, symptoms, or medical history; or

(6) any services provided by a public health dental hygienist in a dental office, a dental clinic or a location other than those set forth in section 17b-262-697(b)(5) of the Regulations of Connecticut State Agencies.

Section 17b-262-699

Payment Rate and Billing Procedure

(a) The provider may sign claims and bill directly and shall submit claims to the department in accordance with the procedures set forth in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to a public health dental hygienist.

(b) The commissioner shall establish the fees for dental hygienist services performed by the public health dental hygienist pursuant to section 4-67c of the Connecticut General Statutes;

(c) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the usual and customary charge;

(2) the amount billed by the provider to the department; or

(3) the amount in the applicable fee schedule as published by the department.

Section 17b-262-700

Documentation

(a) The provider shall maintain a client file that shall include, but not be limited to, the following information:

(1) identifying data:

(A) name of client;

(B) address;

(C) date of birth;

(D) gender; and

(E) Medicaid identification number;

(2) name, address, telephone number and license number of the public health dental hygienist responsible for the dental care;

(3) pertinent past and current health history of the client; and

(4) the medical record for the client.

(b) All notes and reports in the client' s medical record shall be type written or legibly written in ink or maintained electronically, dated and signed by the recording person with his or her full first name or first initial, surname and title. Electronic signatures shall be permissible in accordance with state and federal law.

(c) Each public health dental hygienist shall document action taken to:

(1) refer for treatment any client with needs outside the public health dental hygienist's scope of practice;

(2) coordinate such referral for treatment to dentists; and

(3) provide meaningful medical and dental information to dentists to whom clients are referred.

(d) For fluoride treatments provided to a client pursuant to section 17b-262-697(b)(2)(B)(i) of the Regulations of Connecticut State Agencies, the provider shall maintain documentation substantiating that the client is using radiology services as oncology treatment on a regular basis.

(e) All required documentation shall be maintained for at least five (5) years or longer as required by state or federal law in the provider's file and shall be subject to review by the authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, for five (5) years, or the length of time required by state or federal law, whichever is greatest.

(f) Failure to maintain and provide all required documentation to the department upon request may result in the disallowance and recovery by the department of any future or past payments made to the provider.

Appendix B – HUSKY B basic benefit package (Dental)

1. Preventive dental care, consisting of:
    a. oral exams and prophylaxis;
    b. fluoride treatments;
    c. sealants; and
    d. x-rays;
2. Diagnostic services, including:
    a. Digital dental radiography (DDR) or radiographs;
        i. complete series or panoramic radiograph;
        ii. bitewing films;
        iii. periapical films; and
        iv. occlusal films.
    b. Oral examinations;
        i. initial comprehensive oral examination
        ii. periodic oral examinations, once every six months; and
        iii. emergency oral examinations.
3. Endodontic services;
    a. pulpotomy or pulpectomy for primary or permanent teeth;
    b. root canal therapy in permanent dentition, including the placement of filling material; and
    c. An allowance of $50 per procedure, per enrollee, applies to endodontic services, but not more than an aggregate allowance for all such procedures of $250 per eligibility period; and
4. Oral Surgery, including, but not limited to:
    a. anesthesia, all forms;
    b. exodontia;
        i. simple extractions of primary and permanent dentition, including third molar exodontias.
            a). an allowance of $50 per procedure, per enrollee, applies to simple extractions, but not more than an aggregate allowance for all such procedures of $250 per eligibility period; and
        ii. surgical extractions of primary and permanent dentition, including impacted third molar exodontias;
    c. fracture reduction, closed and open methods;
    d. lesion and tissue removal;

i. soft tissue;

a). vestibuloplasty

ii. intra-osseus tissue;

e. reimplantation of tooth/teeth;

f. salivary gland procedures;

g. surgical procedures;

i. fistula closure;

ii. foreign-body excision;

iv. maxillary/mandibular osteotomy;

vi. sinusotomy;

v. tempromandibular joint; and

vi. transepital fibrotomy/resection;

h. surgery for trauma;

5. Orthodontics, including, but not limited to:

a. active treatment;

i. comprehensive orthodontia of the transitional and permanent dentition;

ii. interceptive orthodontia; and

iii. limited orthodontia of primary, permanent and transitional dentition;

b. appliances, fixed and removable;

c. diagnostic assessment; and

d. an allowance of $725 applies per enrollee;

6. Preventative services, including:

a. prophylaxis;

b. fluoride treatment for children under 19;

c. sealants for permanent dentition in premolars and molars that are free from non-incipient decay;

7. prosthodontic services, except for implants, associated attachments, abutments, and tooth associated restorations designed to fit in implants, including, but not limited to:

a. artificial crowns;

b. fixed partial dentures/bridgework; and

c. removable complete or partial maxillary and mandibular dentures;

d. an allowance of $50 per procedure, per enrollee, applies to prosthodontic services, but not more than an aggregate allowance for all such procedures of $250 per eligibility period; and

8. Restorative services, including:
    a. amalgam restorations;
    b. resin-based composite restorations;
    c. sedative fillings;
    d. temporary fillings; and

HUSKY B Co-payment requirements

1. Co-payments shall be charged for non-preventative dental visits excluding the following:
    a dental exams and prophylaxis;
    b x-rays;
    c fillings;
    d fluoride treatments; and
    e sealants.

HUSKY Plus Physical Dental benefit package:

Dental care and orthodontia for children who have malocclusive disorders or periodontal disease resulting from their underlying qualifying condition or related treatment;

Appendix C QUALITY 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 Dental Administrative Services Organization (ASO).

3. At its discretion and/or as required by the State Medicaid agency, the ASO'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 ASO 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 HCFA Medicaid Bureau's list of priority clinical and health service delivery areas of concern, the ASO monitors and evaluates quality of care through studies, which include, but are not limited to, the quality indicators also specified by the HCFA 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 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 ASO 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 ASO 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 ASO. 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 ASO. The committee or other structure has:

A. *Regular meetings* - 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 Clinical 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 ASO 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 ASO access to the medical records of their members.

Standard VIII: Delegation of QAP Activities

The ASO remains accountable for all QAP functions, even if certain functions are delegated to other entities. If the ASO 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 ASO.

B. The ASO 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 ASO demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. Written policy on enrollee rights

The ASO 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 ASO, 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 ASO 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 ASO 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 ASO 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 ASO acts to ensure that the confidentiality of the specified patient information and records is protected.

1. The ASO has established in writing, and enforced, policies and procedures on confidentiality of medical records.

2. The ASO 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 ASO 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 ASO has written policies regarding the appropriate treatment of minors.

K. *Assessment of member satisfaction* - The ASO 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 ASO reevaluates the effects of the above activities.

Standard X: *Standards for Availability and Accessibility*

The ASO 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 ASO 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 ASO 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 ASO 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 ASO 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 ASO 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 ASO 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 ASO 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 ASO has put a basic system in place which promotes continuity of care and case management.

Standard XIV: QAP Documentation

A. *Scope* - The ASO 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 ASO 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 ASO 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 ASO, such as: network changes, benefit redesign, medical management systems, practice feedback to providers, patient education and member services.

Schedule 1 - Facilities and Operations Expenses

8/1/2008 - 7/31/2009

Connecticut Facility Rent		
	7,000	square feet
	$ 17.00	per/ft sq
Total Rent	$ 119,000.00	
Security Deposit	$ 25,350.00	
Facility Repair & Maintenance	$ 17,850.00	
Utilities	included in rent	
Corporate Facility Rent		
	2,130	square feet
	$ 21.00	per/ft sq
Total Rent	$ 44,730.00	
Corp. Facility Repair & Maintenance	$ 6,709.50	
Utilities	included in rent	
Total Annual Rent	$ 189,080.00	
Total Annual Repair/Maintenace	$ 24,559.50	
Equipment & Operational Expenses		
Computer & IT Equipment	$ 113,250.00	
IT Maintenance & Repair	$ 16,987.50	
Copy Equipment	$ 5,200.00	
Copy Equipment R & M	$ 2,150.00	
Telecom Equipment	$ 85,000.00	
Telecom Usage	$ 65,000.00	
Telecome Maintanance	$ 4,250.00	
Data Communications	$ 5,000.00	
Equipment Rental	$ 8,500.00	
Other Equipment	$ 25,000.00	
Other Equipment Repair and Maintenance	$ 4,500.00	
Postage/Freight	$ 62,000.00	
Office Furniture	$ 80,000.00	
Software Expense	$ 22,000.00	
Software Maintenance	$ 5,500.00	
Accounting Services (Internal)	$ 10,000.00	
Consultants	$ 30,000.00	
Insurance (Other than health benefits)	$ 29,000.00	
Legal Services	$ 25,000.00	
Leasehold Improvements	$ 25,000.00	
Licenses	$ 5,000.00	
Lodging	$ 5,000.00	
Meals & Entertainment	$ 5,000.00	
Office Supplies	$ 19,000.00	
Off-site Tape Vaulting	$ 1,500.00	
Personnel Recruitment	$ 100,000.00	
Printing Costs	$ 35,000.00	
Professional Services(ie Tanslation)	$ 10,000.00	
Public Relations	$ 15,000.00	
Training		

Schedule 1 - Facilities and Operations Expenses

8/1/2008 - 7/31/2009

Transportation	$ 15,000.00
Travel	$ 90,000.00
Taxes	$ 32,000.00
Profit	$ 245,000.00
TOTAL OTHER DIRECT COSTS	$ 1,414,477.00
TOTAL STAFF & DIRECT COSTS	$ 4,132,127.00

INDIRECT COSTS	PMPM	Members	Per Month	Per year
QA Claims Review Data Processing	$ 0.34	410,000	$ 139,400.00	$ 1,672,800.00

Total Projct Costs Year One	$ 5,804,927.00

Schedule 1

Staffing

8/1/2008 - 7/31/2009

	Salaries	Direct Project Cost	Corporate Allocation	Total Costs	Direct FTE	Corporate FTE
Project Administration						
Corporate Dental Director	$ -	$ 25,000.00	$ 5,000.00	$ 30,000.00		0.20
Corporate Operations VP	$ -	$ 70,000.00	$ 14,000.00	$ 84,000.00		0.40
Project Director - Operations/Compliance	$ 150,000.00	$ 150,000.00	$ 30,000.00	$ 180,000.00	1.00	
Project Director - Care Coordination/Outreach	$ 150,000.00	$ 150,000.00	$ 30,000.00	$ 180,000.00	1.00	
Clinical Directors	$ 160,000.00	$ 40,000.00	$ 1,200.00	$ 41,200.00	0.25	
Support Staff	$ 50,000.00	$ -	$ -	$ -	0.00	
Fringe	--	$ 58,500.00		$ 58,500.00		
Total Project Administration		$ 493,500.00	$ 80,200.00	$ 573,700.00	2.25	0.60
Provider/Network Relations (PNR)						
Network Development Manager	$ 85,000.00	$ 85,000.00	$ 17,000.00	$ 102,000.00	1.00	
Provider Relations Manager	$ 65,000.00	$ 32,500.00	$ 6,500.00	$ 39,000.00		0.50
Provider Services Representatives	$ 40,000.00	$ 200,000.00	$ 40,000.00	$ 240,000.00	1.00	4.00
Other	--					
Fringe		$ 65,300.00		$ 65,300.00		
Total PNR		$ 382,800.00	$ 63,500.00	$ 446,300.00	2.00	4.50
Care Coordination/Mgt (CCM)						
Director/Manager	--					
Dental Health Care Specialists (DHCS)	$ 50,000.00	$ 350,000.00	$ 70,000.00	$ 420,000.00	7.00	
Other CCM Staff	$ 45,000.00	$ 45,000.00	$ 9,000.00	$ 54,000.00	1.00	
Fringe	--	$ 70,650.00	$ -	$ 70,650.00		
Total CCM		$ 465,650.00	$ 79,000.00	$ 544,650.00	8.00	0.00
Member Services (MS)						
Member Services Supervisor	$ 50,000.00	$ 50,000.00	$ 10,000.00	$ 60,000.00	1.00	
Member Services Call Center	$ 35,000.00	$ 280,000.00	$ 56,000.00	$ 336,000.00	8.00	
Member Service non Call Center	$ 30,000.00	$ 30,000.00	$ 6,000.00	$ 36,000.00	1.00	
Other Support Staff						
Fringe	--	$ 88,050.00	$ -	$ 88,050.00		
Total MS		$ 448,050.00	$ 72,000.00	$ 520,050.00	10.00	0.00
Quality Assurance (QA)						
Director/Manager	--					
QA Staff (Dental Consultants)	$ 160,000.00	$ -	$ -	$ -	0.00	0.00
QA Staff (Administrative)	$ 55,000.00	$ 55,000.00	$ 11,000.00		1.00	
Staff Training		$ 25,000.00	$ 3,750.00	$ 28,750.00		
Fringe	--	$ 11,850.00	$ -			
Total QA		$ 91,850.00	$ 14,750.00	$ 106,600.00	1.00	0.00
Data Reporting (DR)						
Director/Manager	--					
Staff	$ 45,000.00	$ 45,000.00	$ 9,000.00	$ 54,000.00	0.00	1.00
Fringe	--	$ 11,150.00	$ -	$ 11,150.00		
Total DR		$ 56,150.00	$ 9,000.00	$ 65,150.00	0.00	1.00
Information Systems (IS)						
Manager	$ 85,000.00	$ 85,000.00	$ 17,000.00	$ 102,000.00	1.00	
IS Programmer	$ 60,000.00	$ 120,000.00	$ 24,000.00	$ 144,000.00	1.00	1.00
IS Support Staff						
Fringe	--	$ 34,150.00	$ -	$ 34,150.00		
Total IS		$ 239,150.00	$ 41,000.00	$ 280,150.00	2.00	1.00
Utilization Management (UM)						
Director/Manager	--					
Statistical Consultant	$ 25,000.00	$ 25,000.00	$ 750.00	$ 25,750.00	0.00	1.00
Fringe	--	$ -		$ -		
Total UM		$ 25,000.00	$ 750.00	$ 25,750.00	0.00	1.00
Grievances & Appeals (GA)						
Manager	$ 55,000.00	$ 55,000.00	$ 11,000.00	$ 66,000.00		1.00

Staffing

8/1/2008 - 7/31/2009

	Salaries		Direct Project Cost	Corporate Allocation	Total Costs		Direct FTE	Corporate FTE
Support Staff	$ 35,000.00		$ 52,500.00	$ 10,500.00	$ 63,000.00			1.50
Fringe	--		$ 26,300.00	$ -	$ 26,300.00			
Total GA			$ 133,800.00	$ 21,500.00	$ 155,300.00		0.00	2.50
Other								
Security & Confidentiality Officer								
Other								
Fringe	--							
Total Other								
TOTAL			$ 2,335,950.00	$ 381,700.00	$ 2,717,650.00		25.25	10.60

Schedule 2 - Staffing

8/1/2009 - 7/31/2010

	Salaries	Direct Project Cost	Corporate Allocation	Total Costs	Direct FTE	Corporate FTE
Project Administration						
Corporate Dental Director	$ -	$ 26,250.00	$ 5,250.00	$ 31,500.00		0.10
Corporate Operations VP	$ -	$ 73,500.00	$ 14,700.00	$ 88,200.00		0.20
Project Director - Operations/Compliance	$ 157,500.00	$ 157,500.00	$ 31,500.00	$ 189,000.00	1.00	
Project Director - Care Coordination/Outreach	$ 157,500.00	$ 157,500.00	$ 31,500.00	$ 189,000.00	1.00	
Clinical Directors	$ 168,000.00	$ 42,000.00	$ 1,260.00	$ 43,260.00	0.25	
Support Staff	$ 52,500.00	$ -	$ -	$ -	0.00	
Fringe	--	$ 57,885.00		$ 57,885.00		
Total Project Administration		$ 514,635.00	$ 84,210.00	$ 598,845.00	2.25	0.30
Provider/Network Relations (PNR)						
Network Development Manager	$ 89,250.00	$ 89,250.00	$ 17,850.00	$ 107,100.00	1.00	
Provider Relations Manager	$ 68,250.00	$ 34,125.00	$ 6,825.00	$ 40,950.00		0.50
Provider Reps	$ 42,000.00	$ 210,000.00	$ 42,000.00	$ 252,000.00	1.00	4.00
Other	--					
Fringe		$ 65,965.00		$ 65,965.00		
Total PNR		$ 399,340.00	$ 66,675.00	$ 466,015.00	2.00	4.50
Care Coordination/Mgt (CCM)						
Director/Manager	--					
Dental Health Care Specialists (DHCS)	$ 52,500.00	$ 367,500.00	$ 73,500.00	$ 441,000.00	7.00	
Other CCM Staff	$ 47,250.00	$ 47,250.00	$ 9,450.00	$ 56,700.00	1.00	
Fringe	--	$ 70,982.50	$ -	$ 70,982.50		
Total CCM		$ 485,732.50	$ 82,950.00	$ 568,682.50	8.00	0.00
Member Services (MS)						
Member Services Manager	$ 52,500.00	$ 52,500.00	$ 10,500.00	$ 63,000.00	1.00	
Member Services Call Center	$ 36,750.00	$ 294,000.00	$ 58,800.00	$ 352,800.00	8.00	
Member Service non Call Center	$ 31,500.00	$ 31,500.00	$ 6,300.00	$ 37,800.00	1.00	
Other Support Staff						
Fringe	--	$ 88,452.50	$ -	$ 88,452.50		
Total MS		$ 466,452.50	$ 75,600.00	$ 542,052.50	10.00	0.00

Schedule 2 - Staffing

8/1/2009 - 7/31/2010

	Salaries	Direct Project Cost	Corporate Allocation	Total Costs	Direct FTE	Corporate FTE
Quality Assurance (QA)						
Director/Manager	--					
QA Staff (Dental Consultants)	$ 168,000.00	$ -	$ -	$ -	0.00	0.00
QA Staff (Administrative)	$ 57,750.00	$ 57,750.00	$ 11,550.00		1.00	
Staff Training		$ 25,000.00	$ 5,000.00	$ 30,000.00		
Fringe	--	$ 12,042.50	$ -			
Total QA		$ 94,792.50	$ 16,550.00	$ 111,342.50	1.00	0.00
Data Reporting (DR)						
Director/Manager	--					
Staff	$ 47,250.00	$ 47,250.00	$ 9,450.00	$ 56,700.00	0.00	1.00
Fringe	--	$ 11,307.50	$ -	$ 11,307.50		
Total DR		$ 58,557.50	$ 9,450.00	$ 68,007.50	0.00	1.00
Information Systems (IS)						
Manager	$ 89,250.00	$ 89,250.00	$ 17,850.00	$ 107,100.00	1.00	
IS Programmer	$ 63,000.00	$ 126,000.00	$ 25,200.00	$ 151,200.00	1.00	1.00
IS Support Staff						
Fringe	--	$ 34,657.50	$ -	$ 34,657.50		
Total IS		$ 249,907.50	$ 43,050.00	$ 292,957.50	2.00	1.00
Utilization Management (UM)						
Director/Manager	--					
Statistical Consultant	$ 26,250.00	$ 26,250.00	$ 787.50	$ 27,037.50	0.00	1.00
Fringe	--	$ -		$ -		
Total UM		$ 26,250.00	$ 787.50	$ 27,037.50	0.00	1.00
Grievances & Appeals (GA)						
Manager	$ 57,750.00	$ 57,750.00	$ 11,550.00	$ 69,300.00		1.00
Support Staff	$ 36,750.00	$ 55,125.00	$ 11,025.00	$ 66,150.00		1.50
Fringe	--	$ 26,615.00	$ -	$ 26,615.00		
Total GA		$ 139,490.00	$ 22,575.00	$ 162,065.00	0.00	2.50
Other						
Security & Confidentiality Officer						
Other						
Fringe	--					
Total Other						
TOTAL		$ 2,435,157.50	$ 401,847.50	$ 2,837,005.00	25.25	10.30

Schedule 2 - Facilities and Operations Expenses

8/1/2009 - 7/31/2010

Connecticut Facility Rent			
		8,450	square feet
	$	17.50	per/ft sq
Total Rent	$	147,875.00	
Facility Repair & Maintenance	$	22,181.25	
Utilities	included in rent		
Corporate Facility Rent			
		2,130	square feet
	$	22.00	per/ft sq
Total Rent	$	46,860.00	
Corp. Facility Repair & Maintenance	$	7,029.00	
Utilities	included in rent		
Total Annual Rent	$	194,735.00	
Total Annual Repair/Maintenace	$	29,210.25	
Equipment & Operational Expenses			
Computer & IT Equipment	$	45,000.00	
IT Maintenance & Repair	$	6,750.00	
Copy Equipment	$	5,200.00	
Copy Equipment R & M	$	2,150.00	
Telecom Equipment	$	-	
Telecom Usage	$	67,000.00	
Telecome Maintanance	$	4,250.00	
Data Communications	$	5,200.00	
Equipment Rental			
Other Equipment	$	5,000.00	
Other Equipment Repair and Maintenance	$	4,500.00	
Postage/Freight	$	64,000.00	
Office Furniture	$	1,500.00	
Software Expense	$	5,000.00	
Software Maintenance	$	5,500.00	
Accounting Services (Internal)	$	10,000.00	
Consultants	$	10,000.00	
Insurance (Other than health benefits)	$	22,000.00	

Schedule 2 - Facilities and Operations Expenses

8/1/2009 - 7/31/2010

Legal Services	$	10,000.00
Licenses	$	5,000.00
Lodging	$	5,200.00
Meals & Entertainment	$	5,200.00
Office Supplies	$	20,000.00
Off-site Tape Vaulting	$	1,600.00
Printing Costs	$	36,000.00
Professional Services(ie Tanslation)	$	10,500.00
Public Relations	$	15,000.00
Training		
Transportation	$	15,500.00
Travel	$	93,000.00
Taxes	$	32,000.00
Profit	$	245,000.00
TOTAL OTHER DIRECT COSTS	$	980,995.25
TOTAL STAFF & DIRECT COSTS	$	3,774,295.25

INDIRECT COSTS	PMPM	Members	Per Month	Per year
QA Claims Review				
Data Processing	$ 0.34	410,000	$ 139,400.00	$ 1,672,800.00

Total Projct Costs Year Two **$ 5,447,095.25**

Schedule 3 - Staffing

8/1/2010 - 7/31/2011

	Salaries	Direct Project Cost	Corporate Allocation	Total Costs	Direct FTE	Corporate FTE
Project Administration						
Corporate Dental Director	$ -	$ 25,000.00	$ 5,000.00	$ 30,000.00		0.10
Corporate Operations VP	$ -	$ 70,000.00	$ 14,000.00	$ 84,000.00		0.20
Project Director - Operations/Compliance	$ 165,375.00	$ 165,375.00	$ 33,075.00	$ 198,450.00	1.00	
Project Director - Care Coordination/Outreach	$ 165,375.00	$ 165,375.00	$ 33,075.00	$ 198,450.00	1.00	
Clinical Directors	$ 176,400.00	$ 44,100.00	$ 1,323.00	$ 45,423.00	0.25	
Support Staff	$ 55,125.00	$ -	$ -	$ -	0.00	
Fringe		$ 59,759.25		$ 59,759.25		
Total Project Administration		$ 529,609.25	$ 86,473.00	$ 616,082.25	2.25	0.30
Provider/Network Relations (PNR)						
Network Development Manager	$ 93,712.50	$ 93,712.50	$ 18,742.50	$ 112,455.00	1.00	
Provider Relations Manager	$ 71,662.50	$ 35,831.25	$ 7,166.25	$ 42,997.50		0.50
Provider Reps	$ 44,100.00	$ 220,500.00	$ 44,100.00	$ 264,600.00	1.00	4.00
Other						
Fringe		$ 66,663.25		$ 66,663.25		
Total PNR		$ 416,707.00	$ 70,008.75	$ 486,715.75	2.00	4.50
Care Coordination/Mgt (CCM)						
Director/Manager						
Dental Health Care Specialists (DHCS)	$ 55,125.00	$ 330,750.00	$ 66,150.00	$ 396,900.00	6.00	
Other CCM Staff	$ 49,612.50	$ 49,612.50	$ 9,922.50	$ 59,535.00	1.00	
Fringe		$ 63,331.63	$ -	$ 63,331.63		
Total CCM		$ 443,694.13	$ 76,072.50	$ 519,766.63	7.00	0.00
Member Services (MS)						
Member Services Manager	$ 55,125.00	$ 55,125.00	$ 11,025.00	$ 66,150.00	1.00	
Member Services Call Center	$ 38,587.50	$ 308,700.00	$ 61,740.00	$ 370,440.00	8.00	
Member Service non Call Center	$ 33,075.00	$ 33,075.00	$ 6,615.00	$ 39,690.00	1.00	
Other Support Staff						
Fringe		$ 88,875.13	$ -	$ 88,875.13		
Total MS		$ 485,775.13	$ 79,380.00	$ 565,155.13	10.00	0.00

Schedule 3 - Staffing

8/1/2010 - 7/31/2011

	Salaries	Direct Project Cost	Corporate Allocation	Total Costs	Direct FTE	Corporate FTE
Quality Assurance (QA)						
Director/Manager						
QA Staff (Dental Consultants)	$ 176,400.00	$ 132,300.00	$ 26,460.00	$ 158,760.00	0.75	0.00
QA Staff (Administrative)	$ 60,637.50	$ 60,637.50	$ 12,127.50		1.00	
Staff Training		$ 25,000.00	$ 5,000.00	$ 30,000.00		
Fringe		$ 12,244.63	$ -			
Total QA		$ 230,182.13	$ 43,587.50	$ 273,769.63	1.75	0.00
Data Reporting (DR)						
Director/Manager						
Staff	$ 49,612.50	$ 49,612.50	$ 9,922.50	$ 59,535.00	0.00	1.00
Fringe		$ 11,472.88	$ -	$ 11,472.88		
Total DR		$ 61,085.38	$ 9,922.50	$ 71,007.88	0.00	1.00
Information Systems (IS)						
Manager	$ 93,712.50	$ 93,712.50	$ 18,742.50	$ 112,455.00	1.00	
IS Programmer	$ 66,150.00	$ 132,300.00	$ 26,460.00	$ 158,760.00	1.00	1.00
IS Support Staff						
Fringe		$ 35,190.38	$ -	$ 35,190.38		
Total IS		$ 261,202.88	$ 45,202.50	$ 306,405.38	2.00	1.00
Utilization Management (UM)						
Director/Manager						
Statistical Consultant	$ 27,562.50	$ 27,562.50	$ 826.88	$ 28,389.38	0.00	1.00
Fringe		$ -		$ -		
Total UM		$ 27,562.50	$ 826.88	$ 28,389.38	0.00	1.00
Grievances & Appeals (GA)						
Manager	$ 60,637.50	$ 60,637.50	$ 12,127.50	$ 72,765.00		1.00
Support Staff	$ 38,587.50	$ 57,881.25	$ 11,576.25	$ 69,457.50		1.50
Fringe	--	$ 26,945.75	$ -	$ 26,945.75		
Total GA		$ 145,464.50	$ 23,703.75	$ 169,168.25	0.00	2.50
Other						
Security & Confidentiality Officer						
Other						
Fringe	--					
Total Other						
TOTAL		$ 2,601,282.88	$ 435,177.38	$ 3,036,460.25	25.00	10.30

Schedule 3 - Facilities and Operations Expenses

8/1/2010 - 7/31/2011

Connecticut Facility Rent			
		8,450	square feet
	$	18.00	per/ft sq
Total Rent	$	152,100.00	
Facility Repair & Maintenance	$	22,815.00	
Utilities	included in rent		
Corporate Facility Rent			
		2,130	square feet
	$	23.00	per/ft sq
Total Rent	$	48,990.00	
Corp. Facility Repair & Maintenance	$	7,348.50	
Utilities	included in rent		
Total Annual Rent	$	201,090.00	
Total Annual Repair/Maintenace	$	30,163.50	
Equipment & Operational Expenses			
Computer & IT Equipment	$	35,000.00	
IT Maintenance & Repair	$	5,250.00	
Copy Equipment	$	5,200.00	
Copy Equipment R & M	$	2,150.00	
Telecom Equipment	$	-	
Telecom Usage	$	70,000.00	
Telecome Maintanance	$	4,250.00	
Data Communications	$	5,500.00	
Equipment Rental			
Other Equipment	$	5,500.00	
Other Equipment Repair and Maintenance	$	4,500.00	
Postage/Freight	$	66,000.00	
Office Furniture	$	1,500.00	
Software Expense	$	5,000.00	
Software Maintenance	$	5,500.00	

Schedule 3 - Facilities and Operations Expenses

8/1/2010 - 7/31/2011

Accounting Services	$	10,000.00
Consultants	$	10,000.00
Insurance (Other than health benefits)	$	22,000.00
Legal Services	$	10,000.00
Licenses	$	5,000.00
Lodging	$	5,400.00
Meals & Entertainment	$	5,400.00
Office Supplies	$	22,000.00
Off-site Tape Vaulting	$	1,700.00
Printing Costs	$	38,000.00
Public Relations	$	15,000.00
Training		
Transportation	$	16,000.00
Travel	$	96,000.00
Unamortized Leasehold Improvements	$	70,000.00
Taxes	$	32,000.00
Profit	$	245,000.00
TOTAL OTHER DIRECT COSTS	$	1,050,103.50
TOTAL STAFF & DIRECT COSTS	$	4,086,563.75

INDIRECT COSTS (Explain)		PMPM	Members	Per Month	Per year
QA Claims Review					
Data Processing	$	0.34	420,000	$ 142,800.00	$ 1,713,600.00
Total Projct Costs Year Three	**$**	**5,800,163.75**			

ACCEPTANCES AND APPROVALS

Documentation necessary to demonstrate the authorization to sign must be attached.

CONTRACTOR

Dental Benefit Management, Inc. d/b/a BeneCare
Contractor *(Corporate/Legal Name of Contractor)*

11 / 14 / 08
Authorized Official *(Signature)* Date

Vice President
Title

DEPARTMENT OF SOCIAL SERVICES

for Michael P. Starkowski 11/18/08
MICHAEL P. STARKOWSKI, *Commissioner* Date

OFFICE OF THE ATTORNEY GENERAL

/ 11 / 24/08
ASST./ASSOC. ATTORNEY GENERAL (Approved as to form & legal sufficiency)
Date

ASSOC. ATTY. GENERAL